The Application of Acceptance and Commitment Therapy to Obsessive-Compulsive Disorder

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This paper is part of a case series illustrating the application of different therapies to a case of obsessive-compulsive disorder (OCD). It describes the hypothetical application of Acceptance and Commitment Therapy (ACT). This paper covers the philosophy and basic research on language and cognition that inform ACT. It also provides an ACT-based case conceptualization of this case and examples of therapeutic procedures. The goal of this paper is to familiarize clinicians with the use of ACT for OCD.

This paper is part of a case series on the application of different therapies for the treatment of obsessive-compulsive disorder (OCD). In this series, researchers of Cognitive Behavioral Therapy (CBT), Exposure With Response Prevention (ERP), and Acceptance and Commitment Therapy (ACT) describe how each treatment is typically applied to a single case of OCD (Twohig & Whittal, 2009-this issue). This paper describes ACT for the treatment of OCD.

Philosophy and Basic Research on Cognitions That Inform ACT

The therapeutic techniques used in ACT (Hayes, Strosahl, & Wilson, 1999) are guided by a philosophy of science called functional contextualism (e.g., Biglan & Hayes, 1996) and are informed by behavior analysis and research on language and cognition called relational frame theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001). Space does not permit a full description of either area, but a very general description of RFT follows as an aid to understanding ACT.

Actions can be thought of as occurring in a three-term contingency. The three terms involve an antecedent stimulus, a response or behavior that is occasioned by the stimulus, and a punishing or reinforcing consequence. From the behavioral perspective, the antecedent and the consequence are both stimuli. The antecedent evokes a response, and the consequence makes that response more or less likely to occur. It has long been a central focus of behavioral theory that stimuli require experience to acquire functions, but that notion is coming into question (e.g., Sidman, 2000). Research on RFT has shown that the ability to respond relationally allows stimuli to acquire functions without experience (Hayes et al., 2001). The ability to determine functions of stimuli without interacting with them is not a new concept to clinical psychologists. But RFT is useful because it clarifies the process through which cognitions affect more basic behavioral processes, what effects cognitive activity has on behavior, and offers a particular therapeutic approach to cognitive activity.

People learn how to transfer the functions of stimuli to other stimuli using a variety of frames, including similarity, opposition, distinction, comparison, hierarchical, time, space, causality, and relationship and perspective. For example, if a person with contamination-type OCD experiences “dirty” things as dangerous, anything similar to “dirty” will acquire the functions of “dangerous.” Many arbitrary stimuli can thus acquire fearful and anxiety-provoking functions even though a person has no experience with them (as shown in Dougher, Hamilton, Fink, & Harrington, 2007).

This is particularly important because it shows that much of our behavior is influenced by processes other than our interaction with our environment. And it results in behavior that is inconsistent with environmental contingencies and is instead guided by cognitive contingencies (that is, contingencies based largely on relational-framing processes; e.g., Hayes, 1989; Shimoff, Catania, & Matthews, 1981). Behavior guided by cognitive contingencies—not learned through interaction with stimuli—is often problematic because the behavior does not change when the actual, or real-world, contingencies change. Another possibility is that the contingency that is specified is incorrect. The cognitive contingency specifies one thing, and the real-world contingencies specify something else. Because of our cognitive abilities we can respond to contingencies that are only in our heads and
not to the way the world really works. Cognitive abilities are not “bad”; in fact, they are useful in most situations. Cognitive abilities free us from having to interact with every event to know if it is safe or dangerous, and they are used in almost every aspect of our lives. But the dark side of cognitive abilities is they can become too dominant. For example, humans are the only living things that kill themselves to escape negatively evaluated thoughts and emotions. Being dead is not something we have experienced, but cognitively we can compare our current situations to a predicted one where pain is not present, and choose to be in that one. As humans, we need to find a way to act on our cognitions when they are beneficial, and not act on them when they are problematic.

Cognitive abilities provide two beliefs that support pathology: (a) negatively evaluated inner experiences are dangerous; (b) negatively evaluated inner experiences need to be diminished or controlled. It is sometimes useful to regulate emotions, but this is not a rule to be applied in all situations. In fact, attempting to control or regulate obsessions (and associated anxiety or fear) is largely what makes OCD a disorder. Support for conceptualizing OCD as a disorder of misplaced rules regarding dangerous inner experiences that should be controlled comes from the diagnostic criteria for OCD (American Psychiatric Association, 2000), and from self-reports of people diagnosed with OCD in which 90% admit that compulsions are performed to reduce distress from obsessions (Foa & Kozak, 1995). Attempts to suppress obsessions are generally not effective (Purdon & Clark, 2001), and a key component of effective treatments for OCD involves exposure and reduction of neutralizing responses (Abramowitz, 1996). Finally, attempts at regulating these inner experiences (e.g., compulsions) backfire and result in reduced rather than increased quality of life (e.g., Koran, Theinemann, & Davenport, 1996). OCD is pretty clearly a case where the cognitive contingency is very different than the real-world one.

