A Newsletter Dealing with Obsessive Compulsive Disorder

NEVER say NEVER

In the midst of the seemingly endless storm,
look to the promise of the rainbow -
the rain shall not prevail!

Spring/Summer 2014

Let's Talk about Support Groups

The OCD Foundation of Michigan has long maintained a list of Support Groups (also called Self-Help Groups) that are available at no cost for anyone who wants to participate. They can be helpful and informative for OCD sufferers themselves, but also for parents of OCD children, spouses, significant others, family members, friends, or anyone who might have an interest in the subject. Our list of groups (which can always be found in our newsletters and on our webpage ocdmich.org) has changed many times over the years, as groups are added when a member or volunteer wishes to start a new group, and closed when low attendance, lost interest, or a lost group leader makes a group untenable. We want to encourage everyone to make use of the OCDFM support groups so that these valuable resources will continue to be available to our local OCD community.

In this issue of ***Never Say Never***, we have included a couple of articles that address the importance of support group participation. Especially interesting is a description of the GOAL (Giving Obsessive-compulsives Another Lifestyle) format pioneered by Dr. Jonathan Grayson in Philadelphia in 1981. We hope you find this issue useful.

LANSING SUPPORT GROUP CELEBRATES 20 YEARS!

Jon Vogler is one of our unsung heroes. He has quietly been running the Lansing OCD Support Group for 20 years. On Monday, August 18th, Lansing will celebrate their anniversary in style. Their meeting will be preceded by a potluck dinner, followed by a speaker, Dr. Rodney C. Howard from Okemos. The time is from 6-8pm, at Delta Presbyterian Church, 6100 W. Michigan Ave., Lansing, MI. Contact Jon at 517-485-6653.

THE OCD FOUNDATION OF MICHIGAN

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NEVER say NEVER

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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)
Call Joan at (734) 479-2416

FARMINGTON HILLS:
1st and 3rd Sundays, 1-3 PM
Trichotillomania Support Group
Botsford Hospital
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 (all forms)
Meets every Wednesday, 7 to 8:30 p.m.
Open to individuals who have any kind of anxiety problems as well as their friends and family members.

Teen Anxiety Group
1st, 3rd, and 5th Wednesday, 5:30 to 6:30 p.m.
Open to individuals who have any kind of anxiety problems as well as their friends and family members.

Adults Obsessive-Compulsive Disorders
Every Tuesday, 7 to 8:30 p.m.
Open to any adults who have or think they may have Obsessive-Compulsive Disorder.
Friends and family members welcome.

Body Focused Repetitive Behaviors
1st Tuesday, 7 to 8:30 p.m.
A monthly support group for adults who have Compulsive Hair Pulling, Skin Picking and Nail Biting problems.
Open to friends and family members.

Social Outings
3rd Tuesday and 4th Saturday, call for details
Challenge your anxiety in the comfort of others while attending fun-filled events.
Past activities have included: game night, visiting a bird sanctuary, concert and comedy events, sunset strolls on the beach and even canoeing.

LANSING:
3rd Monday, 7-8:30 PM
Delta Presbyterian Church
6100 W. Michigan
Call Jon at (517) 485-6653

LAPEER:
2nd Wednesday, 7:30 - 9 PM
Meditation Self-Healing Center
244 Law St. (Corner of Law & Cedar Streets)
Call Mary at (810) 793-6544

PETOSKEY:
2nd Tuesday, 7-9 PM
NOTE NEW LOCATION FOR 2014
The John & Marnie Demmer Wellness Pavilion
820 Arlington Ave.
Petoskey, MI 49770
Call Kevin at (231) 838-9501
E-mail Runocd@gmail.com

ROYAL OAK:
1st Wednesday, 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 Terry at (586) 790-8867
E-mail tmbrusoe@att.net

FROM THE NEVER SAY NEVER ARCHIVES:

This article first appeared in the Fall 2002 issue of ***Never Say Never***. Unfortunately, it is still relevant today. We all need to think about the value of self-help groups, and make the time and commitment to help ourselves. (rws)

Empty Chairs At Empty Tables

by Roberta Warren Slade

In every issue of ***Never Say Never***, we include a list of the Self-Help groups that are available to OCD sufferers, their families, friends, and anyone else with an interest in the disorder. It is an impressive list, containing close to twenty groups located throughout the State of Michigan, in Northern Ohio and in Windsor, Ontario. That is, there WERE close to twenty groups. Have you taken a look at the list lately? We're down to seven active groups, and some of those are in danger of closing due to lack of attendance. [*Editor's note: our list currently contains twelve groups, and none in Ohio or Windsor*.]

