

**THE GOAL HANDBOOK:
RUNNING A SUCCESSFUL SUPPORT GROUP
FOR OBSESSIVE-COMPULSIVE DISORDER**

by

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DEDICATION

I want to thank the many people with OCD I have worked with over the years. All of my successes are the result of learning from their insights, their courage and most of all their generosity. Those who know me know that I see people as individuals and hate to make generalizations. However, it seems to me that those suffering from OCD are among the kindest and most understanding people I have ever met.

I'd also like to thank my wife, Cathy and my son, Josh. They are the most precious parts of me and they make it all worthwhile.

OBSESSIVE-COMPULSIVE CREED

Today I am going to help myself by confronting uncomfortable situations, and discontinuing my rituals, for avoiding and ritualizing will only hurt me.

Today I will make an effort to expose myself to situations or objects I found difficult dealing with yesterday, for each day I do so, I move one step closer to my goal.

Today if I slip, I will immediately re-expose myself to the upsetting object or situation, for confronting a fear is the only way to overcome it.

Today if I find it hard to cope with my fears, I will call a friend, because encouragement and support always helps.

And last of all, I will try to keep in mind, that if I try just a little harder today, I will make living a little easier tomorrow.

Written by Linda Gourley of GOAL

INTRODUCTION

Support groups for obsessive-compulsive disorder (OCD) are rapidly multiplying across the country. This is a wonderful development for those suffering from OCD, but it is not without its pitfalls. Oftentimes, a support group that began as a positive experience may either disband or worse become harmful to its members. GOAL (**G**iving **O**bsessive-compulsives **A**nother **L**ifestyle), the support group of the Philadelphia Affiliate of the OC Foundation, has been running since 1981 – perhaps giving us the distinction of being the oldest OCD support group in the country. As a result, we have frequently been asked for advice about how we keep our group both alive and vital. Over the years we have gone through many transformations to survive and I believe that others will find our format helpful in starting and maintaining their own groups.

Before going further I think some history would be in order. GOAL began while I was working with Dr. Edna Foa on the first of her many NIMH grants to study OCD. Two independent events lead to the group's formation. Gayle Frankel, the current president of the Philadelphia Affiliate and whom Dr. Foa had treated for OCD, had asked Dr. Foa if she could start a support group. At the same time, having observed the similarity of relapse in OCD and substance abuse disorders, I had begun talking to Dr. Foa about the possible use of groups as a relapse prevention intervention.

Dr. Foa put us in touch. With Gayle doing most, if not all, of the initial leg work, the group was born. From the beginning I emphasized the idea of choosing behavioral goals to work on between meetings. It wasn't long before the members began calling themselves goalies and found a way to make an acronym out of GOAL (**G**iving **O**bsessive-compulsives **A**nother **L**ifestyle). Now, over twenty years later, it is still running – although at a different location and with some changes in our format. The changes are both the result of our experiences and a modification of our original purpose.

Initially, the group's purpose was relapse prevention, as all members had been through an intensive behavioral therapy program of exposure and response prevention. In 1987 we broadened the group's mission to serve the entire range of those suffering from OCD; from those who had been treated in an intensive behavioral therapy program to those who had just discovered that their problem had a name, that others suffered from it and that there was help. Under these circumstances two questions need to be addressed: what goals can such a diverse group hope to accomplish and what makes for an effective support group?

Although support groups are not meant to function in place of therapy (for OCD this usually means an intensive behavioral therapy program of exposure and response prevention in conjunction with an SSRI medication) their therapeutic value shouldn't be underestimated. Over the years we have seen people make significant gains by actively participating in GOAL. One function our group shares with all support groups is freeing the individual from the isolation of feeling alone; that no one, including friends and family, understands. New members are frequently filled with wonder when they finally meet people, whom they know understand exactly what they feel. At the same time, new members are able to see that everyone present are not simply obsessive-compulsives, but individuals, who share a common problem, but differ in all of the ways people do. We mustn't lose sight of the fact that no matter how we structure a group, the heart and power of the group comes from the sharing between members. For any group, care must be taken to foster and encourage members to express and share their feelings.

However, our purpose is to go beyond this. We want to help those suffering from OCD to also:

- 1) understand the nature of their OCD, to understand how they can engage in seemingly irrational behaviors and still be as sane as anyone,
- 2) understand how a problem can have biological components, but still require an intervention that goes beyond simply taking a medication
- 3) take steps to begin to gain control over their OCD.

This answers the first of the two questions we posed: what goals can a group hope to accomplish? As our group serves anyone with OCD, it accomplishes its mission differently for each member of the group. For those who have been through an intensive behavioral therapy program of exposure and response prevention, the group becomes part of their relapse prevention program. For newcomers, this may not only be the first time they have found others who can understand how they feel and what they have been through, it may also be the first time they have been introduced to behavioral concepts. The success of the support group will not only depend upon the structure of the group, but also upon the group's having a common understanding regarding the nature of OCD in terms that everyone can understand and relate to. Thus, to answer our second question, what makes for an effective support group, this manual is broken into two sections: understanding OCD and structure of the group.

FOR PROFESSIONALS STARTING A GROUP

This manual is meant to help both professionals and lay people to run a group. We believe that the ideal group is one which is *professionally assisted*. By this we mean that a professional is present at every meeting, but tries to allow the members to run the group. Obviously a professional starting a group or helping an existing group to change to the GOAL format may have to assume the role of group leader. However, over time, s/he can have the more experienced group members take over this function. Answering questions is one of the places a professional can be most useful, so professionals may want to pay particular attention to the section on understanding OCD. Throughout the manual, those situations in which professional assistance will be most needed – even when there is a core of experienced members/leaders – are highlighted.

UNDERSTANDING OCD

We have found for both professionals and those suffering from OCD that understanding the disorder is not the same as being able to explain it to another. In this section we offer our interpretation of what we believe the current research suggests about the nature and treatment of OCD. The metaphors and examples presented are used in our own work. We would caution professionals to keep in mind that understanding OCD is not the same as knowing what it feels like. For group leaders using this manual, we are not suggesting that every new member to the group should read this section or needs to be presented with all of this information at once. Rather, we expect the concepts and examples provided here, along with the leaders' own experiences, to be raised during meetings when relevant.

UNCERTAINTY THE COMMON FEATURE

Anyone suffering from OCD can tell you that they *feel* crazy, that there are thoughts they *feel* they can't get out of their minds, and that there may be senseless rituals that they *feel* they can't stop themselves from performing. The range of fears, feared consequences and rituals is limited only by human imagination. For fears we have seen the more common ones such as fear of contamination or harming others to fears that a particular image, harmless and meaningless by itself, will stay in one's consciousness forever. Similarly, rituals can cover an unlimited range of behaviors from excessive washing, excessive checking (hours spent standing by a door to make sure it is locked), ordering objects, counting, rereading to complicated mental rituals. And knowing one's fears and rituals doesn't necessarily tell us what the individual is afraid might happen. For example, some individuals with contamination fears may be concerned about contracting a disease, while some may worry that they will cause others to become infected, while others may simply feel tremendous anxiety at the thought of contamination with no concern over getting or giving disease.

