In both the treatment of OCD and in living a disciplined life, there is no word more important than "choice."

> Choice
> The conscious, independent behavior (physical or mental) of selecting, making and or acting upon a decision when faced with two or more possibilities: the choice between good and evil, skilled and unskilled as well as, fight or flight.
> • A range of possibilities from which one or more may be selected.
> • A course of action (mental or physical), object, or person that is selected or decided upon and **summarily put into effect**.

This writing is a call to arms! Its purpose is to inspire readers to come to terms more honestly with the choices that will be required if they are to achieve their goals in life.

It is unfortunate that our schools do not teach us that our brains are comprised of many systems, some of which operate with considerable independence from the others. The independence of these systems is reflected in the way individuals suffering from OCD respond to episodes of extreme anxiety. Like all human beings, those with OCD have a strong basic survival instinct and are likely to experience great distress at the prospect of leaving a perceived threat unresolved. However, when what they experience as a threat is actually a function of their OCD (and therefore, is essentially the product of misfiring brain circuitry), they still react to this perceived threat as if their very lives were in danger. A conflict of independent systems also can affect those who do not have OCD. For example, a person may have the goal of exercising, but when the opportunity to do so presents itself, she may find herself thinking, "I'll begin tomorrow." Similarly, when tempted, someone whose goal is to save money may find himself thinking, "Yes, but this sale is so tremendous! Look at all the money I'd be saving!" The point is that we can only make disciplined and values-based choices that challenge instinctive or self-defeating urges when we are mindful of the contradictory agendas presented to us by our brains.

To date, the focus of my writing has been on educating sufferers and professionals alike about the various forms of OCD and the methods of behavioral treatment I have found to be effective. In contrast, this article attempts to identify the essential qualities within the patient that contribute to the success or failure of treatment. In my discussion of this subject, I will give considerable attention to such concepts as *agency, mindfulness, and autonomy*. *Agency* can be defined as the faith we have in our capacity to respond effectively to challenges in our lives. *Mindfulness* is the non-judgmental awareness of an experience in real time – that is, as that experience is unfolding – and an acknowledgement of our responsibility for the choices we make and/or the beliefs or perspectives we endorse in relation to that experience. The willingness of patients to be accountable for the choices they make has a profound effect both on the recovery process and the achievement of their goals in life. And finally the term *autonomy* refers to the choices and actions of the "Gatekeeper," the "I" or "me" who, based upon his or her goals and values, makes the final decisions on matters of importance to the individual.

Behavior therapy is an extremely powerful clinical intervention with specific replicable guidelines. "Exposure with Ritual Prevention (ERP)," a research-based treatment for anxiety disorders is a prescribed approach. Any experienced clinician can apply the techniques of ERP such that if the patient complies with the treatment protocols, there is a high probability that the

desired outcome eventually will be achieved. I want to emphasize, however, that the success of ERP is dependent upon the patient's day-to-day adherence to the guidelines established by the therapist in sessions. The scientific and objective approach of this type of treatment was one of the reasons I chose to specialize in OCD and other anxiety disorders.

John Parrish, Ph.D., my "mentor" at Johns Hopkins University Hospital, once said, "The mystery of therapy is not what works, but the aspects of therapy or qualities within the patient that contribute to treatment failure." After treating OCD for more than twenty-five years, I am convinced that the patient's understanding of what *making a choice* really means has a powerful influence on the success or failure of treatment.

All too often, patients are unaware of how certain basic misunderstandings interfere with the process of making a choice. For example, many patients seem to want to assign the responsibility for the choices they make to others – particularly their therapists. This tendency can seriously hamper the treatment process. In this article, I will highlight what I believe is required to truly take responsibility for one's own choices. I also will focus on the ways in which people tend to relinquish their **autonomy** by avoiding accountability for living in accordance with their chosen goals.

"CAN YOU HELP ME DOC?"

The question most often asked during the initial phase of therapy is, "Doc, do you think you can help me?" To this question, I always respond with some version of the following:

> "It may come as a shock to you, but my job is not to help you, but to work with you. Therapy is a partnership in which you, the patient, decide whether this is a good time in your life to take on a great challenge. In therapy, your hands are on the steering wheel, and your foot is either on the accelerator or the brake. As your partner, I hold a map with directions and instructions, but where we go and how fast we get there is entirely up to you."

Patients who simply *attend* therapy looking for help are at a disadvantage from the start. Often, they have experienced failure in their efforts with traditional psychotherapy and/or interventions like acupuncture or hypnosis, in which they are the recipient of treatment, rather than a participant in their own recovery. A patient's willingness to take responsibility for actively contributing to the treatment process is critical to the success of the therapy.

Even patients who have made significant progress in therapy often will say something like, "Steve you have helped me immensely." My response usually is, "You have made a tremendous investment in your own recovery, and I am privileged to have been a contributing partner in your dedication to success, but it was you who made the moment-to-moment choices necessary to achieve this wonderful goal."

WE ARE NOT OUR BRAIN

The power and intractability of the condition we call OCD has puzzled sufferers, clinicians, and researchers alike for years. How is it that highly intelligent people with well-developed reasoning skills can react so strongly to, and be so effectively controlled by, ideas that are so irrational? The answer, I believe, is that our brains are capable of sending signals that we experience as thoughts, feelings, and/or physiological responses independent of our conscious, volitional control. For example, if a person stubs his toe, he may find himself thinking, "You're a clumsy idiot!" What's important here is not the content of thoughts like these, but the fact that no one can prevent his or her brain from sending messages like this in the first place. The automatic, involuntary manner in which such thoughts emerge suggests that they are products of what I call *independent systems* in the brain. Unfortunately, patients often find it difficult to distinguish such reflexive thoughts from those that reflect their core beliefs, and may mistake them for sincere insights about themselves. And since these automatic thoughts can be harshly self-critical, patients may agonize over what this internal dialogue suggests about their potential for good or ill.

The question then arises, what do our *feelings* say about our fundamental beliefs? I believe that the answer to this question is, "Not necessarily very much." Our feelings are *not* a reliable measure of our self-perception. Why? Because automatic thoughts can create feelings that are just as convincing as thoughts that reflect our deeply held beliefs. So, it is vital that we do not reflexively take the thoughts and feelings that *our* brains send *to us* at face value.

In the example above about someone who stubs his toe, this individual's reflexive self-criticism may well contradict his actual perception of his ambulant composure. Patients with OCD often state that despite being painfully aware of the fact that the actual risks they face from what their brains have identified as threats actually are negligible, they still experience profound fear, guilt, anger, or depression at the prospect of not attempting to resolve or escape from these "threats." Indeed, at such times, reason and logic are rendered ineffective as a means of restoring their emotional equilibrium. Patients often find that the feelings they are experiencing seem so authentic and compelling that it is very difficult for them to accept that their fears are unjustified. They feel that they are confronting threats from which they must escape, and they become desperate to eliminate these threats and restore their sense of safety. Patients say things like, "I know that I can't catch AIDS from touching that door knob, but it *feels* so dangerous that I actually believe I'm at risk." These individuals are not delusional, but because they are using their feelings as a measure of the legitimacy of their concerns, they find it extremely difficult to ignore their brain's irrational assertions.

In the treatment of OCD, how patients view their own perspective can profoundly influence treatment outcome. My hope is that this article will shed some light on how patients can reframe the way in which they view themselves and the world so as to acknowledge that their perspective is a *choice,* not something determined by past experience. It is essential that patients view their perspective as something that is under their conscious control, rather than seeing themselves as victims of their own perspective.

IRRELEVANCE

Fundamental to the treatment of OCD is the concept of irrelevance. Since OCD is a condition in which sufferers feel compelled to resolve or escape from imagined threats, the goal of treatment is for patients to become *habituated* to that which the disorder has identified as a threat. For habituation to take place and the symptoms of anxiety to decrease, patients must make a fundamental shift in how they relate to the signals the OCD is sending them. First and foremost, they must stop taking them at face value and *choose to see them as irrelevant*. These signals may well include messages of doom or impending disaster that can provoke anxiety, guilt, depression, anger and other powerful emotions, and it is precisely because of the presence of these emotional components that reframing the disorder's messages as irrelevant is so difficult. But that is the task that must be accomplished if the treatment is to be successful.

I often use the two versions of the following account to demonstrate, first, how those with OCD respond to the signals of the disorder before treatment, and second, how those who have successfully undergone treatment have become habituated to these signals by reclassifying them as irrelevant.

> *David and Ester had just viewed the house of their dreams. For some reason, the house also was a great bargain, and they wondered why the asking price was so low. Nevertheless, everything seemed to check out, so they negotiated a price and purchased the house, and soon they had begun their new life in their dream home. Three days after the couple moved in, however, as they were getting ready for bed, they noticed a distant rumbling that rapidly became a roar, accompanied by a shaking and rattling of the house. David ran out into the backyard and, peering through some foliage at the edge of his property, was shocked to discover that the noise was coming from a freight train that was passing only a short distance from their property line. The railroad tracks had been hidden from view by the foliage at the edge of the property, and the previous owner had elected not to inform them of the house's proximity to the tracks. The next day, the unhappy couple confirmed that twice a week their lives would be disrupted by the roar of a freight train passing in the night. The couple's dreams had been shattered. They realized that they had been deceived, and repeatedly asked themselves why they hadn't done a better job of checking out the house and the neighborhood. In the years that followed, every time a train passed by, they cursed the day they had made the ill-begotten choice to purchase this house.*

Now consider the following version of the story:

> *David and Ester had just viewed the house of their dreams. For some reason, the house also was a great bargain, and they wondered why the asking price was so low. They took a look at a map of the property and the surrounding area and discovered that there were railroad tracks running behind the house only a short distance from the property line. Further research revealed that twice a week, freight trains were scheduled to pass by the house at night. Now they understood why the house was such a bargain. Ordinarily, they would not have been able to afford such a large and well-maintained home. Armed with this knowledge, they engaged in some tough negotiations, and soon settled on an agreeable price. Two months later, they moved into their beautiful new home. On the six-month anniversary of purchasing*

the house, the couple had a party to celebrate their good fortune. At one point during the festivities, there was a distant rumbling that rapidly grew to a roar, accompanied by a shaking and rattling of the house. Alarmed, the guests asked the couple what was causing all the noise. David and Ester looked at each other and smiling, together responded, "What noise?"

In the first story, the noise of the train is viewed as the predominant feature of a flawed situation. In the second, the couple's attitude is that because it enabled them to purchase such a wonderful home, the noise is irrelevant. And because they did not find the noise of the train distressing, their brains stopped processing this otherwise powerful signal.

Since OCD involves the brain's attempt to warn you about something it has (incorrectly) identified as a threat, I encourage the patient to consider responding to the warning signal with a degree of "appreciation" for their brain's attempt – albeit, a misguided one – to protect them. These warning signals come from the brain's primitive "fight or flight" center, and they reach one's conscious mind accompanied by intense emotions and sensations. But since the brain is capable of sending us involuntary thoughts that reflect nothing meaningful about us, we can independently reject such thoughts – even when they assume the form of self-critical insights.

THE GHOST IN THE MACHINE

In many respects, the functioning of our brain is very mechanistic. Numerous metabolic functions are regulated automatically by the brain without any conscious input from us. And yet, the part of us that possesses values and exercises choice – what I call the "Gatekeeper" – constitutes what we consider to be our "identity" despite the fact that it has no clear seat in any specific center of the brain. Its influence is preeminent, yet it remains somehow hard to define, and it seems to have an existence that is independent of the "machine" we call our brain. In that sense, it is the "ghost" in the machine.

The "ghost," so to speak, represents our unique and independent volitional thought capacity, our ability to choose the thoughts on which we focus and to which we assign relevance. The Gatekeeper makes the final decisions when we are mindfully aware of the options available to us. For example, when I am standing on a high balcony, the thought that I should jump might enter my consciousness, but the Gatekeeper, the "I" or "me" who is accountable for choosing the thoughts and feelings I endorse and those I reject, has the ability to examine such an idea and to dismiss it as a passing thought with no significance. The Gatekeeper enables each of us to decide which part of our body to move, which ideas are pertinent to our goals in life, and which conversations have meaning and value for us. We can focus our attention on certain ideas in our mind and ignore others. It is interesting to note that although brain mapping studies have located the specific regions of the brain from which speech or emotions originate, no one has been able to locate the area of the brain from which free will originates.

The words of Viktor E. Frankl remind us what the concept of autonomy means when he says, "…between stimulus and response there is a space. In that space, there is a freedom to choose our responses. In choosing a response, we affirm our potential for growth and our freedom." To effectively exercise this freedom to choose, the discipline of *mindfulness* is required, so that we can make choices in accordance with our values, rather than our conditioning or instincts.

As I said before, the human brain controls numerous metabolic processes without any conscious input from us. When we have OCD, however, the brain (the "machine") also sends disruptive involuntary signals to our conscious awareness that can cause acute emotional distress and make it more difficult to function. The Gatekeeper is presented with powerful emotional distress signals and thoughts that typically include some threatening component. If you, the Gatekeeper, find these emotional distress signals overwhelming, you may choose to seek reassurance or safety, especially if (as is often the case) you are unaware that you are being victimized by your own brain. In fact, patients often feel terrible guilt and frustration about the compulsions and obsessions that plague them because they mistakenly believe that they – as the Gatekeepers – are responsible for the cognitive components (what I call "spikes") and the painful emotions that accompany them. This belief is completely unjustified, however, as the symptoms they experience result from messages that are generated automatically by their brains, and over which they have no control.

