The Marriage of ACT and ERP for OCD Treatment: How To Do It, When to Do It, and Checking If It Works!

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Brian disclosures:

Relevant Financial Relationships:

- Employed at the Portland Psychotherapy Clinic, Research, & Training Center (PPC)
- Research partially funded by 2 internal PPC grants: (a) Aaron S. Luoma; (b) and the Dalai Luoma Portland Psychotherapy Behavioral Science Research Grants

Patricia

BA. Educational/school Psychologist
Bolivia, South America

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Psy.D. Clinical Psychology
Bay Area, California

Formally trained in CBT, DBT behavioral activation, exposure, & ACT

Passionate behavior therapist

East Bay Behavior Therapy Center
Intensive Outpatient Program (IOP)
67% intensive - 12 – 15 hrs/wk

Goals

- Provided theoretical foundations for conceptualizing ERP for OCD in an ACT context and drawing from Inhibitory Learning Theory
- Discuss different decision points for conducting exposure for OCD in ACT treatment
- Use case examples and client data to illustrate

How do I do ACT...
...when I’m not as cool as Steve? (or Robyn or Kelly or Russ or…?)

UNDER
CONSTRUCTION

What is exposure?

"The repeated and systematic confrontation of feared stimuli" (Moscovitch, Anthony, & Swinson, 2009)

Types of exposure

- In vivo (*“in life”*)
- Imaginal
- Interoceptive

Is use of exposure inconsistent with ACT?

ACT & Exposure

- ACT has been called an "exposure-based treatment" (e.g., Luoma, Hayes, & Walser, 2017)
- Core ACT interventions can increase client willingness to engage in exposure (Levitt et al., 2004)
- Exposure can be used to target and strengthen any of the core ACT processes (Thompson, Luoma, & LeJeune, 2015)

ACT for OCD without ERP

- Early studies deliberately left out ERP to demonstrate ACT offered something new (Twohig, Hayes, & Masuda, 2006; Twohig, Hayes, et al., 2010; Twohig, Plumb, et al, 2010)

APA Division 12

- STATUS: "modest research support" for OCD

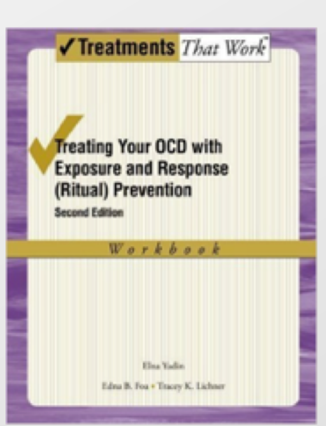
´**Key reference**: Twohig, Hayes, Plumb, Pruitt, Collins, Hazlett-Stevens, & Woidneck. (2010). A randomized clinical trial of acceptance and commitment therapy versus progressive relaxation training for obsessive-compulsive disorder. *Journal of Consulting and Clinical Psychology,* 78, 705-716.

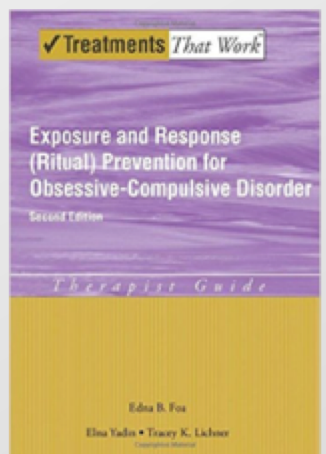
ACT for OCD with ERP

- In a sample (N = 128) of participants with mixed anxiety disorder (OCD = 13.4% or 17 total participants), ACT as effective as CBT (both included exposure) (Arch et al., 2012)
- ACT + ERP for OCD compares favorably against traditional ERP for OCD (Twohig et al., in press)

What do we mean by “traditional exposure”?

Habituation
(e.g., symptom reduction)





A)
SUDS
Time (in min)
Ses 5
Ses 8
Ses 10

B)
SUDS
Time (in min)
Ses 12
Ses 15
Ses 17

Gramich, M.A., & Neer, S.M. (2018). Firefighter-Paramedic With Posttraumatic Stress Disorder, Horrific Images, and Depression: A Clinical Case Study. Clinical Case Study, 17(3), 150-165.

"Symptom reduction?!"

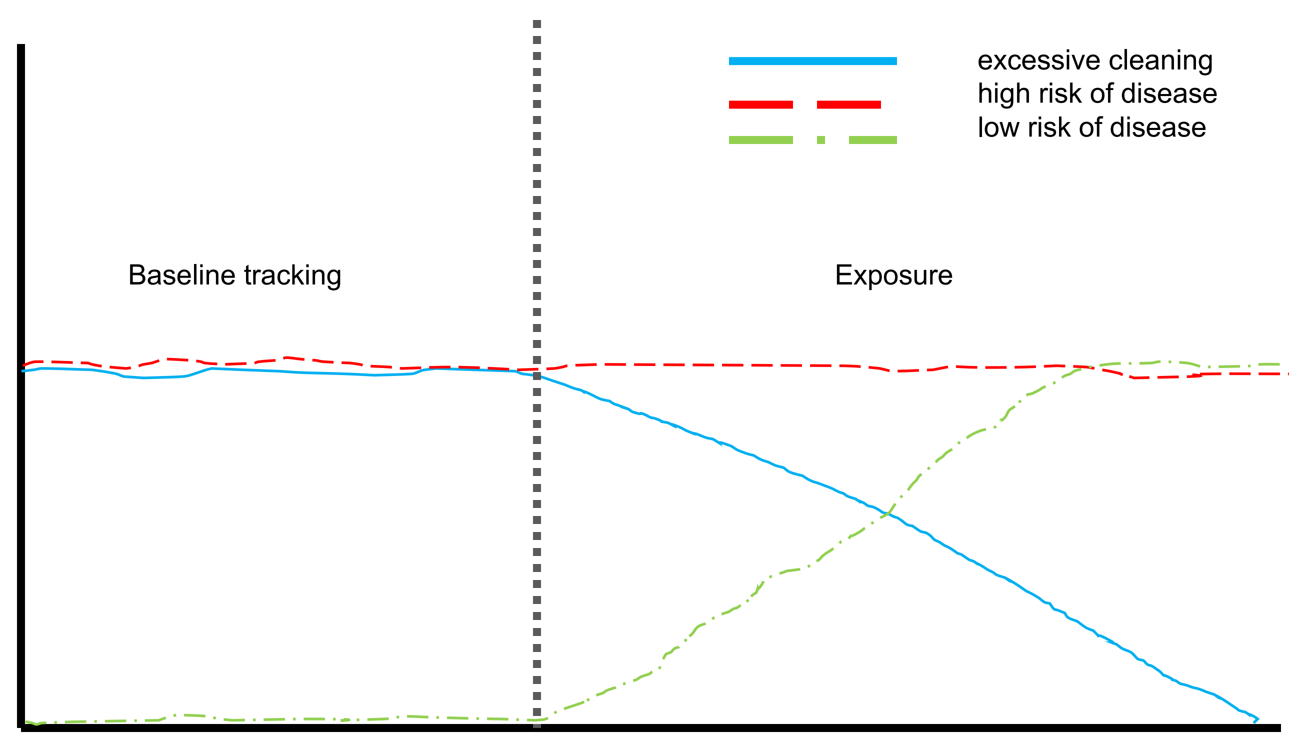
Call the ACT Police!