Hmmmm, I thought, there must be a good explanation for this. **I KNOW!** The OCD Foundation of Michigan has fulfilled its mission, everyone is now OCD-free, and the community no longer needs our help. We should congratulate ourselves on a job well-done, close our doors, and move on. . . . . **NOT!**

We know that OCD suffering is ever-present and never-ending. We know that the disruption, destruction, despair and devastation caused by OCD is very real, and many are still reaching out for a lifeline. And we know that the value of self-help group participation is well-documented. The Obsessive-Compulsive Foundation states that "support groups . . . provide a forum for mutual acceptance, understanding, and self-discovery." The Office on Women's Health in the Department of Health and Human Services similarly states "Many people find it helps to join a support group because they can share their problems and successes with others who are going through the same thing"

Still, the OCDFM self-help groups continue to fail. Could it be that we are unwilling or unable to make the commitment necessary to help ourselves? Yes, it takes time and considerable effort to attend meetings on a regular basis. We are busy, we are stressed, we are tired, we are preoccupied. Time has become a precious commodity, and I find I am jealously possessive of every free minute that happens to come my way. And yet I am reluctant to spend those very minutes on MYSELF. Something in my consciousness keeps telling me that making time for myself is taking it from others, and that would be selfish. Never mind that the better I feel about myself, the better I am able to give of myself to others.

That sounds like OCD talking. "Wait, don't go to that support group – it might make you feel better." "No, it's too dangerous - they'll try to make you think you don't NEED me." Maybe OCD is being just a tad self-protective? Just think of it as one more false message. **I KNOW!** Let's all send OCD a message and tell **IT** where to go . . . . . .

WHAT IS A GOAL GROUP?

From the Anxiety and OCD Treatment Center of Philadelphia

GOAL (**G**iving **O**bsessive-compulsive **A**nother **L**ifestyle) support groups started in Philadelphia in 1981 when Jonathan Grayson and Gayle Frankel started the first support group for OCD in the country. From that time on, the GOAL approach has been a way has been a powerful way for individuals suffering from OCD to help themselves. Below are some question/answers about GOAL support groups.

1. What is a GOAL support group?

Think of GOAL as a support group plus. That is, like all support groups, members find the comfort and support from one another that sharing a similar problem brings. However, there are times when unstructured support groups, deteriorate into destructive complaint groups (or as one of our members calls them a "pity party"), in which members spend their time together comparing symptoms and medication side effects. GOAL goes beyond providing support and gives members a way to help one another.

2. What are the features of a GOAL support group that makes it effective with OCD?

Meetings are broken into three parts: 1) the Question, 2) GOAL planning, and 3) socializing. These three parts are all necessary and each fulfills a very important function for every member.

First there is the **Question**. Before the meeting, the leaders pick a topic to discuss; hopefully one that is of interest to everyone (e.g., how do you cope with uncertainty and how does that affect your OCD?). Remember, one purpose of a support group is to share ideas and thoughts about a common problem and maybe even come away with new ways of looking at your problem. Without a question, meetings tend to ramble and can easily become monopolized by a single individual's issues or again, simply comparing symptoms and medication side effects. The Question provides members a stimulus for examining their situation from a different angle, which helps them focus their ideas, thoughts and feelings about different aspects of OCD and its effects upon their lives – or in other words, a good question helps everyone learn from one another and grow. Of course, this depends upon the question; sometimes we will come up with great questions and other times not. We save the good ones and over time have developed a pool to draw from.

Second is **GOAL Planning**, the heart of the meeting, this is what keeps our meetings a place of hope and progress. Quite simply, members break into small groups, and is each lead by a more experienced member and everyone chooses behavioral GOALs to work on between meetings. Usually they will be some form of exposure or response prevention. In this way the focus of the group is always positive as it reflects our belief that everyone can help themselves and others to move forward.

Finally, there is **informal socializing**. The heart and power of a group resides in the friendship and trust people develop towards one another. These kind of relationships depend upon the sharing that best occurs without a structure beyond providing a place to meet. Fighting OCD is hard work and having friends who can help is the defining feature of what makes a support group work.