Differentiating mechanistic brain activity from the activity of the Gatekeeper is facilitated by understanding that anything about which we are not able to make a choice is not a representation of "us." Dreams, mental associations, panic, sleep, and even sexual arousal are just a few of the aspects of human experience over which we often mistakenly believe we have volitional control. Associative thoughts might include linking the sight of a knife with the thought of stabbing someone.

Old-time movies sometimes depicted the use of an archaic therapeutic device called "word association," in which the psychologist would say a word and then have the patient say the first thing that came to mind. For example, the therapist would say "mom" and the patient might respond by saying, "love." This technique supposedly was used to uncover deep-seated feelings or desires or suppressed memories of the patient. Unfortunately, what this unscientific method of inquiry inadvertently instilled in the mind of the public was the belief that our spontaneous and involuntary mental associations can reveal valuable or meaningful data about us. This concept, along with many other Freudian postulates, has set psychological theory back many decades.

One of psychology's greatest clinicians, Albert Ellis, advanced the concept of "automatic thoughts." He posited the idea that our mind independently sends spontaneous irrational messages to our conscious awareness, and that each of us has the capacity either to endorse or disqualify these ideas. He applied his theories to the treatment of clinical conditions like depression and low self-esteem. His approach was to help patients identify their automatic thoughts, and to dispute these irrational ideas and replace them with more rational beliefs. To build upon what I said earlier in this article, I find it inexcusable that our schools do not teach us that that the messages our brain automatically sends us are not necessarily significant or meaningful. Although Albert Ellis' work is not directly applicable to the treatment of OCD, his

basic premise affords us all the opportunity not to be misled by our involuntary irrational thoughts.

VISITING THE CAVEMAN

As therapists, it is crucial that we work to help those who suffer from OCD learn to "forgive" themselves for having the disorder and to understand why their own brain seems to work against their best interests. OCD sufferers are not weaker, emotionally, than other human beings. Rather, they are confronted with an emotional distress signal fueled by one of the most powerful of all human instincts – the instinct to survive. OCD is a faulty expression of this fundamental instinct. Compulsively performing an escape ritual in the face of a perceived threat is not weakness, but rather the most functional response to an instinct designed to protect us from danger. Indeed, it requires considerable mindfulness, determination, and fortitude *not* to respond to prompts from one's OCD as if they were warnings of legitimate threats.

Research has shown that OCD is caused by a malfunction of a tiny brain structure called the *amygdala,* which is responsible for activating the familiar "fight or flight" response. With this information in mind, the symptoms of OCD can be viewed as misguided attempts by the brain to carry out one of its primary functions – to protect you from harm. Your brain is warning you of a potential threat so that you can escape and avoid similar situations in the future. The only problem is that the "danger" does not really exist.

Our instinct for survival is a vital safeguard against legitimate dangers, but for those suffering from OCD, this instinct is activated needlessly and repeatedly in relation to improbable or absurd possibilities. Nevertheless, the anxiety, fear, and other emotions that accompany these false alarms feel as authentic as any you might experience when facing a legitimate threat to your life or safety. Furthermore, prior experience of such false alarms does not in any way lesson the strength and urgency of the current warning. Each occurrence of the alarm feels as intense and compelling as the first. Thus, it is pointless to try to draw on one's memory of similar events in an effort to convince your brain that it is being fooled. The emotional distress you are experiencing at the moment will overwhelm any attempt to logically and reasonably disqualify the legitimacy of the perceived threat. You can resist this miscued survival instinct, however, by choosing to disregard the warning signals your brain is sending you, and purposefully exposing yourself to the perceived danger while accepting the possibility that the threat is real. In making this choice, the OCD sufferer is engaging in an "exposure exercise" with ritual prevention. To get a sense of how this exercise might feel, imagine yourself standing on the railroad tracks as what appears to be a speeding train bears down upon you, and as it is about to hit you, choosing *not* to step off of the tracks.

The brain is programmed to escape or confront threats, to seek basic necessities such as food and shelter, and to pursue pleasure and avoid pain. Left to these primal instincts, the brain will seek the path of least resistance in its attempt to get these needs met. The nature of this basic programming explains why the treatment of OCD is so difficult. To be effective, the treatment requires that the individual – the Gatekeeper – repeatedly engage in daily exposure exercises that contradict the brain's basic programming to avoid or escape from danger. In other words, to be in compliance with the treatment protocols, patients must repeatedly make an autonomous choice to disregard their instinct to stay safe. Needless to say, this is not an easy task. Often, patients must choose to disregard threats that they or those that they love will die or suffer some other terrible fate if they do not ritualize.

SELF-ESTEEM

Those who believe in self-esteem, like those who believe in ghosts, will be haunted by their beliefs. How is it that we can hate our "selves?" As previously stated, the brain is programmed to ensure that certain basic needs are met. To maximize the chances of success, it constantly evaluates the individual's performance and places a weighted bias on any deficiencies it finds. Now, if the process stopped at this point – with the brain's identification of specific aspects of one's behavior needing improvement – this would not lead to low self-esteem. However, the human brain also tends to create generalizations based upon the behavioral problems it finds, such that the individual's "personhood" is judged, rather than elements of his or her behavior. The *person* is labeled as deficient, not just his or her behavior. To illustrate this point, consider the following tongue-in-cheek account of the unfortunate "caveman" below. The story goes that this caveman has developed great skill at winning the affections of cavewomen. He is known by the tribe as quite the cave-ladies' man! On the other hand, his spear-throwing skills are woefully underdeveloped, and he is not considered much of an asset in hunting mammoth. Instead of looking with pride upon his reproductive skills and seeking out the most adept spear-throwing cavemen in the tribe to teach him how to throw spears more accurately, his brain generalizes about his "personhood" based upon his deficits and tells him that he is a "loser" because no self-respecting cave woman would want someone who was consistently unsuccessful as a hunter and would have trouble providing for his family. In the case of modern day *Homo sapiens*, a person may have a great job, a wonderful education, a loving family, lots of friends, and live in a beautiful home, and still hate himself because his brain generates automatic thoughts about doing harm to others, and he believes that these dreadful associations indicate that he is an evil person.

The antidote to low self-esteem is *no* self-esteem. As human beings, we can choose simply to accept ourselves as human and not to engage in any qualitative assessments of ourselves as people. We can accept that increasing our dedication to honesty does not actually make us a better person, but simply indicates our increased commitment to a single value. A life where we consciously reject all labels for ourselves and others can create a great deal of emotional peace. A humorous catch phrase of the CBT community is "Labels are for jars, not people." Once you adopt this perspective, the guy who is driving aggressively and cuts you off is no longer a "jerk," but now is simply a fellow human being whose driving style is different from your own. I realize

how satisfying it can be simply to label the guy, but for the sake of emotional harmony, I choose to correct my brain when it makes such judgments about others.

OCD IN A NUTSHELL

OCD is a condition in which the brain attempts to help the sufferer survive against serious threats. The only problem is that these "threats" are never legitimate. After listening to a lengthy description of the mechanisms of OCD in the brain, a patient summed it up nicely by saying, "So basically, OCD is a malfunctioning amygdala looking for a thematic justification for the intense emotional discord." The irrational mental associations that constitute these threats are given credence by sufferers only because they are accompanied by intense emotional emergency signals that produce a compelling need to seek safety.

Those suffering from OCD often mention that their obsessional concerns *feel* legitimate. Their emotional responses to the irrational associations of the disorder are identical to those they would experience when confronting legitimate threats to their lives or safety. Because of this, one often finds very intelligent and rational individuals engaging in elaborate rituals to escape nonsensical risks. As another of my patients put it, "Steve, this is a very stupid disorder that carries a very powerful and compelling emotional persuasiveness." The fear of catching AIDS from a doorknob is irrational. A loving mother's concern that the sexual associations generated by her brain in relation to her daughter are evidence of her own deviancy is unfounded, and yet she worries about it for hours each day.

To be diagnosed with OCD, patients must exhibit behavior resulting from anxiety and their efforts to escape from distress that is disruptive and handicapping to their life in a significant way. More than 80% of the adult population admits to having bizarre automatic mental associations, and the nature and content of these mental associations are no different for those suffering from OCD. However, the associations of OCD sufferers are accompanied by an overwhelming sense of panic and desperation. I came up with the term "spike" for the pairing of these mental associations with anxiety to reflect the painful way they "pierce" sufferers' consciousness.

If individuals endorse the belief that their spontaneous, irrational associations reflect deep and meaningful truths about their basic nature, they may be resistant to treatment. Those who adopt such a perspective also often evaluate the success of their treatment by whether these mental associations and the painful emotions that accompany them have stopped or at least decreased in frequency. However, since it is natural for human beings to have these associative thoughts, the goal of ending them is not realistic. Unfortunately, a great deal of time and effort is often devoted to convincing patients that they cannot measure their progress by whether or not they

continue to have these associations. Since the primary goal of behavior therapy is to convey to the brain that these threatening associations are meaningless and irrelevant, choosing to accept the presence of these thoughts actually constitutes a significant step toward recovery.

AUTONOMY

Autonomy is a reflection of a person's unique and independent perspective. For the purposes of this writing, the word "autonomy" will be defined as the awareness and acceptance of one's responsibility for choosing one's own beliefs, values, opinions, and agenda and for having one's own perspective. To be autonomous is to act upon the belief that you, the G*atekeeper*, are responsible for making independent choices and for choosing your own beliefs, as well as for the consequences of your independence of thought and your unique understanding of the world. Autonomy is the recognition that although you are not responsible for the creation of most of the ideas in your head, you *are* responsible for choosing the ideas that you endorse. Essentially, autonomy is what makes us human. The most important factor in the successful treatment of OCD with behavior therapy undoubtedly is the patient's understanding and application of what is called "autonomous choice." Since for someone with OCD, the brain's agenda is to keep the sufferer safe from "threats" that do not really exist, *o*nly in making *an* autonomous choice that contradict*s* the "machine's" *(the brain's)* inclination*s* can *the individual liberate him- or herself* from the *quicksand* of ritualization.

When one speaks about autonomy, the concept of "centeredness" is always close at hand. To be centered requires that you engage in the disciplined evaluation of your own perspective, and that you strive to develop ideas and views that are independent of those of your peers. Centeredness is also critical to one's awareness of and differentiation from the brain's wishes and impulses. It is very important to engage in the mental discipline of remaining centered, even as the brain sends to your conscious awareness automatic involuntary thoughts that confound and contradict your genuine perspective. Being centered is integral to the maintenance of an emotional "stronghold" in which you are unaffected by the judgments of others. For example, if you were to remain centered when someone tells you that he thinks you are a good person, you would remind yourself that the person who complemented you is merely celebrating your favorable qualities, and *your* sense of what your desirable qualities are would not be altered or influenced by this person's judgment about you. In other words, being centered means your assessment of your self-worth is not influenced either by the positive or negative statements that others make about you.

In a state of centeredness, you are focused on your own agenda. This is not to be confused with selfishness. Being giving, empathic, generous and forgiving can foster emotional growth and reflect tremendous centeredness. In this context, "focused on your own agenda," means that you always endeavor to stay in touch with your own understanding of the world without attempting to impose your perspective on others.

The following anecdote illustrates how being centered can contribute to friendship and communication:

Sam tells his good friend, John what a good time he had at the party he attended the previous night*, with its fun people and great music. John, who was not invited, feels left out and finds it difficult to* express *happiness about the* enjoyable time *Sam had. But he makes an effort to stay centered, and being mindful that he is enjoying Sam's company right now despite his disappointment at not being invited to the party, he reminds himself that even though he was not a part of Sam's enjoyable experience, he still can share in Sam's celebration, and he can take pleasure in the close friendship that they share.*

When you hold the door open for a perfect stranger, and the person doesn't even say "Thank you," what are you to do? Should you give in to the temptation to say, "You're welcome!" in a sarcastic and disgruntled tone? Is it your duty to inform this stranger that that he was supposed to have gratefully acknowledged this random act of kindness? Your brain may send you a message that this person needs to be taught a lesson, and you may find yourself inclined to act in accordance with this impulse to retaliate. The centered response, however, is to look to your own values, which may guide you to take the emotional high ground and remain silent, with the understanding that you have followed your agenda and upheld your values by this small act of kindness.

Remaining centered also can be very helpful with the sense of vulnerability that often is experienced in the early stages of a romantic relationship. Every moment you are apart from your love interest, you desperately want to be reassured that your partner still is attracted to you and remains invested in the relationship. Being centered means maintaining the emotional discipline to remind yourself that the only information that is relevant in this situation is that *you* still are excited to see your partner again, and that you do not need to be reassured about your partner's reciprocal interest.

WHO IS DRIVING THE BOAT?