Traditional CBT moving away from habituation...

Within-session habituation unrelated to outcome (Jaycox et al., 1998; van Minnen & Foa, 2006)

- Suggests limited support for between-session habituation (Craske et al., 2008)
- Learning occurs without habituation (Baker et al, 2010; Craske et al, 2008; Kircanski, et al, 2012)

Inhibitory Learning



Inhibitory Learning and ACT -- Similarities

- Does not emphasize habituation to distress (e.g., reduction in SUDS). Concerned that over-emphasis on habituation can create "fear of fear"
- Decrease SUDS is not a predictor of learning
- Focus on context and generalizability
- Teach clients to put words to experience (e.g., feelings) during exposure
- Do not focus on methodically working through hierarchy in order of least to most difficult
- Not a lot of clinical studies

Arch, J.J., & Abramowitz, J.S. (2015). Exposure therapy for obsessive-compulsive disorder: An optimizing inhibitory learning approach. *Journal of Obsessive-Compulsive and Related Disorders, 6*, 174-182.

Inhibitory Learning and ACT - Differences

Inhibitory Learning

- Focus on training non-threat associations through expectancy violations to inhibit retrieval of threat association. Emphasis on safety (non-danger) learning
- Fear toleration
- Recommends exposure conducted in random order

ACT

- Values-based exposure
- Larger use of language and contextualizing through metaphor and experiential exercises
- ACT approach goes beyond IL fear tolerance in emphasizing radical acceptance of private events

Arch, J.J., & Abramowitz, J.S. (2015). Exposure therapy for obsessive-compulsive disorder: An optimizing inhibitory learning approach. *Journal of Obsessive-Compulsive and Related Disorders, 6*, 174-182.

Inhibitory Learning ERP

Before you start

1. Describe the exposure (*What fears will you face and what anxiety-reduction strategies will you give up?*)

2. What do you most fear will happen when you try this exposure (*be specific*)?

3. How long do you think you can stick with this task? ______________________

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Inhibitory Learning ERP

During the Exposure

1. Every ______ minutes during the exposure note (a) your anxiety level and (b) the strength of your urge to do anxiety-reducing behaviors on a 0-100 scale.

	Anxiety	Urge
1.	______	______
2.	______	______
3.	______	______
4.	______	______
5.	______	______

2. Describe your feelings during the exposure (*use phrases like "I'm feeling very scared about…"*)

http://jonabram.web.unc.edu/recent-conference-presentations/

Inhibitory Learning ERP

After the Exposure

1. Describe the outcome of the exposure in relation to your answers to questions #2 and #3 (*What happened? Did your fears come true? How did your feelings of fear and anxiety respond? How did you get through the experience? What would happen if you tried it again?*):

2. What did you learn from this experience? In what ways were you surprised by what happened?

3. What could you do to vary up this exposure?

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Inhibitory Learning ERP for OCD - Monica

Samples ERP exercises

- Eat store bought non-organic blueberries to sit with anxiety and uncertainty that eating would evoke (e.g., uncertainty about future illness)
- Eat unnatural food in multiple contexts (e.g., therapy, home, work, restaurants, traveling)
- Use unnatural hygiene products that she purchases, that friends and family use, that are freely available in public restrooms
- Wash hands with unnatural soap, briefly rinse, and leave some residue on her hands (e.g., fear of getting cancer from unnatural soap)

Arch, J.J., & Abramowitz, J. S. (2015). Exposure therapy for obsessive-compulsive disorder: An optimizing inhibitory learning approach. *Journal of Obsessive-Compulsive and Related Disorders*, *6*, 174-182.

ACT ERP for OCD - Monica

Samples ERP exercises

- Eat an organic apple that touched a non-organic apple so that she can more easily share foods with friends
- Washing hands with soap in a public restroom so that she can get better at being social
- Eating a food that the therapists chooses, that has no label, so that she can be more spontaneous
- Washing face nightly with non-organic or non-natural soap so that she could practice being more flexible in related situations where she cannot choose soaps
- Eating a non-organic apple so that she can eat at friends' homes

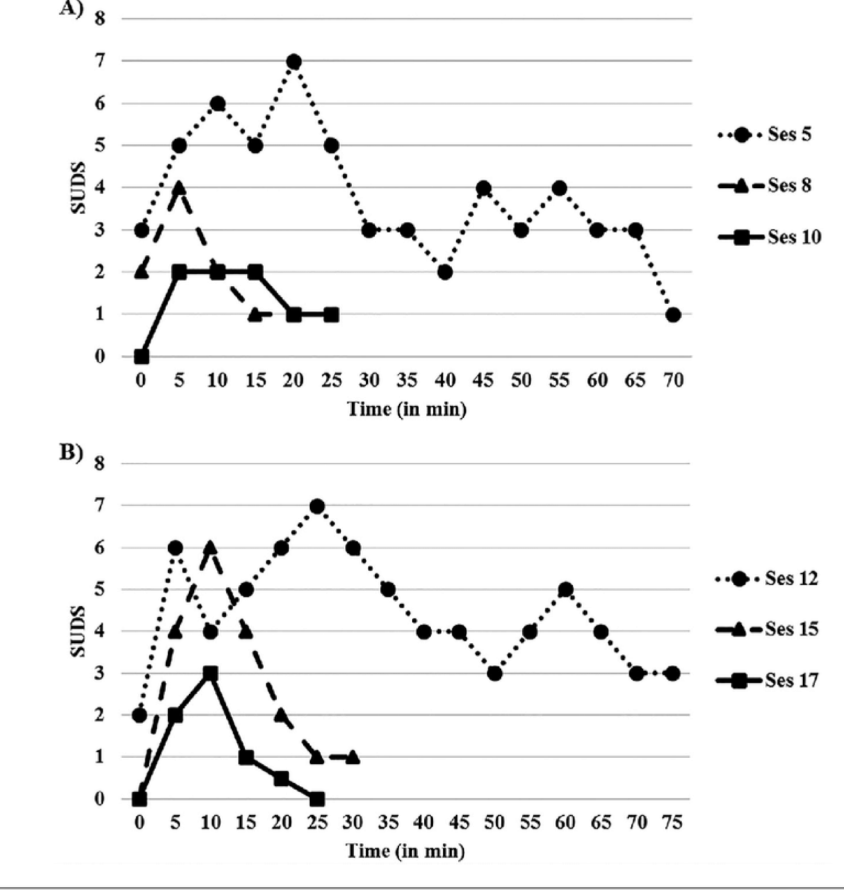
Twohig, M. P., Abramowitz, J. S., Bluett, E. J., Fabricant, L. E., Jacoby, R. J., Morrison, K. L., ... Smith, B. M. (2015). Exposure therapy for OCD from an acceptance and commitment therapy (ACT) framework. *Journal of Obsessive-Compulsive and Related Disorders*, *6*, 167-173.

