A Newsletter Dealing with Obsessive Compulsive Disorder

THE OCD FOUNDATION OF MICHIGAN

NEVER say NEVER

Fall 2020/Winter 2021

Thinking About Our Thoughts

As we noted in the last issue of this newsletter, the International OCD Foundation (IOCDF) last year held its Annual Conference virtually, entirely online. In that issue, we reviewed two of the presentations from that weekend. In this issue of ***Never Say Never***, we will discuss three more presentations from last year's conference. The IOCDF will be holding its 2021Conference live in New York on July 9-11, and remotely October 8-10. The virtual event makes attendance much more affordable, hopefully within the reach of many, many more of you, and we do strongly recommend that you take advantage of this opportunity.

Also in this issue you will find a couple of articles that we found particularly thought-provoking, literally alternative ways of thinking about our thoughts. We hope you find them as intriguing as we did.

Proposed New Support Groups

In response to the many requests we receive for support groups for family, children/teens, and spouse/partner/significant other, we are currently looking into adding groups to focus on these needs. When we have attempted this in the past, such groups turned out not to be sustainable because of low or no attendance. Now that our support groups are meeting remotely on Zoom, we feel we might have the flexibility to make these work. This can be accomplished in different ways, and we will be soliciting your input. We can have completely separate groups meeting on different days and times, or we can incorporate them into our existing groups, breaking out into subgroups for separate discussion. How would you like to see this done? You can let us know by e-mailing your thoughts to OCDmich@aol.com or calling our voicemail at (734) 466-3105.

INTRODUCING
Our new logo

Tell us what you think

THE OCD FOUNDATION OF MICHIGAN

THE OCD FOUNDATION OF MICHIGAN

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a 501(c)(3) non-profit organization.

To submit articles or letters, write or e-mail the OCDFM at the above addresses.

LIST OF SELF-HELP GROUPS

ANN ARBOR:
1st Thursday, 7-9 PM
St. Joseph Mercy Hospital Ann Arbor
Ellen Thompson Women's Health Center
Classroom #3
(in the Specialty Centers area)
5320 Elliott Drive, Ypsilanti, MI
Call Bobbie at (734) 522-8907 or (734) 652-8907
E-mail OCDmich@aol.com

DEARBORN:
2nd Thursday, 7-9 PM
First United Methodist Church
22124 Garrison Street (at Mason)
In the Choir Room (enter under back stairs)
Call Bobbie at (734) 522-8907 or (734) 652-8907
E-mail OCDmich@aol.com

FARMINGTON HILLS:
1st and 3rd Sundays, 1-3 PM
BFRB Support Group
Body-Focused Repetitive Behaviors
Trichotillomania and Dermatillomania
(Hair-pulling and Skin-picking)
Beaumont Hospital Botsford Campus
Administration & Education Center, Classroom C
28050 Grand River Ave. (North of 8 Mile)
Call Bobbie at (734) 522-8907 or (734) 652-8907
E-mail rslade9627@aol.com

GRAND RAPIDS:
Old Firehouse #6
312 Grandville SE
Call the Anxiety Resource Center
(616) 356-1614
www.anxietyresourcecenter.org

Anxiety Disorders
Meets every Wednesday, 4:30 to 5:30 pm and
7 to 8:30 pm (two groups offered at this time to keep group size smaller)
A weekly support group open to anyone who has an anxiety problem (including trichotillomania and Obsessive-Compulsive Disorder).

Teen Anxiety Disorders
Meets every Wednesday, 4:30 to 5:45 pm
A weekly support group open to teens aged 14-18 who have an anxiety problem.

Open Creative Time
1st Wednesday, 6:00 to 7:00 pm
Take your mind off your worries by being creative. Bring a project to work on or enjoy supplies that are available at the ARC.

Social Outing Groups
Offered once a month.
Dates and times change.
Check the ARC website for current listings.

LANSING:
1st Monday, 7-8:30 PM
Delta Presbyterian Church
6100 W. Michigan
Call Jon at (517) 944-0477
E-mail jvogler75@comcast.net

LAPEER:
DISCONTINUED

PETOSKEY:
DISCONTINUED

ROYAL OAK:
NOW, TWICE A MONTH!
1st and 3rd Wednesdays, 7-9 PM
Beaumont Hospital, Administration Building
3601 W. Thirteen Mile Rd.
Use Staff Entrance off 13 Mile Rd.
Follow John R. Poole Drive to Administration Building
Park in the South Parking Deck
Meets in Private Dining Room
(If the building is locked, press the Security button next to the door, tell them you are there for a meeting, and they will buzz you in.)
Call Kevin at (248) 302-9569
E-mail kevinkuhn2015@gmail.com

DUE TO COVID-19, GROUPS ARE NOT MEETING LIVE

MANY OF OUR GROUPS ARE MEETING REMOTELY ON ZOOM

For connection information, contact the group leaders or e-mail OCDmich@aol.com

Oh, The Controversy! That's Not Me, That's My OCD

by Jon Hershfield

(Jon Hershfield is the Director of The OCD and Anxiety Center of Greater Baltimore and a specialist in the treatment of OCD and related disorders. In this article, he addresses the struggle many sufferers face about distinguishing between personal thoughts and "OCD thoughts." By owning all of our thoughts, we are then free to disown the mental rituals and other compulsions that cause us to suffer.)

How can we view our most disturbing thoughts as our own without getting caught up in false beliefs about who we are as people?

A common approach to the treatment of OCD is to encourage externalizing of the disorder and attributing unwanted thoughts to this external source.

This can be particularly effective for children, who may not have the cognitive abilities to make abstract distinctions between one's self and one's thoughts or feelings. The idea of relabeling thoughts as "OCD thoughts" was popularized by the groundbreaking book ***Brain Lock*** by Jeffrey Schwartz. Though this book offers an excellent comprehensive look at the way OCD operates in the brain, as well as a treatment approach that many have found useful, I believe the act of labeling one's thoughts as "OCD thoughts" and attributing their existence exclusively to the disorder may be inherently problematic for many OCD sufferers.

If we want to make a clear distinction between a thought and the identity of the person having it, we are better off viewing all thoughts as thoughts, rather than attributing some to a disorder and some to an identity. The question is, how can we view our most challenging or disturbing thoughts as our own without getting caught up in false beliefs about who we are as people? Here I think we can benefit from distinguishing between content and process.

Content vs Process

Content refers to the words and images that make up your thoughts. If you could print the thought out and look at it as a series of words, what would those words be? Mindfulness, the ability to observe internal experiences without judgment, very much asks us to do just this, to look at our thoughts as we look at words on a page. The content of the thought is merely what the thought is comprised of, like ingredients are the content of a soup.

Process, on the other hand, refers to how we taste, experience, and think about the soup and the chef who made it. One person may say the soup is delicious and applaud the chef and another may say the soup is disgusting and admonish the chef, but this is independent from the veracity of whether the soup contains carrots.

People with OCD may be predisposed to perceive certain thoughts as threats, mandates to do compulsions, or evidence that they have done something wrong. Someone without OCD might take the same thought content and process it as meaningless background chatter or junk mail. In other words, OCD sufferers process their experiences in an OCD way, but the content itself is not unique to the disorder.

Let's look at some examples. I happen to be writing this blog while on an airplane. "Airplanes are busses with wings and full of germs, which can spread disease." What is this? It is a thought. What else can we say about it? Well, it may be true, it may be an opinion, it may be a cynical way of looking at a situation. Is it an "OCD" thought? If you have contamination OCD, you might assume so. You might figure no one would think such a thing if they didn't have OCD. But nothing in the thought itself is all that controversial or even interesting.

