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Changes in psychological flexibility during acceptance and commitment therapy for obsessive compulsive disorder

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ABSTRACT

Acceptance and commitment therapy (ACT) has a small research base as a treatment for obsessive compulsive disorder (OCD) and related disorders. It is presumed that the process of change in ACT is an increase in psychological flexibility. This study focuses on session by session changes in psychological flexibility in 41 adults diagnosed with OCD who were treated with ACT compared with 38 individuals who received progressive relaxation training. In a randomized controlled design, participants received 8, one-hour weekly sessions with posttreatment assessment one week after treatment and follow up three months later. Results showed that treatment effects were gradual with significantly better outcomes for ACT occurring in the final two sessions. Multiple levels of analyses show that changes in psychological flexibility predict changes in OCD better than changes in OCD severity predicting changes in psychological flexibility. Similarly, multiple levels of mediational analyses showed that posttreatment levels of psychological flexibility mediate pretreatment to follow up reductions in OCD severity.

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1. Introduction

Obsessive compulsive disorder (OCD) is characterized by obsessive thoughts, images, or impulses and related compulsive actions that are aimed at neutralizing or regulating obsessions (American Psychiatric Association, 2013). OCD affects about 1% of the population (Kessler, Chiu, Demler, & Walters, 2005) and is associated with deficits in many areas of functioning and low quality of life scores (Kugler et al., 2013). The most supported psychosocial treatment for OCD is exposure with ritual prevention (ERP) or ERP with cognitive therapy procedures (generally labeled CBT for OCD); but while effective for many, these treatments are not effective for everyone (Olatunji, Davis, Powers, & Smits, 2013). Thus, additional treatment options and conceptualizations of OCD are needed.

One treatment approach with growing empirical support for the treatment of OCD is acceptance and commitment therapy (ACT; Bluett, Homan, Morrison, Levin, & Twohig, 2014; Twohig, Morrison, & Bluett, 2014). Cognitive theorists have long held that thoughts with obsessive content are common across most people, but that there is something unique about the way individuals diagnosed with OCD experience and react to these thoughts (e.g.,

Rachman & de Silva, 1978). The ACT theory of OCD is consistent with this basic notion. The theory of cognition that undergirds ACT, Relational Frame Theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001), suggests that the meaning and function of cognitive events are regulated by separate contexts and that these contexts can be independently addressed. Specifically, ACT primarily focuses on putative functional contexts under which obsessions and associated anxiety are argued to occur including those that promote literal meaning, reason giving, and escape and avoidance of particular internal experiences. ACT attempts to change these contexts through such methods as cognitive defusion (experiencing cognition as an ongoing process rather than allowing the results of this process to overly structure the situation and overly regulate behavior), experiential acceptance (willingness to contact inner experiences without needless defense), and values-based action (choosing desired consequences of ongoing patterns of behavior so as to establish reinforcers in the present). Thus, ACT focuses much more on the function of obsessions rather than the accuracy or frequency of their content.

ACT for OCD seeks to broaden the range of responses possible in the presence of obsessions and anxiety so that improved functioning is not dependent on levels of obsessions or anxiety (Twohig et al., 2014). This approach, focused on fostering psychological flexibility (Hayes, Levin, Plumb-Villardaga, Villatte, & Pistorello, 2013), has been supported in component studies (Levin, Hildebrandt, Lillis, & Hayes, 2012) and a similar number of process

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studies (e.g., Hayes et al., 2013). Research has consistently found that deficits in psychological flexibility are related to OCD symptoms (Bluett et al., 2014) as well as the broader development and maintenance of a range of mood and anxiety disorders (Spinhoven, Drost, de Rooij, van Hemert, & Penninx, 2014). ACT as applied to OCD facilitates growth in psychological flexibility through in-session exercises, examples and metaphors, and discussions as well as modeling and reinforcing these processes within the context of the therapeutic relationship. Although structured exposure sessions provide another opportunity to foster psychological flexibility, ACT for OCD postulates that psychological flexibility can be taught without needing to do traditional exposure exercises during the therapy sessions.

Treatment based on this conceptualization has support in a number of studies for OCD and related disorders such as compulsive pornography use, skin picking, trichotillomania, and OCD (Arch et al., 2012; Bluett et al., 2014; Twohig et al., 2014). In the largest randomized controlled trial of ACT for OCD, Twohig et al. (2010) treated 79 adults with either eight sessions of ACT or progressive relaxation training (PRT) with no in-session exposure in either condition. Results showed that ACT produced greater changes at posttreatment and follow up over PRT on OCD severity as measured by the Yale Brown Obsessive Compulsive Scale (Y-BOCS) and clinically significant change in OCD severity occurred more in the ACT condition than PRT using multiple criteria (clinical response rates: ACT post=46–56%, follow up 46–66%; PRT post=13–18%, follow up 16–18%). Also of note, treatment refusal (2.4% ACT, 7.8% PRT) and drop-out (9.8% ACT, 13.2% PRT) were low in both conditions, and ACT participants showed an average score of 4.4 (on a 5 point scale) on the treatment acceptability measure used (Kelley, Heffer, Gresham & Elliott, 1989) as compared to a score of 3.7 in the PRT condition, a significant difference.