3. What makes the GOAL group therapeutic as opposed to a mutual support meeting?

The GOAL concept is very flexible. Providing support to one another is more than just than words – providing support can be helping individuals help one another. The idea of people empowering one another in a support group is

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not original with us. In AA meetings, the support is not simply people getting together and saying they have a biological problem and their only hope is depending upon a higher power. They also encourage members to take very active steps and make life changes (e.g., taking responsibility for what each individual can control by supporting positive non-drinking behaviors and confronting one another when they engage at risk behaviors). Similarly, GOAL encourages members to do the same with their OCD. On the other hand, the GOAL approach can be adapted to a variety of formats and could be incorporated into a programmatic group therapy program or into the obsessive-compulsives anonymous format. GOAL is about empowering individuals and enabling them to take some control over their OCD.

4. Isn't the concept of a GOAL sort of intimidating for someone with OCD?

The first rule of choosing a GOAL is picking something you are willing to do, because we want the individual to be successful. It doesn't matter how small the GOAL is, because anything achieved is a start. If someone doesn't want to choose a GOAL at our meeting, that is fine. For such individuals, we believe that over time they will change, because they will see others coming to the meeting and making changes and seeing improvement in their lives. You ask why would anyone voluntarily submit to this and the answer is the desire to overcome OCD and the hope the comes with seeing the success of others who do take GOALs.

5. What are the main objectives of a GOAL group?

The group's primary stated purpose is to help sufferers to gain some control over their OCD through the use of self chosen behavioral GOALs. There are three groups of sufferers we try to support:

a. To help to prepare people for exposure and response prevention (E&RP) who are too afraid to immediately commit to treatment. For these sufferers, the meeting is a gentle introduction to E&RP that allows them to see that they can both cope and make progress.

b. To support those in the middle of individual E&RP treatment. For these sufferers the group encourages and supports the individual's efforts to persevere.

c. To support relapse prevention. Finally, for those who have overcome their OCD, the group's focus on relapse prevention and GOALs makes it harder for the individual to pretend slips can be ignored, which could result in a small slip becoming are major relapse.

6. How does the group help with relapse prevention?

OCD is both a learned and biological problem. With regard to the learned aspects, we know that for any long term behavior that a person tries to change, slips will occur. After all, how many people do you know, who have gone on a diet, stopped drinking, stopped smoking, started exercising and so on and have never slipped. In addition, there are biological components in OCD and in some people these can rise and fall over time, making them more or less susceptible to relapse. The gist of what we are saying is that slipping is inevitable. And if this meant being overwhelmed by OCD again and becoming dysfunctional, that fact would be overwhelming. But let me make this very clear, we are not saying that. Again think of a dieter who has lost 100 pounds and then gains 2 pounds. Do they want to do all that dieting for a mere, unnoticeable 2 pounds? 5 pounds? 50 pounds? The problem is not in the slipping, but in how far you let it go. Do you "get back on the wagon" when "illegal" handwashing is 5 minutes extra a day or 5 hours? The good news is that either way, 5 minutes or 5 hours, you can recover again. Your behavior, like the example with dieting, just determines how hard you will have to work.

The GOAL support group can be used as a way to monitor yourself and make sure that you keep to your maintenance program and that if you slip, it puts some pressure upon you to not lie to yourself.

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7. Should families be excluded families from GOAL meetings?

Family involvement can be a very important part of recovery and, obviously people could choose to run a GOAL group with family and friends present. One of our rules in choosing a GOAL is the individual chooses something they are willing to do – not something to try, but something they will do. And if they choose nothing, they are not overly pressured. In allowing a potentially coercive family to be present, the meetings could lead to greater discord at home. We are also concerned that this may discourage sufferers from returning to the meeting. At our center, we run a separate meeting for families and friends that meets at the same time as GOAL. Obviously, this isn't a rule that must be followed. There are GOAL groups that do include family members.

8. Who runs the GOAL meetings and how are they organized?

Our meetings are therapist assisted. This means that I and some of my staff volunteer our time to be present at every meeting, but we don't run the meeting. We leave that to our more experienced members and just jump in when the need arises. I think this is the ideal, sufferers running the meeting with a professional available. But there are times this won't be possible. If a professional is starting a GOAL support group, it will take some time for members to be experienced enough to take over. On the other hand, we realize that there are many areas where there are no professionals experienced with OCD available and we hope that the manual we wrote for the OC Foundation would enable sufferers to run their own meetings.