Disorders in which “a person is unwilling to remain in contact with particular private experiences and takes steps to alter the form or frequency of these events and the contexts that occasion them”—even when attempts to do so negatively affect quality of life—is termed experiential avoidance (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996, p. 1154). Experiential avoidance is highly correlated with many pathological processes (Hayes, Luoma, Bond, Masuda, & Lillis, 2006), including anxiety disorders, (e.g., Karekla, Forsyth, & Kelly, 2004; Kashdan, Barrios, Forsyth, & Steger, 2006; Stewart, Zvolensky, & Eifert, 2002), and is a central target of ACT.

ACT as a Treatment for OCD

The following account suggests that OCD is a problem of cognitive process over cognitive content. Psychological inflexibility is an inability to change behavior even though doing so would serve valued ends (Hayes, Strosahl, Bunting, Twohig, & Wilson, 2004)—another example of following cognitive contingencies even though the results are problematic. A fair question here is, Why doesn’t therapy teach the client the real-world contingency? Intuitively that makes sense, but research has shown that relational framing is under operant control just like all other responses, and once frames are learned they are very difficult to minimize or extinguish (Hayes et al., 2001; Wilson & Hayes, 1996). In other words, it is very difficult to remove the cognitive contingency once it has been learned. This finding is consistent with research on operant and classical extinction (defined as a reduction in one response topography and in increase in other responses in a given context) showing that responses are not unlearned, but that additional responses are also learned (Bouton, Westbrook, Corcoran, & Maren, 2006; Reed & Morgan, 2006), and that an extinguished response will reappear given the right environmental or emotional context (Bouton et al.). An alternate approach is to target the functional context under which relational framing occurs (e.g., Steele & Hayes, 1991) such that thoughts still exist in their same form but have a different effect on behavior.

ACT does not address any specific cognitive content, emotion, or physiological sensation. Treatment targets both the cognitive space in which obsessions, anxiety, and the like occur and the responses to these cognitive experiences. When the dominance of the cognitive contingency is reduced, the client can be in greater contact with the real-world contingencies that shape more functional behavior. ACT accomplishes this by focusing on two general areas: (a) the cognitive system that supports treating thoughts as literal as well as avoiding them, and (b) the absence of meaningful, values-based actions.

Case Conceptualization

This conceptualization is of “Caroline” (presented in Twohig & Whittal, 2009). Caroline’s disorder developed the same way that most disorders develop. We live in a world that actively teaches us that many inner experiences are dangerous, and should not be experienced. We are taught that anxiety is “bad” and are reinforced for removing it. Obsessive thoughts such as, “I am inherently a bad person and can cause others to die” are treated literally, and steps are taken to regulate those types of thoughts. There is evidence that individuals who develop OCD are more likely to be raised in contexts that support emotional control, such as controlling environments that do not foster autonomy (Dumas, Lafreniere, & Serketich, 1995; Krohne & Hock, 1991; Siqueland, Kendall, & Steinberg, 1996), teach avoidance of difficult situations (Dadds, Barrett, Rapee, & Ryan, 1996), and model
avoidance and fearfulness (Henin & Kendall, 1997). Caroline was certainly raised in such an environment. Instead of modeling acceptance of her frustration, her mother constantly complained about the negative effects of having Caroline. Throughout Caroline’s life, her mother also modeled that she (the mother) could not handle difficult situations and emotions. Even though she was medically healthy, her mother required Caroline’s constant assistance, and she made multiple suicide attempts (additional attempts to cease painful emotions). The stage was set for Caroline to develop OCD because she experienced emotions as literally dangerous events that should be feared and controlled.

Caroline’s critical and emotionally abusive mother, and other events in Caroline’s life (such as the death of friends), provided the cognitive content for her to fear and fight. But these events are not the cause of her disorder per se. This analysis stresses the cognitive context of her thoughts and emotions over the specific thoughts. Caroline experiences obsessions and self-criticisms in a highly literal way. They are very “important” and “real,” and she works very hard to not experience them. She engages in a number of compulsions that are somewhat logical, such as avoiding people, but many of her compulsions are very cognitive and clearly not learned through experience. For example, she makes fists or circles with her arms or fingers or she bites her tongue to control the “dust,” and she thinks or says certain things because she believes that doing these things keeps people safe. So when bad things happen, she believes it is because she did not do these things well enough, even though this is inconsistent with observations of real world.