We believe that the major feature linking all of the various symptom presentations together is uncertainty and anxiety. That is, if you suffer from OCD you are attempting to obtain 100% certainty about something and the failure to do so is creating anxiety. And it is this anxiety that drives you to carry out your rituals. For example, an individual with contamination fears might say, *"I know I must be clean because I've been washing my hands for 2 hours, but I can't stop. Why am I doing this?"* If we were to carefully question this individual, we would probably find that they think they are probably clean, but are concerned that there is a slight chance they might not be (i.e. not absolutely certain) and the resulting anxiety feels horrible.

When family members tell an individual with OCD to stop ritualizing or avoiding because their behavior makes no sense, the sufferer already knows this. But the sufferer also knows that the family member doesn't know how awful they feel and can't assure them that their anxiety will go away if they listen. Indeed, it is likely that the sufferer has been confronted with some accidental exposure to their fear

that resulted in horrible anxiety and perhaps hours of ritualization. As near as that individual with OCD knows, exposure will make matters worse, so listening to their family would be crazy.

So the individual with OCD recognizes they can't obtain 100% certainty, feels anxious because of it and then, makes a mistake – by accident, from literally not knowing any better – of trying to obtain absolute certainty to change feelings. And that doesn't work. As anyone with OCD can tell you, for every logical answer there is a what if. And so logic fails as it must.

If one's goal in treatment is certainty, there is no hope. To beat OCD is to choose the goal of living with uncertainty, without fear and rituals, to be free. We need to remember that the inability to be certain is normal. When anyone says they know something, what they really mean is that they attach a very high probability to their belief. I might be very sure that I'm sitting at my desk writing these lines, but can I be 100% sure that I'm not having a very delusional hallucination. Unlikely yes, but definite, no.

Suppose I felt that I must know – how would I feel? If you are reading this and have OCD, you should know – think of how you cope with your areas of concern. If you don't have OCD, try to imagine with me. First of all, my anxiety would begin to mount. I would wonder what is wrong with me, why should I worry whether or not I'm really here. Of course, this concern will raise my anxiety, I am having a crazy worry, so maybe I am going losing my mind. As I argue with myself as to whether or not I should worry about whether I'm really writing at my desk, part of me will say, if I am not really writing at my desk, that's would be very important to know. And of course, it *feels* like my anxiety will go away if I could figure out the answer. So, even though I may know the question is senseless, I believe that working it out will make me feel better. And if I am unable to find a way to reassure myself, my anxiety will rise, my thoughts will go in endless circles, telling myself I'm crazy for devising proofs that I'm here, and then doubting them. Because I am so anxious and obsessed, I may have trouble keeping up with my work. And part of me is scared of what I'm feeling, it *feels* like I won't be able to tolerate another moment, that I will lose control if I don't find a way to calm down. ***No matter what disaster one may fear with their OCD, whether it be illness, death, or whatever, usually that feeling that I can't take another second or I will lose control or go crazy is present.*** So even if my obsessions or compulsions focus on trying to avoid a disaster, they are also trying to make my anxiety go away. To prevent myself from going crazy I will do my rituals. Unfortunately, *feelings aren't rational*. We'll return to this momentarily.

Having convinced someone that uncertainty is often the core of OCD and conquering OCD means learning to live with uncertainty, what is the next step? Obviously, no one can just say, okay, I will accept uncertainty and now the problem is over. In fact, often the idea of living with the uncertainty of their fears is so overwhelming that the individual can't imagine coping with disastrous uncertainty. Our response is to ask them a question: is your spouse/parent/sibling alive? Their usual answer is yes, to which we respond: how can you be sure? It doesn't take much prodding for the individual to admit they don't know for sure. Our point is that the individual is coping with this particular uncertainty in the same way everyone else does; that is, until there is definite evidence that the disaster has occurred, they will assume everything is okay. The goal in treatment is to learn to apply this to their OC symptoms. Obviously this isn't a matter of simply deciding, but one can decide to start the process of trying to learn how to do so.

HOW CAN I NOT KNOW WHAT I KNOW

One of the most frustrating things about having OCD is doing a ritual over and over again, saying you know it isn't necessary, but continuing to do it. We would tell you that you do know what you know. I have often asked people, if you had to make a guess as to what the truth is at this moment, and you only get one guess, and if you guess wrong, you and your loved ones will be killed: what is your guess? To date everyone comes up with the "right" guess. I put right in quotes, because in this case right means what most people would say. There is a difference between what you know and what you *feel* you know. Remember, earlier we noted that feelings aren't logical; as a result, logic can't change feelings.

In the areas of your life that are unaffected by OCD, you accept this. If I'm walking down the street, see an attractive individual and respond with arousal, I don't worry about it. I don't say, "I'm married, why is my body doing this – it should stop," or, "If I'm feeling this, do I have to act on it?" I accept these feelings and accept that whatever I logically think, I can't make the feelings disappear. ***Logic doesn't make my feelings go away, it helps me to decide whether or not to listen to the them.***

OCD MAKES ME RITUALIZE

In the preceding example must the person who *feels* attracted to another pursue that individual regardless of the consequences? S/he has a choice. Do you have to listen to your urges that tell you to ritualize? Do you have to wash your hands? Do you have to check the locks? Do you have to get your thoughts right? If you answered yes to any of these, because you believe urges are irresistible, then think about following questions. Do you ritualize as much in public as you do in the privacy of your home? If the answer is no, why? And as I asked earlier, if I held a gun to your head or the heads of your loved ones and told you I would shoot if you perform your ritual, would you? If you answer no, that you wouldn't engage in the ritual, you are saying that you can make a choice. Remember, saying you have a choice doesn't mean it is easy, that you can simply stop OCD by a decision. Deciding to not ritualize can be a very painful choice resulting in a great deal of anxiety. But, deciding to ritualize can be equally painful!

If engaging in a ritual can result in tremendous anxiety, why does it matter whether or not it is a choice? Why would anyone choose to feel tremendous anxiety? There are two answers: 1) sometimes rituals do help you to avoid anxiety, but at a cost; engaging in them ensures that your OCD will not improve and may even get worse. Learning to resist rituals helps fight your OCD. 2) If you have convinced yourself you have no choice, then why would you even try to resist them. Recognizing you have choice, makes resisting possible.

IF RITUALIZING IS A CHOICE, WHY CAN'T I STOP?

