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.

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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 obsessional 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.
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 engaging in the exposures supports moving in valued directions, 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 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.”

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), 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
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