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Now let's add a process to it. Imagine taking the thought and integrating it with another thought like, "I have to make sure I don't touch anything and I must use hand sanitizer regularly." Now the content of "germs" takes on a value. Consider that another way of processing the same content could be "Well, so be it, but at least I get to travel and that's awesome." What if we further built on the first process by adding anxiety, self-criticism, increased heart rate, shortness of breath and a powerful urge to check, avoid and wash? Sound familiar? That's OCD! So here saying, "That's my OCD" may actually be really helpful because it may lead to a change away from compulsive behavior. "That's OCD junk and I'm better off leaving it alone. Let's see what the in-flight movie options are." The thought about planes being germy is not "OCD" but the processing of that thought towards compulsive behavior is.

Another example, picture yourself standing on a train platform. In front of you is a child and you think, "I'd enjoy pushing that child off the platform and watching it get hit by a train." Now, presuming you don't have an illustrious history of murdering people, you might find this thought pretty disturbing. It represents pretty much the opposite of your identity. What is the content? The content is the idea of pushing a child to his/her death. Who thought it? You did (literally, you the reader just thought it too). Now, what is the process? Well, you could process the thought in an OCD way and say something like, "I shouldn't have had that thought. Only horrible people think that way. I have to back away from the child because I must be some kind of a sicko and it would be immoral to ignore this horrible thought." Or you could process it in a healthy way, as in, "Well, that's creative."

Owning Your Thoughts

So what's the real problem with just calling all thoughts with the word "germs" or "death" in it "OCD thoughts"? The problem lies in the dis-ownership of thoughts. And yes, this applies equally to thoughts like "I want to have sex with an animal" or "I love Satan" or "I'm in denial about loving my wife" or "I may have touched someone inappropriately and not remember" or "I may never stop thinking about blinking" and so on…

Owning your thoughts does not mean assuming the thoughts are a reflection of your identity. Owning your thoughts simply means accepting that these are the thoughts going on in your head. Perhaps you process these thoughts in an "OCD way" (i.e. you take them too seriously and assume they deserve urgent responses) and in that case, it's fine to say that it's your OCD that's upsetting you. But the thought itself is not an "OCD thought." The thought itself is simply a thought.

If your first response to any thought is to disown it (i.e. "that's not my thought"), then you are starting off by framing your thought as a threat and this is what kicks off the obsessive-compulsive loop. There is nothing to disown. It's just what you happened to notice going on in the mind. If you want thoughts to stop being intrusive, you have to stop treating them like they are intruders. If you want them to come and go with ease, you have to allow them free passage.

The OCD sufferer is a noticer, a person who notices things that others overlook. It is a gift when it comes to noticing greatness in music or art, when noticing the little things that make our loved ones so lovable, or noticing the revealing details in complex problems that we solve at work. It is a burden when noticing that someone touched their nose before shaking our hand, or noticing that one mistake on the road could lead to a terrible accident, or noticing that we can't remember with perfect certainty where we were an hour ago and might have done something shameful.

But the point is we notice our thoughts, the delightful ones and the sinister ones, and they are undeniably ours to notice. If we attribute their mere existence to a mental disorder, we tell ourselves a lie about the nature of

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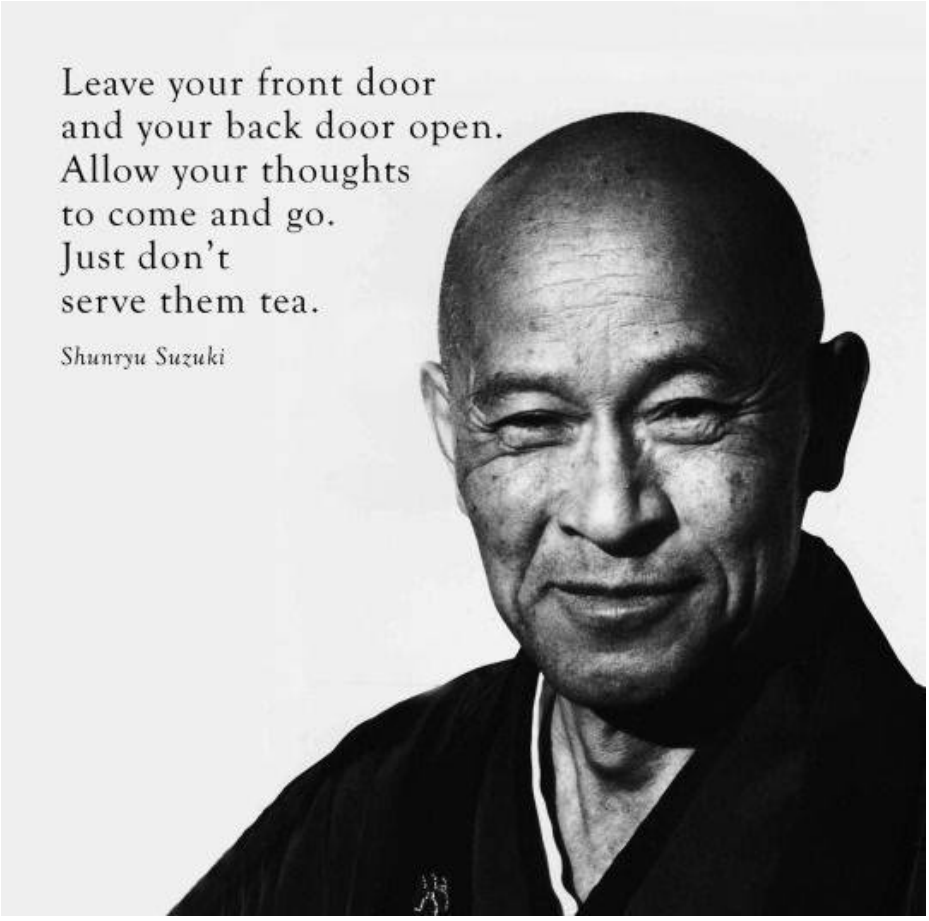
thoughts, and that puts us at a disadvantage when fighting the disorder. Plus we open ourselves up to so much unnecessary self-criticism for having too many "OCD thoughts" and not enough "good" thoughts of our own.

If I stand at a window, I am likely to notice a thought about jumping out of it. These are my thoughts. That is how I think. And the less I mind this, the more open and available I am to the arrival of thoughts about the beauty of the sunset outside that window. Mindfulness is not minding. But if I begin to worry about why I had these thoughts and whether they will lead to horrific ends, then that is my OCD and that is what I would want to change. Developing mastery over OCD is all about learning to love having a mind like an hd 3d imax screen, full of texture and color, regardless of what is being projected on it. By owning all of our thoughts, we are then free to disown the mental rituals and other compulsions that cause us to suffer. That's not you. That's your OCD.

Jon Hershfield is the Director of The OCD and Anxiety Center of Greater Baltimore and a specialist in the treatment of OCD and related disorders. He has previous experience as the Associate Director of the UCLA Pediatric OCD Intensive Outpatient Program and as a Psychotherapist for the OCD Center of Los Angeles.

This article came from the website Made of Millions, and can be found here: https://www.madeofmillions.com/articles/oh-controversy-thats-not-thats-ocd



OCD is Fake News

by Tom Corboy, MFT, and Lauren McMeikan, MFT

(Ed note. This is a blog post from the OCD Center of Los Angeles dated September 9, 2017. It can be found at www.ocdla.com/ocd-fake-news-5740. rs)

By now, virtually anyone with even a passing interest in politics and current events has heard the term *"fake news"*. If you haven't heard this term, just turn on a cable news channel on any given day and you are bound to hear a news story (or ten) about how we are being inundated with fake news that is designed to alter our political beliefs (and our votes). Regardless of your political persuasion, a Google search of the term "fake news" will lead you to a multitude of articles that describe somebody (or some country) that is presenting reality in a distorted fashion in an attempt to persuade you to see things their way. So what does this have to with Obsessive Compulsive Disorder (OCD)? Allow us to explain…

The writers and producers of fake news stories manipulate reality, sometimes by taking facts out of context, and other times by entirely fabricating story details (i.e., lying). Fake news stories always build their narrative on what can most charitably be called *"unsubstantiated claims"*. But even a cursory examination of these claims would lead any objective observer to conclude that these stories are at best misleading, and at worst, utterly untrue. The stories aren't backed up by facts, but they sound just real enough to seem feasible.