The first problem with the above question is the word can't. In our support group, anytime someone says, "I can't..." or "I have to..." they are met by a chorus of voices asking, "What?" This is our way of reminding them that they won't, not can't, do something. The above question is best asked, "Why do I *feel* like I can't stop?"

Such an individual may tell us that when they do try to resist performing rituals, their anxiety builds and builds until they can't stand it anymore – it seems like they will explode, or at the very least, be stuck this way forever. Why do these feelings arise?

First of all, we know that whenever one confronts a fear, it starts to get worse before it gets better. If this weren't the case, if fear started to decrease the moment it was confronted, no one would have OCD, because sooner or later an exposure would occur, perhaps accidentally, fear would decrease and then the problem would be gone. Because anxiety and fear increase when you first start to resist, most individuals conclude that their only hope and escape is to ritualize. In fact, if the urge to ritualize is resisted, after

initial increases in levels of anxiety and urges, both start to diminish and healing can begin. When you give in before this, no real improvement takes place.

Sometimes clients tell us, "I know I can't, because I have never been able to and whenever I try it gets worse." I always ask what they mean by worse. Usually it means tremendous anxiety, frustration and more ritualizing than usual – maybe even hours. For most people with OCD, their very worst experiences weren't simply overwhelming anxiety and fear of what would happen. For most, their worst experience was also accompanied by rituals and/or obsessions. On such occasions, the person feels trapped, every attempt to do the ritual "right" fails, anxiety and frustration mount. What is actually happening? Each time the ritual fails, the person becomes upset, thinking, "what is wrong with me, what is going to happen to me if I can't control this?" In other words, fear of the ritual failing is increasing anxiety, so that each failed repetition actually increases rather than decreases anxiety. If rituals make OCD worse, why would anyone perform them unless they had to? How can it be that it true that is just *feels* like one can't stop?

Two of the reasons for this feeling have to do with learning. In general, all animals, including humans, will engage in a behavior that pays off in the short run. That is, we tend to like an immediate payoff, so that an offer of \$200 today may be more attractive than \$210 two months from now. When rituals work, the payoff is immediate, anxiety relief versus waiting for the anxiety to gradually dissipate. Unfortunately, each time they work, you are practicing avoidance, thus increasing the strength of urges to avoid and weakening your will to confront anxiety. Think of it as a diet. Every time you overeat, it may feel good, but now it will take more work to lose weight. On the bright side, you can always lose the weight, your behavior just determines how long and how much work it will take.

To make matters more complicated, we are motivated not only by real payoffs (money, food, success, relief from anxiety), but by expected payoffs. Imagine a gambler at a slot machine. The gambler knows that the machine is set so that he will lose. He can tell you that if he starts playing, the most likely outcome is that he will lose money. But what happens when he is standing in front of the machine. He thinks about how incredible it would be if he hit the jackpot. He has wonderful fantasies about what he will do with his winnings. It could happen, some people win. He wants it so badly, it is as if it wouldn't be fair if he lost. So he puts his quarter in, three if he is really serious, pulls the lever and then... Shock! Exactly what he would have predicted would happen, did, but he can't believe it. Does he walk away? No, he puts more quarters in and every now and then he does win, not enough to offset his losses, but enough to keep him playing.

And that is what happens with OC rituals. You can tell me that if you get started, you won't be able to stop. But when you are in the middle of an OC situation you are faced with a choice: I can walk away and suffer or if I can just get this right, I'll be free for the rest of the day. And like the gambler, your prediction comes true – either you get lost in endless rituals or just as bad, it works, which will make it more of a struggle to give up your OCD.

The other reason related to learning is that you don't know you can successfully fight OCD – that because you have always given in sooner or later, you believe you have no choice. This reminds me of an experience I had with my son when he was ten years old. We were riding our bikes in Valley Forge National Park. As we were riding up a big hill, Josh expressed his very sincere belief that he needed to stop and rest. Now I knew that he could make it up the hill without resting, and I also knew that if I didn't stop he would keep riding. So being the pain in the neck that I am, I kept riding – cheerfully saying things like, "oh sure you can." He made it to the top of the hill, the epithets coming from his mouth sounding mature beyond his years.

Later, when we were driving home, I said, "So Josh, I hate to say this, but I was right, you made it to the top of the hill. How do you feel about that?" Of course he was proud of himself, but I pointed out to him, "Do you know what the real lesson of the hill is? Let's face it, when you asked me to stop, you really were tired. And going all the way to the top without stopping took a lot of extra effort. But if you had stopped when you wanted to, you wouldn't have known you could make it to the top. You would have thought that whenever you got that tired, you have to stop, because that's what you always do. The real lesson of the hill is that when you think you have reached your limit, you are underestimating yourself."

If you have OCD and believe that you can't fight it, you are underestimating yourself, assuming that just because you always give in eventually you will always have to. Not giving in can be very hard, but hard is not impossible.

BIOLOGICAL VS BEHAVIORAL CAUSES OF OCD

One of the first things someone will learn about OCD is that it is a neurobiological disorder – a chemical imbalance. Although this is true, this little bit of knowledge is dangerous as it leads people to erroneous conclusions. People constantly ask us how can anything other than medication affect or help with a biological disorder? One response to this has come out of the work with PET scans (a brain imaging technique) of those with OCD (Baxter, 1992, Schwartz 1996). They found that those suffering from OCD who had benefitted from a behavioral treatment showed the same kind of changes in their PET scans as those who benefitted from an SSRI medication (eg Prozac).

The fact that a behavioral technique can alter brain chemistry is not the amazing finding of this study. All learning and habits are going to be represented in some way in the brain and thus all changes in habits are also going to be represented. What is amazing about these studies is that we can see where these changes are taking place and this may allow us to better understand OCD.

Also the fact that cognitive behavior therapy (CBT) can effect changes in neurochemistry does not mean that medication and CBT are interchangeable. They may act on the identified areas through different routes that have not yet been identified.

In terms of understanding OCD, it is not enough to say I have OCD because there is more activity in my caudate nucleus. Why does greater activity there lead to OCD? Hewlitt (1993) has suggested some possibilities that are consistent with what we currently know about the brain. What is presented here is greatly abbreviated in the interest of space.

All of us respond with discomfort to uncertainty. Evolutionarily this makes sense. Imagine primitive man walking across the savannah and hearing a noise behind him. His survival might depend upon him feeling nervous enough to find out whether or not he is being stalked by a predator. Similarly, we all feel a sense of satisfaction in completing what we have started. Again, such feelings form part of what has driven mankind to create our technological society. Hewlitt hypothesizes that in OCD the threshold for these responses is lower. That is, it takes less uncertainty for an individual with OCD to respond with greater anxiety, and that when something is completed, the individual's body doesn't respond as if it is completed.