GOAL is really a system of recommendations of how to run a support group and to keep it positive. With that in mind, it is almost irrelevant whether it is therapist run, assisted or run without a therapist. We actually call ours therapist assisted, because although my staff and I attend meetings and help out, the actual meeting is run by our more experienced members.

Words of Wisdom

Quotes from Epictetus, 55-135 AD

- It's not what happens to you, but how you react to it that matters.
- When something happens, the only thing in your power is your attitude toward it; you can either accept it or resent it.
- It is not external events themselves that cause us distress, but they way in which we think about them, our interpretation of their significance. It is our attitudes and reactions that give us trouble. We cannot choose our external circumstances, but we can always choose how we respond to them.

More on OCD

An Interview on CBT, Medications, OCD Misconceptions, and Mindfulness

BUD CLAYMAN INTERVIEWS OCD SPECIALIST JON HERSHFIELD

This is part two of a four-part interview series on OCD with specialist Jon Hershfield. See: oc87recoverydiaries.com/more-on-ocd

Bud Clayman: So talk about the therapist [in] cognitive behavioral therapy.

Jon Hershfield: Cognitive behavioral therapy is divided into the 'C' and the 'B' of CBT. The C is for cognitive, which refers to "thought" and one of the things we know about OCD is that while you can't control the thoughts you have, you have some influence over how you respond to those thoughts and how you think about those thoughts.

This is kind of a nuance thing. There's a difference between the having of a thought, meaning something pops up into your head and there it is – and thinking which is a behavioral act, analyzing, figuring out, addressing. So when you're thinking, there are different ways of thinking about things and what we know is that people with OCD tend to have some distorted ways of thinking about things that push them into doing compulsions.

For example, if a thought pops into my head about hurting a loved one and –

Bud Clayman: Which is very frightening.

Jon Hershfield: – which is very frightening and then I'm processing that through a lens of, "If I have one violent thought, it means I'm a violent person." Now, I'm not only thinking about how I might hurt a loved one but I'm also thinking about myself as a violent person. That's very scary so I'm immediately going to feel discomfort, I'm immediately going to want to do a compulsion to convince myself that that person's not going to get hurt.

However, if I noticed that I'm thinking in this very black and white of, "Oh, if I just think one violent thought, it makes me a violent person," I can challenge that and say, "Well, wait a second. I don't actually believe that. That's a distorted belief. That's me processing information. Yes, I have this violent thought and yes, it disturbs me. But the presence of a violent thought does not necessarily create my entire identity."

Maybe I'll take the risk this time and not do the compulsion and just say, "Well, okay, that's the thought that went through my head. Let's see how this goes." So with the rest of cognitive therapy, there's many different kinds of cognitive distortions which is what we call these, the errors in thought processing that you can learn to challenge.

I think most people treating OCD today recognize that there's a role for that but it's not nearly as significant as the role that the 'B' in CBT plays. The B, the behavioral therapy, that's what we were talking about earlier, exposure with response prevention. So focusing on what is it that you're doing in response to these obsessions – it's actually sending the message to your brain that these thoughts are important, that these thoughts are dangerous. That these thoughts are producing an experience that you're not capable of tolerating and how can we modify that behavior so that you can send a different message to your brain that these thoughts, unpleasant as they may be, are part of the normal way that the mind functions, that you could tolerate them, that you're not going to let something like a thought get in the way of your values or of your objectives in life.

Bud Clayman: What is the treatment time [for OCD?] I've been told there isn't a cure for OCD but it's more managing the illness. Is that true?

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Jon Hershfield: Yes. I like to say *mastering* the illness; managing sounds kind of like a downer. You know, the word 'cure' I think is problematic because obsessions being unwanted, intrusive thoughts are normal events. Everybody has unwanted, intrusive thoughts. We can't control what goes on in our mind any more than we can control what happens to show up on the TV when we turn it on. It's just what's there. And compulsions are normal events. We all have little rituals that we engage in throughout the day that are part of the culture that we live in or just part of the way that we were raised and really serve no function at all but we're just sort of used to doing them. So obsessions and compulsions themselves aren't the problem. It's the disorder, that's the problem.

And so when you're able to effectively treat the disorder and get it to a place where the obsessions and compulsions aren't grossly interfering in your life, we can call that a cure because that's pretty much as good as it's going to get and that's pretty good.

Bud Clayman: Somebody reading this interview, let's say recognizes that, "Hey, I have OCD, but I don't want to go through therapy. It's going to take forever." Is there a rough amount of time it takes or do you have to live with the uncertainty of that?

