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Exposure therapy for OCD from an acceptance and commitment therapy (ACT) framework

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ABSTRACT

This article addresses the use of exposure therapy for OCD as informed by an acceptance and commitment therapy (ACT) framework. The model on which ACT is based is covered, including its philosophy, basic research, targeted process of change, individual treatment components, and general manual. Specific suggestions for how to prepare, select, set up, and conclude exposure exercises from an ACT perspective are included and illustrated using the case of Monica as an example. Empirical support for this approach is briefly covered.

1. Introduction

Acceptance and Commitment Therapy (ACT) is an experiential, contextual approach to psychotherapy that falls within the broad category of cognitive behavior therapies (CBT; Twohig, Woidneck, & Crosby, 2013). This approach is grounded in a philosophy of science known as functional contextualism, based on behavioral theory and research including relational frame theory, with this larger line of work often called contextual behavioral science (Hayes, Levin, Plumb-Vilardaga, Villatte, & Pistorello, 2013). ACT promotes *psychological flexibility*, which is defined as being able to be in the present moment, just noticing inner experiences, while engaging in actions that are personally important. In order to increase psychological flexibility, ACT targets six core processes of change, including acceptance, cognitive defusion, awareness of the present moment, self as context, values, and committed action. These processes are described in Table 1. Data exist on ACT for OCD alone (see Twohig, Morrison, & Bluett, 2014), but its incorporation with exposure and response prevention (ERP) is new.

1.1. Exposure therapy from an ACT perspective

Exposure therapy entails the repeated direct confrontation with feared stimuli in the absence of compulsive rituals (i.e., response prevention). From an ACT perspective, and consistent with the functional contextual philosophy, the goal of exposure is to learn to interact with feared stimuli in new and more functional ways so that the client can move in the direction of values—the things that are important and meaningful in life—which are currently disrupted. As an example, for Monica (described in Conelea & Freeman, 2015), being able to more fully engage in studies, friendships, and activities such as basketball and piano would be the aims of engaging in therapy for obsessive compulsive disorder (OCD). Unlike in some other approaches to using exposure (Kozak & Foa, 1997), reductions in the frequency, intensity, and duration of experiences such as dysfunctional beliefs, anxiety, and obsessions are generally not explicitly targeted when exposure is used from the ACT perspective—although such changes might be observed in the long-term. Rather, ACT explicitly targets helping the client learn how to pursue valued-based living regardless of obsessional anxiety and compulsive urges.

Accordingly, in the treatment of OCD, ERP from an ACT perspective primarily taps into three of the core ACT processes described in Table 1: acceptance, cognitive defusion, and values (with being present and self as context targeted as needed, and behavioral commitments generally engaged in via exposure exercises). ERP taps into acceptance as these techniques are used to help the patient *welcome* unwanted obesssional thoughts, images, doubts, and anxiety. Different than "tolerating" or "enduring" these inner experiences until habituation occurs, *acceptance* means genuinely being open to having them for as long as they occur—without attempting to change them—even if one does not like or enjoy

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Table 1
The six core ACT processes.

Process	Description
Acceptance	Embracing unwanted internal events (i.e., thoughts, feelings, memories, physical sensations, and other internal experiences) without attempting to change them. Acceptance is the opposite of *experiential avoidance*, which is the tendency to avoid such inner events even when doing so interferes with one's values.
Cognitive defusion	Changing how one interacts with internal events by allowing one to experience such events for what they are, rather than what they present themselves to be.
Awareness of the present moment	The ability to attend non-judgmentally to that which is occurring now, rather than getting lost in thoughts about the past or future.
Self as context	Taking a perspective as the place where inner experiences occur rather than being defined by them.
Values	Statements about areas of life that are meaningful to the individual. Values are life directions that help to guide actions (e.g., "pursuing knowledge") rather than achievable goals.
Committed action	Specific actions taken that produce movement toward values.

them. Thus, as in the inhibitory learning approach to exposure, habituation of anxiety is not a priority in ACT-based exposure. In fact, instead of monitoring ratings of anxiety levels during exposure (i.e., subjective units of distress; "SUDS"), patients are asked to provide ratings of their willingness to experience anxiety and obsessions throughout exposure tasks.