There is more to his theory, but for our purposes a more detailed account isn't necessary. What we find most interesting about his theory is that the biological aspects don't describe all of the complexities of OCD, but they do form the basis for learning OCD responses. Initially, an individual at risk for OCD will feel uncertain and anxious about something and in response will perform a ritual (e.g. see if the door is locked; rinse some "contamination" off their hands; look in their car's rear view mirror to see if they hit

someone) to take care of it. Few people instantly become severely symptomatic with OCD, where, for example, yesterday they were washing normally and today they are washing for 5 hours. Hewlitt further suggests that for people who will develop OCD, it is easier for their brains to learn the OC responses. Without realizing it, the rituals they initially perform are the beginning of the learned component of OCD. Learned responses can be very powerful and under the right circumstances very resistant to change. Most important is that learned responses are not affected by medication. It is for this reason medications, on the average, only result in a 30 to 50% improvement in OCD symptoms, which would be better than nothing, but for many means they are still diagnosably OCD and still dysfunctional.

Reducing biological urges is helpful, but it is not enough. For those infrequent individuals who have shown greater benefit from medication, we assume that this reduction enabled them to do their own CBT. On the other hand, we have found that many of the people who say medication cured them, really mean that they have improved to the point where their symptoms no longer interfere with daily functioning, though their level of OC symptomatology may still be greater than normal.

An examination of the history of one of our clients may illustrate the interplay of learning and biology. M had come to us with an eight year history of OCD. For our present purposes it is not necessary to describe her symptoms; suffice it to say that M wasn't able to function. In describing her last eight years, she would characterize some of those years as absolute torment and others as awful, but not as bad. She participated in an intensive outpatient CBT program and worked very hard. Within two months she had conquered her OCD. During the year that followed, she would occasionally call for an appointment, because she found she was slipping. We would make an appointment for the following week, but she would always cancel. She did so, because in the time between her phone call and our appointment, she did all of the things I would have told her to do and the symptoms abated. After about a year, she made an appointment and came in. For the next few weeks she did everything we told her, but the urges continued relentlessly. In response to this we put her back on medication and within a few weeks, the symptoms abated.

In examining M's experience, we believe that pre-treatment, during the periods she described as absolute torment, her symptoms were the result of biology and learning, but that during the years that were just awful, she was remaining symptomatic and dysfunctional on the basis of the learned part of OCD. Looking at her post treatment functioning; we see that during her first year a number of her slips were not biological in nature and so CBT alone took care of them. Then, after about a year, she began to experience urges that CBT didn't reduce. We assume that this represented a shift in her biology so that medication again became necessary. This is not to say that continued CBT was useless during this period. Although our behavioral work didn't eradicate her urges or anxiety, it did prevent her from again becoming dysfunctional.

M's experience points out another important concept with regard to OCD – relapse. It is important to recognize that relapses will occur. And not only for biological reasons. For any behavior that an individual has engaged in for a long time and then tries to change, relapse will occur. Though we will not go into detail here, think about other areas of life. How many people do you know who have went on a diet, stopped drinking, started an exercise program, stopped smoking and never relapsed? The issue is not whether or not you relapse, but how far do you go? Think of a dieter who has lost 100 pounds and after five months gains two pounds. Is this enough for them to start dieting again? How about seven pounds? Fifty? The same is true for OCD. If you have beaten OCD and are starting to slip, when do you return to your program? After five minutes of extra handwashing a day or five hours? As I pointed out earlier, the good news is that no matter how far you slip you can always come back, but the longer you wait the more work it will take.

SUMMARY OF UNDERSTANDING

Obviously this section is not long enough to provide a total understanding of OCD. There are a number of good pamphlets and books that can be obtained through the OC Foundation. The purpose of this section was to provide an understandable explanation of some of the common questions that are asked about OCD, whose answers reflect the philosophy of the group. In running your group you may want to use our examples or your own to answer and explain OCD to new members.

RUNNING THE GROUP

As we mentioned earlier, our group has been running since 1981. We believe that to survive in the long run, meetings must serve a threefold purpose:

- 1) provide a place to discuss issues directly and indirectly relevant to OCD;
- 2) foster and support individuals taking control over their OCD symptoms (goal planning);
- 3) allow informal socializing.

It may seem obvious, but it took us seven of our sixteen years to figure out that we needed to formally break the meeting into three parts to accomplish the above. Meetings begin with a general discussion of a topic chosen by the group leaders *prior* to the meeting. This generally lasts from 8:00 pm to 9:15 and is followed by goal planning. Goal planning lasts another half-hour to an hour. Then with our formal business completed, refreshments are served, everyone socializes and how long this lasts is unpredictable. Our group meets every other week. We think that less makes it harder for members to support each other in carrying out their goals (see below). A group that met every week might help its members even more, but it is possible that over time members would be less willing to come this frequently. If the reader knows of any long running, free support groups for OCD that do meet on a weekly basis, we would be interested in hearing from you. Finally, there is no charge to attend our meetings, the only requirement is that the individual is suffering from OCD. Although meetings that include family members can be very useful, they do serve a different function than the kind of group we are describing.

The first question to consider if you are starting a group is: will there be a professional present? Having a professional present can be very helpful. His/her major contribution will be keeping the meeting on track. Interrupting a member who is either monopolizing the time, changing the subject, or talking about personal issues that aren't appropriate to the current topic can be exceedingly difficult to accomplish, especially if the individual in question is in obvious pain or distress. If the person's distress is very great, a professional can take them aside to help them, while allowing the meeting to continue. Finally, the professional can be present to answer questions that may come up that others do not have the expertise to answer. In a recent survey of our group members, almost everyone found it helpful to have a professional present to answer questions, handle difficult problems and help keep the meeting on track. As for the potential downside of having a professional, only 3 out of 77 respondents to our survey reported that the presence of a professional made it harder to talk. If possible find a professional experienced with OCD and willing to donate his/her time.

OPENING THE MEETING

If you are to succeed, you need to have a core of group leaders who are in agreement as to how meetings should be run. The leaders are responsible for; keeping the group on the chosen topic, sensing when the group wants to move on to another individual and ending the initial discussion at a previously agreed upon time. The OC Foundation has a useful set of guidelines on how to do this. The

leaders will also be responsible for maintaining an up-to-date phone list for members to contact and help one another between meetings. Finally, they will take care setting up for meetings and cleaning up afterwards. Periodically, a speaker will be invited to present at the meeting. The leaders will be responsible for selecting them.