And this is exactly what OCD does – it offers up scary thoughts for which there is no factual support, yet which appear plausible enough to lead one to believe that they may actually be true. OCD takes unimportant thoughts that occur in one's mind completely out of the context of the real world and who the individual actually is as a person, and fabricates nightmarish scenarios (i.e., obsessions) that are not even remotely based in reality. But because these obsessive thoughts initially manifest in the sufferer's own mind, they seem realistic, even though there is no compelling evidence to support them. In other words, OCD is fake news written, produced and directed by your own wayward brain.

OCD is a condition in which an individual is barraged by repeated, unwanted, intrusive thoughts that cause the sufferer to experience extreme anxiety. These thoughts often focus on issues that the individual views as terrifying threats to either their well-being or their self-image. Some typical OCD obsessions include:

"What if I have been exposed to a horrible virus like AIDS."
"What if I forgot to turn off the stove and the house burns down."
"What if my sexual orientation is not what I want it to be."
"What if I molested my child."
"What if I am a killer."
"What if I committed a terrible sin."
"What if I don't really love my spouse."

But here's the thing about these thoughts – *they are just ideas that the OCD sufferer's brain makes up*. Of course, there actually are killers and pedophiles in the world, and some people really do get AIDS, and sometimes people do accidentally burn down their house. But for those struggling with OCD, these unwanted thoughts are just baseless obsessions that pop into the sufferer's head, and which they believe may be true, despite all evidence to the contrary. It's as if they have been exposed to a fake news story about

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themselves, and they have bought it, lock, stock and barrel.

So how does this happen? How is it that people come to believe something for which there is absolutely no evidence whatsoever?

The Brain is a Machine For Jumping to Conclusions

In his book ***Thinking, Fast and Slow***, Nobel-prize winning economist Daniel Kahneman describes the human brain as being *"a machine for jumping to conclusions"*. He writes how humans have two types of thinking. System 1 thinking is fast, automatic, intuitive…*and frequently wrong!* It is thinking on autopilot, in which we make quick decisions based on the limited information we have available at any given moment. System 1 thinking serves us well in that it provides a cognitive shortcut that helps us to quickly evaluate threats so that we can protect ourselves. For example, if a woman is walking alone down a dark street late at night and sees a group of young men up ahead, she probably won't spend a lot of time rationally analyzing the situation – her System 1 thinking will just signal *"potential threat!"* and she'll likely take action by crossing the street, or quickly getting into her car, or dodging into a local building.

Conversely, System 2 thinking is slow, deliberative, and rational…and usually more accurate. It's how we would ideally approach any situation – by thinking it through and making a logical evaluation. But we naturally seek the quick fix provided by System 1 thinking. It's just simpler and quicker, and can be really helpful in a pinch. Unfortunately, it's oftentimes wrong. Most of the guys you see up ahead on a dark street are not a threat – they're just trying to get home, like you.

Fake News, Instinct and The Pleasure Principle

Why do we engage in System 1 thinking if we rationally know that it is frequently inaccurate? In a word: *instinct*. It's automatic! System 1's quick judgments keep us safe from threats and lead us toward rewards. System 1 thinking operates in alignment with one of psychology's foundational precepts, the *"pleasure principle"*, which postulates that we instinctually seek pleasure and avoid pain. We don't generally put a lot of mental effort into figuring out why we don't like pain – we just instinctually avoid it because it doesn't feel good. That's the pleasure principle in action.

And so, when a painful, unwanted thought appears in the consciousness of the OCD sufferer, they don't react with well-reasoned System 2 logic. Instead, their System 1 thinking senses a threat and kicks into gear. Their brain quickly jumps to the conclusion that this unpleasant, uncomfortable thought must mean something terribly important. After all, the thought is present in their consciousness. Why would it be there unless it meant something important? And because the thought's content is scary, the sufferer's brain instinctually puts the pleasure principle into practice and tries to get rid of it.

But the truth is that <u>everybody</u> has all sorts of bizarre thoughts that don't mean much of anything. We all daydream and fantasize about all sorts of weird things that we would never do in real life. And we all have unexpected thoughts that don't reflect our actual intentions. Nevertheless, System 1 thinking often leads the OCD sufferer to believe that their strange thoughts are extremely important, and that they must be addressed and resolved *as quickly as possible*. And if there's one thing that System 1 thinking is good at, it's coming up with quick, albeit often bad, answers.

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For example, if I am on the 405 freeway on a hot summer afternoon during rush hour, and someone cuts me off in order to gain an extra 20 feet of asphalt ahead of me, I may have a passing thought about killing the guy. That doesn't mean I actually want to kill him – it means I am frustrated by the mercilessly slow LA traffic, and I am having a less than stellar emotional response to someone cutting me off.

While those without OCD will quickly write off this type of thought as being ridiculous, a person with Harm OCD may just as quickly jump to the conclusion that this thought must mean something important about their character and intent. We have treated people with these types of harming thoughts who have stopped driving entirely because they feared they would willfully kill someone on the road. Likewise, we have treated new moms with Postpartum OCD who won't change their infant child's diaper for fear that they will molest them. And we have treated many others with HOCD who won't spend time with members of the same sex because they fear they will act on random thoughts they have had about being gay.

In all of these cases, the thoughts were *ego-dystonic*, meaning that they were inconsistent with the individual's true character, values and desires. In fact, those with OCD are often most tormented precisely because their obsessive thoughts are diametrically opposed to how they see themselves and who they really are. The mere presence of these thoughts in their minds tortures them, despite the fact that their experience over time very clearly indicates that these thoughts are not in any way a reflection of who they actually are, or what they want. But once fake news is presented to the brain, the sufferer immediately jumps to the conclusion that these thoughts reflect who they really are, even though the only "evidence" they have to support this conclusion is a thought that made them extremely uncomfortable.

System 1 Thinking and The Obsessive Compulsive Cycle

OCD starts when System 1 thinking runs amok. As the pleasure principle dictates, we instinctually want to avoid discomfort, and compulsive behaviors are an overzealous attempt to do just that as quickly as possible. It is an unreliable, disproportionate response that makes OCD get worse, not better. The process goes something like this:

1) An uncomfortable thought (i.e., an obsession, aka fake news) presents itself to you.

2) System 1 thinking quickly (and incorrectly) leads you to believe that this thought is a significant threat, which in turn leads you to feel anxious,

3) The pleasure principle dictates that you take action against this supposed threat and the unpleasant emotional state of anxiety that comes with it.

4) In an effort to proactively address this threat, you choose to do a behavior (i.e., a compulsion) that you hope will eliminate or at least reduce the threat and the related anxiety.

5) This behavior works in the short-term – your distress is reduced.

6) Unfortunately, this success reinforces the idea that the thought was indeed a significant threat (even though it was just a thought), and that the best way to deal with the anxiety that this kind of thought produces is to take swift action to eliminate it.