Let’s talk about ACT & ERP

Is there a place for SUDS in ACT-consistent ERP?

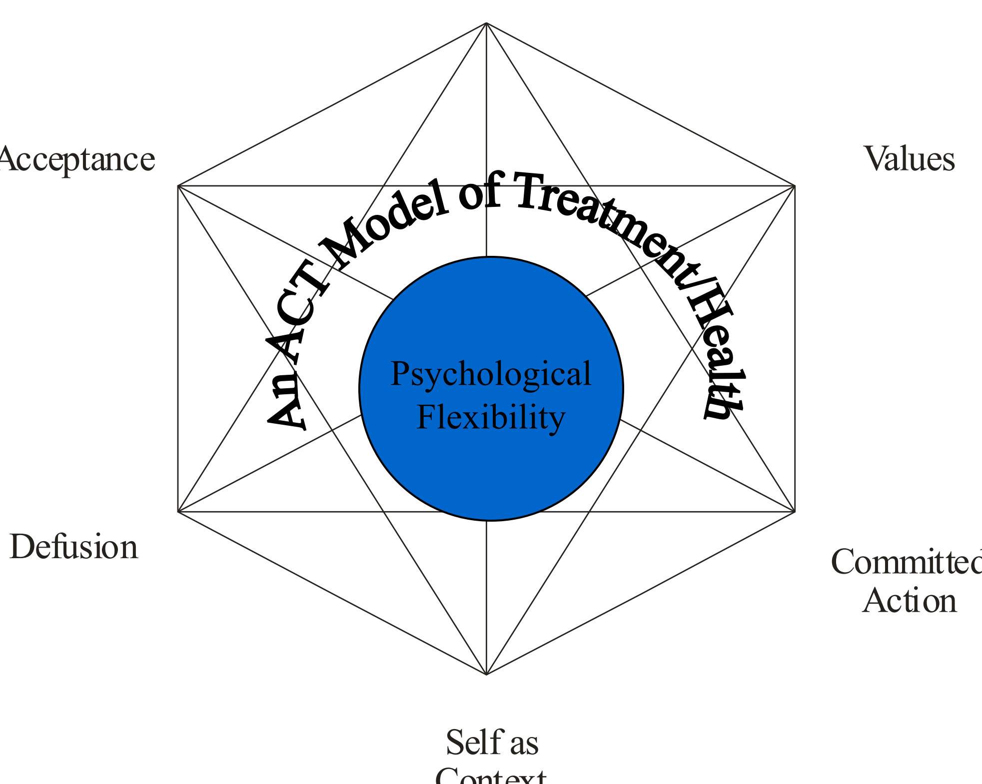
SUDS = Subjective Units of Distress (or Discomfort) Scale

- E.g., 0-100; 0-10



Gramich, M.A., & Neer, S.M. (2018). Firefighter-Paramedic With Posttraumatic Stress Disorder, Horrific Images, and Depression: A Clinical Case Study. Clinical Case Study, 17(3), 150-165.

If not SUDS, is there anything else we should track?


Contact with the
Present Moment
Acceptance
Values
An ACT Model of Treatment/Health
Psychological
Flexibility
Defusion
Committed
Action
Self as
Context

What are other ACT therapists using?

Eifert & Forsyth (2005)

FEEL Sensation Record
(Feeling Experiences Enriches Living)

Date: ______________________________ Time: __________________ A.M./P.M.

0 Low | 1 | 2 | 3 | 4 | 5 Moderate | 6 | 7 | 8 | 9 | 10 Extreme

Exercise	Sensations Intensity (0–10)	Anxiety Level (0–10)	Willingness to Experience (0–10)	Struggle with Experience (0–10)	Avoidance of Experience (0–10)

Eifert, G.H., & Forsyth, J.P (2005). *Acceptance and commitment therapy for anxiety disorders: A practitioner's treatment guide to using mindfulness, acceptance, and values-based behavior change strategies*. Oakland, CA: New Harbinger.

Eifert & Forsyth (2005)

Weekly Valued Life Goal Activities

Life Enhancement Exercise Record Form

Record your FEEL exercises and other goal-related activities for each day of the week, based on your commitments made in session. Record whether you engaged in the activity and how much time you spent on each activity. Then rate how much anxiety you experienced, how willing you were to have what you experienced, and how much you struggled with your experience at the beginning and at the end of each activity using the same 0 (low) to 10 (high) scale as on the FEEL forms.

Day	Activity Commitment	Yes/No	Duration (minutes)	Anxiety Beg/End	Willingness Beg/End	Struggle Beg/End
Mon		Y / N		/	/	/
Tues		Y / N		/	/	/

ACT + ERP for OCD (Twohig et al., in press)

	Willingness* (0-100)
Beginning	____
5 minutes	____
10 minutes	____
15 minutes	____
20 minutes	____
25 minutes	____
30 minutes	____
35 minutes	____
40 minutes	____
45 minutes	____

*willingness to experience anxiety

Patricia's Values-based exposure practice

ACT: Exposure Coaching Practice Form (for therapists)

Name: ____________________ Date: ____________

What's my core fear/obsession?

____

How has this obsession affected my life?

____

____

What really matters to me?

____

What exposure exercise (s) am I willing to practice today so I can get closer to what matters to me?

Trials	Exposure Activity	Willingness	Exposure variables

Willingness in residential ERP program

- Higher willingness (0-100 scale) immediately before beginning ERP, willingness during ERP, and willingness to engage in future ERP associated with faster improvements in 6-week residential treatment for OCD (Reid et al., 2017)
  - ➢ Willingness may be a more effective process to track during within-session ERP than habituation

I thought Willingness was Yes or No? All or Nothing?