At the beginning of each meeting, special attention should be given to new members to explain how the meetings work. Try to remember the first time you met others suffering from OCD. It can be an overwhelming experience. Some of you may recall the wonderful relief of not being alone and the desire to share everything about yourself with people who know exactly what you are talking about. At the opposite end of the spectrum are those who were afraid that their OCD is different from everyone else's; they will listen to everything the others say to discover those differences. In any event, new members will have 10,000 questions, hoping that someone present has the magic answer. You may want to include these sentiments in your brief introduction of the group, while assuring them they will have time to ask everything they want to at the meeting's end. Having a handout that describes the general structure of the meeting is especially useful to new members. These can also be useful to send to local mental health professionals, physicians and the local media to make them aware of your group (See Appendix A for an example).

Sample Introductory Remarks:

"This is the GOAL support group that is run by the Philadelphia Affiliate of the OC Foundation. I see some new faces and I'd like to welcome you to our group. I just want to take a moment to explain how we run the meetings. First we'll be having a discussion around the question that you found on the piece of paper on your seat. We will go around the circle and give everyone a chance to share their thoughts. If you don't want to say anything, it is okay to pass. Around 9:15 we will break into small groups to work on GOALS. At that time, new members will be with SueAnn, who will explain what GOALS are. Let's just take a moment to go around the circle and introduce ourselves. I'm Gail..."

If a professional is assisting, but not leading the group, the leader may want to introduce him/her.

THE QUESTION¹

The open discussion part of the meeting in our group has come to be called The Question.

As noted earlier, the topic should be chosen by group leaders *prior* to the meeting. Topics can be directly related to OCD (e.g., What are we besides obsessive-compulsives? Why do we hold back in treatment?) or indirectly (e.g., How do you cope with anger? Guilt?). In the past, we have xeroxed the question, so that everyone could have a copy of it as we went around. We have graduated to writing it upon a blackboard. Appendix B provides a list of 40 questions that we have used in past meetings. Obviously the list is not exhaustive. It is very helpful if the leaders start off by describing how they are personally affected by the issue.

Topics concerning medication are taboo. This is not to deny a biological component in OCD, but a group can't change biology. It can provide support and help members to learn how to regain control of their behavior. Information about medication is appropriate to discuss: at a special meeting with an invited speaker who is knowledgeable about OCD and medication; with one's own doctor; or informally at the end of the meeting.

¹ A list of questions used in our meetings appears in Appendix 1.

Obviously new members won't be aware of this. Quite often during the discussion of the question, a new member may say something like, "I'm curious, I'm taking X drug. Are other people here on medication?" Or their response to the question may have the potential to raise this issue. At one of our meetings the question was: "What frightens you most about having OCD besides its symptoms?" One of the new members replied that they were most afraid that medication wouldn't work. She was new to the group and had little knowledge of the existence of the behavioral components of treatment. On this occasion, however, we did *not* admonish her about discussing medication, because neither she nor the group pursued this line any further.

You will want to gently guide the person back to the meeting.

"During this part of the meeting we try to stay on the topic. We especially try not to discuss medication issues for a number of reasons. First of all, medications can affect different people in very different ways, so one person's successes or problems on a medication can be very different from another's. In general, there are currently six medications used for OCD: Prozac, Paxil, Luvox, Zoloft, Celexa and Anafranil. Research finds them roughly equal in effect, but, again, there can be many individual differences. Medication may lead to about a 30 to 50% reduction in symptoms. The research literature, as well as pharmaceutical companies, recommend a program of CBT to achieve greater freedom. During goal planning, we use behavioral principles to try to gain some control over our problem. However, remember, we're a support group, so what we do isn't in place of therapy. As for your questions about medication, I hope it is okay with you to wait until after goal planning to further discuss this with others..."

PROFESSIONAL NOTE: As previously mentioned, your goal is to help the group reach the point where you are able to allow the more experienced members to lead and your role has evolved into assisting them. However, guiding a new member away from the topic of medication often requires a good bit of delicacy and you may want to assume leadership at this point.

Generally, we go around the room letting each member share his/her thoughts and feelings about The Question. Nobody is forced to speak, so it is perfectly acceptable to "pass." Others may have useful comments or similar feelings to express and we permit this even if it isn't their turn to speak. However, the group leaders are responsible for guiding the topic and discussion. At times, they may find it necessary to gently confront someone with, "yes, *that's important and maybe we could focus on that in another meeting, but now we want to try to stay with...*" or "*I don't really want to stop you, but I have to make sure everyone gets a chance to share their thoughts.*"

Sometimes we switch to GOALS after everyone has had a chance to share their thoughts about the question and other times a more open discussion will follow the going around the circle. At some predefined time, between an hour and an hour and a half the leaders need to shift to GOALS.

PROFESSIONAL NOTE: After everyone has had a chance to share their thoughts, it can be helpful if the professional stimulates further discussion by summarizing the feelings and thoughts of what was shared and asking another question to based on his/her observations.

GOALS: THE HEART OF THE MEETING

Goal planning will take about 45 minutes. We often break into small groups of five to nine people, each lead by a more experienced member of the group. It is important that small group leaders reliably come to meetings to provide continuity. They will need to write down the goals of each subgroup, so that they will be available at the next meeting. It's helpful if the small groups can remain constant over time. However, with the constant influx of new members and the inconstant attendance of other members, this can be almost impossible. For example, in our own group we usually have about 25 to 40 people in attendance. Often there may be one group of 5-8 that is stable for a few months. We periodically encourage consistency, but don't demand it.

New members, whether there are 1 or 5 are taken aside for their own group. This allows us to explain goals them as well as answer general questions about OCD and the group. As noted earlier, for many of them, this will be their first contact with others suffering from OCD and/or with people who know about the treatment of OCD. This may be the place to discuss many of the concepts presented in part one of this manual.

At this point, you'd probably like goals explained to you. Allow me to caution you, it sounds easier than it is.

PROFESSIONAL NOTE: If you are starting a group, it is very likely that you will be the one to run the GOAL group. Over time, as the group becomes more experienced, you should be able to identify those people who will be able to take this over for you. Even if your group size stays around 5-8 people we would encourage you to allow the members to take over. When you feel comfortable doing this, take yourself out of the circle and stand by. This allows you to offer suggestions as necessary, but allows the leader/member to run the group. The advantage of this is that if the group becomes too large to have a single GOAL group, you will be able to split your attention between the groups.

WHAT ARE GOALS?

The basic idea is very simple, members choose a goal that is possible to accomplish between meetings that will be helpful in obtaining some control over their OCD. Usually this will be in the form of exposure and/or response prevention. It is critically important that the goal be behavioral and small. Everyone, especially new members, has a tendency to pick something too vague (e.g., "I'll cut down on my washing") or too big (e.g., "I won't obsess this week"). The problem with the first is how does the individual know when s/he is successful? Have they been monitoring how much or how long they wash? And if they do well for one day, is that a success? The same considerations apply to the second goal. It also has the additional problem of being impossibly huge – as if recovering from OCD was a simple decision. To make a goal behavioral requires you to be very specific, for example, at what times and under what circumstances will you not wash and for how long? Thus an appropriate goal for washing might be: "on Tuesday and Thursday this week between 2:30 pm and 3:00 pm I'll do my household chores without washing," or "on Tuesday and Thursday I will touch the trash can, contaminate my kitchen, not wash for one half hour and leave it contaminated for the rest of the day."