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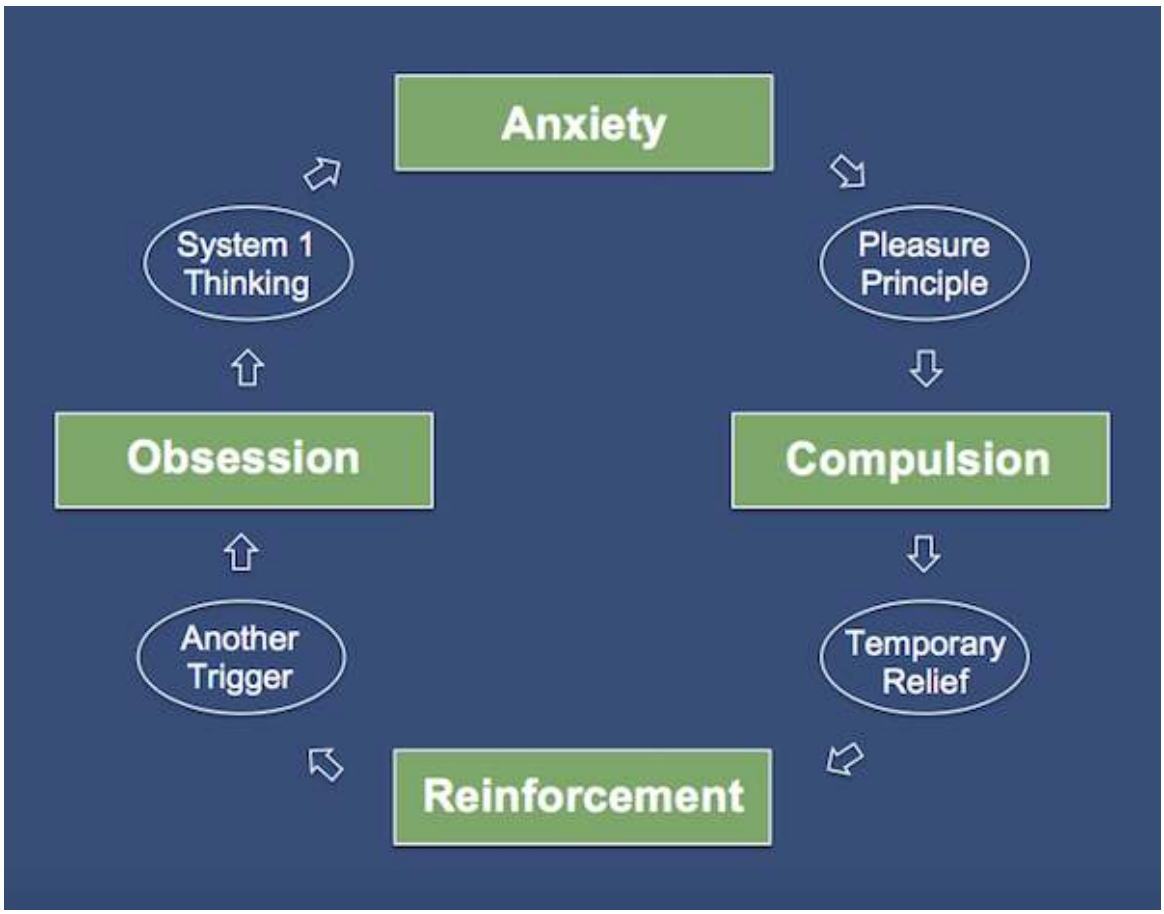
7) The next time this, or a similar, anxiety-provoking thought arises in your consciousness, your System 1 thinking quickly remembers that the compulsive behavior worked before, and you once again do that behavior, or some other equally counterproductive behavior.

8) Again, the behavior works…in the short-term. The cycle continues, ad infinitum.

Basically, OCD is like a dog chasing its tail – lots of work going around in circles, never actually catching the object of its pursuit. This tail-chasing process is known as the Obsessive Compulsive Cycle, and can be conceptualized like this:



We would be far better off if we did not over-react to our thoughts, but instead chose to tolerate our discomfort in the short-term, thus giving us the opportunity to discover that it is, in fact, quite tolerable. Then we could use System 2 thinking to logically pursue a more viable response to it. If we were to instead use system 2 thinking, the process would go something like this:

1) An uncomfortable thought (i.e., an obsession, aka fake news) presents itself to you.

2) System 2 thinking leads you to rationally consider the thought's importance.

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3) You are likely to feel some anxiety, but it is less intense and more manageable.

4) Because of the pleasure principle, you might be tempted to run from even this reduced amount of anxiety. But because you are using System 2 thinking, you have the capacity to make a different choice.

5) Instead of doing compulsions, you choose to sit with your discomfort until it naturally dissipates or even disappears completely.

6) When you sit with the discomfort instead of over-responding to it, you eliminate the reinforcement that has been feeding your anxiety. As a result, your anxiety decreases even more.

7) You eventually are faced with another trigger. This is normal. Triggers happen. There is no way to get through life without being exposed to things that trigger you.

8) Your brain responds to the trigger by generating more uncomfortable thoughts (i.e., obsessions). This too is normal. Uncomfortable thoughts are a natural part of the human experience. But you are now getting better at quickly switching to System 2 thinking. As a result, you feel less anxious and you do fewer compulsions. You are learning a new, more effective way of responding to your unwanted thoughts.

When using System 2 thinking, your thought process looks something like this:

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Words of Wisdom

"You don't have to control your thoughts; you just have to stop letting them control you." - *Dan Millman*

"We believe we own our thoughts and have to do something about them, especially if they are negative. This is bound to create suffering." - Ayya Khema, "Be an Island"

"Don't believe everything you think. Thoughts are just that - thoughts."
- Allan Lokos

"If you are distressed by anything external, the pain is not due to the thing itself, but to your estimate of it; and this you have the power to revoke at any moment.
- Marcus Aurelius

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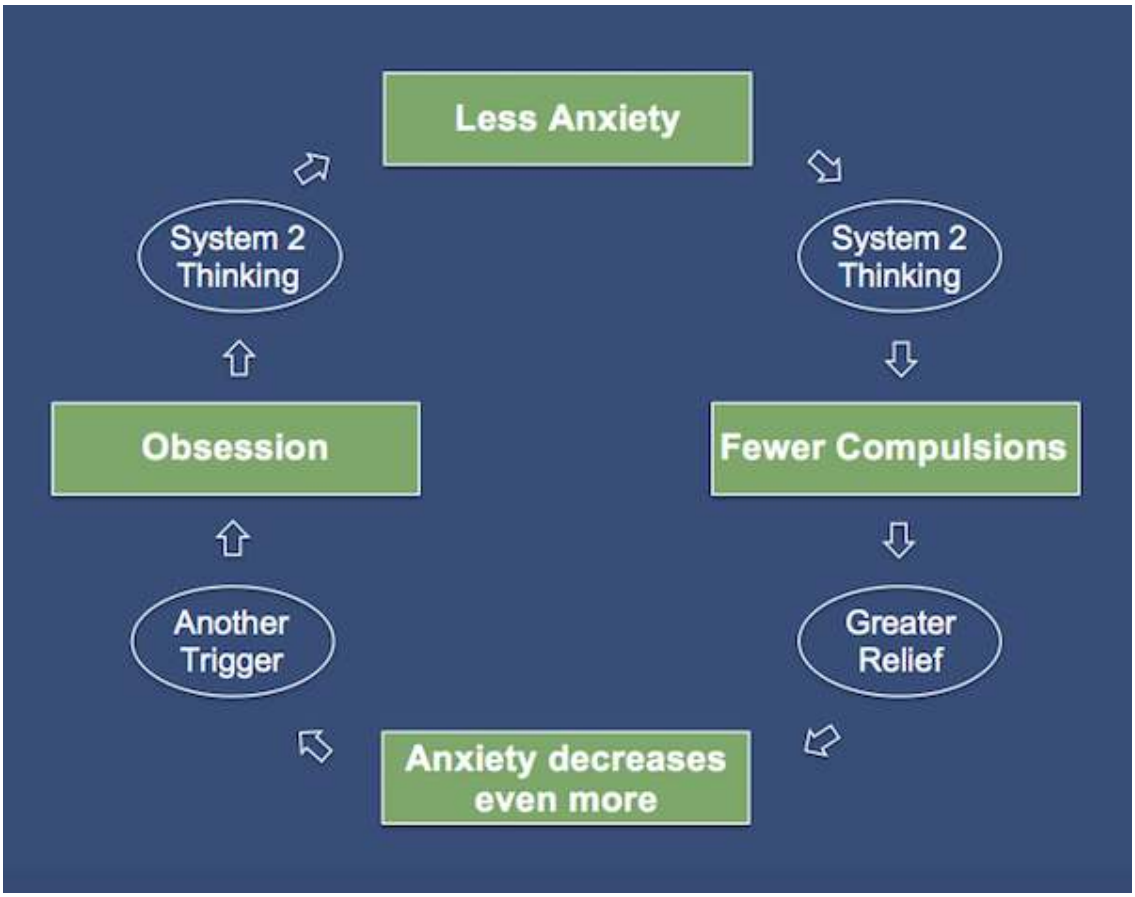

When we use System 2 thinking, and give ourselves the opportunity to tolerate discomfort related to unwanted thoughts, we learn four important lessons.