"NO!
Try not!
DO or DO NOT,
There is no try."

Valued ACT *(Valued Action Commitment Tracking* form)

Value: ______________________

Action I'm Willing to Take Towards Value: ______________________ ***Self-practice instructions (What/When/Where/How):***	**Importance** *(0 – 10)* ______

Date	*Time*	***Willingness***	***What Happened?*** *(outcome, thoughts, feelings, body sensations, impressions)*
		ON------OFF	
		ON------OFF	
		ON------OFF	
		ON------OFF	
		ON------OFF	

Why track anything at all?

- Encourages clients to pay attention to their moment-to-moment experiences
- Offers some insight in client’s subjective experience
- Helps track learning (e.g., changes in scores)
- Match clients predictions (e.g., “My anxiety will spiral out of control”) with what actually happens (e.g., “My anxiety remains tolerable”)

<u>During practice</u>: ___ Alone ___ Accompanied (*mark X*)

Rate your experiences every ____ minutes. (Or circle N/A)

- **Time** = Frequency of rating (e.g., 5 min; 10 min)
- **SUDS** = Subjective Units of Discomfort Scale (i.e., 0 - 10)
- **Willing** = Willingness to experience discomfort without struggle (i.e., 0 - 10)

Date: ________

Time	SUDS	Willing
___	___	___
___	___	___
___	___	___
___	___	___

About the practice:

1.) Describe the exposure practice:

2.) What is meaningful to you about this practice? What is it a step towards doing?

3.) What is your fear about this practice? What does your mind tell you will happen as a result?

4.) How long will I practice (e.g., daily; 20 minutes)?

After the practice:

1.) What did I learn from this practice?

2.) What might I do to improve or vary practice? (Ex., Could I combine this with another fear?)

3.) What is important to me about this practice? How will this help me live the life I want?

Interoceptive Exposure

Valued ACT (*Valued Action Commitment Tracking* form)

Value: I'm willing to experience uncomfortable bodily sensations if it allows me to:

____

Exercise(s) I've committed to practice: ____________________________________

Self-practice instructions (description, time, trials per day):

Date	Trial #	Similarity (0 – 10)	Willingness (0 – 10)	***What Happened?*** *(bodily sensations, thoughts, feelings, impressions)*

Should I still create an Exposure Hierarchy? If so, how should I arrange it (e.g., SUDS; Willingness; Values)?

Table 2
Sample exposure hierarchy: Monica.

Willingness (0–100)	Exposure exercise/behavioral commitment linked to a value
100	Talking or reading about diseases like cancers or Parkinson's disease, without reassurance, so that she can be more open to conversations with friends
90	Allowing family members to use whatever soap they choose so that she can have stronger relationships with them
80	Eat an organic apple that touched a non-organic apple so that she can more easily share foods with friends
70	Washing hands with soap from public restroom so that she can get better at being social
60	Eating a food that the therapist chooses, that has no label, so that she can be more spontaneous
50	Visiting a medical center where cancer is treated so that she can learn to be more present with friends who are ill rather than worrying about herself
40	Washing face nightly with non-organic or non-natural soap so that she could practice being more flexible in related situations where she cannot choose soaps
30	Eating a non-organic apple so that she can eat at fiends' homes
20	Letting a friend cook for her without checking on what is in the food
10	Eat at a restaurant that she finds disgusting so that she can be more flexible and spontaneous with friends
0	Going on a date and being open to desired level of intimacy

Note: willingness = client's level of willingness to experience whatever internal experience shows up during exercise; 0 = none at all, 100 = totally confident that she can maintain openness to whatever occurs during exercise

Twohig, M. P., Abramowitz, J. S., Bluett, E. J., Fabricant, L. E., Jacoby, R. J., Morrison, K. L., ... Smith, B. M. (2015). Exposure therapy for OCD from an acceptance and commitment therapy (ACT) framework. *Journal of Obsessive-Compulsive and Related Disorders*, *6*, 167-173. DOI: 10.1016/j.jocrd.2014.12.007

Exposure “Menu”

Benefits:

- Saves time
- Keep treatment on track
- Client may observe improvement re-rating scores

Creating an ACT rationale for ERP

Anxiety

10

0

Willingness

10

0

If habituation doesn't matter, how do you decide on the length of ERP exercises?

- How long can they be willing?
- How much time do that have or are they willing to set aside?
- *More time can allow for more learning*

The lengths I'll go to avoid climbing a ladder to my roofline.

Reducing time to train Willingness

Interoceptive exposure to breathing through a straw

Trial	Time	Willingness (0-10)
1	60s	4
2	30s	3
3	20s	5
4	15s	6
5	15s	7
6	20s	7
7	25s	7
8	25s	7
9	30s	6
10	30s	7
11	30s	7

Willingness rating: 0 = *unwilling to experience sensations*, 10 = *completely willing to experience sensations*

If habituation doesn’t matter, how do you know when to move onto a new ERP exercise?

Let the client tell you.

E.g., *“Is there anything else you think you could learn from additional practice, or are you ready to move on?”*

When client can engage in ERP without rituals (Jordan et al., 2016)

Patricia's case example:

Age: 50

Ethnicity: Caucasian

Gender: Female

Current meds: Prozac

Obsession: fear of not being able to stop focusing on her breathing

Consequence of the fear: I'll be homeless

Compulsions: mental compulsions (listing all the times therapy worked for her, body checking when breathing, and asking for reassurance that she will be okay (1-3 hrs. a day)