Being specific makes it easier for one to know when one has succeeded. Most people suffering from OCD will or have attempted to confront and control their symptoms at some time. What generally follows is some period of short success, that may be as brief as a few minutes or as long as a few days. This is followed by slipping back to their OC behavior. Then the individual makes the mistake of considering themselves a failure, and assumes that because they have not succeeded in either controlling

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their behavior or reducing their anxiety that they are helpless against their OCD. Although long term freedom is certainly everyone's greater goal, outside of a well-designed intensive behavioral therapy treatment program, rapid long-term improvement is difficult to obtain.

A GOAL should be active – pick something a dead person can't do. Dead people are notoriously good at not obsessing, not washing, etc. On the other hand, they are terrible at confronting their fears. Passive goals are harder to accomplish and will be less effective in producing behavioral change. Some examples of GOALs might be:

For contamination problems;

- 1) touching something contaminated in the meeting room and agreeing to spread it around the home;
- 2) touching a contaminated object with one's hands, touching food and then eating it;
- 3) put groceries away without washing them;
- 4) touching a contaminated object and contaminating a fellow group member.

For checking problems;

- 1) face away from the stove, turn it on, turn the knob to the position that might be off and leave the house;
- 2) leave lights on or water faucet dripping;
- 3) read a newspaper article and black out the print with a magic marker while reading, so that checking is impossible;
- 4) read 5 pages of a book and use an index card to cover what has just been read to make it more difficult to repeat. Do this tomorrow and Sunday.

For "hit and run" fears;

- 1) tomorrow drive by a school when children are being let out and don't look in rear view mirror;
- 2) after arriving home spend fifteen minutes saying to yourself, "I'll never know if I hit anyone on the way home unless the police come for me, so I have to get used to this uncertainty." Do this three times this week.

For ordering;

- 1) turn food cans in cabinet without labels facing front and out of size order;
- 2) purposely fold towels wrong and put them away this way;
- 3) arrange desk by knocking everything a little bit.

For obsessions;

- 1) if the individual "freezes" whenever they want to "figure out an obsession", we might ask them to continue rather than stop their activities when obsessing;

- 2) for obsessive concerns about health and dying in which obsessions focus upon trying to be convinced that death is far off, the goal for the coming week could be to spend five minutes daily thinking about the fact that death could come at anytime and there is no way to have significant control over this.

We don't talk about failures to achieve a goal, not because we're positive and nice, but because the group is committed to helping everyone get around their difficulties. For us, a goal that wasn't achieved merely means we have to find a *different* way to accomplish the same goal. Different, because if one didn't succeed this time, then why should one succeed if no changes are made in how the goal is approached? The first possible way to make a goal different is to make it smaller, perhaps too much was attempted for a first time. For example an individual who has attempted to touch a public restroom toilet with the intention of going home and contaminating all of their clothes, beds and towels may have tried too much for the first time. A more reasonable goal might have been simply touching the toilet during the meeting and not washing until they go home or perhaps touching a light switch in the room and then contaminating everything at home. A second possibility is arranging a situation so you can't fail. There are many ways to do this and they are limited only by the imagination of the group.

In general using the support from the group will accomplish this. For example, the individual could call a member when they are having trouble, or if they fail at this, a member could call them at a prearranged time and wait on the phone while the goal is accomplished, or the member might actually visit them at their house to help them. Sometimes, if someone is intent on trying a goal without support, we try to get them to agree in advance that if they don't succeed the first week, that they will permit support the second.

Sometimes people find the very idea of calling difficult, especially if they feel the need at 3:00 am in the morning. We often have these people agree to taking a goal of calling someone in the group at that time, when they aren't having a problem. We do this because we have found that an individual who has difficulty with this, has even more difficulty calling for help when they are in distress. Thus, not all goals that will lead to improvement are directly related to OCD symptoms.

For those of you familiar with the idea of exposure and response prevention the above goals are familiar. To others, I'm sure it seems that either what I'm suggesting is impossible or that I am out of touch with reality. Research has shown that confronting your fears is critical for recovery. Because exposure is anxiety provoking (please don't forget that the alternative, giving into OCD urges has provided you with unending agony and robbed you of your freedom) the goals you initially choose should be ones that you know you can accomplish. Don't worry about them being too small; starting somewhere and having success is more important. Remember, when you are successful you will add new goals to your old ones, so that over time your gains will increase. Over time, new members are able to see what differentiates those who benefit from the group from those who don't – hopefully, they strive to follow the example of the successful.

Because a support group is not the same as therapy, members are encouraged, not pressured into taking goals. Another major difference between the GOAL support group and a behavioral program for OCD concerns the intensity of the treatment. In an intensive treatment program, response prevention involves the complete cessation of all rituals (for example, no handwashing under any circumstances during treatment). For exposure, by the second or third week an individual may be coming into contact with their most feared exposures. Because this can require a great deal of support, most individuals would have difficulty doing this completely on their own or even within the support of the group. For these reasons, the goals taken in group are expected to be helpful and to result in progress, but we do not

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expect them to lead to the recovery seen in an intensive treatment program. On the other hand, in our group there are a few individuals who have achieved total recovery through the group alone.

INFORMAL SOCIALIZING

During the final part of the meeting, informal socializing, refreshments are available and everyone is free to share anything and everything they couldn't during the meeting. This includes friends catching up with one another, continuing informal discussion of the question and people asking for additional advice from the leaders, the professional and one another.

SUMMARY OF RUNNING THE GROUP

We believe all three parts of the meeting are critical. The first part allows a sharing of feelings and ideas on issues of general concern to everyone. Goal-planning keeps the meetings focused on what everyone can do to help themselves. Socializing helps bring everyone closer, which is crucial, since members will need to depend upon the others for support in accomplishing goals.

SUMMARY

We believe that support groups can play an important role in coping with and overcoming OCD. That role will be determined by numerous factors. In some parts of the country, if you suffer from OCD the problem isn't simply finding mental health professionals experienced in the treatment of OCD, it may be impossible to find anyone in the mental health community who is willing to learn how to use exposure and response prevention techniques for the treatment of OCD. In such places, a support group will be the only place the individual can receive help beyond a prescription. And if that group is a GOAL group, the individual has open to them the possibility of making significant improvements in their life. For individuals in communities where good behavioral treatment is available, a GOAL group will be able to provide additional support during an intensive treatment program. The individual will be with friends, who not only encourage their progress, but will actively help them to accomplish their behavioral homework and will share in the elation of each success. Finally, for those in the enviable position of having recovered from OCD, a GOAL group can be one of the cornerstones of their relapse prevention program.