1) The feared event almost never occurs. For example, you are highly unlikely to purposely kill another driver on the road. Yes, some people do kill others in a fit of road rage, but the great majority of people don't.

2) The anxiety almost always goes down all by itself. Just by sitting with the discomfort, it dissipates – often quite quickly.

3) If the feared situation or event actually does come to pass, it is not necessarily catastrophic. You may get a disease from a dirty doorknob, but it is more likely to be a common cold, not AIDS.

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4) You are far more capable of tolerating the anxiety than you think.

This last point is the most important lesson. You are unlikely to ever *like* feeling anxiety, but if you let yourself feel it without over-reacting, you will become far better at tolerating it. And in so doing, you will break the Obsessive Compulsive cycle that directly feeds your OCD. Simply put, the goal is to become more comfortable with your discomfort so that your actions can serve you, your goals, and your values, instead of serving to compulsively quiet your anxiety.

Over-Reacting to Obsessions

Another way to conceptualize OCD is to see it as a three-step process of over-reacting to thoughts that are not particularly important or meaningful.

Step one in this process is to **over-attend** to one's thoughts. People with OCD tend to pay way too much attention to their thoughts, going so far as to actively monitor their thinking in an effort to see if their unwanted thoughts are still present, and whether or not those thoughts continue to upset them. Conversely, people without OCD spend virtually no time at all analyzing their thoughts or their reactions to those thoughts.

Step two is to **over-value** one's thoughts. This is where System 1 thinking rears its ugly head. Those struggling with OCD assign meaning and import to what are arguably meaningless, unimportant thoughts. Everybody thinks crazy stuff, but people without OCD laugh off the weird things that pass through their minds, while those with OCD often take their weird thoughts very seriously. Remember, OCD is fake news, and deserves to be valued as such.

Step three is to **over-respond** to one's thoughts. This is the "compulsive" part of OCD, where the pleasure principle comes into play. The sufferer takes action to reduce or eliminate the discomfort that arises in response to their unwanted thoughts. This action commonly occurs in any of four ways:

- **Overt Compulsions**. A physical action done in an attempt to feel less anxious, such as hand washing, or checking locks or stove burners.
- **Avoidance Compulsions**, wherein the sufferer attempts to avoid situations in which they anticipate unwanted thoughts (and anxiety) might arise.
- **Reassurance Seeking Compulsions**. For example, asking others to confirm that you did not run over a pedestrian, or molest a child, or commit a terrible sin.
- **Mental Compulsions**. For example, repeatedly reviewing a past event in your mind, compulsively fretting about something you fear you may do in the future, purposely calling up a "bad" thought to check if it still causes you distress, or compulsively praying in an attempt to eliminate an unwanted thought.

If done in an effort to control one's thinking, all of these compulsive behaviors will consistently backfire by reinforcing the importance of the thoughts, causing OCD to worsen rather than improve.

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Mindful Acceptance and Cognitive Behavioral Therapy (CBT) for OCD

Just as fake news is unlikely to stop showing up in your Facebook feed, the intrusive, unwanted thoughts experienced by those with OCD are unlikely to spontaneously remit. The first step in better managing your anxiety-provoking thoughts is to accept their presence. Many people with OCD struggle with this concept, thinking that it means resigning themselves to a life of constant, unmitigated misery. But acceptance is not resignation – it is accepting reality as it is, instead of fighting what is out of your control. Resisting reality does absolutely nothing to change it, just as becoming upset by every fake news story doesn't change the fact that fake news exists. A more useful reaction is to accept the existence of whatever life presents to you – whether it be fake news or the unwanted thoughts that pop into your mind – without reacting impulsively or compulsively.

It's important to stress that this doesn't mean accepting that your obsessive thoughts are meaningful or accurate. It only means accepting that they exist without fighting them so much. In other words, it means accepting the presence of fake news without accepting the content it offers. We liken it to accepting that it is raining on a day that you had planned to go to the beach. You can get upset about the presence of the rain, but that will do nothing to stop it. The most helpful reaction is to accept the presence of the rain, and to choose to spend the day doing something else despite it. Mindful acceptance of reality is a shift in consciousness away from fighting what is out of your control, and towards focusing on what is in your control. Rather than over-responding to your thoughts, choosing instead to accept their existence without a struggle, and getting busy living exactly as you would if you weren't experiencing them.

At the same time, you can challenge the *content* of your thoughts. This is the "cognitive" part of Cognitive Behavioral Therapy (CBT). Gently reminding yourself that your OCD thoughts are nonsense with no real evidence whatsoever to support them can help you to reframe these thoughts as being unworthy of your attention. This is the essence of System 2 thinking – vetting the fake news that your brain is presenting to you, considering whether the information is realistic and accurate, and then formulating a more objective appraisal of, and response to, the situation. The goal is to move from a default stance of blindly accepting that your obsessions are meaningful, and towards a place where you are more likely to quickly reject these unwanted thoughts without getting drawn down the rabbit hole with them. The key is to be sure that you don't use this cognitive step compulsively in an effort to reduce your anxiety. Compulsively challenging your thoughts is every bit as much of a problem as any other compulsion.

The most important tool in challenging the fake news generated by your mind is called Exposure and Response Prevention (ERP). This is the "behavioral" part of Cognitive Behavioral Therapy. The simplest way of describing ERP is that it focuses on purposely exposing yourself to the very situations that cause you to be anxious, without doing any compulsive or avoidant behaviors to ameliorate your discomfort. Many people with OCD are *extremely* resistant to this technique, believing that they will be overwhelmed by unbearable anxiety. But ERP done with a compassionate, well-trained therapist isn't torture. It should be done gradually, in a structured manner, and at a pace that works for the sufferer. Any attempt to jumpstart your recovery by taking on more anxiety than you can reasonably handle is likely to lead to a spike in your anxiety, and a subsequent rejection of ERP. Done correctly, ERP will be the cornerstone of your recovery from OCD.