Prior history of OCD: adolescence, young adulthood

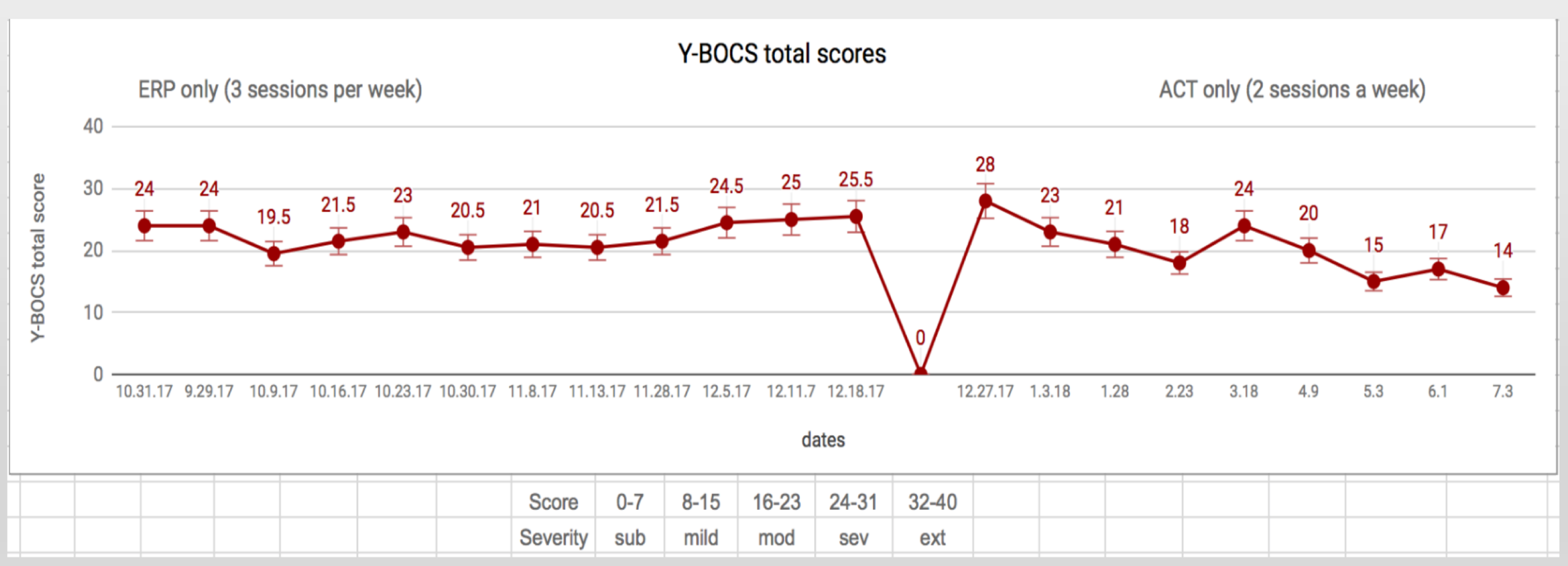
Patricia's client

Hi Dr. Z,

Here is my list:

1. Soccer games with
2. Helping with homework
3. Not avoiding going to movies and enjoying them
4. Hiking.both with and without
5. Going to dinner and concerts with friends
6. Getting Kitchen painted
7: clothes shopping for spring break
8: PT exercises/appointments
9. Favorite long walk
10. Spring Break, enjoyed, focused on outside
11. Reading a book, almost finished.

Y-BOCS: Yale-Brown Obsessive compulsive scale ERP and ACT/ERP treatment



Score	0-7	8-15	16-23	24-31	32-40
Severity	sub	mild	mod	sev	ext

Patricia’s client

Defusion from the breathing thought

Finally, a here is a sample of a defusion exercise we did in-session

Brian’s case example

Age: early 30’s

Ethnicity: Latina

Gender: Female

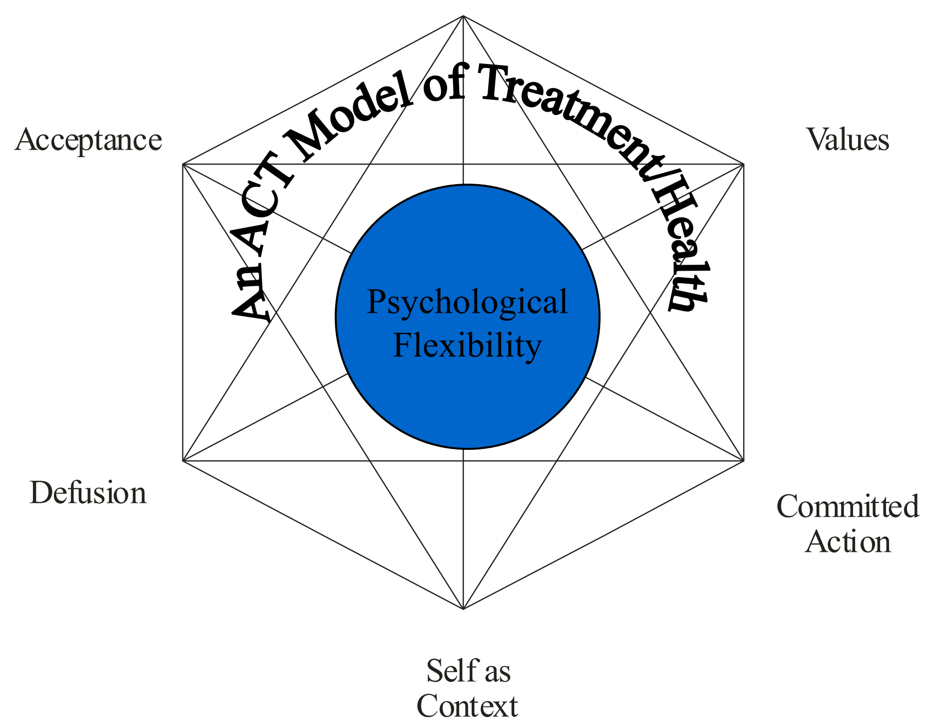
Current meds: None

Primary obsession: Harm obsessions, especially hit-and-run

Primary ritual: Reviewing past day to reassure she did not cause harm (1-3 hrs)

No prior experience with ACT or ERP

Using exposure to strengthen ACT processes



Multiple-Baseline Single Case Design

18-session protocol

N = 4

<u>Phases</u>:

- **A** = Baseline
- **B** = Exposure and Response Prevention
- **C** = ACT

	Baseline		Phase: ERP				Phase: ACT or ERP				Phase: ERP or ACT				Phase: ERP			
Sessions:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Condition A	**AA**		**BBBB**				**CCCC**				**BBBB**				**BBBB**			
Condition B	**AA**		**BBBB**				**BBBB**				**CCCC**				**BBBB**			

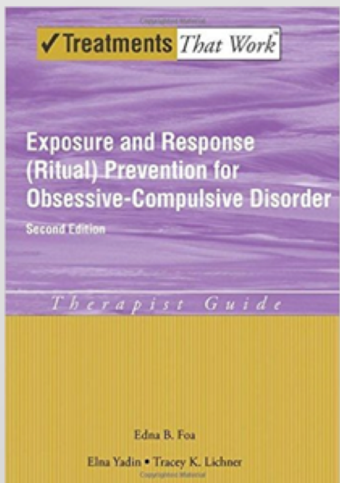
ERP

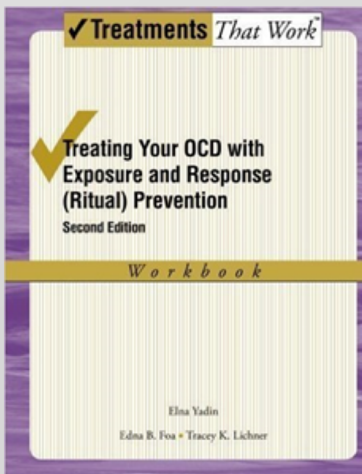
Adapted from:

- *ERP for OCD Therapist Guide* (2nd ed; Foa, Yadin, & Lichner, 2012)
- *ERP for OCD Workbook* (2nd ed; Yadin, Foa, & Lichner, 2012)

Some changes:

- Adapted for 45-minute sessions
- Phone contact not scheduled
- Did not emphasize habituation





ACT Phase (adapted from Eifert & Forsyth, 2005)

Session A

- Acceptance of Thoughts and Feelings exercise
- Tug-of-War with a Monster
- Finger Traps

Session B

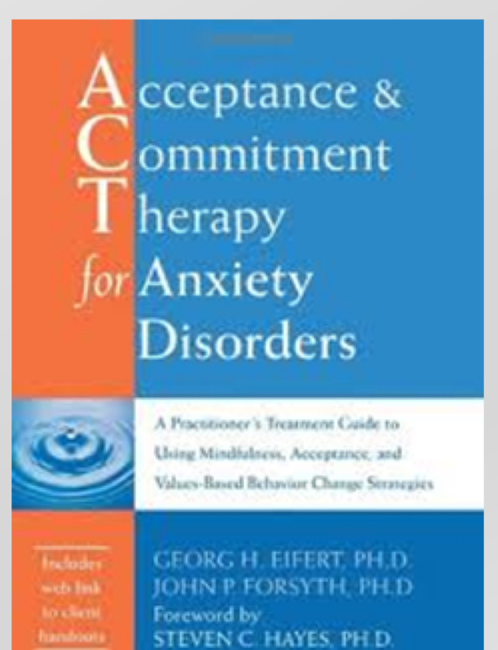
- Passengers on the Bus
- Misc. defusion with thoughts on cards

Session C

- Acceptance of Anxiety exercise
- Willingness Switch
- Bull's Eye (*ACT Made Simple*, adapted from Dahl & Lundgren)

Session D

- Chessboard metaphor
- Prepare to return to ERP



Assessment scores for pre-, mid-, and post-treatment

	Pre	Mid	Post	Δ
Y-BOCS	30	22	15	-50%
OCI-R	38	30	16	-58%
AAQ-II	25	29	26	4%
CFQ7	44	32	27	-39%
PHLMS				
Aware	37	35	34	-8%
Accept	22	27	29	32%

Y-BOCS = Yale Brown Obsessive Compulsive Scale; AAQ = Acceptance and Action Questionnaire; CFQ7 = Cognitive Fusion Questionnaire – 7;
PHLMS = Philadelphia Mindfulness Scale; OCI-R; Obsessive-Compulsive Inventory – Revised.

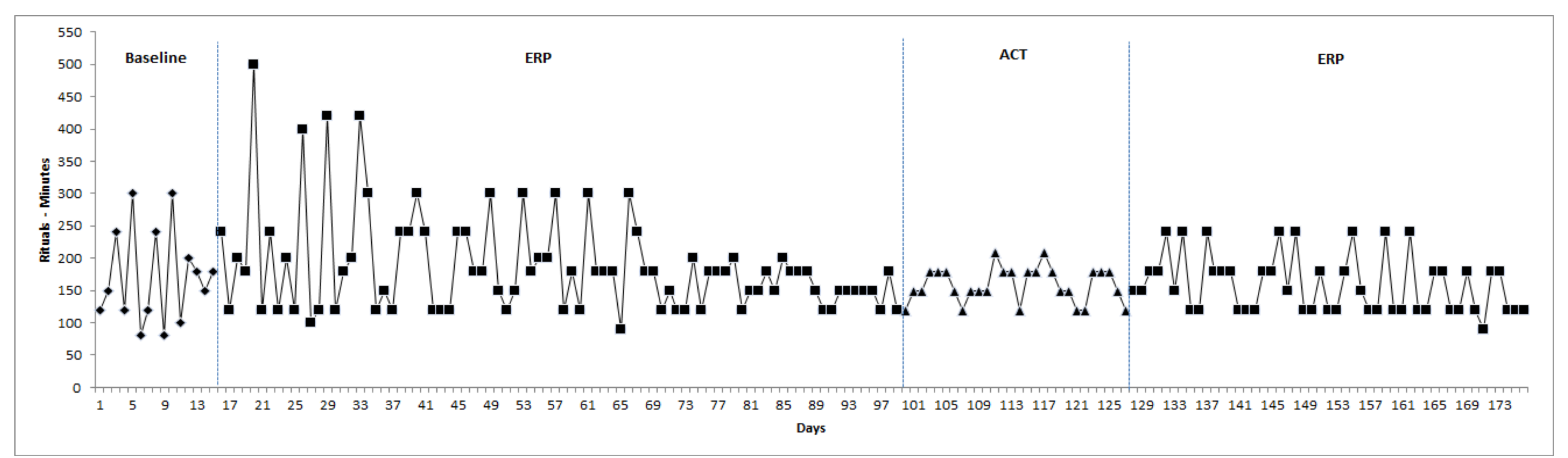
ACT Daily Process items

The following questions ask about how things have been going for you over the past day. Please read each statement carefully, and then rate on the scale provided as to how much the statement applies to you *over the past day*. Leave voice mail or enter rating online each day.