How do you make your most important life choices? Are you controlled by your own brain's impulses? When your brain says jump, do you say, "How high?" Or can you behave in a way that is independent of the automatic thoughts sent to you by your brain? OCD is a condition in which these automatic thoughts are accompanied by powerful emotions that originate in a part of the brain that simply reacts, where autonomy does not exist. When you have OCD, if you do not remain constantly vigilant about making choices that are directed toward your recovery, if you allow yourself to be manipulated by the reactive signals from your brain, you will find yourself surrendering more and more control to the disorder.

Does the tail wag the dog? Do our constantly changing emotional states determine what we choose at any given moment? Does the successful treatment of OCD depend upon the brain's perceived readiness to take on the challenges of daily ERP assignments, or does it depend upon the patient's determination to do whatever is necessary to be successful? It takes constant

vigilance to assume responsibility on a consistent basis for making the conscious and deliberate choices that express our autonomy. At the end of the day, we need to choose our path based upon our autonomous goals, not the feeling states of our pleasure-seeking, discomfort-avoiding brain. In therapy sessions, I regularly ask my patients, "Who is driving the boat?" This question challenges patients to examine whether they are making mindful, deliberate choices that fulfill their agenda for recovery. To paraphrase Viktor Frankl, between stimulus and response, there is an opportunity for all of us to be mindful of our freedom to choose a response that serves our best interests and furthers the expression of our highest values.

Emily is considering performing an exposure exercise at a higher emotional threat level than any she has attempted thus far in her treatment. Her brain tells her that she is overreaching and that she will not be **able** to withstand the intensity of the stress she will experience with this exposure. Her involuntary thought is that this exercise is too great a challenge for her to take on at this point in her treatment. As a result, Emily now feels immobilized. She feels that she must wait for her brain to release her from its emotional grip before she can take on this challenge. However, seeking permission from her own brain to engage in this exercise removes her from the captain's chair in life and puts her in the back of the boat as a passenger being taken for a ride. I ask her, "Who is driving the boat?" I remind her that if she waits for her brain to give her the green light and lower the emotional wall of terror, her recovery will depend on a malfunctioning system that is trying to protect her from dangers that never existed in the first place.

A lack of agency occurs when people decide that they lack the ability or potential to achieve a goal. This often happens when they endorse their brain's negative programming that is based upon their personal history. A common response reflecting a lack of agency is when patients say to me that they did not accomplish a task because they "couldn't find the time." I usually respond to this by saying, "I think you'll find some time hiding under the cushions of the living room couch." Time is not found! It is allocated by one's own choices. When I see patients who claim that they are "incapable" of making growth-oriented choices, I quote John Bach's words, "Argue for your limitations, and sure enough, they're yours." Patients often complain that the exposure exercises assigned to them are too difficult. "The anxiety was overwhelming," they may say. Such ideas convey a belief that our freedom to make choices is contingent either upon external influences or securing permission from our own brain to proceed.

It can be unpleasant to take full responsibility for the way we choose to allocate our time. We often regard life's processes as a series of obligations, "musts," and responsibilities. In other words, we tend not to "own" our own time. A lack of agency is demonstrated when you say, "I can't do this," instead of, "I'm choosing to not endure the discomfort." When you use the word "can't," you are taking the possibility of making an autonomous choice out of the picture, and you miss the opportunity to honestly assess your resources or resilience in relation to the challenge you are considering.

How often have we set out to achieve a goal only to find that because of a perceived lack of control, our efforts were unsuccessful? In such cases, do we blame external circumstances or, even worse, do we then conclude that we simply were incapable of achieving the goal? If we are not mindful of who has the right and the responsibility to make our choices, then the emotional difficulty of the tasks we face most likely will determine what we choose. When we feel weak, we may make the non-disciplined decision – the path of least resistance can be very seductive. "Hit the snooze button; it's too painful to get out of bed now." Left to its own devices, the mind does not always choose the path that will be most beneficial in the long run. If you are going to a club in the evening, decide in the sobriety of the morning how many drinks you will allow yourself to consume that night. Then as the evening wears on, see if you can keep the commitment you made to yourself and disregard your brain's seductive invitations to have just one more. The brain tends to seek pleasure above all else. If you do not distinguish between this pleasure-seeking internal voice and the more disciplined agenda of your autonomous self, you are likely to end up repeating many of the choices that you have come to regret.

As stated earlier, when you have OCD, your brain sends you the most compelling messages it can to get you to perform ritualistic behavior to obtain relief. According to your brain, you are in grave danger and desperately need to extricate yourself from the perceived peril. Without being **mindful** of your ability to identify signals with an OCD theme, you most likely will give in to your brain's impulse to escape. Unfortunately, the more you give in to your OCD, the more entrapped by it and the less functional you become. When you obey the brain's directives to stay safe at all costs, this life-limiting cycle is potentially endless. On the other hand, when you are educated about your condition and learn the skills that allow you to assert your independence from the disorder, you can instead make choices that reflect your autonomous values and interests. In the tremendous tug-of-war between your autonomy and the brain's urgent efforts to "protect" you, unless you ensure that you always remain in the captain's chair, you will find yourself living a more and more handicapped, anxiety-ridden existence.

FEELINGS ARE NOT THE GOAL

Why try to affect something over which you have no control?

Obsessive-Compulsive Disorder is characterized by a malfunctioning emotional alarm system in the brain. Although it repeatedly issues what essentially are "false alarms," the emotions that accompany these warnings *feel* completely authentic. However, if patients make relevant life choices based on these emotional distress signals rather than on their autonomous goals, their condition will inevitably deteriorate. Remember that even when misguided, the instinct for survival remains one of the most powerful instincts we have, and the illusions created by the disorder that one's survival is in jeopardy are absolutely convincing. And yet, the treatment for OCD requires that patients disregard this instinct and engage in the extraordinarily difficult task of *not* heeding their brain's warning while still accepting the possibility that the threat is real. Needless to say, this can be quite painful, because ignoring what feels like a legitimate warning from your brain that you are about to be harmed can feel like you are about to jump off a cliff.

When engaging in this process, bear in mind that "feeling good" is not the immediate goal of the treatment. You must first go through the pain of ignoring your brain's false alarms in order to feel better in the long run. Remember, when you have OCD, you cannot use your feelings to determine if a threat is "real." Doing so is a little like asking the Devil for directions to Heaven.

For the past few months, Kathy has been struggling with the question of whether she is a lesbian, and at this point, she is desperate to find the answer and put an end to the torment of not knowing. She leans in for a kiss from her long-term boyfriend, and hopes that this time she will feel the passion that seems to have been missing from their relationship since her struggles with the issue of her sexual orientation began. When he kisses her, however, she feels nothing. This absence of passion only increases her anxiety that she might be gay, and she wonders how much longer she can sustain her relationship with him when so little of the passion and excitement she used to feel when they were together remains.

Kathy's reaction is an unskilled one. If she were a skilled veteran of OCD therapy, she would have given herself credit for having gone ahead with her commitment to being affectionate with her boyfriend and understood that the absence of an emotional response on her part was not a relevant factor at the time. She would have recognized that her lack of responsiveness had much more to do with the anxiety she felt about her sexual orientation than any problems in their relationship. Both

OCD and depression are conditions that are driven by powerful emotions like anxiety, guilt, despair, a sense of fragility or weakness, distress, panic, hopelessness, and demoralization. But feelings, like thoughts, can be created by independent systems within our brain. When feelings are spontaneously generated in this way, the Gatekeeper has no control over the process. We cannot consciously shape our emotional responses; we simply experience them. Feelings also can be the "dividend" of the choices that we make. And one of the basic premises of cognitive therapy is that feelings are the products of the meaning we assign to our experience. In other words, our interpretations of the events in our lives determine our emotional responses. Other factors that can influence emotional variability include sleep deprivation, dietary choices, brain chemistry, circadian rhythms, diabetes, and hormonal changes during the menstrual cycle.

The work of Steven Hayes, who developed Acceptance and Commitment Therapy (ACT), closely parallels the treatment protocols of behavior therapy. In speaking about the sadness a patient of his experienced upon the death of his hamster, he says, "A CBT expert would say that his sadness was not caused by the event of his hamster dying. This expert would acknowledge that the pain was a result of the love he freely gave his hamster. CBT has unfortunately neglected to take into account that feelings can vary even without a cognitive component." Acceptance and Commitment Therapy (ACT) encourages patients to live their lives with daily structure and to remain loyal to their life processes, independent of the emotional variability that in the past has thwarted disciplined living.

"Don't let the tail wag the dog!" In reference to our feelings, this familiar saying serves as a reminder of the importance of not letting our emotions determine the choices we make in life. A patient with issues of mood instability is making a clinically dangerous choice when he takes a day off from work because he is "not feeling up to it." This so called "mental health day" is usually spent in bed or just hanging around the individual's home. Such a choice, the purpose of which is to mollify the pain of the morning, actually can exacerbate the patient's negative mood and create a spiral of negative, unproductive choices. Often, the temptation the next morning to stay home again will be even stronger. When we allow our emotions to determine the choices we make, we tend to yield to our negative emotions and avoid challenges, rather than making disciplined choices reflecting our autonomous values and beliefs.

As stated earlier in this article, helping the patient being treated for OCD learn to regard the prompts and themes of the disorder as irrelevant is by far the most important goal of behavior therapy. The choice to classify something as irrelevant falls under the purview of the Gatekeeper. The psychological dividends of regarding the "spikes" (the irrational, disruptive warnings) from the disorder as irrelevant – even in the face of acute anxiety – are *habituation* to the spikes, which leads to their *extinction*. Habituation is the brain's tendency no longer to react with anxiety after the patient has repeatedly chosen to expose him- or herself to the stimulus (spike) without seeking to escape from the "threat."

When considering the therapeutic goal of choosing irrelevance, the greatest quandary that patients face is that the spikes do not feel irrelevant. The warnings of impending doom that they are receiving from their brains feel as authentic as those they would experience when facing bona fide threats to their well-being. So, when your mind is sending you signals (spikes) that feel relevant, how do you demonstrate the irrelevance of these thoughts and feelings to your brain? By not altering your choices and plans – your life path -- *in any way* to accommodate the spikes, no matter how turbulent and painful your emotions may be. By unmistakably communicating to your brain that the irrational warnings it is sending you will have no effect whatsoever on your behavior, you are making it clear that there is no point in continuing to send them, and eventually, your brain will get the message and stop.

Sometimes, one finds that an event or experience that has been celebrated by others does not live up to one's expectations. Some years ago, I was told by my friends that "Forrest Gump" was "like the best movie ever," but when I finally got around to watching it, I was very disappointed. In fact, it wasn't until I saw it for the third time that I
began to appreciate its genius. Initially, however, my anticipation of how much I was going to love this movie was not matched by the actual experience of seeing it that first time. Patients in therapy for OCD often will receive a bit of symptom relief after aggressively applying one of the therapeutic techniques they have learned to a challenge from the disorder. However, subsequent applications of newly-learned techniques often do not produce the same degree of relief as was obtained with that initial application. Moreover, the expectation that future aggressive exposures will bring as much relief as the first might actually cause the patient to panic when the that level

of relief is not obtained. Patients may think, "The technique 'worked' before. How come it's not working now?"

The paradox of OCD is that very intelligent and rational people behave in extraordinarily irrational ways. Sufferers' brains are sending them signals of terror linked to what often are nonsensical ideas. These sane, intelligent and rational people already know, on some level, that their fears are unreasonable, and yet the disorder's spikes are experienced as legitimate and compelling to such a degree that the patient feels driven to perform escape responses. Choosing not to alter one's plans despite the panic one feels requires tremendous fortitude because this choice involves disregarding one of the most powerful basic human instincts – the instinct to survive. In therapy, patients are directed to bypass their feelings and act with emotional independence. The willingness to confront one's fear and repeatedly demonstrate its irrelevance is at the heart of Exposure with Ritual Prevention (ERP).

If your goal is to have "positive feelings" on a consistent basis, then you are setting yourself up for much disappointment and despair in life! A more productive goal is to keep your focus on the choices that "set the stage" for such rewards. Positive feelings can be a dividend of having made choices that are in accordance with your autonomous goals, choices that can be as simple and straightforward as those that enable you to do things you enjoy. For example, I attended the US Open this year with my family and had a great time. That is not surprising – I have always enjoyed this event, and I go every year. When I plan my next trip, however, I will focus on the actions that make it possible for me to be there, like purchasing the tickets, arranging for a place to stay, and actually getting to the event, rather than the joy I anticipate experiencing when I am there.

Many of my patients believe that I hate the word "feel." Nothing could be further from the truth. A patient once abruptly terminated treatment after I said to him, "I don't care how you feel." While he assumed that the remark was indicative of callousness on my part, I was merely trying to teach him to focus his attention on the healthiness of the choices he made, rather than the chronic low feelings he was experiencing. After each skilled life choice, he quickly would examine whether he felt better as a result. His attachment to the potential rewards of making healthy life choices made it difficult for him simply to allow himself to experience (and enjoy) feeling good when it occurred naturally. Patients often joke with me by saying "I know, Steve, you don't care how I feel." They understand that my priority with them is to be vigilantly focused on their choices being skilled and independent of the moment-to-moment variations in their mood.