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OCD is Fake News
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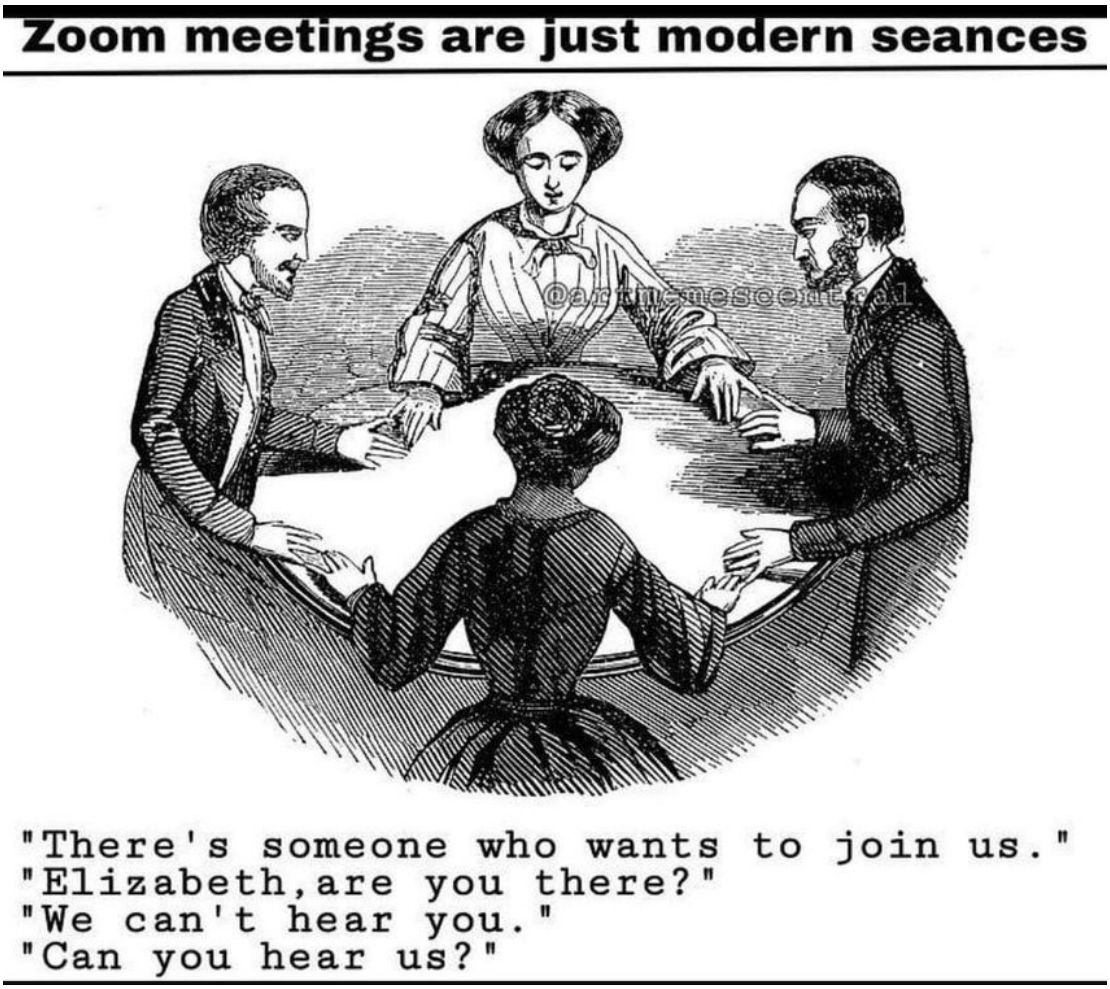
Just as you don't believe everything in your newsfeed, you'd be wise not to believe everything that you think. While our thoughts sometimes directly and objectively reflect reality, they are often nonsense that makes us unnecessarily afraid and behaviorally overprotective. Using CBT, you can learn to implement System 2 thinking – to slow down and consider your thoughts instead of jumping to the conclusion that they are universally accurate and important. As you begin to practice this more measured response to your thoughts, your actions will no longer be dictated by the fake news generated by your brain, and you can begin to free yourself from enslavement to OCD.

Tom Corboy, MFT, and Lauren McMeikan, MFT, are psychotherapists at the OCD Center of Los Angeles, a private, outpatient clinic specializing in Cognitive-Behavioral Therapy (CBT) for the treatment of OCD and related anxiety-based conditions.



online OCD conference

Session Highlights

OCD, Relationships, and Sex

By Laurie Krauth, MA, PLC

If you have OCD and are in a committed relationship with a partner, both of you are involved with OCD. In "OCD, Relationships and Sex," a workshop for therapists at the International OCD Foundation national conference in July, Michael Heady, MA, LCPC and Kim Rockwell-Evans, PhD., said couples need to learn how to become a team.

Therapists can help their clients and their partners cultivate this attitude: It's you and me versus the OCD. Couples need to be allies together against the OCD, although the OCD often tries to get between them. The goal is to figure out how to make the OCD—and not each other—the enemy.

"In relationships, OCD is no longer mine or theirs, it effectively becomes ours. The responsibility for healthy change is on both partners," said Heady.

Heady and Rockwell-Evans offered some ways for OCD sufferers and their partners to work together. This teamwork will enhance couples' relationships, they said. And improving the relationship will increase the likelihood of successful treatment with Exposure and Response Prevention, the gold standard in treating OCD.

Both partners have issues

As couples work together against the OCD, they said, it's helpful for them to remember that the person with OCD isn't the only one with challenges. To be human means to be imperfect.

The partners without OCD have baggage too. They may have their own difficulties with anxiety, distress, unhelpful communication patterns or other concerns. In fact, partners may want their own therapist to address personal and relationship issues.

"A common relationship misunderstanding is that the person with OCD is the one in need of fixing," said Heady.

Recognizing that both partners have strengths, weaknesses, and challenges can increase the partners' alliance against the OCD and make the growth challenge collaborative.

Try this:

Rockwell-Evans suggests this exercise for both people in the couple:

- Create a culture in the relationship around facing fears. Everyone can benefit from going out of their comfort zone.
- Commit to taking a daily risk that is out of each person's comfort zone and share over dinner what they did to face fear and discomfort.

Partner as teammate

Communication patterns characterized by empathy, hopefulness, and assertiveness are associated with improved treatment outcomes.

When OCD stresses out a couple, both partners can become defensive. When partners feel powerless and exhausted, they can act out rather than communicate with compassion.

Developing empathy with each other is essential. From the outside, OCD obsessions and compulsions often seem irrational and easy to resist. Even people with OCD can observe the triggers of another OCD sufferer objectively and wonder why the sufferer can't dismiss them, while their own triggers are experienced as compelling and believable in the moment.

One of the biggest challenges for people with OCD is living with uncertainty: their intrusive thoughts demand of them an immediate resolution. Partners can enhance their compassionate understanding of their loved one by experiencing their own uncertainty about something important to them.

Try this:

Heady suggests this exercise for the partner without OCD: Conjure up the image of a person you care

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about. In this second, how do you know they're not dead? How can you be certain? Think about something that worries you about the future: Will your kids make good life choices? Will you have enough money to retire? How can you be certain? Get a taste of uncertainty and sit with it without any safety behaviors, such as seeking reassurance, reviewing the data for or against, or distracting yourself.

The partner can also keep these guidelines in mind:

- Fight fair: don't use your knowledge of the partner's OCD when arguing, as that punishes their honesty with you about their struggles.
- Listen to learn (not just to hear).

End the accommodation dance

The person with OCD often recruits their partner to help them reduce their anxiety. The partner may be asked to do rituals for them (like checking door locks), provide reassurance (such as confirming that no one was run over on the road), or hear confessions (such as hearing about finding another woman attractive). In challenging that accommodation dance, it's helpful to respond with humor and creativity, instead of being punitive.

Remember, it's not the partner's job to rescue the person with OCD from their distress, the speakers said. While it provides short-term relief to the OCD sufferer, accommodation is self-defeating as it reinforces the OCD and is detrimental to the relationship.

Try this:

- Accommodation Hunting: each partner can win points when they identify and stop an accommodation;
- Reassurance Coupons: provide permission to seek reassurance in a structured way aimed at decreasing reassurance seeking. For example, a partner might provide fewer coupons to their loved one than the OCD sufferer normally "needs" so that the person with OCD must actively choose to request reassurance each time, knowing it's a limited commodity. Ask: "Are you sure you want to spend your coupon on that?" Then provide a one-sentence response; another coupon must be used for a second sentence.
- Confession responses: When the person with OCD chooses to ritualize with a confession, the partner can read it and limit their response to reading it and writing, "I have reviewed this page."
- Attend the OCD sufferer's therapy sometimes if appropriate.

Use supportive statements with your OCD suffering loved one:

- "The most compassionate thing I can do for you now is to not answer your question."
- "If I do that for you, OCD will get stronger."
- "I can see you are struggling – you've got this."
- "I've already answered that. Are you seeking reassurance?"
- "I know this is hard."
- "I can't offer you certainty – I don't know."
- "What would your therapist say?"
- "I want to be supportive, so I won't _____."
- "It sounds like OCD is disrupting you right now."