We believe that the GOAL approach helps make support group meetings a place of hope. Inherent in GOAL is the belief that no matter how bad your situation is, there is always something you can do to improve. We try to help those suffering to understand that taking steps to fight your OCD, no matter how small those steps may be, is better than doing nothing. And though those steps may be difficult, there is the support of a group that knows what that person is going through, whether it be; the pain of confronting fears, the agony of not doing so, and/or the dread of having to cope with uncertainty.

People with OCD are not the only ones who attempt to flee from the uncertainties of life – philosophers have written endless volumes on the subject and from the time history has been recorded, we find stories of people trying to gain some control over their lives. In the end, all of us are victims of uncertainty. Most of the time we find out if our life guesses are right or wrong when it is too late. I've been married to my wife for over twenty-eight years – at this point in time it is safe to say that our getting married was a good decision. Had our marriage only lasted a year, we'd be able to say it wasn't. Either way, the proof came too late. Good decisions may take planning and thought, but they are educated guesses not guarantees. So while we make our plans for tomorrow, we need to learn to appreciate what we have, because the only thing we can depend on is the present. For those suffering from OCD, our hope is that GOAL will play a role in helping them to learn to live with uncertainty, without rituals, without anxiety, to be free.

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- Grayson, J.B. *Freedom from Obsessive Compulsive Disorder: A Personalized Recovery Program for Living with Uncertainty*. New York. Tarcher Penguin. 2003.
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APPENDIX A: SAMPLE WELCOME HANDOUT
WELCOME * WELCOME * WELCOME
GOAL² I GROUP

The main objective of the **GOAL I** group is to help each member develop self-help skills in an atmosphere that offers emotional and practical support. The support system will be encouraged to provide constructive support, rather than permitted to become sidetracked into non-productive discussions of members' symptoms. The group also will avoid becoming a forum for debate regarding what is the "best" treatment; however, from time to time, professionals will be invited to present their views on treatment approaches.

The structure of the meetings will be as follows:

- 1) Introductory remarks by co-chairpersons.
- 2) Open discussion on topics chosen by the Executive Committee of the Philadelphia Chapter of the OCD Foundation (see examples below). Everyone in attendance will be given an opportunity to share their feelings and thoughts on the topics. This time will also be used for our guest speakers.
- 3) Goal Planning. The meeting will be broken into small groups and each member will be encouraged to choose a specific goal for the coming week. The purpose of choosing goals is to help formulate concrete, constructive behaviors which will aid in the reduction and control of OCD symptoms. Though each member will be encouraged to choose a goal at each meeting, the decision to do so remains voluntary. The chairpersons and other members will offer advice on how to achieve the goal based on their personal experiences.
- 4) The meeting will conclude with the confirmation of the next meeting time and place. The remaining time will be for members to socialize informally and perhaps raise issues that weren't addressed during the meeting. A "question box" will be available at each meeting to allow members to communicate their ideas for future meetings and to submit their suggestions or criticisms anonymously.

Topics to be discussed at meetings or presented by guest speakers, will include:

- ② information about advancements in the treatment of OCD and their current status (experimental, tested)
- ② handling slips
- ② anger
- ② guilt
- ② death
- ② stress
- ② coping with family members
- ② handling the absence of family support.

The group will meet every other week on Wednesday nights from 8:00 - 10:15 p.m. Rosemont Plaza, 1062 Lancaster Ave., Rosemont, Pa. Meetings will be co-chaired by two recovering OCD sufferers with a therapist in attendance. Meetings will be offered free of charge.

The **GOAL** group is open to all individuals who suffer from OCD. Since the purpose of the meeting is to provide a peer support system and information exchange for people with this disorder, the meetings are **not** open to family members or friends.

²Giving *Obsessive-Compulsives Another Lifestyle*

SAMPLE QUESTIONS FOR DISCUSSION

1. What else are you as an individual, besides OCD?
2. What emotion best portrays how your family reacts towards you and your OCD? What emotion best portrays how you feel about your family during an OCD episode?
3. (A seasonal question) The holiday is upon us, and we all realize that it will bring with it additional stress. What problems do you ANTICIPATE having at this time of year? How are you going to cope with them in order to help yourself?
4. When you are angry, how does it affect your OCD?
5. When you have done exposures and response prevention and feel that you are contaminating the people around you without telling them, do you feel guilty? How do you handle your feelings?
6. How often do you give yourself credit for the achievements you've already accomplished in group or in treatment? Do you find it easy or hard to give yourself credit for past successes or do you dwell only on the work left to be completed?
7. Have you told anyone about your OCD, if so whom, and under what circumstances? Who do you feel you would not choose to share this information with?
8. What 1 thing was the most difficult for you this week? How did you handle it? How would you handle it differently in the future?
9. How has the way you have been handling things helped or hurt you in your goal of living a symptom free life?
10. Where would you like to be this time next year? What is your part and/or what do you plan to do to get there?
11. Do you consider yourself an optimist or a pessimist? How does this attitude affect your working on your OCD?
12. David Bowie, freshly 50, tells Total TV magazine that he is 'happy to resign myself to the knowledge that the search for certainty is the road to insanity. I'm quite content just being a shoveler of knowledge; it compensates for not having the certainty.'
13. I must not fear. Fear is the mind-killer. Fear is the little-death that brings total obliteration. I will face my fear. I will permit it to pass over me and through me. And when it has gone past I will turn the inner-eye to see its path. Where the fear has gone there will be nothing. Only I will remain. — from Frank Herbert's *DUNE*
14. No one can make us get better if we don't do our part. At the same time, having the support and comradery of this group helps us. **How do you expect the group to help you and how are you going to make it possible for the group to help you?**
15. What risks did you take this weekend? How did this affect your life and your OCD? If you didn't take any this past weekend, what risks will you take for tomorrow?
16. Fantasy Series 1: Do you have "fantasies" about the way things should be? In what ways does this affect your life?
17. Fantasy Series 2: Two weeks ago we discussed fantasies and goals. We concluded that each can make us feel better or worse about ourselves. Continuing our discussion from two weeks ago:
18. a) What fantasies do you have about your OCD or life that make your life more difficult.