Statements about one's feelings tend to place too much emphasis on an aspect of life over which we have no control – our moods. All too often, I hear sentences like, "I feel anxious about my hands being dirty," or "I feel guilty that I had a sexual thought regarding my mother-in-law." A much healthier approach is to say something like "I chose not to wash my hands, even though I felt anxiety about the possibility of getting sick if I didn't wash them." In statements like this, the focus is kept on the constructive actions that were taken, rather than on the painful feelings that accompanied them.

I feel happy when I play cards with my family or friends. I feel exhilaration and joy when I am on a sailboat, whether I'm racing or just cruising. I do not engage in these activities with a guarantee that I will experience such positive feelings, but instead, the increased probability that I will experience such positive feelings when I participate in these activities motivates me to choose to do them. I believe that our tendency to surrender our autonomy to our feelings leads to much despair and frustration in life. When we expect to be rewarded with positive feelings for participating in certain activities, we may find ourselves looking desperately for these "rewards" once these activities have concluded, and this, itself, may prevent us from experiencing such feelings simply as the natural by-products of having engaged in these activities in the first place. What a "buzz-kill" when the wise guy at a party says, "Hey, are we having fun yet?" If things really haven't gotten going yet, a question like this only increases the pressure on host and guests alike to make the party live up to everyone's expectations. And in such cases, it rarely does.

Determining how well we are doing based upon how we feel really is "the tail wagging the dog." One's capacity to make mood-independent choices is a much better measure of success. To be able to make a disciplined choice despite a diminished affect (a less than optimal emotional state) is a great accomplishment, deserving of praise and respect.

CHASING THE DRAGON

People who use heroin report that the experience of their first high is absolutely the ultimate state of euphoria, and that all their subsequent experiences with the drug amount to little more than attempts to recreate that initial euphoric experience. This futile and dangerous quest is called "chasing the dragon." Similarly, individuals who suffer from OCD tend to be aware of a time in their life when they were not tormented by their brain's constant, attempts to escape from illusory threats, and people who have experienced remission or previous treatment success tend to fixate upon the time when they were relatively free of the disruptive effects of the OCD. This focus on recreating a state in which they did not experience the burdens of their disorder creates an urgency in their desire to see their brain stop generating all the spikes and anxiety they experience. However, since the brain's purpose in creating these symptoms is to warn them about dangers they face (albeit nonexistent ones), impatiently looking for this protective mechanism to stop is antithetical to the basic programming of our survival instinct. Similarly, the desire of sufferers to see their OCD go away and to re-experience a time when they were free of its disruptive effects contradicts the processes and philosophy of behavior therapy. If relating to the spikes of their OCD as irrelevant is critical to patients' recovery, then consider the adverse effects of desperately looking for the brain to stop producing these challenges. A question frequently faced by behavioral psychologists is, "If I'm attending therapy to feel better, then why shouldn't I be frustrated when, after this amount of time and money, I'm still feeling lousy?"A skilled response involves reminding the patient that the *goal* of behavior therapy is for them to consistently be able to make disciplined choices, regardless of how they feel or of the expected emotional dividend. Patients are encouraged to allow an improvement in their emotional state to occur on its own and at its own pace. The primary goal of this type of treatment is to enable the patient to demonstrate to his or her brain that the prompts from the disorder are inconsequential.

The indirect effect of achieving this goal is that both the frequency and intensity of these prompts will decrease progressively over time.

A significant number of my patients enter therapy with the belief that they have the potential to live "the good life." They take stock of their background and current "assets" – friends, family, finances, connections, etc. – and conclude that if they could rid themselves of their OCD, they would finally be able to enjoy the wonderful life almost within their reach. Unfortunately, the dogged insistence of such patients that life can truly to be that good creates a kind of desperation for recovery which, along with their resentment of the disorder's presence and challenges only impedes that process. Mind you, I am fully aware of how disruptive to one's life OCD can be. Being tormented relentlessly about inane, nonsensical topics is terribly painful, unfair, and burdensome. But to idealize life without OCD is to misrepresent the realities of human experience. Indeed, if the OCD were somehow to be magically removed from these patients' lives, they simply would join the rest of humanity in living flawed lives marked by inconsistency, moments of weakness, and handicaps. In order to challenge these patients' idealization of life without OCD, I sometimes tell them that as human beings, we are all "stuck in the mud hole." We are all slogging through the "muck," we are all equally dirty, and we all "stink," but we give meaning to our lives by pursuing our goals and overcoming challenges.

What does being human really mean? This certainly is one of life's most important questions, and how we answer it can have a powerful effect upon of our lives. It is my belief that embracing our humanity means accepting our respective craziness and understanding that we all can be inconsistent and weak. But it also means that we all have the capacity for greatness, and we all can reap the rewards of living purposeful, disciplined lives.

INDEPENDENT SYSTEMS

You may be wondering why we give so much attention to the subject of *independent systems* in an article about the nature of choice. The answer is that many patients waste a great deal of time and energy and experience considerable frustration living with the mistaken belief that we as human beings can or should be able to avoid, control, or alter independent mind-body systems. Independent systems are processes within our mind and body that are not subject to our choice-making ability. We cannot start or stop these processes.

There is a pledge that people in AA, who are attempting to recover from alcohol abuse, make to each other: "May I possess the strength to change the things in my life I can, the patience to accept the things in my life I'm not able to change, and the wisdom to know the difference." Being educated about the things in our lives that are not within our control can contribute significantly to the maintenance of our emotional equilibrium and can facilitate the healing process.

The independent systems involved in OCD are 1) the physiological/sensory manifestations of emotions like anxiety, guilt, anger, and depression, and 2) the spontaneous cognitions that constitute the disorder's *spikes*. Keep in mind that these spontaneous thoughts would have little relevance to us if not for the tidal wave of emotional distress that accompanies them.

Contrary to popular belief, feelings are not the direct result of our choices; rather, they are indirect responses that are likely to be experienced after a choice is made. Your feelings can be influenced by your perspective, but you have no direct control over the particular emotions you experience. What most people don't realize, however, is that independent systems within the brain have the capacity to generate emotions as well as thoughts. Thus, when you give in to the brain's natural instinct to seek safety during moments of anxiety, you are inadvertently substantiating the output of these independent systems. Giving in to the need to escape from what your brain determines to be a threat because it "feels" dangerous gives credence to the automatic thoughts that have caused a malfunctioning amygdala to activate your brain's instinct for survival and deprives you of the resolution of your anxiety that you are so desperately seeking.

Behavior therapy does offer methods to *influence* the independent systems discussed above. However, the changes that may occur as a result of implementing the skills learned in behavior therapy often are not immediate. Many years ago, a very determined and therapeutically aggressive patient complained to me that he was not being sufficiently challenged to recover quickly enough, and I told him that his aggressive pursuit of challenges was actually inhibiting his brain's need to warn him of danger. I explained that since his OCD was based upon his brain's programming to make him aware of potential threats, if he actively sought out these threats, his brain might interpret this to mean that the warnings no longer were necessary.

Below is a list of common spontaneous reactions created independently by our body and brain, and over which we have no direct control.

Feeling anxiety or having a panic attack: Rapid heartbeat, lightheadedness, tingling sensations, dizziness, sweaty palms, racing thoughts, pressure in the temple, constriction of the throat, nausea, stomach upset, and feelings of depersonalization.

Chronic pain: Chronic pain of the back, neck, or legs consists of independent symptoms that usually are associated with stress. People spend millions of dollars each year trying to treat these issues medically when they actually result from mismanaged stress and anger.

Feelings of muscle weakness, twitches or spasms: These experiences are all too often mistaken for MS, Lou Gehrig's disease (ALS), or Parkinson's disease.

Mood states: People can experience feelings of sadness, depression, or elation for no apparent reason. There is a subset of OCD sufferers who experience anxiety and desperation in relation to any dip in their mood because of their over-attentiveness to such changes. They tend to say things like, "I'm terrified that I'm slipping into a deep depression."

Conscious awareness: Being aware of each blink, each swallow, and each breath. The mind can also make us aware of parts and functions of our body to which we typically pay little or no attention.

Falling asleep or waking up: As all of us know, we have no control over going to sleep or staying asleep. I could easily author an entire article entitled "Sleep, the Hostage of Anxiety."

Sexual arousal: No one, man or woman, can produce a state of sexual arousal or sexual climax on demand, although, paradoxically, people can experience symptoms of arousal when it is the last thing on earth they would want.

Blinking: This normally happens reflexively.

The symptoms cited above represent some of the ways in which our human physiology demonstrates to us that we are not in full control of our bodily reactions and mental associations. When these independent systems cause disturbances in our lives and we respond with intolerance, desperation and frustration, we become even more acutely conscious of the very symptoms we want to see go away. And believing that we should be able to control these symptoms only deepens the disruption they cause in our lives.

There is a distinct subset of OCD sufferers who become preoccupied with independent systems to which we usually pay little attention. For example, they may become painfully aware of each time they swallow, blink, or breathe, or they may become obsessed with visual floaters, etc. Since we have the capacity to "choose" when to breathe, blink, or swallow, people become obsessed with the challenge of deciding when is the "correct" time to perform one of these actions. The OCD sufferer experiences considerable distress because he or she constantly is being reminded of these options. Since we "ought not to be made aware of our own breath, heartbeat, blink, or swallow response," the constant reminder of these events becomes maddening. That our own mind keeps us alerted to each occurrence seems to us like a betrayal. The ensuing desperation not to be aware of these processes paradoxically creates a heightened sensitivity to, and panic and distress about, being constantly reminded of them. People with this kind of OCD also often have perfectionistic tendencies. They may be painfully aware of their unrealized potential for living a gifted life, and may feel that these distractions prevent them from developing their talents. The chronic distraction of constantly being made aware of systems that most people hardly notice casts an emotional pall over their sense of mental clarity and freedom.

Other

OCD sufferers find themselves subjected to their brain's constant generation of thoughts with sexual content. Individuals with this variant of the disorder often try to prove to themselves that they are not sexually aroused by these thoughts to reassure themselves that they are not "perverts." Since sexual response is involuntary, however, their attempt to reassure themselves can backfire as, to their horror, they find themselves responding sexually to these thoughts. For these sufferers, the realization that they have become sexually aroused leads them to the inexorable conclusion that they truly *are* sexual deviants. One patient I worked with would have an erection each time he approached a coffin. He was appalled by this response and concluded

that he had a deviant sexual attraction to death. A female patient would notice significant vaginal lubrication when she had her daughter sit on her lap for a bedtime story. She was mortified by this, believing that this response indicated that she could not be trusted to be alone with her daughter.

A frame of mind I often encourage with my patients is **"If I'm not choosing it, let it be!"** The headache, the sudden urge to vomit, the panic, the sleep disturbances, and the scary mental associations are just ways we experience the spontaneous output of the machine that is our brain. The brain does not have a desire to torment us; it sends us these reminders to test the acceptability of these prompts. The brain's creative mental associations are a natural part of our mental processes. For example, when you are waiting at a stoplight, watching a mother push a stroller across the street in front of you, and the idea of running them over comes to mind, this is not evidence that you are deranged or evil; this is the kind of association the brain typically makes. It is imperative that one does not assign any significance to the occurrence of such thoughts because doing so most likely will increase the chances that they will recur again and again, bringing with them more distress each time they surface. The dynamics of this process are very much like those at work in the mental game of "Try not to think of a pink elephant."

All too often, my patients believe that recovery means a discontinuation of such upsetting associative thoughts. Frank started off his last appointment by saying, "I got challenged five times today, and the anxiety was overwhelming. I can't believe after all this therapy that I'm still being defeated like this! What is wrong with me?" The problem here is that he is focusing on the wrong elements as measures of his recovery. If we focus on the activity of the automatic systems that produce anxiety, depression or apathy to determine if we have made progress in therapy, then we are sending a message to our brain that the presence of these feelings is a problem, and often the result will be that you experience more of these feelings. When we are distressed over stress, we only invite more stress. "Don't give yourself a headache for having a headache." Don't be upset for feeling depressed. A depressed mood often is the product of an automatic system, and should be managed by making *mood independent choices*. "I felt lousy, but I still went to the gym and did not cancel the party I had planned for that evening."

The independent system governing the quality and/or duration of one's sleep can have a dramatic impact on another automatic system – mood. The best way not to get caught in the negative gravitational field of an automatic system is to make sure that your life choices are not determined by your emotional states and that your autonomous goals guide your decisions every minute of every day.

MANAGING THE INDEPENDENT SYSTEMS

Recently a new treatment for the independent system active in depression emerged from the field of behavioral psychology. Called "Behavioral Activation," it is

a therapeutic initiative in which the patient is encouraged to make a number of commitments to specific goals over the period of a day or a week. The patient is instructed to follow through with these plans regardless of the state of his mood or negative cognitions. Progress in treatment is not measured by the immediate elevation of mood, but rather by the degree to which patients remain committed to their goals – called Activities of Daily Living (ADL's) – that they have selected for themselves. As the old adage goes, "Let the muscles teach the mind." Undertake the action first, and let the reward of elevated feelings follow. Although, the desired mood elevation may not come as quickly as desired, patients are encouraged to focus on the behavioral discipline they have exercised, rather than on the emotional dividend they are seeking. It is important to keep in mind that an attachment to getting emotional relief actually can have the paradoxical effect of reminding you just how far you are from your goal, and may, in fact, prolong your suffering.