If asked, “What brings you into therapy?” Caroline would say, “I have thoughts that are so bad that I just don’t know what to do about them.” Control of her obsessions and anxiety is her primary goal. This is consistent with what she was taught by her mother: “If difficult emotions can be controlled, life will be better.” If pressed to explain why she wants to control these inner experiences, Caroline would say that it is because she has a very low quality of life and that she believes it will improve if her obsessions and anxiety decrease. Most people think that certain thoughts and emotions need to be managed before they can start focusing on quality-of-life issues, but that does not mean the therapist must support this perspective. The therapist might say something like, “Is it possible that there are multiple routes to improving the quality of your life? Maybe the war against your obsessions does not need to be won before you can move forward. What if the easiest route to an improved quality of life involves stepping out of this war?” ACT for the treatment of OCD aims to alter the functions of Caroline’s OCD-related thoughts in the service of increasing her quality of life.

ACT is consistent with Mindfulness-Based Cognitive Therapy (MBCT), in which “there is little emphasis on changing the content of thoughts; rather, the emphasis is on changing the awareness of and relationship to thoughts, feelings, and bodily sensations” (Segal, Teasdale, & Williams, 2004, p. 54). Within this framework, Caroline’s level of anxiety and frequency of obsessions could stay the same throughout treatment, and it would still be a successful case as long as her relationship with them changed. A good clinical outcome would be one where Caroline is able to experience her obsessions and anxiety as just thoughts and feelings. She would not have to engage in activities to alter their content, frequency, or situational sensitivity. Finally, she would spend her time working on quality-of-life issues. Quality-of-life issues are the larger goals; acceptance and mindfulness are seldom the main focus, but long-term success is partially dependent on developing them.

An ACT conceptualization of this case might contain less specificity than is commonly provided in other therapy conceptualizations because the central issue is not the content of obsessions. How literally Caroline experiences her obsessions and how often she responds to them is the greater focus. Further, the specific topography of the behavior is of less concern than its function. Obsessive thoughts that are experienced as just thoughts have little effect on behavior. If Caroline were to continue to experience the obsessions but not respond to them, she would not meet the criteria for OCD. This outcome can be achieved through ACT processes. The same approach to conceptualization could be taken if this was a hoarding, checking, or scrupulosity case. ACT for OCD studies have included all subtypes of OCD (including hoarding and primary obsessions) in the same trials because from the ACT perspective, topography is not material (e.g., Twohig, 2007; Twohig, Hayes, & Masuda, 2006a).

**Implementation**

ACT is not a particular set of techniques. It is a therapeutic approach that targets six specific psychological processes: acceptance, defusion, self as context, contact with the present moment, values, and committed action, all of which support behavioral flexibility (see Fig. 1) (Hayes et al., 2006). The therapist is practicing ACT when she “moves” these processes. Thus, many topographically different procedures may all be ACT consistent as long as they are affecting ACT processes. ACT even borrows procedures from other therapeutic approaches with the intent of affecting ACT processes. This is similar to the way that a cognitive therapist might use exposure procedures to teach clients that something is less dangerous than expected—the same procedure may have different functions depending on how it is used.
From the beginning of therapy, a therapeutic relationship is developed in which the importance of inner experiences is decreased. The therapist models this by never “rescuing” the client from any emotions and by treating all inner experiences as though they are welcome rather than a problem. Very little weight is placed on the particular inner experiences occurring and what they mean, and inner experiences are not treated as the cause of behavior. Finally, ACT is purposefully confusing and paradoxical, and it often employs metaphor in exercises and homework assignments so that they won’t be taken literally or turned into rules.

ACT is seldom done process by process—there is usually a dance between the six processes, depending on what would be most useful at the moment. A description of each process and evidence for its utility follow, as well as discussion of how each process could be addressed with Caroline. This is only a brief description of ACT for the treatment of OCD; fuller descriptions are provided elsewhere (Eifert & Forsyth, 2005; Hannon & Tolin, 2005; Twohig, Moran, & Hayes, 2007).

Acceptance

Acceptance involves allowing your inner experiences to occur without taking steps to regulate or control them. It is different than tolerance. Acceptance is more akin to welcoming certain inner experiences the way somebody might welcome slightly troublesome relatives into the house: we might not really like them, but we can find a way to live with them that is not a constant struggle. “Acceptance” has multiple meanings in psychology, but in ACT, it refers only to how people respond to their inner experiences and not to accepting situations or actions. Acceptance targets avoidance, which has long been known to be the cornerstone of many disorders, particularly anxiety disorders. Component analyses have demonstrated that use of acceptance procedures increases participants' willingness to experience panic sensations in a carbon dioxide challenge (Levitt, Brown, Orsillo, & Barlow, 2004), reduces heart rate when participants are exposed to an emotion-provoking film (Campbell-Sills, Barlow, Brown, & Hofmann, 2006), increases pain tolerance (Masedo & Esteve, 2007), and makes it easier to have unwanted thoughts (Marcks & Woods, 2005).