Enhancing a partner's understanding of the OCD experience

When OCD sufferers choose to share details of their OCD, the goal is to improve understanding. The goal is to disclose to enhance intimacy, not to use their partner to reduce distress and uncertainty, which is a safety behavior that makes OCD stronger. It is about deepening the relationship.

Disclosure is an exposure: it makes OCD sufferers vulnerable when they confront their obsessions and compulsions by speaking them out loud, and exposing them to sunlight.

Exposures are most powerful when they are committed to in the service of one's values: sharing to enhance intimacy rather than to unburden yourself.

For people with OCD who have taboo intrusive thoughts, such as harm or sexual obsessions, the disclosure can be more complex. It may make sense first to know how much the partner understands OCD: particularly that the content of intrusive thoughts is not

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reflective of how the person with OCD really feels. Their knowledge can be enhanced by reading materials about this common form of OCD, joining their loved one's therapy sessions, and becoming clear that these disturbing intrusive thoughts are not consistent with what the sufferer actually believes or wants.

Once the partner understands that the content of OCD thoughts "is garbage", that information is more safe to share.

Try this:

Before sharing, the person with OCD can ask themselves:

- Will it help our relationship grow or I am I doing it because it will reduce my distress or I have a rigid belief that I need to tell a partner everything?
- Do I have an urgent need to share this? If it feels really urgent that you share this immediately, that's a good sign that it is the OCD-driven ritual to reduce the distress by satisfying the need for confession or reassurance.
- Treat your disclosure as sharing "private information rather than revealing a secret. A secret is smuggling in all this shame."
- Be "willingly vulnerable rather than apologetic."
- Share because it is obvious (the elephant in the room that no one is addressing), or because it will help the partner understand why their partner with OCD is reacting as they are, perhaps being irritable or distracted because they've been triggered.

Recognizing that OCD can affect sex

People with OCD may have particular challenges in their sexual relationships, said Rockwell-Evans. In some cases, those challenges may be tied to related anxiety, depression or medication side effects:

- One-third of clients on SSRIs have sexual dysfunction; the higher the dosage, the more likely the side effects;
- Fifty percent of people with OCD have a depression diagnosis, and low libido can accompany depression;
- Anxiety decreases libido, through mental distraction, obsessions, worry, and "spectatoring" — watching yourself perform and focusing on performance and appearance worries over connecting with the partner. Distracting negative thoughts can inhibit genital response.

All sexual relationships, with or without OCD, can have these and other challenges. Rockwell-Evans highlighted a model from anxiety specialist David Barlow, showing the sexual side effects of anxiety: Anxiety during sex shifts attention from erotic cues to performance worries, which decreases sexual arousal. This can lead to increased performance issues, which then can increase anxiety in future situations (due to fear that the pattern will continue—which can be a self-fulfilling prophecy).

There is a wide range of what constitutes "normal" sexual experiences for all people, whether or not OCD is at play. Couples with an OCD sufferer may pathologize their experience as uniquely problematic when in fact it is universal. For example:

- sexual thoughts come up doing non-sexual activities;
- people can be distracted during sex by external concerns, negative thoughts, worries about performance and appearance. Cognitive distraction during sex predicts a lower sexual satisfaction and performance. Distracting negative thoughts can inhibit genital response;
- people can have a genital response to something that they don't think of as sexually appealing. Genital response is automatic, and may occur in situations not deemed "appropriate" or "logical" (such as involving a priest, someone not of the gender they associate with their sexual preference or even a pet sitting on their lap).

People can experience "arousal non-concordance" (a lack of overlap between how much blood is flowing to their genitals and how "turned on" they feel). Their psychological arousal may not always match their physical arousal. Their mind may say "no" when their genitals say "yes." In other words, sexual signals in their brain are not equal to what they find appealing, and genital response is not equal to desire.

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When people without OCD have such experiences, they're likely to dismiss them as "mind spam." When OCD sufferers have these responses, they may make a cognitive misappraisal: misinterpreting normal sexual functioning as pathological.

They may be terrified that their sexual thoughts, feelings, and sensory experiences reflect who and what they are, and their partners may be similarly confused and disturbed. Those fears may be greatest for those with OCD obsessions that involve intrusive sexual thoughts, from sexual orientation to relationship doubting, obsessive jealousy to pedophilia.

Some examples of cognitive misappraisal with OCD sexual intrusive thoughts, said Rockwell-Evans, include: "[A genital twinge] when holding a child means I'm a pedophile." "Noticing that someone of the same gender looks attractive means I'm gay." "Distraction during sex means I don't love my partner."

OCD sufferers, and sometimes their partners, have added challenges from related anxiety, depression and medication:

- One-third of clients on SSRIs have sexual dysfunction; the higher the dosage, the more likely the side effects;
- Fifty percent of people with OCD have a depression diagnosis, and low libido can accompany depression;
- Anxiety decreases libido, through mental distraction, obsessions, worry, and "spectatoring" — watching yourself perform and focusing on performance and appearance worries over connecting with the partner. Distracting negative thoughts can inhibit genital response.

There are multiple strategies for addressing sexual concerns. Couples will benefit from:

- normalizing these universal experiences;
- understanding how intrusive sexual thoughts are false alarms about OCD sufferers' true beliefs and behaviors.
- couples therapy, possibly with a sex therapist who can address sexual issues.

Turning knowledge into compassion

Heady and Rockwell-Evans conclude that there are multiple building blocks for a couple to maintain a supportive, intimate relationship in the face of OCD. It starts with shared knowledge about how OCD, related disorders and medication impact sex and intimacy.

Equally necessary is empathy from both partners, a recognition that your loved one is struggling. The goal is self-compassion for each member of the couple and the constant reminder that it is "you and me" as allies against the OCD.

For those interested in reading more about these issues, Heady and Rockwell-Evans recommend these resources:

Hershfield, J. (2015). When a family member has OCD. California: New Harbinger Publications.

Hershfield, J., Corboy, T. (2013). The Mindfulness Workbook for OCD. California: New Harbinger Publications.

Landsman, K.J., Rupertus, K.M., Pegdrick, C. (2005). Loving someone with OCD. California: New Harbinger Publications.

Schnarch, D. (2011). Intimacy & desire: Awaken the passion in your relationship. Beaufort Books.

Williams, M.T., Wetterneck, C.T. (2019). Sexual obsessions in obsessive-compulsive disorder. New York: Oxford University Press.

Laurie Krauth, MA, PLC, is an Ann Arbor psychotherapist specializing in the treatment of OCD, and is a valued member of the Science Advisory Board of The OCD Foundation of Michigan

Session Highlights

Understanding and Treating Obsessive Compulsive Personality Disorder (OCPD)

Anthony Pinto, Ph.D.
Program Director, Northwell Health OCD Center

Reviewed by
Roberta Warren Slade

The conference program described this presentation as follows:

"*Obsessive compulsive personality disorder (OCPD) is a chronic maladaptive pattern of excessive perfectionism and need for control over one's environment that frequently co-occurs with OCD. Despite its prevalence, many clinicians are not aware of how to treat OCPD. Dr. Pinto will review the core features of OCPD, how it impacts functioning, and explain how to differentiate it from OCD. Dr. Pinto will also cover cognitive behavioral therapy interventions that target OCPD traits and behaviors."*

OCPD is an enduring pattern of behavior that leads to clinically significant distress or functional impairment, defined in the DSM-5 as four out these eight criteria:

- Preoccupation with order, detail, rules;
- Self-limiting perfectionism, unreasonably high standards that get in the way of task completion;
- Excessive devotion to work and productivity, so inability to engage in leisure activities;
- Inflexibility about morality and ethics, so judgmental of others;
- Inability to discard worn-out or worthless items;
- Reluctance to delegate tasks, leading to micromanagement or re-doing the work of others;
- Miserliness toward self and others;
- Rigidity and stubbornness, a need to control.