The human body is remarkable in its capacity to maintain its equilibrium in harsh or stressful conditions and to restore that equilibrium once it has been lost. The brain/body machine is constantly monitoring countless metabolic processes, and when a deviation from the norm is detected, it quickly acts to correct the problem and restore an "all-systems-normal" status. For those with OCD, a part of the brain called the *amygdala,* which is designed to warn us of threats to our survival, malfunctions, causing it to send repeated emergency signals to our conscious awareness. When this occurs, it is natural for human beings to seek safety. If we do this, however, we inadvertently provide the brain with confirmation that these alarms are necessary because we are responding to them. On the other hand, if we give our brain permission to malfunction, and then demonstrate to it the irrelevance of the signals it is sending us by choosing not to respond to them, the mind eventually will recognize that sending us these warnings is ineffective, and it gradually will stop issuing them. This accepting relationship between the Gatekeeper and the independent systems of our mind and body in which we make allowances for malfunctions can greatly facilitate the healing of commonly disrupted systems such as sleep, sexual responsiveness, and chronic pain.

In life, it is much more important to prioritize *acting with strength* over *feeling strong*. Focus on making therapeutic choices, rather than on your constantly changing emotional experiences. If you gauge how well you are doing by how you feel from one moment to the next, then you are likely to make choices based upon transitory emotional experiences, rather than long-term priorities and goals. A diminishing sense of agency can result from attempting to regulate independent systems – systems over which you have little or no control – and repeatedly failing in your efforts. This can result in feelings of helplessness and demoralization.

THE DANGERS OF MOTIVATION

The definitions of words like "motivation" are often vague or inconsistent. After much discussion, debate, and research, it seems to me that the most useful definition is, "Emotional energy directed towards a goal, based upon some internal or external **incentive**." Concluding that you "lack motivation" is even more self-limiting than calling yourself "lazy." It also is based upon a false premise. People tend to view motivation as an energetic or emotional state that they "need" to have in order to go about achieving their goals. Motivation generally is defined as a response to the provision of an incentive or the application of a compelling force that results in the active pursuit of one's goals. This definition highlights a common difficulty that patients

encounter in therapy, such that they decide whether to follow through on assignments based upon how motivated they *feel*. However, exposure exercises by their very nature are aversive, and if patients were to proceed with them only when they felt "motivated" to do so, no one would choose behavior therapy in the first place. Perhaps that is why people often try behavior therapy only after other types of therapy have failed.

Often, patients seem to seek some external factor to provide them with an incentive to pursue therapeutic goals, rather than basing their decision upon their autonomous goals and priorities. Too many people come to therapy to find or improve their motivation. (Revisit the section of this article entitled, "Can you help me, doc?") For most patients dealing with the torment of OCD, the factor that drives them – at least initially – to try behavior therapy is their desperation to get rid of the constant pain associated with their anxiety, obsessions, and compulsive rituals. But the urgency to end the pain they experience cannot sustain patients for long because the therapy involves deliberate repeated exposure to the stimuli that induce the pain, and the reduction or elimination of the pain is not so much a goal as it is a byproduct of learning to treat the symptoms of the disorder as irrelevant. Following through on our commitments should not be dependent upon our feelings, especially something as intangible as motivation. In behavior therapy, the ill-defined phenomenon of motivation is replaced by a commitment to pursue our goals independent of how inspired we feel to do so. The patient is encouraged to *be engaged in a values-based process in which the emphasis is not on the level of inspiration, but on making* a *conscious and deliberate choice to* observe *the treatment protocols*. The false premise that some kind of emotional impetus is required for us to be able to make disciplined choices is abandoned. Runners engage in a similar process when they dedicate the time and energy necessary to reach their mileage goals as a matter of course, instead of waiting to experience the emotional "inspiration" to do so.

The perspective I encourage my patients to develop is to be willing to commit to a *non-negotiable choice*. A non-negotiable choice is one in which we are mindful of our brain's temptation not to honor our decision to pursue our goals, and we consciously affirm that our commitment to achieving them is not up for negotiation or modification. Our dogged adherence to our goals is considered unalterable and irrevocable. Despite the mind's seductive entreaties to avoid the pain that might accompany the required exposure exercises, I encourage patients to independently commit themselves to the completion of these home-based assignments, irrespective of the pain they might experience.

It may seem counterproductive for a psychologist to say, "I don't care how you feel; I care how you choose." It is essential, however, that patients understand the difference between "feeling weak" and "choosing weak." In regard to facing anxiety, the author, Clair Weekes writes, "Weak knees can still carry you across a room."

A great deal of time is devoted in therapy sessions to patients' discussions of the anxiety-related challenges they faced the preceding week. However, patients often tend to focus on extraneous

aspects of the anxiety-producing thoughts (spikes), like the subject matter of the spikes or the degree of discomfort they felt in relation to these spikes. A case in point: John has been a patient for six months. He has worked his way up the hierarchy of spike exposures to a level of five out of ten. He starts this particular session by disclosing that the prevailing theme of his spikes (that he is a pedophile) has morphed a bit, such that he now is spiking that he wants to harm his children in other ways than by molesting them. He is distressed and frustrated that instead of going away, his OCD has shifted the focus of its spikes to a different theme. Amazingly, he no longer finds the idea of having sexual contact with his children disturbing. As I listen to him talk, however, I am dismayed to find that he says nothing about how he managed to free himself of the anxiety and upset he had been experiencing when he had thoughts about molesting his children. The new subject of his spikes presented a therapeutic opportunity for John to write these new thoughts down on cards and review them ten times a day. Doing so would give him the opportunity to demonstrate to his brain that he was just as willing to accept having thoughts about the new theme as the old. Instead, John's main focus was on how emotionally distressing he found the new associations. The effect of prioritizing his upset about having these new thoughts was to send a message to his brain that these thoughts had significance, which only increased the likelihood that he would have more of them.

It can take weeks, months, or even years for a patient to truly begin to understand and act upon the phrase, "The headline of the story is the choice you make in response to the challenge." It is not productive to focus on the content of the mental associations that have been generated independently and spontaneously by your brain. Allowing yourself to debate whether or not to engage in an exposure exercise actually can drain you of emotional energy, and this sense of emotional depletion can become a pretext for choosing not to engage in an activity or to pursue a goal that might be experienced as aversive. Unfortunately, our brain's basic programming to seek pleasure and avoid pain does not serve us well when we are about to do exposure exercises, which (at least for the duration of the exercise) are likely to increase our levels of stress and emotional pain.

As a child with dyslexia, I found the prospect of doing my homework quite painful because doing so involved confronting my severe academic shortcomings. I generally did my homework after dinner, and when engaged in this struggle, I wanted nothing more than to go to sleep and put an end to my suffering. When I finished my last page of schoolwork, however, I would experience a burst of energy and plead with my mother to let me stay up late to watch my favorite TV show. What I ultimately learned from this scenario was that the emotions I experienced when pursuing goals that were in my long-term best interests would not always be pleasant and could not be relied upon to provide me with the "motivation" to undertake these challenges. When you have an anxiety disorder, your emotions always will direct you to choose the path that is likely to provide relief. If you follow this guidance, however, you will empower the disorder and weaken your agency for recovery.

WHAT IS NOT A CHOICE?

Before we can understand what is involved in making an autonomous choice, it is essential that we be very clear about the factors that lead individuals to deceive themselves about what making and following through with a choice really means.

CONCEPTUALIZED CHOICE

"Today was my first day of therapy; I'm finally going to put this condition behind me! If I'm going to pay this much for treatment, I will definitely be on my way to a successful recovery. I'll just perform these last few rituals and escape the anxiety for now, so I can be in a clearer state of mind to begin my recovery."

A very common way of avoiding choice is to engage in what I call "conceptualized choice." A person who falls prey to conceptualized choice is substituting *planning* to make a choice for the choice, itself. **A** true choice involves follow through – taking concrete steps to realize that choice. A true choice is not just committing to make that choice at some point in the future! The saying, "The road to hell is paved with good intentions" speaks to the perils of mistaking the intention to make a choice for following through with the actions that are required to make that choice a reality. For example, the act of showing up at behavior therapy appointments is a far cry from actually *doing* the repeated exposure exercises that produce the changes that lead to recovery.

There are many instances in our everyday lives where our autonomous interests -- our goals and our values -- and the brain's impulses, instincts and anxieties conflict. Essentially, the scenario is as follows: Choice A is in my best interest, and choice B reflects what I desire or what I wish to avoid. For example, John believes that it is in his best interest to wake up an hour earlier on Saturday morning and exercise, and he sets his alarm for 8:00 AM. When the alarm goes off the next morning, however, John doesn't want to get up and thinks about how "terrible" it feels to be awake at that "ungodly" hour, and he decides that what he really needs is another hour of sleep. His decision certainly is understandable and at first sight doesn't seem so unreasonable, but consider the demoralizing impact of starting a day in which the very first action you take upon awakening is to betray your prior intentions and allow your sensations of fatigue to determine the actions you choose. In my view, whoever invented the "snooze" button – not to mention hand sanitizer -- has made it that much easier to allow our feelings (whether of fatigue or anxiety) to divert us from the pursuit of our autonomous goals. How often have we brought a project for work or school with us on vacation with the intention of completing it, only to keep putting it off until we find ourselves on our way home? If I say I'm going to do something, like washing the car first thing in the morning, doesn't that mean I'm *really going to do it?* For most of is, the answer probably is "no." We may have had intended to do it, but when the next morning arrives and we realize how much effort following through with that choice actually will require, we allow our minds to convince us to abandon our plans. We allow thoughts like, "Well, maybe not today. After all, it's going to rain on Tuesday," or "Great! I let myself sleep an extra hour. Now the day is shot! I might as well just go back to sleep," to serve as excuses for not following through with our plans.

Bob is determined not to continue to be victimized by his OCD. He is well aware that his compulsive hand washing is perpetuating his condition. When he is out, however, he accidently

touches a homeless person on the street and promptly runs to a drug store to purchase some hand sanitizer. How many of us would like to lose weight, and yet find ourselves regularly giving in to the impulse to eat sugary and/or high-fat foods that inevitably cause us to gain weight? When our attention shifts from our chosen goals, or we are unwilling to confront the pain that pursuing them might bring, we ultimately are doomed to give into our impulsive desires and veer away from our goals.

The human brain seems to be engaged in a constant battle between our autonomous goals, which often require considerable effort and may involve discomfort or pain to achieve, and the brain's attachment to pleasure and avoidance of pain. Although Daniel desires treatment success, his mind constantly finds excuses not to follow through with his home-based exposure exercises. To be successful in treatment requires tremendous discipline, because when left to its own devices, our brain will try to take the path of least resistance – seeking pleasure and avoiding pain.

Consider how many people purchase memberships to gyms, but then rarely (or never) actually go to the gym to work out. There is an enormous difference between making a mental commitment to seek a major life change and actually devoting the time and energy necessary to achieve that goal. For example, it takes a great deal of fortitude to repeatedly engage in exposure exercises, especially when these exercises might require you to tolerate very unpleasant emotional experiences. Imagine for a moment that it's 2:00 PM and you have been anxiety-free for the past four hours. Your phone alarm buzzes, alerting you to the fact that it is time to engage in another exposure exercise. When you originally set the alarm four hours ago, it was your earnest intention to comply with the therapeutic guidelines, but now that this moment has arrived, the last thing you want to do is upset the apple cart and risk sacrificing this sense of tranquility. What are you to do? Well, if you want to continue to make progress in therapy, you need to find the strength to forego the peace of the moment for a future without the constant torment of the disorder.

I have encountered people who have been firmly resolved to start eating in a healthier way in the future, and then they actually celebrate having made this difficult choice by choosing to indulge in the unhealthy foods that they love. This is what I call a "conceptualized conviction." Being very upset about how your life is falling apart and talking to a loved one about how you really are going to make significant life changes sometimes actually can decrease the likelihood that you will follow through with the actions that are required to bring about that change. I often suggest to people who have committed themselves to giving up smoking to refrain from telling others about the change they intend to make. If they are at a point where they are ready to embark on a course of action requiring considerable discipline, I urge them to proceed on the basis of their internal autonomy and not in the belief that sharing their intentions with others is tantamount to actually making the day-to-day sacrifices that are required to achieve this goal. Conceptualizing a choice also occurs when we say meaningless things like, "I'm going to do it," or, even worse, "I have to do it." These statements suggest that the decision has already been made – "It's as good as done!" However, saying, "it's going to happen," does not take into account the preparation that may be necessary, the need for a sober consideration of the resistance to change that we all share, and, most importantly, the critical juncture when you demonstrate your commitment to follow through on your intentions with actions, not words.