Jon Hershfield: I think you have to live with the uncertainty of that but I can give you a somewhat satisfactory answer. It's the other problem with looking at it in terms of cure, I think [it's] also understanding that besides the obsessions and compulsions and how they get in the way of your life, – there's an OCD mind. There's an OCD way of looking at the world and this has somewhat to do with your genetic makeup and literally just the way your brain is designed. And although you can influence these things through cognitive behavioral therapy, there's a level of acceptance of, "You know what? This is just how I think. If I didn't have OCD, I probably wouldn't think this way but this is just how I think."

And if you can learn to master that and actually appreciate that, that's also another way of looking at a cure. I think people with OCD have a very wide open mind and there's a window in your brain that sort of opens to a lot of stuff coming in that for other people, it exists, but it's shrouded in a kind of darkness. They have to try to think about it whereas you don't have to try to think about it. It just presents itself to you. This can work both ways. Yes, it means you have to deal with all the nasty stuff but it also means that a lot of really creative interesting ideas come your way with limited effort because of the way that your minds works; you have an OCD mind.

So even at your best, there's a part of this disorder that you carry with you and that doesn't have to be looked at as a curse. It should just be looked at as a thing that is.

Bud Clayman: It's how you embrace it.

Jon Hershfield: Yeah. Now, in terms of how long does it take to get from being really sick and you know, being on top of it? I think it would depend on a lot of different factors. I think on average, CBT is not considered the longest of therapies. It's usually measured in months. But when we say it's measured in months, what we really mean is it would be anywhere from – well, let's take sort of intensive residential treatment out of the equation for a second and just look at regular outpatient treatment. You'd probably see an OCD specialist once a week, maybe twice a week for a process of a few months. And then you would gradually start tapering those sessions down, every other week, once a month, and so on and so forth. Then it just becomes as needed, sometimes you can just go in every two months, every two weeks, whenever you feel that you need to get your screws tightened.

But how long does it take overall? It kind of depends on how you look at it. What is your goal here? It's a journey that really shouldn't ever end. When should we decide to stop improving the way that we look at our mind and improving the way that we deal with interesting thoughts?

MEDICATION

Bud Clayman: That's a good attitude. Do meds help?

Jon Hershfield: Meds help some of the people some of the time. I would say a lot of the people a lot of the time. It's obviously a contentious issue for some but it's undeniable that research shows that there's some medications out there that clearly help reduce the intensity of obsessional thinking, reduce the intensity of anxiety and depression, and for many people, the way their brain chemistry is set up, it actually makes it very difficult to do the therapy that would get you better without medication because for that person without medication, their anxiety may be too high for them to ever really effectively do exposures because an exposure should

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take you from a somewhat neutral state to an anxious state.

If you're already at a 10 on your anxiety scale, there's not a lot of work to do. Or perhaps they're too depressed to be motivated to think their life has enough worth and value to fight so hard to beat the disorder. I think without medication for people who need it, the treatment that works, the cognitive behavioral therapy isn't really going to fly. There's a lot of people who get better on medication. The medication is helping them but what's really helping them is the medication is allowing them to make the choice, to stop doing compulsions in the face of their obsession and that's what's ultimately getting them better.

Bud Clayman: I was on Anafranil at one point I think for OCD.

Jon Hershfield: My understanding is that Anafranil is one of those medications that is considered to be very effective for OCD. It's often not prescribed as a first-line medication only because many people have difficulty tolerating the side effects.

But there's a class of medications that are typically prescribed as first-line medications for OCD called SSRIs and they effect the transmission of a neurotransmitter, a chemical in the brain called serotonin and the way that it affects how serotonin is transmitted throughout the brain seems to help with depression and OCD and with OCD, it's typically prescribed in higher doses.

There are several other medications that are sometimes prescribed along with an SSRI that affect other areas of brain chemistry that can also be helpful for managing anxiety, managing the intensity of intrusive thoughts and things like that.

Editor's Note: *It's important to make any medication decisions in consultation with a psychiatrist.*

OCD MISCONCEPTIONS

Bud Clayman: What would you say are some of the most popular misconceptions about OCD and its treatment?