Caroline engages in considerable amounts of avoidance, both cognitively and behaviorally. She tries very hard not to experience her obsessions and to calm herself after thinking them. She reviews her day to reassure herself that she did not cause harm to anyone. Behaviorally, she avoids situations that might trigger her obsessions and engages in many compulsions for the same reason. It is safe to say that most of her day is focused on regulating her obsessions.

Previous trials of ACT for the treatment of OCD have generally targeted acceptance first (Twohig, 2007; Twohig et al., 2006a). To begin to address acceptance with Caroline, the therapist would ask why she was seeking therapy. Caroline would likely indicate that she needs help getting her obsessions, anxiety, and fear under control so that she can go back to living her life the way she did before OCD. The therapist would take a nonjudgmental stance on this issue and say, “Sounds like a plan, but first let’s take a step back and see how these thoughts and feelings work.”

The therapist would work with Caroline to see if her attempts at managing or regulating her obsessions have resulted in a decrease in OCD symptoms. Typically, clients report that actions such as avoidance, cognitive-change techniques, or compulsions result in short-term decreases in obsessions but are ineffective in the long term. Most people report that obsessions usually return within minutes or hours. Next, the therapist would ask if the obsessions had become more frequent and intense after Caroline had started trying to regulate them. (It is likely that the more she struggles against the obsessions, the more frequent and intense they become.) Finally, the therapist would ask Caroline if her attempts to manage her obsessions using these techniques have increased or decreased her quality of life. Caroline would very likely note that she has only been able to control her obsessions for very brief periods of time, that the obsessions seem to be becoming more frequent and
intense, and that her quality of life is negatively correlated with how much she struggles against her obsessions. The therapist would take a nonjudgmental stance and say, “Interesting isn’t it? Given the time you put into it, you’d think you would be more successful at controlling your obsessions” and “With this much work, life should be getting easier, not harder.” The therapist would gently let Caroline see that obsessions cannot be controlled in the short- or long-term and that attempts at control are actually damaging rather than helpful. The therapist would stress that, because these strategies have had such poor outcomes, attempting to control the obsessions may be part of the problem rather than part of the solution. And that, “maybe the exact thing you wanted me to help you with [getting control of obsessions] is the thing you need to get control of [stop trying to control obsessions].”

Some of this discussion would be more functional than technical, because in many cases, obsessions will decrease as a person stops struggling against them—a result of the process of extinction. Even though obsessions may decrease in the end, this is not a focus of ACT because the goal of decreasing obsessions sets the client up for continued struggles after treatment. Obsessions will occasionally reappear, and the client will likely be more successful if her behavior is not guided by their presence or absence.

Once Caroline has experienced that she cannot control her obsessions—and that attempts to do so are more of a problem than the obsessions themselves—the therapist offers control attempts as the actual treatment target. This can be presented as follows:

**THERAPIST (T):** Let me give you an example of what I think has been going on, and you can tell me what you think. You have been playing this game of basketball against your obsessions for most of your life. But there is something that is really unfair about this game; you and four of your friends are playing against a professional basketball team. Obviously, your team does not do very well. You gain points every once in a while, but the scores just keep getting more lopsided. In a way the game is fair: it follows the usual rules of a basketball game. But it is unfair in that you will never win. They are professionals! But you want to keep playing because it feels like if you win this game, the obsessions will stop, and then you can go and do all those things that are important to you. Does this seem like your situation?

**CLIENT (C):** Yes, so what do I do? That is why I am here. How do I beat them?

**T: I think you have tried beating them, haven’t you?**

**C: Yes—I have tried lots of things to control my obsessions: telling myself it’s okay, reassuring myself, avoiding situations, I have purchased books, looked it up on websites. I even worked with a therapist.**

**T: Are the obsessions still there?**

**C: Yes, and they are getting worse.**

**T: There is another game over here that most people do not pay attention to. It is similar to the first game in some ways but also different in other very important ways. To begin with, this game is fair: it is your team playing against five people who are about as good as you. Therefore, the more you put into it, the more you generally get out of it. Most importantly, instead of playing for control of your obsessions, you play for quality of life. So instead of getting your emotions under control before you move forward, what if you just started moving forward? What if our job here was not to help you win that first game, but to help you stop playing it?**

**C: Are you saying that I will never get rid of my obsessions?**

**T: Look at your experience. What does your experience tell you about your obsessions?**

**C: They are very hard if not impossible to manage.**

**T: Here is my offer: you can have obsessions and a life that is cut off from the world or you can have obsessions and a rich meaningful life. You get the obsessions either way, but with the second choice, you can start living right now without having to change anything about yourself.**

The function of this dialogue is to reveal the conflict: avoidance versus following values. As a result, experiencing and not trying to manage obsessions begins to be more important, and avoiding or trying to control obsessions is experienced as problematic. Such a dialogue with Caroline could help her to expose herself to things that she has been avoiding, such as events with friends and family, thus allowing her to contact the real world, reinforcing contingencies of these events rather than her cognitively created version of these events.