"The pep-rally does not win the football game." Don't equate getting yourself all psyched up to change for the discipline that actually will be required to face the challenges that lie ahead. When you are in the grips of the terror that accompanies OCD, the
inspiration and emotional fortitude you had in yesterday's therapy session will fly out the window. Many of my patients have looked for the therapy to provide them with the inspiration to face the emotional challenges of this condition. However, when you are experiencing fear, hopelessness, guilt, depression, or other painful emotions in relation to the spikes from the disorder, you must be willing to jump into the inferno of terror whether you "feel" like it or not, and not just because you got "psyched up for it." Many patients leave therapy sessions – or, for that matter, other venues, such as church and temple services – feeling inspired to go out and change the world. They have been infused by the psychologist, rabbi, priest, or minister with a new spirit and suddenly feel capable of living the life they seek. The problem with this "go with the spirit" approach is the short-lived nature of this experience. As I've stated before, don't be fooled into mistaking the emotional incentive you may feel when leaving a therapy session for the hard work that will be required to complete the home-based assignments that are of central importance to the therapy. Being "motivated" or "inspired" is a transient experience; in the end, choice, discipline, and hard work are the agents of change.

When it comes to difficult tasks like home-based challenges, it actually is counter-productive to reassure yourself that you will successfully complete the assignment. The steps involved in completing an unpleasant task include setting aside the time, facing the discomfort of doing it, and accepting the possibility that performing this task will be a miserable experience. In addition to this, you must navigate through all the excuses to "put it off" and then actually start the activity. In fact, I often suggest that patients predict that they most likely will fail to follow through on their commitment. In making this negative prediction, they have the opportunity to confront their own mind's non-compliance.

LESSONS FROM CHARLIE

What can Charlie Brown teach us about the difference between autonomy and an acceptance of what is likely to happen, and being seduced by what we hope will happen. Charlie Brown is a kind of "Everyman." All of our insecurities, our hopes, our dreams, and our faith in the potential of humanity are represented in Charlie Brown's life and character. Charlie's nemesis is Lucy. In each episode of "Charlie Brown," Lucy offers Charlie the opportunity to kick a football that she promises to hold for him. She has made this promise many times before, and always, at the last moment, just as Charlie is about to kick the ball, she takes the ball away, and Charlie flies through the air, distraught, as he realizes that once again he has been duped. Each time she offers to hold the ball for him, Charlie thinks "This time Lucy is completely sincere. She acknowledges that she has been deceitful in the past, but this time she is being completely honest. This time she promises things will be different. She will not fool old Chuck." Charlie teaches all of us that "hope does not spring eternal!" Making choices based on what we hope for, rather than on what is likely to occur, is a mistake. It is essential to keep in mind that quite often reality is not what

we want it to be. Reality often means finding ourselves in an undesirable place or in unpleasant circumstances.

I encourage patients to find meaning in a life process in which they are prepared to meet the challenges that life presents and make the best even of harsh circumstances that they had no part in creating. I suggest that overcoming the challenges presented by their own brains is a noble task that will foster emotional growth and development.

UPSETTING THE APPLE CART

Consider the following: In the two days since you had your therapy session, you have been very aggressive about completing all of the exposure exercises you agreed to perform. You have faithfully performed ten difficult and painful exposures on each of the past two days. It is now Thursday, and you awake to discover that you are experiencing little to no anxiety at all in relation to the central theme of your OCD. How glorious to be so free from distress! Then, the alarm from your smartphone goes off, and you are reminded that it is time to perform yet another exposure exercise. What do you do? How tempting it is simply to skip the day's exercises! How could your therapist possibly expect you to disrupt the wonderful sense of peace you are experiencing?

This critical moment can be a significant predictor of the whether this patient will make a successful recovery. Patients who understand the nature of the therapy and the importance of being aggressive throughout the treatment – no matter how "good" they are feeling – will be willing to upset the apple cart. These patients will build upon the advances they have made despite the temptation to preserve the calm. Interestingly, patients who at this moment actively engage in the exposure and are willing to disrupt their sense of peace are likely to discover, paradoxically, that they experience yet another day of relative quiet. Most likely, their brain will interpret the conscious choice they have made to aggressively seek out and activate its **warning system as a message that the target topic** is not really a danger. On the other hand, **patient**s **who avoid the day's exposure exercise**s **in order to sustain the peace send signal**s **to the**ir **brain that the t**houghts to which they are unwilling to expose themselves are threats, and their brain will likely start to test these **topic**s again **with more frequent and** more **intense spikes.**

Most patients enter therapy in considerable distress, and at that point are determined to follow the treatment protocol with unwavering commitment and fortitude. As their treatment progresses, however, the distress they experience from the disorder tends gradually to decrease. Indeed, those who diligently adhere to the treatment protocols generally experience a good deal of symptom relief. A common pitfall that patients encounter at this stage of the treatment process is the phenomenon of "diminishing returns." As I've said repeatedly throughout this article, success with this type of therapy depends upon patients continuing to perform the required exposure exercises on a regular basis. If, as a result of the decrease in their level of distress, patients become less conscientious about performing these exposures, then their rate of progress will slow. Thus, it is critical that patients sustain the momentum they have achieved by continuing to

do the exposure exercises with undiminished diligence even as their symptoms begin to decrease. It takes considerable courage and determination at this point in the therapy to continue to invite the pain and anxiety of the OCD into their lives, but it is essential that patients do so if they want to complete their recovery from the disorder.

THE AUTONOMY DRAINS

I believe that in life it is very difficult to consistently uphold our values and continue progressing toward our goals. Sustaining disciplined living is a little like swimming upstream against the current in a river. When we rest on our laurels and stop swimming, we lose momentum and may begin to drift back downstream. Even maintaining the status quo takes some effort, because just staying in one place requires that we resist the current, which is always pushing us downstream.

It is quite common for patients to look at another's success and conclude that the individual they admire is "special" in some way. They may say things like, "Wow, I wish I had that kind of discipline. I could never do that," summarily dismissing their capacity to achieve similar goals. Even worse, they may conclude that they simply are lazy. It is too common and terribly tragic when patients regard themselves as members of some kind of "subclass" of humanity that lacks the ability to successfully undertake tasks that require a sustained and disciplined effort. Achieving success in the treatment of OCD is a goal that requires great perseverance, commitment, sacrifice, and fortitude. The treatment requires that patients consistently take the initiative to disregard a miscued survival instinct and choose not to respond to their brains' misguided attempts to keep them safe. Unfortunately,

many patients see themselves as victims of circumstance and believe that they have certain inherent limitations that make it difficult, if not impossible, for them to achieve their goals in life. They live in an "I-can't-do-it" frame of mind. Encouraging such patients to test their emotional resilience can result in a "backlash" response wherein the patient conveys some version of the following to the therapist: "If only you understood me better, doc, you would realize that I have limitations that make this task impossible. You're just like the others, who encourage me to try because they are unaware of the profound handicaps I have. Your faith in me is actually a sign that you really don't understand how limited my abilities are, and that makes me less confident that you can actually help me get well." Patients who see themselves as victims require a special therapeutic process. These patients do not benefit from encouragement because they feel that they are constitutionally incapable of making the changes that are necessary to recover from the disorder, and they may interpret encouragement as an indication that they simply are not understood. This can leave them feeling alienated and alone. Sometimes, to facilitate the partnering alliance, a therapist must go along with the patient's feelings of impotence. In such cases, I may tell these patients that I am not going to suggest techniques that can facilitate recovery from the disorder until they can assure me that they are **fully aware of** how they perceive themselves and their **limitations**, and can acknowledge their own role in maintaining this perspective. Until this moment of insight is achieved, I often try to see the world through their eyes, even if this means occasionally agreeing with their assertion that they are helpless. Being empathic to patients' view of themselves as weak can serve as a mirror in which they can see how they are selling themselves short, and this finally may enable them to reject their self-defeating perspective.

When you watch top athletes discussing the factors that have contributed to their success, they often say very similar things. For example, they frequently thank God for their good fortune. They also may state that they are just ordinary people who were willing to commit themselves fully to something about which they cared deeply. They are more likely to talk about perseverance than talent. In fact, they rarely attribute their success to having been born with special talents or abilities. Instead, they may suggest that they believe the same potential for excellence exists within all of us.

"Lazy" is undoubtedly the most common self-limiting word that we use to describe ourselves. Endorsing the concept of laziness is an example of what I call an "autonomy drain." Here we are arbitrarily setting limits on our capacity to make difficult choices based upon non-autonomous factors. In this case, the non-autonomous factor is our assessment of ourselves as undisciplined. A patient may conclude, "Since I'm lazy, I lack the qualities that patients who actually *do* their assignments have." As a psychologist and as the patient's partner in the therapeutic process, I never accept this excuse. It is vital that patients own – that is, take responsibility for – their willingness or lack of willingness to experience pain. "The assignment was too difficult – **I couldn't do it**," is replaced with, "I was not willing to endure the discomfort," or "The anticipated discomfort of doing an exposure exercise that challenging was more than I was willing to face." I often have witnessed the beneficial effects of patients taking responsibility for the choices they make. We tend to make more disciplined choices when we are mindfully aware of all the options available to us, and when we acknowledge our responsibility and accountability for making the final decisions.

I wish I had a dime for every time I've heard a patient say, "I can't do it." This is just another form of "toxic" verbiage. Deploying a careful strategy and taking responsibility for deciding whether to follow through with it is much more productive. If you decide not to complete an assignment, then acknowledging that you are consciously choosing that course of action is a much healthier approach than not taking responsibility for having mindfully chosen the "non-disciplined" path and for letting your emotional experience (your feelings) rule the day. "Is it really that you can't do it, or does the thought of exposing yourself to this challenge seem overwhelming? Are you willing to follow through on your agenda and risk experiencing a possible emotional backlash as a result of taking on this challenge?" Asking these questions represents a therapeutic communication strategy that facilitates mindfulness and autonomy.

Additional "autonomy drains" include statements with words like "need," "have to," "must," and "should" (as in, "I *have to* do this exercise.") Such expressions impose demands upon our brain, conjuring up some mythical "taskmaster" who can compel us to follow through with the assigned task. People tend to resent feeling obliged to perform any task and are likely to resist such expectations, regardless of whether they come from others or from themselves.

TOO SICK TO TAKE THE MEDICINE

Tragically, a small percentage of patients are earnest in their desire to achieve therapeutic success, but adamantly declare that they are too impaired to make the kinds of choices that might lead to recovery. With this group, it seems almost as if their autonomy has been replaced with

the voice of their condition. They can conceptually desire to achieve a therapeutic benefit, but their trepidation regularly overwhelms their agency in making independent choices. Their anxiety says "Jump!" and they ask "How high?" They often attend therapy sessions looking for the therapist to instill in them the conviction, motivation, and/or determination that they need to make progress. Because these individuals seem to lack the independent will to manage and overcome the challenges they face, their prognosis is poor. Over time, they may conclude that the therapist they are seeing is unable to provide them with the resilience that they need to be successful with E&RP, and they either drop out of therapy entirely or seek out yet another therapist they believe is the "one" who can instill in them the fortitude they need to overcome the disorder.

MAKING A CHOICE

With all of the ways human beings seem to be able to avoid making healthy life choices, it is vital that we identify the mental mechanisms that actually support the process of making choices that support the achievement of our goals.

SACRIFICE

Every choice involves the possibility of loss in the sense of the "road not taken." My choice of a beach vacation means that I will miss the adventure of skiing this year. Choosing to run Saturday morning means that I will be sacrificing the possibility of quietly enjoying some leisure time and a well deserved rest after a hard week of work. Attending my daughter's third grade school play means that I will miss my weekly card game with the guys. Obviously, some sacrifices are easier to make than others, but a consideration of what we are willing to do without is essential if we are to achieve our chosen goals. When we find ourselves tempted to choose the path that requires the least amount of sacrifice, it would be wise first to consider which choice reflects our values and is in our long-term best interests.

To recover from OCD, you must be willing to make sacrifices. With this condition, your brain sends false signals that you, someone you love, or innocent people are in danger, and you must decide whether, for the sake of your long-term recovery, you are willing to sacrifice the quick relief from your anxiety that your brain says you can secure if you just perform certain behavioral or cognitive rituals. Of course, according to your brain, not performing this safety-seeking behavior would be foolish, but it is important to remember that you have the option of foregoing the promised relief for the sake of ultimately overcoming the disorder, itself. The gatekeeper must decide whether he or she is willing to sacrifice the feelings of safety in order to prevail over the temptation to ritualize and create a false sense of security. A skilled patient might say, "If I sacrifice this moment's peace and comfort, I will be taking a healthy step toward my long term recovery."

ACCOUNTABILITY

To be accountable to ourselves or to others for our actions can help ensure that we make disciplined choices. One way we can do this is by keeping daily charts of the goals we set and

the actions we have taken to achieve them. Research has shown that the mere act of keeping an accurate daily log can bolster your commitment to achieving your goals. The problem behavior for which such "self-monitoring" can be helpful includes overeating, exercise avoidance, smoking, compulsive hair pulling, and ritualizing in response to spikes from your OCD. In addition to keeping your own log, having a spouse or close friend to whom you report can heighten your commitment to make disciplined choices. I regularly encourage my patients to keep a record on paper or on their computers, tablets, or other digital devices of both the disciplined and the relief-seeking choices they make. When they feel tempted to avoid making disciplined choices, the fact that they will be keeping records of these choices can improve the chances that they will choose actions that support their long-term goals.