Jon Hershfield: Let's see – popular misconceptions – well, one is that – this one always kind of amused me is that people who have contamination OCD are clean. My experience is actually the opposite. People with severe Contamination OCD have trouble touching things that are dirty and if you want to get clean, you have to touch things that are dirty including your body, and bodily fluids, the floor. I've treated several people with severe contamination OCD and you go to their home, expecting it to have this kind of cartoon glimmer and it's covered in garbage because they can't pick it up.

Bud Clayman: That's ironic.

Jon Hershfield: That's ironic, yeah – and you know, a lot of OCD is ironic. I mean if you look at Harm OCD, why are you afraid of lashing out and hurting someone? Well, you don't want to be a bad guy. If you hurt someone, you're a bad guy and then maybe you go to jail, maybe you'd be rejected by society. Yet all of your rituals are keeping you from being social, they're keeping you from leaving the house. They're keeping you from relating in a healthy way to the news and television and stuff like that.

So ironically, a lot of what you're afraid of happening as the result of acting on your intrusive thoughts is kind of already happening as a function of your doing compulsions.

Another common misconception about OCD and its treatment is that the treatment is cruel or dehumanizing or that it's really about torturing people. There've been several things that have shown up in the media that are just plain silly where you're taking somebody who's afraid of something and you're just throwing it in their face. People don't learn to swim by being kicked in the back and thrown into the deep end of the pool and having the word 'swim' shouted at them.

People learn to swim by approaching a pool and not even going in the water for a long period of time until they're ready to just dip

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their toe in and then gradually working their way up to being immersed in their discomfort. That's really how CBT for OCD works. It's about coming up with a plan with the sufferer to gradually confront the fear of theirs. By the time they're dealing with the scariest of the scary thoughts, it's really only a step up from what they've already pretty much conquered or pretty much decided they were capable of tolerating.

Bud Clayman: So they say baby steps is the way to go? Small steps.

Jon Hershfield: I'd say it really depends on the person because you know; a small step for you may not be a small step for another person. I think that the treatment needs to be aggressive and yet it needs to be at a pace that's tolerable. When I'm working with someone, my objective is kind of, you know how I imagine what goes through the mind of my trainer at the gym which is he tells me to pick something up and I say, "I can't pick that up." And he says, "Well, give it a shot." I say, "Oh, this is too heavy." He says, "Okay, well try this one." "Well, this is heavy but I think I can do it." It's the same sort of thing.

I'm kind of saying, "Well, here's an exposure we can do. I think it will be really challenging. Do you think you're up for it?" And if the client is telling me, "No, I'm just going to have a complete meltdown. I can't do it." I say, "Well, what do you think would be a step down from that? What do you think you'd be capable of doing?" and we collaborate on strategies, always keeping the goal in mind which is mastering the presence of these intrusive thoughts.

MINDFULNESS

Bud Clayman: Please talk about mindfulness. I know that's an important part now of OCD treatment. What is mindfulness and how can it help the OCD sufferer or anyone else in life?

Jon Hershfield: Mindfulness is actually a very simple concept and a very old concept. You know, you're reading a lot about it now because people are finding that implementing it in a variety of different therapies for a variety of different disorders, helps in a very big way. But I think people have actually been doing it for a long time without calling it mindfulness.

At its source, it's basically just a very simple concept of paying attention to the present moment and accepting the present moment exactly the way it is.

Bud Clayman: Which is hard for most people.

Jon Hershfield: Which is hard for most people, and especially hard for OCD sufferers because the present moment may involve the presence of a thought that you find abhorrent or an experience of anxiety that you find painful or perhaps you find it intolerable to be able to sit and observe and acknowledge, "Okay, this is what's happening right now in this moment." And the tendency is to think, "what if this lasts forever?" Well, that's not mindfulness, that's looking into the future. Or, "Oh, what if the thing I did before, what if I made this terrible mistake?" Well, that's not mindfulness, that's digging back into your mind and sort of investigating your imagination. Mindfulness is actually being right here and right here right now is, "I'm a person having a thought." That in and of itself, is not particularly threatening.

Bud Clayman: Now, I know you have a book coming out on December 1st entitled, *The Mindfulness Workbook for OCD: A Guide to Overcoming Obsessions and Compulsions using Mindful and Cognitive Behavioral Therapy*. What was the genesis of this book? How did it come about and how would it be able to help the OCD sufferer or anyone else who might want to use it?