A number of studies suggest that changes in ACT processes are associated with and often precede change in outcomes for a variety of disorders treated with acceptance and mindfulness based CBT, including ACT (e.g., Hayes, Orsillo, & Roemer, 2010; Hesser, Westin, Hayes, & Andersson, 2009; Lundgren, Dahl, & Hayes, 2008; Masuda et al., 2009; Wolitzky-Taylor, Arch, Rosenfield, & Craske, 2012). For example, Hayes et al. (2010) found an increase in emotional acceptance and time spent on valued activities in those receiving acceptance-based behavior therapy for generalized anxiety disorder. Change in acceptance and values engagement was related to responder status at posttreatment above and beyond changes in worry. Similarly, scoring of videotapes of ACT for tinnitus sessions showed that increased cognitive defusion behaviors and acceptance behaviors predicted symptom reduction 6 months later even when accounting for prior improvement (Hesser et al., 2009). To date no studies have examined these issues in ACT for OCD. This study will investigate processes of change seen in the randomized clinical trial of ACT versus PRT conducted by Twohig et al. (2010). Standardized outcome and process measures were completed at pretreatment, posttreatment, and three month follow up. Weekly assessments of psychological flexibility and OCD severity were completed throughout the study to allow temporal analyses of changes. The findings from these assessments of process change are presented.

2. Method

Data for the current study were collected as part of a randomized clinical trial comparing ACT to PRT for adults seeking psychological treatment for OCD (Twohig et al., 2010). Further details regarding the clinical trial and its results can be found in the outcome publication. Information relevant to the current study is represented here.

2.1. Participants

Participants were 79 treatment seeking adults who enrolled in a clinical trial conducted in two Western US states. There were 41 clients randomized to receive ACT and 38 who received PRT. Those who enrolled in the study met criteria for OCD via the Structured Clinical Interview for DSM-IV (SCID; First, Spitzer, Gibbon, & Williams, 2002), were 18 years of age or older, were not receiving concurrent psychological treatment and had not ceased psychotherapy within 30 days of enrolling in the study, did not initiate new psychotropic medications or change doses within 30 days of enrolling in the study, and did not meet criteria for a current psychotic disorder or have an organic mental disorder that would interfere with their ability to participate in the study.

The sample was 61% female, primarily Caucasian (88.6%) and was between 18 and 67 years of age ($M=37$, $SD=15.5$). Sixty three percent of the sample had received previous formal treatment (psychotherapy or medication) for OCD, 40% reported taking at least one psychotropic medication at the time of enrollment, and 51% of the sample met criteria for at least one additional disorder via the SCID (most commonly either a comorbid mood disorder or another anxiety disorder). There were no significant differences between the ACT and PRT groups in OCD severity or any other measure at pretreatment.

Of the 79 clients enrolled, 69 completed post-assessments and 63 completed the three month follow up. Clients lost to post-treatment and follow up assessments were equal across conditions. In terms of treatment dropout rates, one ACT participant (2.4%) and three PRT participants (7.8%) did not attend even the first treatment session (labeled treatment refusers). An additional four ACT participants (9.8%) and five PRT participants (13.2%) completed fewer than three of the eight planned treatment sessions.

2.2. Measures

2.2.1. Yale Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989)

The Y-BOCS is a 10 item assessor-rated measure of OCD symptom severity that is commonly used as a primary outcome in clinical trials for OCD. Total scores on the Y-BOCS range from 0 to 40. The Y-BOCS has demonstrated both good interrater reliability for the total score (r s between .80 and .97) and two week test-retest reliability (between .81 and .97). In the current study, Cronbach's α at pretreatment was .79.

2.3. Acceptance and Action Questionnaire (AAQ; Hayes et al., 2004)

The 16 item AAQ was used to measure psychological flexibility. The 16 item AAQ was used rather than the more recent AAQ-II (Bond et al., 2011) due to the study being initiated prior to the publication of the newer version of the measure. Responses on the AAQ are self reported on a seven point Likert-type scale. Lower scores reflect greater experiential willingness and ability to act in the presence of difficult thoughts and feelings. Sample items include: "It's OK to feel depressed or anxious," and "It is unnecessary for me to learn to control my feelings in order to handle my life well." The AAQ has demonstrated good convergent and discriminant validity and four month test-retest reliability was .64 (Hayes et al., 2004; Hayes, Luoma, Bond, Masuda, & Lillis, 2006). In the current study, α at pretreatment was .74.

2.3.1. Thought Action Fusion Scale (TAF; Shafran, Thordarson, & Rachman, 1996)

The TAF is a 19 item self report measure that assesses the degree to which respondents equate thought and action. Items are

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