There are an unlimited number of ways to increase acceptance of obsessions; another is to let Caroline interact with one difficult thought. If she says, “I am, deep down, a terrible person,” the therapist can ask her to write that thought on a piece of paper. The therapist then holds the paper and tells Caroline not to let the thought touch her. Caroline will put her hands up to stop the paper from touching her. The two push the “obsession” back and forth. Next, the therapist tosses the paper on her lap and asks her to let the paper lay there. The therapist then says, “The thought is touching you in both situations; which one takes more effort and
Within the therapeutic relationship, obsessions are created and others of which are structured exercises. which are part of a new therapeutic relationship that is being unsure and confused about the continuum in which thoughts are experienced as “accurate/ inaccurate,” “good/bad,” or “meaningful/not meaningful.” Being defused is like leaving that continuum for one where these cognitive processes are not taken literally—they are just thoughts that have little to do with the person experiencing them. For example, Caroline may experience obsessions and associated anxiety as “words in my head,” “increased heart rate,” and “experiencing the feeling named ‘scared.’” It can be useful to be able to experience some inner experiences as they are, without the verbal additions. Component analyses of defusion have shown it to be effective at reducing the literality of unwanted and disturbing thoughts over control conditions (Masuda, Hayes, Sacket, & Twohig, 2004), increasing pain tolerance of electric shock (Gutiérrez, Luciano, Rodriguez, & Fink, 2004; McMullen, Barnes-Holmes, Barnes-Holmes, Stewart, Luciano, & Cochrane, 2008), and decreasing the importance of not thinking a specific thought as compared to cognitive restructuring procedures (Deacon, Fawzy, & Lickel, 2008).

Caroline is very cognitively fused: she has little awareness of her obsessions as thoughts stripped of verbal meaning. Instead, she experiences her obsessions as literal, concrete events. She is very scared of her own thinking and of the effects of her thoughts. Teaching her to experience her obsessions from a defused place would give these obsessions much less control over her actions.

To decrease cognitive fusion, a therapeutic relationship should be created in which obsessions are treated as what they are—just thoughts and emotions, not real things. Thus, many procedures that are commonly used in other therapies (such as direct discussion, Socratic questioning, and description of models) would likely not be used in ACT. Even though these procedures are useful within other models, they are inconsistent with the ACT model because they would likely increase the client’s dependence on logical, rational thought when dealing with obsessions. ACT as a treatment for OCD seeks to help Caroline get to a place where she does not need to figure anything out before moving forward—a place where being unsure and confused about the “right” or “wrong” choice is not an issue.

There are many ways to support defusion—some of which are part of a new therapeutic relationship that is created and others of which are structured exercises. Within the therapeutic relationship, obsessions are treated as having very little power and meaning; they would be treated as relatively unimportant words in Caroline’s head. The therapist would treat obsessions and compulsions as separate events tied together only by Caroline’s mind. Her “mind” would be discussed as a separate entity to help create a distinction between Caroline and her obsessions. The therapist would make much of the talk in the sessions purposefully confusing and paradoxical to decrease Caroline’s reliance on logical and rational processes for dealing with obsessions. For example, if Caroline said, “I feel like I cause misery and death wherever I go; do you think I am causing harm to people around me?” the therapist could respond, “There your mind goes again; it is always trying to figure this one out” or “Thank your mind for that thought” and finally, “Let’s not play the figure-it-out game; what do you say?”

There are a number of formal exercises that can support cognitive defusion. Caroline can be instructed to treat the thoughts as a number of different things, for example, as passengers on a bus who are telling her (the bus driver) where to go (Hayes et al., 1999). The therapist and Caroline can vocally repeat a given thought over and over until it sounds more like a funny sound rather than like the original obsession (Hayes et al.). Finally, Caroline can participate in a mindfulness exercise and watch her obsessions pass by. In this exercise, Caroline would be asked to close her eyes and pay attention to her inner experiences without grabbing onto or pushing away any of them. She would watch her thoughts and feelings come and go like someone would watch actors enter and exit a stage.

Self as Context

Self as context involves experiencing that there is an unchanging sense of self that cannot be harmed and is always present. This transcendent sense of self goes beyond thoughts, feelings, and past experiences; this sense of self is the observer or context in which those experiences occur. Without self as context, Caroline will experience two problematic processes: (1) she will respond to her obsessions as if she was defined by them and will therefore behave to control them, and (2) she will respond in ways to support her conceptualized self. For example, Caroline might act in ways consistent with the thought, “I am, deep down, a horrible person” by avoiding people so as to not harm them or by never seeking out meaningful activities. From the ACT perspective, the issue is not whether her cognitions are accurate. The issue is whether Caroline can separate herself from that statement and not follow it. If Caroline experiences her obsessions as just thoughts—and not as who she is—then she is in a better place to not behave in ways that are consistent with her obsessions. This particular ACT process is a major target for this client. Caroline has no separation from her obsessions. To Caroline, she is her alternative explanation.
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obsession, which makes her see herself as a serious threat to herself and the people around her.