These might manifest in associated features of:

- Indecision (fear of making wrong choice);
- Difficulty with change;
- Excessively rule-bound; routines;
- Difficulty relating to and sharing emotions;
- Anger outbursts when sense of control is threatened;
- Procrastination.

On the surface, it might seem hard to distinguish OCPD from OCD. Although they are distinct conditions, there is an overlap in symptom presentation. Both are considered impairing in terms of quality of life and psycho-social functioning. Both are marked by ritualized behaviors that have to be done a certain way. The main difference is the presence in OCD of obsessions, intrusive or unwanted thoughts, and in the patient's experience of the symptoms. OCD is considered ego-dystonic, that is, it feels foreign to the person, distressing and unwanted. OCPD, on the other hand, is ego-syntonic; the behaviors are seen as part of who the person is, how they see themselves, thinking "other people should be this way as well."

While Dr. Pinto noted that there is currently no definitive empirically-supported treatment for OCPD, no controlled trials of psychotherapy or pharmacotherapy specifically targeting OCPD, he has found some success in cognitive behavioral formulations and psychoeducation. He makes a point to state that, although this might resemble exposure and response prevention, instead of "exposure," they use "experiments" to challenge the standards and rules that mark OCPD behavior in an attempt to address the underlying cognitive biases that might be driving the behavior.

For more information, you may consult these two books that were referenced by Dr. Pinto: ***Obsessive Compulsive Personality Disorder***, and ***Cognitive-Behavioral Treatment of Perfectionism***, which we have listed on our "Suggested Reading" page.

online OCD conference

Session Highlights

ACT: Creative Hopelessness, Matrix, Values

Kevin Ashworth, LPC; Jesse Crosby, PhD;
Ashley Wray, LCSW

Reviewed by
Roberta Warren Slade

The conference program described this session as follows:

"This presentation will explore how the ACT concepts of creative hopelessness, values, and metaphors can be used as tools to provide validation of experience while introducing acceptance as an option for working with OCD."

This presentation introduced three concepts of ACT (Acceptance and Commitment Therapy). In this overview, I have chosen to specifically address the notion of "creative hopelessness," presented by Jesse Crosby, because I was so intrigued by the juxtaposition of two such contradictory words. Dr. Crosby asks us to recognize the tension this creates, and that there's a bit of a dialectic there, ideas that are in apparent opposition to each other, but perhaps both have some truth to them. Both, when they come together, can provide some useful direction for someone attempting to solve the problems related to OCD.

In hopelessness we find perhaps that the agenda we've been pursuing, the attempts we've been making, or the ways we've been trying to solve OCD and its associated problems are not going the way we want them to. We're not finding the solutions or support or the change that we're looking for. This can certainly be disconcerting, leading to feelings of hopelessness, or even helplessness. It's important to acknowledge and validate that although it is a frustrating, discouraging, at times exhausting process, we also recognize that those efforts have not necessarily been in vain.

Sometimes the acknowledgment that something isn't working might lead us in directions we may not have seen before, opening up the possibility that things we might not have considered might have a chance to work. And that's where the creativity part comes in. In recognizing the tension between the two ideas, we learn that maybe through hopelessness we can find some creativity.

OCD treatment challenges us to think in terms of short-term versus long-term solutions. Can there be a willingness to let an obsession or fear be present without responding to it with a ritual or compulsion? That's the proposal of exposure therapy. ACT provides some additional tools that could be useful in terms of how do you let that fear or anxiety stay instead of trying to neutralize it. The idea of ACCEPTANCE is the first part of that. Perhaps that's why the hopelessness is necessary, because it's an idea many are not willing to consider at first. We come to see acceptance as an alternative - willingly allowing the anxiety or the obsession to be present, and then making the choice not to engage in a ritual or compulsion.

The idea of creative hopelessness, then, introduces another important process that becomes valuable throughout therapy, and that's an openness to experiential learning, to trust our experiences and what they are telling us. Creative hopelessness, through the application of ACT processes, empowers us to be able to learn from our experiences.

PARTIAL HOSPITALIZATION PROGRAMS

There is a treatment option available for adolescents and adults in many areas that is often not known or considered by individuals who are struggling with anxiety or depression.** Partial Hospitalization Programs (PHP) are intensive programs offered by hospitals and clinics, and can benefit those who need more help than traditional outpatient settings can provide. They typically run five days a week, from 8 or 9 am to 3 or 4 pm, and can include group therapy, private time with a psychiatrist, art or music therapy or other activity time, and education programs. They usually include lunch, and some include transportation. Here, we list some of these programs for your information.

St. Joseph Mercy Hospital, Ann Arbor, MI

Adult Partial Hospitalization Program, 734-712-5850
www.stjoesannarbor.org/AdultPartialHospitalizationProgram

Adolescent Partial Hospitalization Program, 734-712-5750
www.stjoesannarbor.org/AdolescentPartialHospitalizationProgram

Beaumont Hospital, Royal Oak, MI, 248-898-2222
www.beaumont.org/services/psychiatry

Henry Ford Health System, 313-640-2637
www.henryford.com/services/behavioral-health/mental-health/outpatient/partial-hospitalization

New Oakland Family Centers, 800-395-3223
www.newoakland.org/programs/face-to-face-php

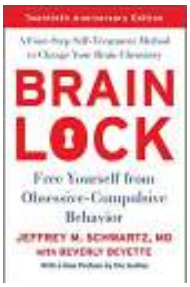
University of Michigan Department of Psychiatry, 734-764-6880
www.medicine.umich.edu/dept/psychiatry/programs/adult-partial-hospitalization-program

**** PLEASE NOTE: These programs can provide extended support and skills building, but they are not specifically designed to treat OCD. They might not have OCD specialists and they don't do ERP.**

Updated 9/15/20

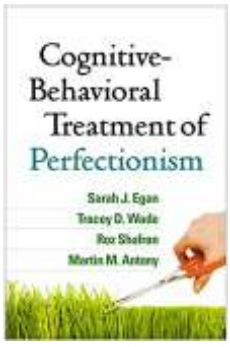
SUGGESTED READING

Jon E. Grant, MD,
Anthony Pinto, PhD,
Samuel R. Chamberlain,PhD
Obsessive-Compulsive Personality Disorder
American Psychiatric Association Publishing, 2019
ISBN 978-1615372249

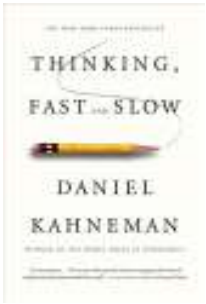


Jeffrey M. Schwartz, MD
Brain Lock, Twentieth Anniversary Edition: Free Yourself From Obsessive-Compulsive Behavior
Harper Perennial, 2016
ISBN 978-0062561435

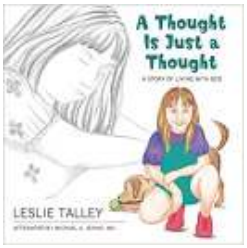
Sarah J. Egan, PhD,
Tracey D. Wade, PhD,
Roz Shafran, PhD,
Martin M. Antony, PhD
Cognitive-Behavioral Treatment of Perfectionism
Guilford Press, 2016
ISBN 978-1462527649



Daniel Kahneman
Thinking, Fast . . . Slow
Farrar, Straus and Giroux, 2013
ISBN 978-0374533557



Martin M. Antony, PhD,
Richard P. Swinson, MD
When Perfect Isn't Good Enough: Strategies for Coping with Perfectionism, 2nd Edition
New Harbinger, 2009
ISBN 978-1572245594



Leslie Talley
A Thought is Just a Thought: A Story of Living With OCD
Lantern Publishing, 2004
ISBN 978-1590560655

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Updated 9/15/20

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The OCD Foundation of Michigan
Mission Statement

- To recognize that Obsessive-Compulsive Disorder (OCD) is an anxiety-driven, neurobiobehavioral disorder that can be successfully treated.
- To offer a network of information, support, and education for people living with OCD, their families and friends, and the community.

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