Occasionally, when patients are finding it hard to follow through on their weekly homework assignments, I suggest what is called a "behavioral contract." The terms of this contract are as follows: The patient puts a certain amount of money in an envelope and addresses the envelope to an organization that he or she despises. The patient then agrees that if he or she fails to complete a minimum amount of the homework over a specified period of time, the envelope will be stamped and mailed out.

Here's how this arrangement worked with one of my patients. Sheldon had not been completing his homework assignments on a consistent basis, and he agreed to enter into a "behavioral contract" with me. He placed $50 in an envelope, and addressed the envelope to the National Rifle Association. Now Sheldon was a staunch Democrat who strongly supported gun control, and he would have done almost anything to avoid making a contribution to an organization he hated as much as this one. To increase his incentive, I warned him that once he contributed to the National Rifle Association, he would be inundated with solicitations for money from every right wing organization in the country. This prospect so horrified him that he very quickly brought his level of compliance up to about 90%, which was well within the terms of the contract.

THE UNALTERED PATH

Of course, before you can reap the rewards of following an "unaltered path," you need to have a path to follow in the first place! A good way to begin is to set goals for relatively short time periods – an hour, a day, or perhaps a week. Beware of getting sidetracked by the kind of "conceptualized" choices previously discussed. Do not set goals that remain forever in the future – that is, goals you cannot begin to pursue right now. Setting a goal for the next hour can become the cornerstone of a disciplined, purposeful life.

The saying, "Man plans and God laughs" highlights the dichotomy that can develop between our conceptualized goals and actually doing what is necessary to achieve them. In addition, unforeseen events in life can make the pursuit of our goals more difficult. Your goals can be as simple and straightforward as walking the dog or folding the laundry, or they can be more ambitious, like making five hundred cold calls at work or starting each day with a five mile run, or, for that matter, performing ten exposure exercises every day.

People engaged in the treatment of OCD often face a quandary when they have an opportunity to do an impromptu exposure exercise. The brain "machine" may say, "If you don't do this exposure exercise right now, you won't recover from your OCD," but if you had not planned on doing an exposure at this time, what are you, as a treatment-compliant patient, to do? Many of my patients are surprised when I suggest *not* doing the impromptu exposure. People desperate for recovery can become overly zealous in their efforts to overcome the disorder, and frequent unplanned exposures can have disruptive effects upon their lives.

Following an "unaltered path" involves setting specific goals for the day. You pick an agenda and rigorously stick to it. We do not have a choice in the way we feel, nor can we control the life events that unfold around us, but if we proceed through the day and keep to our intended path, we can have a major impact on our mood stability. Again, if you want to know how you are doing with the therapy, look at how you are *choosing,* not how you are *feeling*. Completing all the tasks and commitments that you set out to do in a given day despite having been anxious, exhausted, sad, or distracted can boost your morale tremendously. Keep in mind that the *anticipation* of the pain you believe will accompany a particular activity is usually more uncomfortable than the pain, itself. *Recognizing that at each moment we are living our life as we had intended can be a source of great satisfaction – even in the midst of an emotional storm raging around us*.

It goes without saying that unemployment can be a source of great emotional distress. The absence of the imposed structure of a job can send many people into deep depression and despair. When every day is like a weekend, we have little to look forward to (like celebrating the end of another workweek!). I consider unemployment a major contributor to both depression and "behavioral disregulation" (allowing one's mood to determine the choices one makes). This is a very dangerous state of mind in which to find yourself. Establishing some kind of day-to-day structure while unemployed is essential to maintaining your autonomy and emotional equilibrium. Set a hard wakeup time, and *make sure you get up* when the alarm sounds. This simple act can jumpstart a day of disciplined choices. "I committed to waking up at this time, and, sure enough, that is exactly when I got out of bed. I did this despite the enormous emotional pull to reset the alarm and delay the pain of actually starting the day." People for whom procrastination is a problem in their lives will be especially tempted to push the "snooze button," one of the most autonomy-defeating inventions ever created! So, get up, go through your normal morning routines, and get out of the house – even if it's just for a quick walk around the block. Plan your activities, and most importantly, *look for another job*.

REMAINING ENGAGED IN THE PROCESS

Sometimes, when the world seems to be crumbling around you, and you feel that life is most definitely not worth living, the best you can do is to remind yourself that you are "engaged in the process." This is a mental strategy borrowed from the discipline of "mindfulness."

While driving to work on a Monday morning, Brian finds himself being bombarded by disturbing thoughts and emotions to such an extent that he seriously considers turning around and going back to bed. Before making that decision, however, he examines the choices available to him. He can continue on his current course and remain committed to his **unaltered path,** or he can call in sick and hope that tomorrow is a more emotionally hospitable day. Brian chooses to place one foot in front of the other and continue to work. At the end of the day, he feels a distinct satisfaction about having "chosen well" by fulfilling his original goal for the day, even though his feelings that morning ran counter to his intention. To focus on the little choices we make in the course of conducting the day's activities can be very centering. When we behave with autonomy, we recharge our emotional resources. The importance of making disciplined choices, even when those choices are not supported by our feelings, cannot be exaggerated.

To remain on an unaltered path is a crucial component of the discipline that is required to recover from OCD. The therapy involves a great number of daily commitments called exposure exercises. Despite a tremendous amount of emotional and cognitive push back from your brain, it is essential that you consistently do these exercises and follow all the other treatment protocols. In other words, even when you are challenged by anxiety, you need to have the discipline to keep yourself on course with the therapy. By sticking to your chosen path, you achieve the primary goal of the therapy, which is to demonstrate to your brain that the spikes and the attendant anxiety are irrelevant to the choices that you make. Of course, the OCD can create a compelling illusion of the relevance of its themes, which is why my patients often say to me, "Hey, doc, how can I treat my spikes as irrelevant when they *feel* so relevant?" The answer I always give is to *choose* irrelevance and show your brain that despite the disruptive thoughts and seemingly overwhelming emotional distress, you continue to follow your chosen path, and nothing in your life process has changed.

Another common stumbling block for those being treated for OCD is the demoralization they feel when they realize they have no control over the disruptive activity of their brains. At its worst, OCD can flood you with feelings of terror, guilt, distraction, and fatigue. You may begin to feel like you barely know yourself anymore. It may seem that you are functioning at a level far below that of which you are capable, that you are a sorry excuse for the person you could be. You may feel like giving up and giving in. To circumvent these feelings of demoralization, I use what might seem an odd phrase to describe the therapeutic response. I suggest to my patients that they be willing to "live on the crumbs." What I mean by this is that patients should take whatever small part of their choice-making capacity that remains and should continue their life processes with whatever resources they still have. I urge them to take some satisfaction in the fact that they are "still in the game." Don't be crushed in spirit because you are functioning at only 20% of your capacity. By remaining engaged in the process, you have the opportunity to

continue to pursue your agenda, to continue to make progress towards recovery. It bears repeating that you should make *choosing well*, not *f*eeling well your priority. To remain engaged in the process despite the inherent variability of your emotions is the real victory.

Make your decisions and your actions count. Uphold your values. Be guided by your morals. Follow the path defined by your agenda and your goals. Don't wait for the "motivation" – the emotional drive or energy – that you think is necessary to pursue your goals. Plan ahead, allocate the time, and make an unwavering commitment to every step in the journey toward recovery. And when confronted with challenges from the disorder, make sure your autonomous choice always has the last word.

MINDFULNESS

Mindfulness is an essential tool in the treatment of OCD. Patients are instructed to be "aware in the present moment" of the **independent activity** of their brain as it generates the distress signals that characterize the disorder. Patients also are guided to observe rather than react to the aversive experiences and distressing cognitive associations that are produced by their brain. The therapeutic effects of employing this "observational method" can be enhanced by having patients describe their anxiety symptoms using concrete and objective terms. Rather than exclaiming "Oh, my God, I just had the thought that I might harm my baby while changing her diaper! I feel like I'm losing it," the skilled patient would say, "My brain has just produced the thought that I might harm my child, and my heart is now racing, my stomach feels like I drank drain opener, and my head feels like it is in a vice." This strategy enhances the Gatekeeper's sense of independence from the pain, anxiety, and/or guilt that accompany the brain's warnings of danger, and leads to a decrease in the intensity of the pain that this emotional turmoil causes.

Consistent research has determined that when we are mindful of our painful experiences and make a conscious choice *not* to seek relief, the effect is a reduction in the severity of the pain. Thus, choosing to engage in an exposure exercise while simultaneously being willing to face the ensuing emotional discord tends to lessen the brain's inclination to deliver the anticipated emotional backlash.

John inadvertently comes in contact with an item that he believes to be contaminated. In response, he experiences a strong cognitive and emotional impulse to wash his hands. At first, he yields to that impulse and reflexively starts to walk toward the sink with the intention of relieving his anxiety by washing away the imagined contaminants. Just as he reaches the sink and turns on the water, however, he says to himself, "I am now experiencing a level six on the "Subjective Units of Distress (SUDs)" scale, and I am consciously choosing to wash my hands and give in to my anxiety." John is aware of the beating of his racing heart. He is aware of his nausea, his sweaty palms, and his weak knees. He says to himself, "I'm now giving into the anxiety, and I acknowledge that I am forfeiting my freedom by giving in to the threat and performing this ritual." But as he reaches for the soap, he realizes that he has the opportunity at this moment to make a different choice. He pauses, puts down the soap, and walks away from the

sink, having decided to take the discomfort with him. At that moment, John determined that he was willing to make the resilient choice and resist the temptation to wash his hands. In other words, he refused to allow his emotional responses to dictate his actions. In so doing, John exercised the discipline of mindfulness. He did not judge himself for having had an anxious moment; he simply examined his choices and made a commitment to his recovery. And even if John had washed his hands, he would have done so while remaining mindful of the fact that he was in control of his destiny, thus taking full responsibility for giving in to his anxiety.

When you engage in an exposure exercise or face an "inadvertent challenge" (an unanticipated exposure), there is likely to be an opportunity for you to mindfully respond to the independent system responsible for your anxiety. At such times, it is very centering to ask yourself, "In this moment, am I managing this challenge skillfully (without any resistance), or am I ritualizing and trying to escape from or avoid it? In other words, "Am **I responding with resilience**, **rather than resistance?"** If the answer to this question is "yes," then you can be confident that you are doing the best you can, regardless of how you feel.

Like mindfulness, a strategy called "paradoxical intent" also can help you to respond in an autonomous manner to challenges from your OCD. Paradoxical intent is a therapeutic technique most often associated with "reverse psychology." We are employing paradoxical intent when we say to a shouting friend, "Talk louder – I can't quite hear you."

Bob realizes that at social gatherings, he always talks about his favorite topic – himself – and his wife brings to his attention that this is considered a social *faux pas*. Bob resolves that at subsequent events, things will be different. However, every time he attends another event, he falls back into his old pattern of behavior. Paradoxically, Bob's conviction that he is going to change his behavior reduces his brain's vigilance about searching for the problem. Many patients make this mistake again and again when they say things like "I absolutely will not wash my hands the next time I get anxious," or "I won't eat dessert at my favorite restaurant tonight, even though it's my birthday." After a string of such failures, it is very easy to fall prey to feelings of frustration, impotence, and hopelessness. Bob discusses his frustration with his close friend, Kurt, who suggests the following strategy: Instead of expecting or hoping for success in changing his behavior, Bob actually should predict that he will fail completely to make this change, and that he will spend the whole evening talking only about himself. This technique can be very effective because it alerts the brain to the fact that this problem behavior is very likely to occur, and as a result, the brain watches carefully for its appearance.

Early in my career, I worked with a patient who would leave my office every week filled with excitement about conquering his OCD. He repeatedly made the mistake of believing that his rejuvenated spirit and faith in his resolve would carry him through to his long-term recovery. As it turned out, his progress would falter by the second day after our session. I finally told him to start each day with a prediction as to how many times he would succumb to his brain's impulse to ritualize. This approach deployed two very powerful components of the treatment: Self-monitoring and paradoxical intent.

Studies on pain management suggest that our experience of pain is strongly influenced by whether we have control over the experience or not. If a patient takes responsibility for engaging in an exposure, the emotional backlash will be lessened because he or she has deliberately brought it on. Consciously deciding to experience the discomfort and bring the challenge with you in your daily activities can send a signal to the brain that you are voluntarily taking on risk and willing to accept the emotional challenges that may follow. Interestingly, in such cases the actual likelihood of experiencing such emotional challenges are reduced because the brain is less inclined to deliver distress signals when it appears that the warnings are unnecessary.