Just as with other ACT processes, the presence and absence of this process is always in motion and can be affected by the therapeutic context set up by the therapist. The therapist works to reinforce the presence of self as context and to shape it as a skill. Helping Caroline see a separation between herself and her obsessions would strengthen self as context. For example, if Caroline said, “I am, deep down, a horrible person,” the therapist could say, “Is this you, or are you having the thought that you are, deep down, a horrible person?” There are many formal self-as-context exercises, including this commonly used exercise:

T: Pretend there is a chessboard that extends out infinitely in all directions. There are many white and black pieces on this board. Imagine your obsessions as one set of pieces and the ways you try and address the obsessions as the other. The two sides fight against each other as teams. You generally spend your time supporting and cheering on the one side (e.g., “These obsessions don’t mean anything. I am actually a kind person”). It is almost as if you are riding on the back of the queen to battle the obsessions. There are two issues: (1) from this perspective, huge portions of yourself are your own enemy, and (2) your experience tells you that both sides have an unlimited number of pieces. You have been fighting and fighting—and you win sometimes and lose sometimes—but this battle just keeps raging on. But what if this is not a real battle; what if you don’t need to participate in it as a black or white piece? What if it is your job to be the board: the home for the pieces? Without a board, these pieces have no place to be. The pieces need you.

If you are at piece level, the game is very important—you’ve got to win; your life depends on it. But if you’re the board, it doesn’t matter if the war is progressing. Can you imagine what a difference this posture would make on the way you live your life? (Hayes et al., 2001, p. 190)

The function of this exercise is to help Caroline experience her obsessions as events that occur within her rather than as events that define her. If she can sense a separation between her inner experiences and herself, then she is in a better place to not act on her obsessions. These exercises thus decrease the impact of the cognitive contingency and put her in greater contact with real-world contingencies.

Contact With the Present Moment

Contact with the present moment in ACT, means consciously experiencing internal and external events as they are occurring, without attachment to evaluation or judgment. From this perspective, Caroline would be able to notice and describe what is occurring in these ways: “Now I am feeling this,” “Now I am thinking this,” “I am feeling these bodily sensations,” and so on. Being in greater direct contact with what is presently occurring contradicts cognitive fusion because it removes the layer of verbal evaluation. It would allow Caroline to experience the world as it is rather than as it is shaped by her cognitions. Contact with the present moment shares similarities with other mindfulness practices that are part of other empirically supported treatments, including Dialectical Behavior Therapy (Linehan, 1993) and MBCT (Segal et al., 2004). Mindfulness practices do not always have the same purpose in these therapies. In ACT, the intended function is not to distract or lessen emotional impact. The focus in ACT is to increase contact with what is occurring at the moment without buying into cognitive evaluations of these events.

Caroline is not psychologically present. Most of the time that she is in a therapy session, she is obsessing and worrying about her obsessions. She is very “in her head.” She greatly fears her own thinking and tries hard to avoid contacting it. When treating someone like Caroline, there would be considerable focus on being present with inner experiences. Being in contact with one’s own obsessions and experiences is generally supported as a useful component of treatment. The more present a person is with his or her own obsessions, the more effective exposure is (e.g., Grayson, Foa, & Steketee, 1982); and the more time a person is in contact with obsessions, the more successful therapy is, as shown in exposure therapy (Abramowitz, 1996).

The following is an example of a mindfulness exercise commonly used in ACT. Its function is to help Caroline become more aware of her current experiences. Sometimes clients will find mindfulness exercises relaxing, and if that’s the case, the therapist needs to reorient the client to the focus of the exercise by saying something like, “You will experience the feeling of relaxation at times, and at other times you will not. Let’s stay open to either one.”

In this exercise, the therapist would ask Caroline to close her eyes. Caroline would then be instructed to pay attention to different elements of her current experience, such as bodily sensations like her breathing, the different sounds in the therapy room, and her thoughts and emotions. She would be instructed to observe these events as if they were playing out in front of her like a parade, a play on a stage, or images on a movie screen. There would be times when she would be very involved in her thinking—and not aware that she would be doing it—and other times when she would be aware of her thinking and could watch her thoughts. She would be asked to be highly aware of the difference between noticing her thoughts as an ongoing process and being
consumed by her thoughts. This exercise helps separate the way her mind presents the world, from the real-world contingencies by changing the context in which relational framing occurs.