Jon Hershfield: I was working at a place called The OCD Center of Los Angeles under the supervision of co-author Tom Corboy, and I'd been writing blogs there about OCD and the experience that I was having treating people there and using cognitive behavioral therapy and mindfulness. Through that writing, I happened to be fortunate enough to come in contact with New Harbinger and they are well known for publishing many excellent self-help books including The OCD Workbook (by Bruce Hyman and Cherry Pedrick).

Bud Clayman: I've read some other books dealing with mindfulness but this seems like a new approach with specifically OCD. Is that true?

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Jon Hershfield: Pretty much – I mean I think there's a lot of books and various resources on OCD. I think there are a few books about OCD that have chapters devoted to mindfulness but I think in terms of a book that explicitly focuses on, "How do you apply mindfulness to cognitive therapy, behavioral therapy, the CBT, specifically for OCD overall," I think this is the first book that's really going to approach that subject exclusively.

Bud Clayman: Specifically the OCD sufferer, what will they be doing in the workbook? How will they use it?

Jon Hershfield: Well, the way we have it set up is it's broken down essentially into three parts of addressing OCD, acceptance which is what we were talking about before which is mindfulness which is accepting what's going on in the present moment, considering that doing compulsions would be the antithesis of acceptance. That would be trying to get rid of the thought. And the second part is assessment, that's the cognitive therapy part. That's taking a look at, "Well, hold on a second. If I can't deal with this, let me just take a look at what's objective reality here. Can I predict the future? Can I read people's minds? No I can't? Okay. Let's go back to acceptance."

Then action, which is referring to exposure and response prevention. How can I take action against my OCD and what the book offers is a series of strategies for each of those things. How can I accept this thought? If I'm having trouble accepting this thought, how can I assess whether or not I should do compulsions so I can go back to accepting the thought? If I'm having trouble assessing whether or not I need to do compulsions, how can I take action against this obsession and create a hierarchy of exposure that will allow me to overcome this? It's broken down chapter by chapter for most of the major forms of OCD.

Bud Clayman: So this is a very active workbook that gets you involved doing active things.

Jon Hershfield: Yes. There is going to be a lot of things to write and consider and practice, absolutely.

Bud Clayman: Cool.

Jon Hershfield: It was very interesting for me writing a workbook because I'd only ever thought of it in terms of treatment in the room. I'd never really had the experience of saying, "Well, what about a person I've never met? How would I explain to them how to do what we're doing in the room?" because CBT is very collaborative. So writing something in which I'm not able to collaborate directly with the client, I had to kind of think about what the reader's experience would be here.

Bud Clayman: They can use this with their therapist, right?

Jon Hershfield: Yes. I mean technically it's called a self-help workbook but I think certainly, it would be a great benefit to anybody who wanted to use it with their therapist. You might have questions and the questions might not immediately be answered there. The therapist may help to explain what's going on.

Bud Clayman is a moviemaker who suffers from OCD and Asperger's. We screened his movie ***"OC87: The Obsessive Compulsive, Major Depression, Bipolar, Asperger's Movie,"*** *in October 2013, and then talked with him and his co-directors via Skype. In addition to his website oc87.com, he also has a site called oc87recoverydiaries.com. This interview is the second of a series of four that Bud conducted with therapist Jon Hershfield.*

Jon Hershfield, MFT is a psychotherapist in private practice in Los Angeles and the associate director of the UCLA Child OCD Intensive Outpatient Program. His book is ***The Mindfulness Workbook for OCD: A Guide to Overcoming Obsessions and Compulsions using Mindful and Cognitive Behavioral Therapy*** *by Jon Hershfield MFT, Tom Corboy MFT, and James Claiborn PhD ABPP (Foreword).*

Human Brain Donation for Research

By Kay Zeaman

Great strides are being made each day in the field of brain research. For example, postmortem human brain research has played a significant role in identifying the function of an abnormal gene in Huntington's disease and the damage to a specific population of neurons in Parkinson's disease. Brain research provides our biggest hope of producing more effective treatments for brain disorders like OCD. But, did you know that progress is being delayed because of a scarcity of human brain donors?

I have done my own research on the topic as I have made the decision to donate my brain at the time of my death.

First I contacted the University of Michigan Anatomical Donations Program. They accept whole body donations. If you are interested they can be reached at 734-764-4359 or see www.med.umich.edu/anatomy/donors Although the university does not charge for the body donation my funeral director said there would be a charge of $1500 for him to make the arrangements. Also he told me that it is necessary to be registered before death or the body donation will not be accepted.