THE UNJUSTIFIED CHOICE

In the treatment of OCD, it is very common for patients to experience a desperate need to be reassured by the therapist that a particular risk or threat is not legitimate. Patients seek reassurance in a variety of ways, such as internet research, chat room postings, and therapist inquiries. However, these efforts rarely, if ever, produce long-lasting relief and, in fact, are much more likely to exacerbate the condition. The behavioral treatment of OCD relies heavily upon exposure exercises in which the patient purposefully brings on the feared stimulus. This is accomplished either by the patient deliberately thinking about a topic that provokes anxiety, or performing some action that he or she finds threatening. Before many patients are willing to perform the exposure, however, they often want to be reassured by the therapist that the risk is not real, and that they or another person will not actually suffer any negative consequences if they undertake the exposure. A patient may ask, "Steve, if I am successful in this treatment process, and as a result, I am no longer anxious about the possibility of harming others, then could the therapy actually increase the chances that I will harm others?" It is at this juncture that my thinking departs from that of more traditional cognitive behavioral therapists. In response to this question, I encourage patients to choose to perform such exposures without any reassurance that the risks are not legitimate.

One particularly difficult form of OCD involves a fear that others may be harmed by the patient's own negligence or by the patient's inadvertent or accidental involvement in an activity that results in others being harmed. I refer to this type of OCD as "Responsibility OC," as the sufferer feels compelled to protect someone other than him- or herself. What makes this form of OCD especially difficult to treat is the added component of guilt. Not only do patients experience anxiety that others may be at risk, but they also become concerned that they may be responsible for harm coming to others if they fail to perform certain rituals to protect them. Exposure exercises for this form of OCD require that patients betray their instinct to protect loved ones or innocent people from harm. Effective treatment requires that the patient show his or her brain that the emotional alarm is irrelevant. Merely *telling* one's brain that a risk isn't real is insufficient. Successful treatment requires that patients demonstrate by their actions that they will not heed the warnings their brains are sending them about the risk that they will do harm to others or not prevent harm from coming to them.

Much time is wasted when the OCD patient debates whether the topics they fear are legitimate or not. Although this debate might seem justified to many patients, and some therapists may well consider it a part of the therapeutic process, nothing could be further from the truth. Patients often desperately want to ascertain whether or not they really are in danger, themselves, or they are endangering others, and even though their concern is understandable and may even be legitimate, any attempt to determine the answer to the question runs counter to the goal of the therapy. Those with OCD often believe that if they could just get these questions definitively answered, it would enable them to respond appropriately. Ultimately, however, recovery depends upon taking a "leap of faith" in the sense of being willing to challenge the fear, anxiety, guilt or other emotions that a patient may feel in regard to a thought or action *without having proof* that the danger is not real.

Making an *unjustified* **choice** involves taking action without having determined to any degree of certainty whether the potential risk of making that choice is legitimate. An un*justified* choice is one that we make without seeking a rationale for doing so. I once mentioned to a friend that I didn't enjoy eating banana splits. He was very surprised by this and asked me why I didn't like them. My answer was simply, "I don't like banana splits." Why? Because I don't like banana splits. Being centered, you do not have to justify your tastes and preferences. You can simply "own" your own perspective without having to provide an explanation for it.

In order to make an informed decision about whether to pursue a goal, it seems reasonable to determine how much you really want that goal in the first place and if you are willing to make the sacrifices necessary to achieve it. Before John picked up the phone to schedule his first session, he gave serious consideration to whether this was a good time in his life to begin an uncertain and potentially very challenging therapeutic process. Prior to calling a behavior therapist, he had been involved in a number of unproductive, long-term, insight-oriented types of "talk therapy," and he was emotionally exhausted. He looked carefully at behavior therapy and concluded that it offered hope, so he decided to proceed with it. Having made his decision, he expressed a complete readiness to do whatever it would take to recover.

On the other hand, if you are considering an exposure exercise of viewing homoerotic material to expose yourself to the spike that you are gay, shouldn't you first have some evidence that you actually have OCD, and that you are not simply going through a crisis about "coming out?" Unfortunately, the desire to obtain this information before beginning the exposure therapy is just another form of answer-seeking. When you have OCD, the brain is desperate to secure a guarantee of safety. Consequently, you always will feel an urgency to find the answers to such questions before you engage in any exposures. It is when patients inevitably face this uncertainty that I talk to them about "taking a leap of faith." Employing this strategy can make it easier for patients to choose to participate aggressively in the therapy even without any assurance that their fears are illegitimate. As I wrote in one of my articles, "Within the question lies the answer." In other words, if you are uncertain whether the source of your anxiety about a potential risk is your

OCD, then it is best to treat it as such and challenge the anxiety. When dealing with OCD, you must suspend any attempts to determine what is "real," and view all questions related to the particular theme with which you are struggling as unanswerable. When I am asked, "Isn't it possible that I have OCD and I'm also gay," my response is, "I'd suggest that you take this question with you, since it pertains to the theme of your OCD."

When I ask patients, "How have you been doing this past week?" I choose my words carefully. I am not really asking, "How have you been feeling this past week?" or "How much has your disorder challenged you this week?" One of the concepts that patients find most difficult to accept is that the measure of how well they are doing in therapy is the *choices* they make, not how they feel. Whether your brain continues to send you distress signals is not the relevant factor in determining how much progress you have made. In fact, placing an emphasis on how intense and/or how frequent the prompts from your independent brain are misses the point of the therapy completely. If a patient says, "This was a great week because I had so few challenges from my OCD," my response always is, "And how willing would you have been to take on your brain's challenges if they actually had occurred?" If your goal is for your brain to calm down about the theme of your OCD, then show your brain that the topic is not relevant. If you view the absence of challenges as the goal of the therapy, then the brain will process being challenged as a threat, and the result will be more challenges.

I regularly encourage my patients to make choices independent of their moods, as depression often accompanies OCD. This recommendation is predicated upon an understanding of the benefits of pursuing a goal regardless of how we are feeling. Whether you are combating anxiety or a depressed mood, it is critical that you be **engaged in the process** of mindfully keeping to your agenda, regardless of the emotional turbulence you may encounter.

As I mentioned earlier, one of the most misunderstood statements I make in sessions is, "I don't care how you feel." When you focus on how painful or difficult things are, rather than the choices you make in response to these challenges, you are likely to let your emotions determine your choices. OCD is an enormously compelling condition that makes you feel that you must seek relief from the emotions you are experiencing, but *if you want to recover from this disorder, you must emphasize your commitment to distress tolerance over relief-seeking*.

When we look back after an hour, a day, or a week and see that all the goals to which we had committed ourselves have been achieved, we can take great satisfaction in our accomplishment. Having chosen to write a lengthy article and now seeing it nearing completion is enormously rewarding and is in keeping with the life path I have chosen for myself.

Although rewards are an important part of living, research has consistently shown that people tend to choose immediate rewards over the long-term benefits of making disciplined choices. As a species, we have an enormously difficult time delaying gratification. When you are experiencing anxiety and you just want it to stop, it takes great discipline and mindfulness to say, "Okay, I'm willing to face danger and *I am not going to seek safety or relief."* To paraphrase

Victor Frankl, between stimulus and response, there is an opportunity for us to be mindful of our freedom to choose a response that is in our best interests and reflects our highest values.

THE ILLUSION OF HAVING A CHOICE

One of my colleagues once said that he believed that only about three percent of the choices people make are mindful ones. In other words, in his opinion, ninety-seven percent of the actions undertaken by human beings on a daily basis are made without conscious volitional awareness. This may well be true. I am often struck by how few of the choices I make on my daily commute to work are conscious ones. I regularly become mindful of this at the end of my trip when I realize how little of the drive I actually can recall. I wonder, though, if my colleague is right, can any of us really consider ourselves captains of our own life voyages?

In India, elephants are trained to be compliant in a unique way. At a very early age, they are chained to a large tree, which severely restricts their movements. When the elephant attempts to escape, it is met with the reality of its physical restraint and its limited mobility. Over time, the elephant acquiesces to the limitations of its environment. As the elephant matures, the size of the tree and the thickness of the chain are gradually reduced, and by the time the elephant reaches adolescence, it can be lead around by the handler with only a thin stick and string. At this point in its life, the elephant could easily overpower the handler and free itself. However, because it associates the string and stick with the chain and the tree that kept it restrained its whole life, it doesn't even try to escape. Since learning of this training method, I have been haunted by the suspicion that we miss many of life's opportunities for growth because of our blind adherence to the programming from our past.

I had an experience of the "illusion of having a choice" when, at the age of forty, I went with my wife to visit my mother. As soon as we walked in the door, my mother voiced her displeasure at how much weight she believed I had gained and commented that I must "weigh over two hundred pounds." I disagreed and suggested to her that she was mistaken, but to prove her point, she grabbed my arm and led me to a scale to weigh myself. I passively complied and stepped on the scale. Upon seeing how much I weighed, my mother looked very satisfied with the accuracy of her judgment. Shortly thereafter, my wife pulled me aside and emphatically commented that she was awestruck at how I offered no resistance to the way my mother had treated me. She reminded me that I wouldn't have accepted that kind of behavior from anyone else, and suggested that at the very least, I could have protested this demeaning treatment. I realized that it hadn't even occurred to me to assert myself and resist being treated like a child. My mother had raised me in such a way that I never questioned her authority. In our lives, how many of the choices we make – or fail to question – are the products of this kind of conditioning? It is

essential that we become aware of our own possibilities and potential so that we can overcome such limitations. Without the inclination to test our self-limiting perceptions, we remain, like the subservient elephant, unaware of our potential freedom.

A mindful evaluation of our agendas and goals, independent of our perceived limitations, can lead us to test our presumed limits and discover what really is possible for us. Richard Bach wrote a book called "Illusions," the basic premise of which is that we should not be limited by the illusions from our personal history. He wants people to be able to access their fullest capabilities. I often hear patients say emphatically, "I can't do it, I can't take the discomfort -- the anxiety is overwhelming." These false perceptions are among the most compelling factors behind a patient's failure to comply with the therapeutic guidelines.

When you have OCD, it sometimes can feel like you have no choice but to try to escape from the "threats" about which you are experiencing so much anxiety. When the brain sends you such signals, however, your goal should be to remain mindful of *all* the choices available to you, not just those dictated by the disorder. "Do I wash my hands and escape the threat of getting sick, or do I choose to take the risk of getting sick with me?" What is important is that you choose to behave in a way that enhances your freedom and demonstrates to your brain that the "threat" about which it is warning you is irrelevant, rather than repeatedly giving in to the emotional urgency that demands that you seek relief.

"I couldn't get out of bed yesterday." "I didn't have the energy to do it." "I can't take the overwhelming anxiety I feel when I ignore the threat." I hear these kinds of self-limiting statements on a regular basis. As I mentioned earlier in this article, when I attempt to dispute a patient's assertion that he or she is too weak to handle the challenges of the disorder, I am met with great resistance and even resentment if the patient believes that I am not sympathetic to how difficult it is for him or her to choose the therapeutic response. This entrenched lack of agency on the part of the patient can lead a therapist to throw up his or her arms and capitulate to the patient's conviction that he or she truly *is* that limited.

A patient who impressed me greatly flew in to New York one day and entered my office with shaking hands and a pale white face. He looked at me as if he were about to confess to a terrible crime for which I would surely call the police. He grimly informed me that since he was 18, he had been having thoughts of violently harming those about whom he cared the most – the members of his family. Finally, at the end of his rope and no longer willing to live with this terrible secret, he collected all of his worldly possessions and personal financial documents, called his now fully-grown daughters to his side and, mortified, confessed that for many years he had been having murderous thoughts, some of which had included them. One of his daughters, who had been expecting an announcement of some impending disaster, breathed a sigh of relief, sat back, and said with a smile, "Dad, you just have OCD. You need treatment." For over thirty years, this man had been silently suffering with this "secret" because he hadn't been aware that it is completely normal for people to *have* such thoughts. After two months of intensive therapy, he had made so much progress that he was able to joke about how his mind was still generating these silly thoughts. The spikes had become irrelevant.

SUMMARY

The essence of everything that has been said in this article is that whether your goal is to recover from OCD or simply to live a fuller, more meaningful life, you **need to** take **responsibility for making mindfully aware**, **autonomous choices** that reflect your agenda, your goals, and your values**.** Mindfulness means being aware of the difference between the voice of your brain (an automatic system) and the voice of the Gatekeeper (your autonomous voice). **Individuals** involved in therapy for OCD are engaged in an enormously difficult tug-of-war between their autonomous goals and their brain's inclination to seek the path of least resistance. The patient's autonomous voice says, "I want to recover," and the voice of the patient's brain (the machine) says even louder, "Stay away or escape from danger at all costs!" To be successful in therapy, you must make some very difficult and emotionally painful choices, and it is essential that you do not try to place the responsibility for making these therapeutic choices on the shoulders of your therapist. You also must understand and expect that your brain will not automatically guide you toward your goals, regardless of how beneficial they may be.

I predict that the vast majority of people who read this article will believe upon completing it that they have accomplished something material and significant in terms of making changes in their lives. In **feeling** this way, they may be fooled by their brains into believing that just reading and understanding the words will itself bring about significant changes in their lives, and unfortunately, nothing could be further from the truth. Understanding and even being inspired by the words of this or any other article is just the first step in the process of making the kinds of changes I discuss. The much more difficult – and essential – step actually is to make the choices and take the actions that bring these words to life. So don't be satisfied with having gained some insight about OCD or about living a more purposeful and meaningful life. Go out and do the work that is required to turn insight and understanding into real behavioral change. That is what this article is really about – turning understanding and inspiration into intention, and intention into action. And that is what choice really means.