A second exercise involves walking with Caroline outside the therapy office while she says all her thoughts out loud. In the exercise, she would put her inner dialogue “outside” for a brief period. Caroline would say whatever is in her head such as, “It is a nice day, ... I am afraid my dust will reach that person. ... I should do something about it. ... What does it say about me that I think that? ... I am not sure if I am doing this right ...” and so on. These thoughts would not be disputed or tested; they would just be experienced like any other event.

Values

Values are qualities of living that are chosen moment by moment but can never be achieved or possessed as an object. They are the things that we care about and are willing to work for. The concept of “choice” is purposefully addressed in values because it sidesteps cognitive fusion. A distinction between “choices” and “decisions” is made in ACT. A choice involves picking between options with reasons, but not because of reasons. Decisions are made based on reasons. Sometimes it is useful to cognitively work through a decision—such as when doing taxes or baking. But there are other times when following reason becomes problematic—such as when dealing with obsessions. Making a choice to follow a value is useful because the client does not need to come to a rational decision about whether to follow it—she just chooses and acts. The usefulness of an ACT focus on values has been demonstrated clinically (Dahl, Wilson, & Nilsson, 2004) and has been increasingly targeted as a core process in the treatment of anxiety disorders through the incorporation of functionally similar procedures, such as motivational interviewing (e.g., Slagle & Gray, 2007).

Caroline has very strong social values, which makes her obsessions—when taken literally—quite interruptive. She cares strongly about her friends and family and she fears that contact with them might actually cause them harm or even death. Thus, she might assume that she is doing the “right” thing by staying away from her friends and thereby protecting them via her compulsions. Once Caroline is more defused and can sense that she is not the same as her thoughts, she would be able to see that in trying to protect people, she ultimately loses them.

Values can be addressed session by session by asking Caroline what purpose her behavior serves. If Caroline says that she avoids seeing her friends, does not go to a party, or mentally vacuums the room (her compulsion) while at a party instead of talking to people, the therapist could ask her, “What purpose did that behavior serve?” The likely answer would be, “I was trying to control my obsessions.” Then the therapist would ask Caroline what she really wants her life to be about. Caroline would likely say that she really wants to be a good friend, daughter, sister, and so on, that she does not want her life to be about controlling obsessions. Discussions such as these can make controlling obsessions less important and make pursuing valued activities more leading.

Discussions of this type can actually make doing exposure work meaningful and important to Caroline. Exposure exercises would not be about decreasing anxiety or controlling obsessions. It would be about getting closer to her friends and family. For example, if she said, “When I am around children, I am finding that I am vacuuming more than I used to,” this could be taken as an opportunity to contrast the costs of emotional control against areas of life that are really important to her. The therapist could say, “What does this cost you in terms of being with people you care about?” In ACT, there is no discussion of whether Caroline is a danger to people or not; only the costs of following her obsession are discussed.

Entire sessions can be spent discussing the role of values in guiding behavior. A session on values can happen at any point in therapy, but commonly occurs at the end after acceptance and mindfulness processes have been covered. With Caroline, a values session would cover the definition of her values across a number of domains, including friends, family, occupation, and spirituality. Caroline would be asked to rate how important each of these areas is to her. Next she would rate how consistent her actions are with her values. Finally, she would be encouraged to discuss what stands in the way of her following her values. It would become apparent that her energy is going into regulating her obsessions rather than engaging in activities that are meaningful to her. Letting her values guide her actions would be presented as an alternative to letting her inner experience guide her actions. Committed action, the next process covered, focuses on behaving consistently with one’s values.

Committed Action

Committed action focuses on behavior change. ACT is a behavior therapy, but it focuses more on cognitions compared to traditional behavior therapy. ACT seeks to greatly reduce, through acceptance and defusion processes, the influence of inner experiences on one’s actions. ACT also encourages basing actions on one’s values. Thus, after acceptance and defusion processes are targeted, just about any behavior therapy technique (for example, skills building or hierarchy progression) can be used as long as it is done in the service of the previous five ACT processes.

Caroline lives a somewhat active lifestyle. Although she avoids some social contact, she does spend some time with friends and family and spends a little time outdoors, but she engages in these activities at a significantly reduced
level and quality than was the case previously. After the other ACT processes are in place, the therapist and Caroline would work to create weekly behavioral commitment exercises that are linked to Caroline's values. For example, Caroline could choose to talk to one friend she has not spoken to in a while, having a meaningful conversation without engaging in compulsions, or she could choose not to mentally protect people for 1 hour per day to practice defusion and acceptance.

There are a couple of guidelines for doing behavioral commitment exercises in ACT that may differ from those in other therapies. First, the exercises are done in the service of the client's chosen values; they are never done in the service of controlling private events either immediately or long term. Second, the client is instructed to practice the other ACT processes while engaging in the exercise. Third, the exercise is structured by time or activity, not by severity or level of obsessions. Finally, the client, not the therapist, chooses the exercise.