Other whole body donations in Michigan are:

Michigan State University 517-353-5398 or see
www.anatomy.msu.edu/Willed%20Body%20Program/index.html

Wayne State University 313-577-1188 or see
www.home.med.wayne.edu/anatomy/bequest/

Western Michigan University in Kalamazoo 888-436-7366
www.med.wmich.edu/giving/anatomical-gifts

Then I contacted the Eunice Kennedy Shriver Brain Bank at the University of Maryland. I got a letter back saying that they would not accept my brain donation because they specialize in research for brain disorders like autism.

Last I contacted the Harvard Brain Tissue Resource Center at McLean Hospital. I called 1-800-BRAIN-BANK and asked about my brain donation and was told they are very interested in receiving brains with OCD for research. I filled out the online form to be a donor and have sent it to Harvard to be registered.

The family of the deceased must notify Harvard immediately upon the death of a loved one as the brain must be obtained within 24 hours after death to be of value to researchers. Also the body must be refrigerated within 6 hours of death. A small amount of brain tissue provides a large number of samples

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Human Brain Donation
(Continued from page 13)

for many researchers. Harvard has a twenty-four hour answering service at 1-800-BRAIN-BANK.

After notification of death, a pathologist is sent from Harvard to remove the brain. Mine will be done at Spectrum Hospital here in Grand Rapids, MI. There is no cost to the family for this. I am having an open casket viewing which will not be affected by this donation. See www.brainbank.mclean.org for more information.

A neuropathologist does a complete examination of the brain and writes up a report which is given free to the family of the deceased. Samples of the brain tissue and a copy of the report are sent to researchers who are working on OCD/depression. It may be further examined by microscope and other means.

I should also mention brain banks use donations of normal brains too to be used to compare to brains with abnormalities.

Brain donation is still somewhat new to funeral directors so here is the approach I used and it was successful. First I visited several funeral homes and got a contract estimate from each one in writing for their services for the specific services and casket I wanted. Then I compared the contracts for several weeks. After I chose the one I preferred I contacted the funeral home and told them I was interested in signing the contract (dying is not inexpensive so there was a $10,000 contract up for grabs) but I needed one requirement. Then I gave them all the information about the Harvard Brain Bank and they personally contacted them. They had not done a donation to Harvard before. The funeral home I am working with, Metcalf-Jonkhoff, will not be charging me any additional fees but they will be making phone calls and coordinating the brain donation at time of death so there is virtually no cost for this donation.

For your information the Harvard Brain Bank is also accepting brains of individuals with schizophrenia or manic depressive illness as well as parents, siblings and offspring of these individuals to study the genetics involved.

Kay Zeaman is an OCDFM Board member who is always looking for interesting, alternative methods of addressing OCD.

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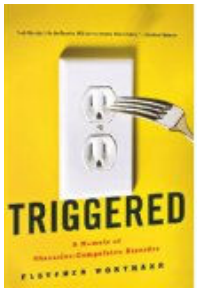

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Martin Franklin, PhD,
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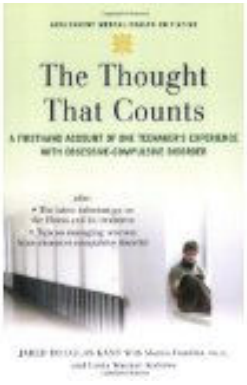

Joan Davidson, PhD, Jeff Bell
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New Harbinger Publications, August 1, 2014
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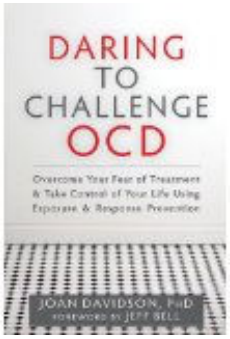

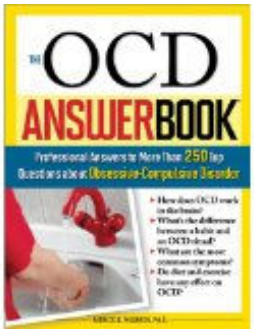

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Sourcebooks, 2007
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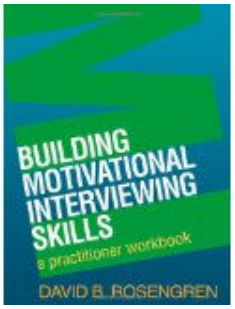

David B. Rosengren
Building Motivational Interviewing Skills
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ISBN 978-1606232996

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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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