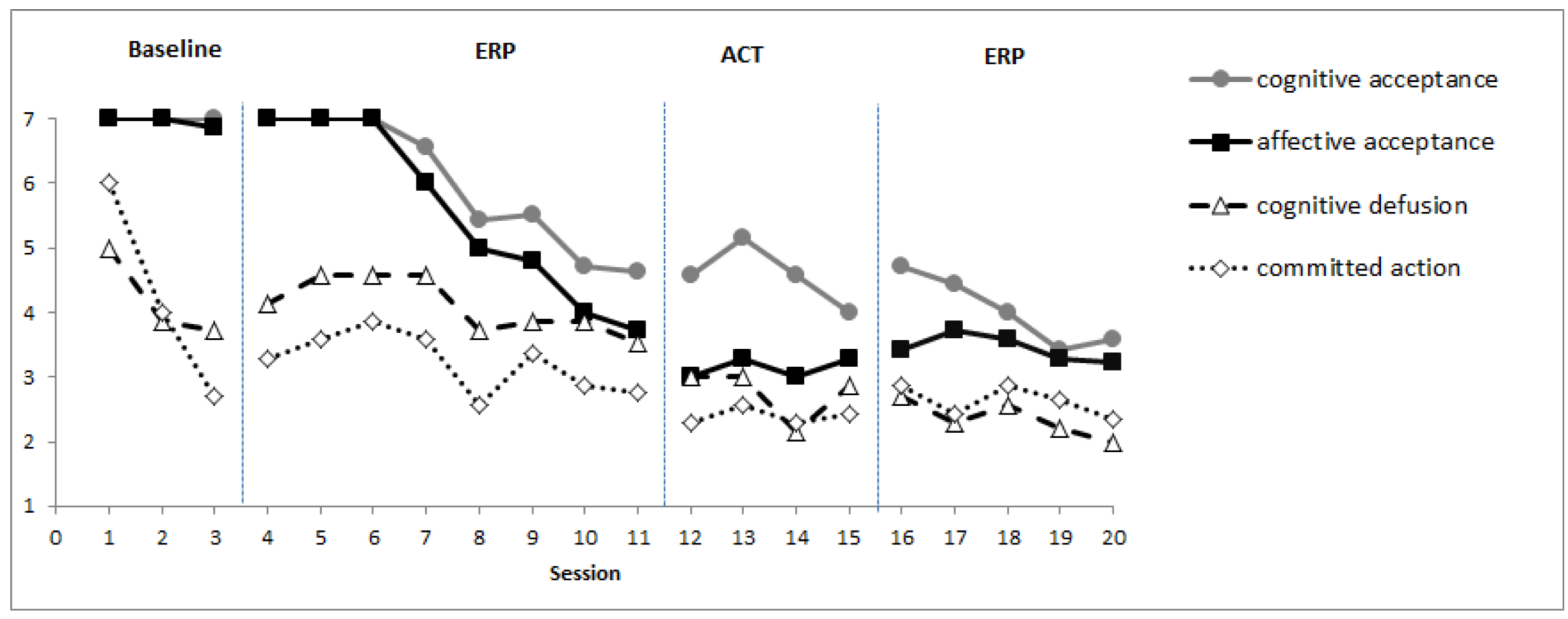
1	Whenever I had ***bothersome thoughts*** over the past day, I tended to...	1 2 3 4 5 6 7 Just notice them without trying to change them … Try to change them or get rid of them
2	Whenever I had ***bothersome feelings*** over the past day, I tended to...	1 2 3 4 5 6 7 Just notice them without trying to change them … Try to change them or get rid of them
3	When I have ***thoughts that I "know" are unrealistically negative***...	1 2 3 4 5 6 7 I'm able to see them as just thoughts and not as the truth … I can't help but take them as the truth
4	In terms of the ***effect of my emotions on my behavior***, my distress...	1 2 3 4 5 6 7 Does not prevent me from doing anything of importance … Keeps me from doing some important things … Prevents me from doing many important things
5	**Number of minutes** spent on rituals	[Can use Self-Monitoring form to track]

Forman, E.M., Chapman, J.E., Herbert, J.D., Goetter, E.M., Yuen, E.K., & Moitra, E. (2012). Using session-by-session measurement to compare mechanism of action for acceptance and commitment therapy and cognitive therapy. *Behavior Therapy, 43*, 341-354.

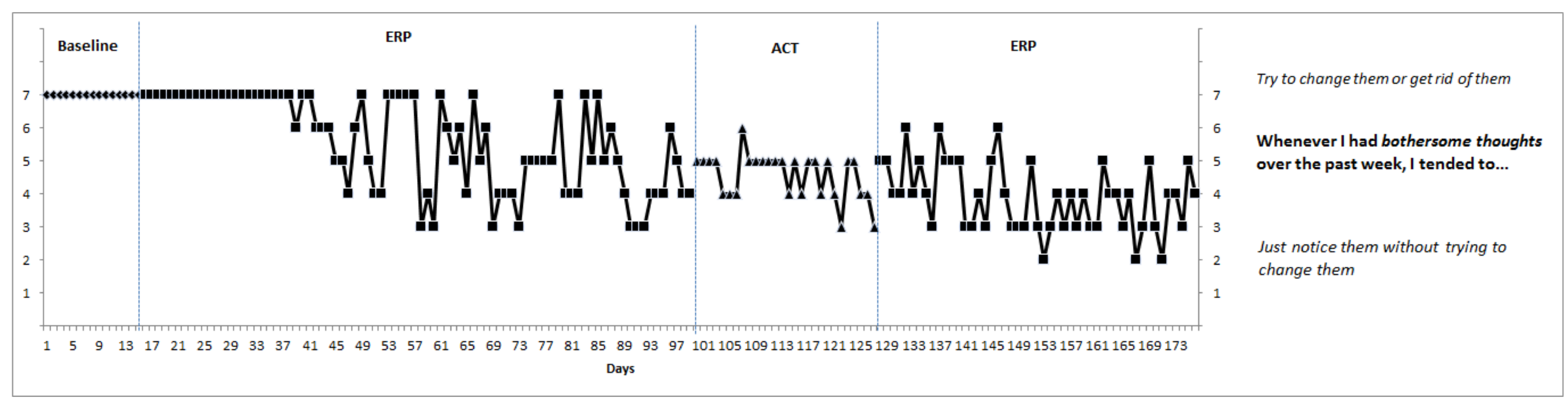
Rituals per day (minutes)