It should be evident by this point that the overall function of ACT for OCD is to increase acceptance of obsessions, notice them for what they are, and move in valued directions while experiencing what is there to be experienced. In most cases, this will result in a reduction of compulsive behavior but only because the compulsive behavior usually interferes with pursuit of values. Therefore, while ACT can be considered an exposure-based treatment, the purpose of exposure exercises is to help the client practice acceptance and mindfulness processes while heading in valued directions; there is no concern for the overall effect on form, frequency, or situational sensitivity of the obsession.

Possible Difficulties

Change would be slow for Caroline, but presumably that would be the case with any treatment modality. Caroline is very entangled in her obsessions and has been working within a very ingrained, literal verbal system. Because ACT processes are taught experientially rather than didactically, it will take time for Caroline's dependence on the cognitive and emotional regulation system to decrease. Between sessions, Caroline will analyze and heavily think over just about anything she is given to work with. Even simple statements such as, “I guess trying to control your obsessions has not worked out that well in the long run” will be turned into verbal rules such as, “Control is bad, and I must stop doing that.” Although that statement is consistent with ACT in content, functionally it is just another verbal rule that will be followed regardless of outcome. The therapist would have to pay close attention to the movement of the ACT processes and constantly adjust and target rule making like this as it appears.

Caroline would likely be in a state of confusion halfway through the therapy, which she would find scary and uncomfortable. The therapist would have to work with her to be present with her feelings of fear and uncertainty—just as she has learned to be present with her obsessions. But once Caroline catches on and starts working within a new system that is not based on emotional control, change would happen relatively quickly. The new system would be very reinforcing because she would be able to do many things that are important to her without first having to gain control over her obsessions. Once Caroline was “on board” with these processes, it is presumed that she would continue to improve after therapy ends. Often outcomes are better at follow-up than at immediately after therapy is completed in ACT trials (Hayes et al., 2006).

Empirical Evidence for the Effectiveness for ACT for the Treatment of OCD

There are limited but growing data on the effectiveness of ACT for OCD and OC-spectrum disorders, including trichotillomania (TTM) and chronic skin picking. The effects of an 8-hour ACT-for-OCD protocol were tested using a multiple baseline design with four adults (two with checking, one with cleaning, and one with hoarding compulsions) (Twohig et al., 2006a). The treatment purposefully excluded any in-session exposure for experimental reasons. Results showed near-zero levels of compulsions at posttreatment and scores in the non-clinical range for OCD as measured by the Obsessive Compulsive Inventory (Foa, Kozak, Salkovskis, Coles, & Amir, 1998). Results were maintained at 3-month follow-up. This same protocol was compared to Progressive Relaxation Training (PRT) with 34 adults with OCD (18 ACT, 16 PRT) (Twohig, 2007). In this study, all subtypes of OCD were represented, including primary obsessions and hoarding. Results on the Yale-Brown Obsessive Compulsive Scale (YBOCS) (Goodman et al., 1989) showed significant improvements for ACT over PRT at posttreatment and follow-up, with ACT also showing greater clinical improvement with over 60% showing a score below 12 on the YBOCS at 3-month follow-up. Lag analyses showed that ACT processes changed prior to changes in OCD severity in the ACT condition, and there were greater changes on ACT-consistent processes in the ACT than in the PRT condition.

ACT with the addition of habit reversal has also been shown to be effective as a treatment for TTM (Twohig & Woods, 2004; Woods, Wetterneck, & Flessner, 2006), and ACT alone has been shown to be an effective treatment for chronic skin picking (Twohig, Hayes, & Masuda, 2006b).

Discussion

One aim of this paper is to clarify the theoretical and empirical basis for the use of ACT for OCD. The larger purpose is to present the application of ACT as a treatment
for OCD so that applied professionals have a better understanding of what this treatment is and how it is implemented. The client presented in this case was verbally entangled and had started living a life that was very cut off from areas that are meaningful to her. ACT is an approach that circumvents her cognitive entanglement and immediately starts focusing on quality-of-life issues.

This type of intervention may have particular utility for certain types of OCD, including clients who are very cut off from areas that are meaningful to her. ACT is as a treatment for OCD might also be of use in the long term because preliminary evidence suggests that it can be successfully implemented without regard for the type of OCD (e.g., primary obsessions, hoarding, cleaning, checking) and because the treatment targets the function of avoidance without regard for the content of the obsessions. Because this treatment has been successfully implemented without in-session exposure, it could be useful for clients who refuse exposure-based therapies. Nevertheless, evidence for its effectiveness is preliminary, and use of these procedures at this time are most appropriate under circumstances where well-validated procedures have either failed or been refused by the participant.

**References**