- b) What realistic goals do you have that help to motivate you.
19. Fantasy Series 3: For the last 2 groups we have talked about how trying to make your life match a fantasy leads to misery. Do you know how to give up the fantasies that make you miserable? Have you given them up? If not, why?
 20. Are you the person you want to be? Would fighting your OCD help you to be that person? How can you use this information in your treatment?
 21. Miracles come in many forms, but they are usually unexpected. The big ones are obvious, but sometimes the important ones aren't. Finding treatment can feel like a miracle. Finding that it can work for you can be a miracle. And that brings us to the question. Often to find a miracle, you may have to take a risk, a leap of faith. Have you taken any such leaps in the past 2 weeks and if so what were the results? Did you experience a small miracle? If you haven't taken any leaps, why?
 22.
 - a) When did you first realize you had a problem?
 - b) How did you find out that it had a name (OCD) and that there was help for it?
 - c) What have you done with this knowledge?
 23. Faith can take many forms. You can have faith in yourself, another person, a higher power. Does faith have any role in your own recovery? How does it help you cope with the uncertainties you fear?
 24. At one time or another, many of us have felt that we would rather die than live with OCD — so why wouldn't we rather do exposure than have OCD.
 25. Since uncertainty in life is unavoidable, what is good about living with this fact besides overcoming your OCD?
 26. Research has shown Exposure and Response Prevention (E+RP) works. All of the people here who have successfully overcome their OCD have used E+RP. Have you committed yourself to E+RP? If not what excuses do you use to avoid it?
 27. Why me? Have you ever asked yourself this question with regard to OCD? Is there any harm in asking this question? If so, what is the danger?
 28. Whenever I come to group, I'm inspired by the people who are doing well and I always hope that everyone will imitate them. However, some members focus on the people who aren't doing well and use them as an excuse to feel hopeless and give up. What do you do? Does this work for you? Do you want to keep doing this?
 29. When you have an OCD urge or you actually are about to give in, how much time do you spend thinking about what would be best to do treatment-wise – or in other words: what would Jon do? Talk about an occasion where you had difficulty and why didn't you do something like this?
 30. What frightens you most about having OCD besides its symptoms?
 31. Overlooking how many things he was wrong about, Freud said that the three most important things in life were love, work and play. Why is play important and can it have a role in fighting your OCD?
 32. Is it fair that you have OCD? Why or why not?
 33. What major non-OCD uncertainties or tragedies have you had in your life? How did you cope with these? Did you cope with them better or worse than you cope with OCD? Which would you rather face?

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34. How do you feel about the way OCD is portrayed in the media? What do they get wrong? What message would you like the public to have about OCD?
35. If you didn't have OCD you might be a different person. What would be different about your life (do not include what would be different about you)? Which would you miss from your current life? For some of what you would like, is it really true that OCD prevents you from having them?
36. What disasters might happen if you don't ritualize? What disasters will happen if you give in to OCD? Which would you prefer to live with and why (neither is not an acceptable answer)? If you preferred the giving into OCD, why are you here?
37. Which is stronger: Your hatred of what OCD has stolen from you or your fear of what OCD might do to you? Which feeling controls your behavior? Does your answer to the second part agree with your answer to the first?
38. Imagine you have been diagnosed with a non-contagious fatal illness that will kill you in two years. What changes will you make in how you cope with OCD. What other changes might you make in your life?
39. If you could put yourself in your family's place, what would you have them do to help you with your OCD?
40. Has OCD hurt any of your close/important relationships? How? Can you use this as part of your motivation to recover?
41. At one time or another, many of us have felt that we would rather die than live with OCD — so why wouldn't we rather do exposure than have OCD?
42. How do you feel when someone in group accomplishes a particularly hard goal? Does it inspire you to try harder? Do you have an obligation to the group.
43. Security is mostly a superstition. It does not exist in nature, nor do the children of men as a whole experience it. Avoiding danger is no safer in the long run than outright exposure. Life is either a daring adventure, or nothing. – Helen Keller Do you believe this is true and what are your reasons? Given your answer, are you true to your beliefs?
44. Why take risks? In what ways has taking risks helped you? Please note we are asking how has taking risks helped, not harmed. What risks have you taken this week?
45. Thomas Edison had many failures before coming up with a light bulb that worked. When asked about this, he replied, "I haven't failed. I've found 10,000 ways that don't work." What does this mean to you?
46. Is there anyway that love can help you in overcoming OCD? Why or why not? If you answered yes, how?
47. If someone could **guarantee** that at some unknown point in your recovery **all OCD thoughts and rituals** would disappear, would you be willing to work on all of behavioral goals suggested by a therapist? How much of a guarantee do you need?
48. What do you feel is your singular biggest success in your fight towards recovery? What has been or still remains your biggest struggle in working on your OCD and towards recovery? Why aren't you successful with both?
49. When, if ever, are decisions best left to chance? Why? Does your answer reflect OCD thinking or healthy thinking?
50. How do you handle a relative or person who thinks s/he understand OCD, doesn't, but nevertheless insists upon giving you advice? If this hasn't happened, how would you handle it?

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51. Knowing that you have OCD and that your children may have it, what can you do to help them?
52. Imagine that your worst feared consequence happened yesterday. There is nothing you can do to undo it. How would you cope? (suicide is not an option)
53. To overcome OCD you are stuck accepting living with uncertainty, but acceptance involves the loss of something you want. What will you lose if you accept uncertainty, do E&RP and give up OCD? If you have gone through treatment, what did you lose besides OCD?
54. What would your OCD say to you if it could talk? How would you answer it? Who would be helped by your answer: you or OCD?
55. What do you love about uncertainty? Why?
56. We are not crippled by our fears, but by our avoidance of fear. Is this true for you and, if so, how?
57. If you had to have a different set of OCD symptoms, what would you choose and why?
58. OCD robs so much from you and can leave you with so much loss and lost time. How do you cope with your losses?
59. What are the advantages of being a slave? What are the problems with having freedom? With regard to your OCD which of these better reflect your coping?
60. Are you overly concerned with what others may or may not think about you? Does this play any role in your OCD?
61. A Hard Task: We often say that it is good to talk back to your OCD, to be angry at it, to fight it. Pretend your OCD is a person in front of you and talk back to it the way you would want to.
62. No matter how hard you work at fighting your OCD, there are often unexpected situations that arise that result in you giving in. What situation would be hardest for you to resist? What can you do to help yourself with this knowledge in mind?
63. What one reaction by an important family member or friend to your OCD or recovery most disturbs you? What did you do about it?
64. Although much of life can be uncontrollable and you can't have everything you want, it is also true that: **You can't do what you won't imagine!** What does this mean to you?
65. Responsibility is not a matter of what you should do. Responsibility is taking the steps to accomplish the things you want to do. How does this relate how you handle OCD in your life?
66. Question: what does a good goal look like – trying to get to think what is goal of goal
67. What does accepting uncertainty mean? Have you or haven't you accepted uncertainty? How has this affected your recovery?