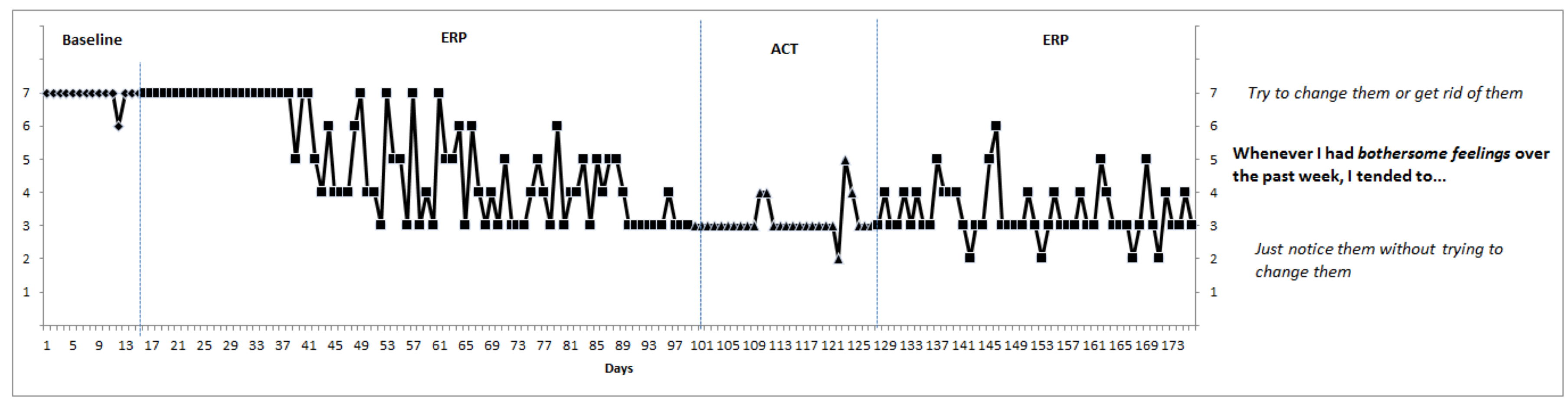
ACT processes



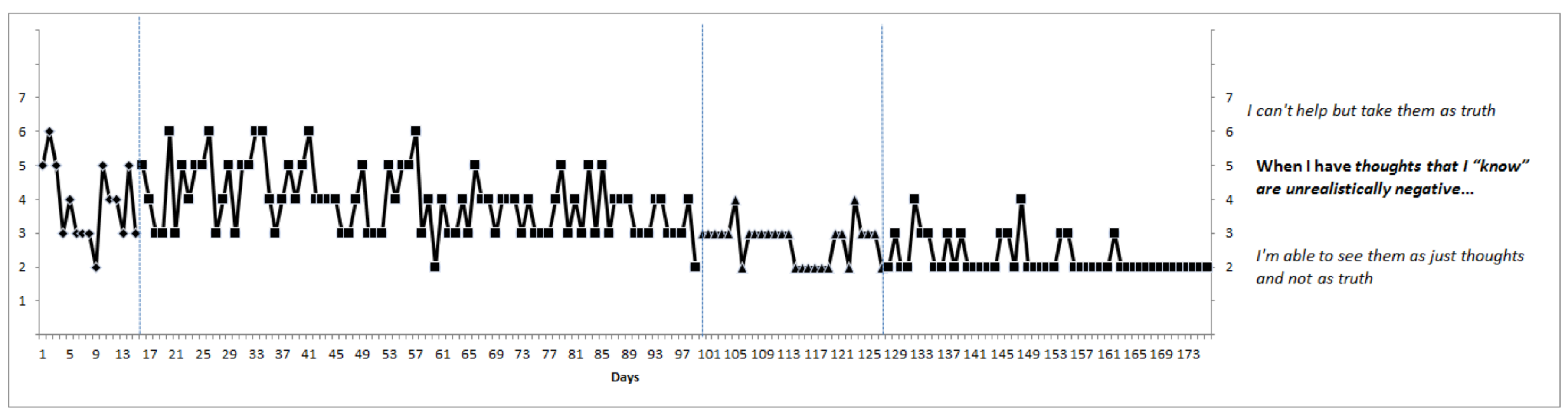
Cognitive Acceptance



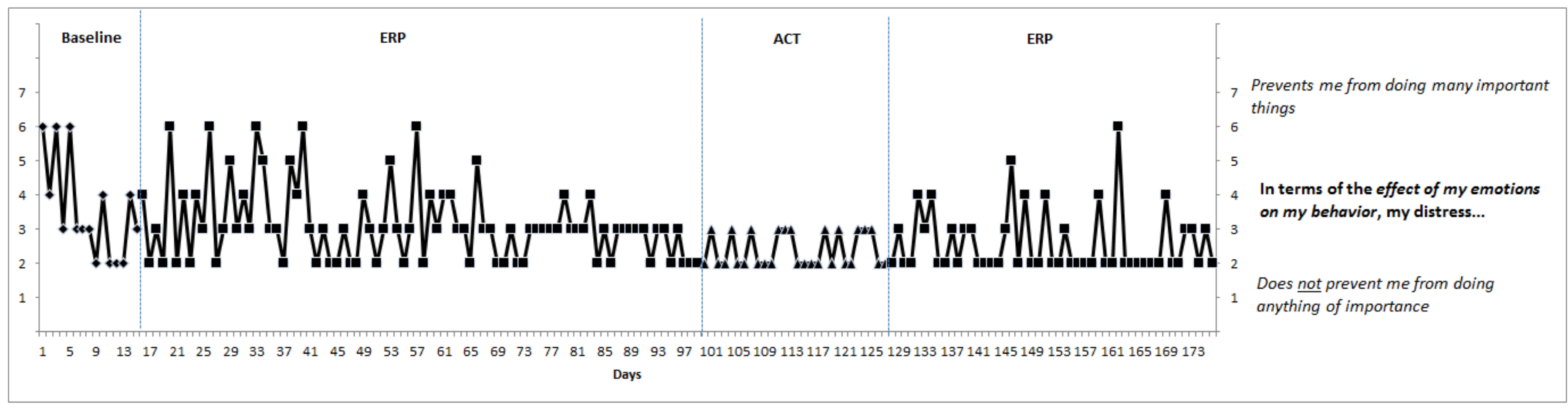
Affective Acceptance



Cognitive Defusion



Committed Action



- ACT may increase client willingness to engage in exposure (Levitt et al., 2004)
- ERP for OCD, even without explicit ACT interventions, may increase psychological flexibility (e.g., Twohig et al., in press)

Recommended readings for learning more

Arch, J.J., & Abramowitz, J.S. (2015). Exposure therapy for obsessive-compulsive disorder: An optimizing inhibitory learning approach. *Journal of Obsessive-Compulsive and Related Disorders, 6*, 174-182.

Eifert, G.H., & Forsyth, J.P (2005). *Acceptance and commitment therapy for anxiety disorders: A practitioner's treatment guide to using mindfulness, acceptance, and values-based behavior change strategies*. Oakland, CA: New Harbinger.

Jacoby, R.J., & Abramowitz, J.S., (2016). Inhibitory learning approaches to exposure therapy: A critical review and translation to obsessive-compulsive disorder. *Clinical Psychology Review, 49*, 28-40.

Twohig, M.P., Abramowitz, J.S., Bluett, E.J., Fabricant, L.E., Jacoby, R.J., Morrison, K.L., et al. (2015). Exposure therapy for OCD from an acceptance and commitment therapy (ACT) framework. *Journal of Obsessive-Compulsive and Related Disorders, 6*, 167-173.

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Questions?