With regard to defusion, ERP is used to help patients change how they relate to their inner experiences, and to view such experiences as what they *are*, rather than what they *present themselves to be*. More specifically, patients "de-fuse" from their obsessional stimuli when they use exposure to practice viewing obsessions and anxiety simply as streams of words or passing bodily sensations (i.e., mental noise), rather than facts or dangers. Although this goal overlaps to some extent with the use of exposure to modify dysfunctional cognitions about the importance of and need to control thoughts (e.g., thought-action fusion or the importance of thought control), exposure from an ACT perspective is different in that it does not explicitly focus on challenging and modifying irrational beliefs (i.e., there is no Socratic questioning). It is also more "meta-cognitive" in that defusion is about thinking in general rather than being applied to target thoughts only. Defusion is also promoted using metaphorical and paradoxical language (as discussed in detail further below). Metaphors, in addition to being memorable, are less likely to turn into rules—which are avoided in ACT.

From an ACT perspective, exposure touches on values in two ways. Firstly, values are used to provide a rationale for engaging in exposure tasks and resisting compulsive urges. For example, before beginning ERP, patients identify their values and discuss how engaging in the exposures supports moving in valued directions. Secondly, ERP is used to help clients practice and learn that they can, in fact, engage in meaningful activities even while they are experiencing obsessional thoughts, anxiety, body sensations, and other unpleasant inner experiences. This is particularly beneficial as the values-based actions serve as their own reinforces, maintaining these actions after the conclusion of therapy. Thus, goals for ACT-based ERP are individualistic. ACT-based ERP is a means to an end, with the end being living a life that the client finds meaningful. Learning processes such as acceptance and defusion from inner experiences, and behavioral commitments of within and out of session ERP, is done in the service of the client's values. Thus, there is no concern for the amount of anxiety or the content of thoughts and obsessions that occur; the therapist is largely concerned with how well the client responds to those inner experiences and how often and fully she is engaging in actions she finds meaningful. While the goal of successful living is consistent with most other forms of therapy, it is front and center in ACT. With no additional concern for levels of inner experience, this approach may be at odds with some other conceptualizations of OCD and some measures of OCD severity.

1.2. Preparing the client for exposure

Before using exposure from an ACT perspective, the client should be socialized to the ACT model of OCD and the rationale and description of ERP. Indeed, this model and rationale often diverge from the goals that clients with OCD, such as Monica, initially have for therapy. That is, Monica might approach therapy thinking, "I need to get control of these thoughts" or "I can't be successful if I have anxiety and urges to ritualize—I need to get rid of these things." An important aim of the first few sessions—before beginning to implement exposure—is for the therapist and client to come to an understanding that therapy is about *behaving differently in the presence of obsessions*, and that this does *not* necessarily require changing the internal experience. Accordingly, the initial part of treatment focuses on these goals as described in this section.

2. The ACT model of OCD

Throughout treatment, the therapist would help a client such as Monica to see that there is nothing inherently wrong with her experiences of anxiety and obsessions. Rather, the difficulty (and a sign of experiencing OCD) is that is that she uses ineffective tools (e.g., logic, rituals) to try to address these internal experiences. To normalize her struggle and help develop rapport, the therapist explains that everyone experiences unpleasant internal experiences of one kind or another. It is also common for therapists to share examples of his or her own intrusions when explaining the model of OCD (e.g., "I've had disgusting thoughts too, and I more commonly have general thoughts I really struggle with such as 'Am I a good parent' or such"). The client is informed that, "how we treat these thoughts is what really makes a difference, rather than what thoughts we have."

The client is then helped to think about OCD as involving three parts: (a) inner experiences of unwanted thoughts, anxiety, doubt, bodily sensations, etc. (i.e., obsessions), (b) behaviors performed to control and reduce the inner experiences (e.g., compulsions, avoidance, neutralizing), and (c) negative effects on quality of life. Using metaphors, the client is helped to see that compulsions are much easier to control than obsessions, and that the negative effects on quality of life are generally the product of attempting to control obsessions and other inner experiences, not these inner experiences themselves. Moreover, through self-monitoring and exploration, the client is helped to see that the compulsive behaviors in "part b" are