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## Expanding our Therapeutic Tools in the OCD Toolbox: "ACT for OCD" Group Therapy

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## Disclosures (support):

Candice Fieg


Relevant Financial Relationships:

- Employed by Epworth Healthcare
- Recipient of the "Tony and Virginia Browne" Scholarship for Innovation 2016, Epworth
  - Funded USA Study Tour of "ACT for OCD" Project

Nil Relevant Nonfinancial Relationships

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## Overview



- About our service
- Treating OCD- The Literature
- Therapy in a Group Setting
- Application of ACT to OCD
- About the 10 week "ACT4OCD" Program
- Pilot Study Overview
- Preliminary Observations
- Process Issues
- Where to from here?

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## About Us

**Epworth HealthCare, Australia**

- Victoria's largest not for profit private health care group
- Sites across Melbourne metropolitan area, delivering excellence in patient care

**Epworth Clinic- Mental Health Service, Camberwell**

- Two inpatient wards, 63 beds total
- Day Patient Therapy Group Programs- run by multidisciplinary Allied Health Team

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## Obsessive Compulsive Disorder

- A chronic and often disabling condition
- Presence of Obsessions, Compulsions, or both
  - Obsessions: Persistent, intrusive and unwanted thoughts/ images
  - Compulsions: Repetitive/ ritualistic behaviours or mental acts that individuals feel driven to perform. Goal to "neutralize" intrusions and prevent associated distress
- Behaviours not always overt eg rationalising, reassurance seeking, mental acts
- Associated with multiple morbidities



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## Treating OCD- The Literature

Gold Standard/ First Line Treatments:

- Psychotropic: Selective serotonin reuptake inhibitors- SSRI's (Fineberg & Gale, 2005)
- Exposure and Response Prevention (ERP) (CBT)
  - Consistently found to be efficacious in improving OCD symptoms (Lewin et al., 2014; Ponniah et al., 2013; Gava et al., 2007; Abramowitz, 2001)

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## Gold Standard, "One Size Fits All"?

- Refusal to undergo exposure work due to the confronting nature of exposures
- Early dropout (Mancebo et al., 2011)
- Poor treatment motivation
- Inadequate response to treatment (Steketee et al., 2001)
- Persistence of residual symptoms
- Relapse
- Questionable efficacy in predominantly obsessional presentations and hoarding (Rufer et al., 2006)



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## ACT for OCD- The Literature

Gradual but clinically significant improvements seen in an RCT comparing ACT to progressive relaxation training - Twohig et al., 2015	Clinically significant reductions in compulsions & improvements in measures of OCD, depression, anxiety after 8 weeks - Twohig et al., 2006
Clinically significant reductions in self-reported compulsions at treatment completion and 3 month follow up - Twohig et al., 2006	
ACT processes effective in increasing willingness to experience obsessive thoughts - Marcks & Woods 2005	ACT effective in reducing self reported compulsions in adolescents with OCD, maintained at follow up. - Armstrong et al., 2013

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## ACT for OCD- The Literature

A meta-analysis of ACT for anxiety & OCD found positive and significant relationships between psychological flexibility and general measures of anxiety & OCD - Bluett et al 2014	ACT Vs SSRIs Vs Combination: Patients treated with ACT (either alone, or combined with SSRIs) experienced a significantly greater improvement in OCD symptoms and experiential avoidance compared with SSRIs alone - Vakili et al., 2015
ACT was effective in reducing the symptoms of OCD patients, especially for patients that resisted to exposure treatment. - Esfahani et al., 2015	N=1 Case study: ACT led to reductions in symptoms of OCD, depression and anxiety. Gains were maintained at 1,3,6 month follow-up - Vakili & Gharraee, 2014

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## ACT for OCD- The Literature

*What about ACT for OCD in a Group setting?*

Only 1 known study with 11 participants  
- Foret, 2012. Dissertation

- Improvements were seen compulsion frequencies, psychological flexibility, & thought suppression.
- Individual improvements in OCD symptoms (36%), though, group statistics not significant.

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## Group Therapy

Becoming increasingly more common. Benefits include:

- increased cost effectiveness
  - therefore increased accessibility for individuals
- increased social support
- accountability

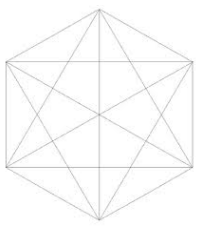


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## How Can ACT and OCD Fit Together?

**ACCEPTANCE vs Avoidance**

**MINDFULNESS vs Past Future**



**VALUES vs Lack of direction**

**DEFUSION vs Fusion**

**COMMITTED ACTION vs Inaction**

**SELF AS CONTEXT vs Content**

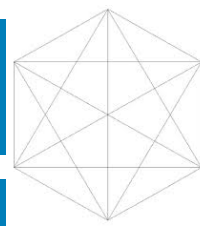
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Refocusing to the present moment. Non-judgemental awareness and observation of obsessions and urges

Being "stuck" in the obsessive mind-time travelling. Operating on auto-pilot and impulses

**ACCEPTANCE vs Avoidance**

**MINDFULNESS vs Past Future**



**VALUES vs Lack of direction**

**DEFUSION vs Fusion**

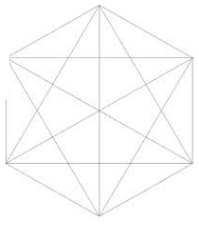
**COMMITTED ACTION vs Inaction**

**SELF AS CONTEXT vs Content**

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**ACCEPTANCE vs Avoidance**  
of emotions (e.g.: anxiety, uncertainty)

**MINDFULNESS vs Past Future**



**VALUES vs Lack of direction**

Control & avoidance of discomfort & fear (compulsions)

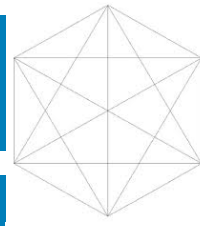
**COMMITTED ACTION vs Inaction**

**SELF AS CONTEXT vs Content**

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**ACCEPTANCE vs Avoidance**

**MINDFULNESS vs Past Future**



**VALUES vs Lack of direction**

Decisions guided by flexible principles of what is most important to me

**COMMITTED ACTION vs Inaction**

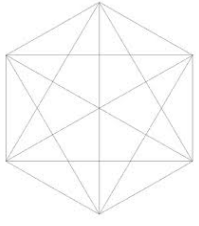
Decisions formed by avoiding discomfort: Rigidly held beliefs -> rigid repetitive behaviours

**SELF AS CONTEXT vs Content**

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**ACCEPTANCE vs Avoidance**

**MINDFULNESS vs Past Future**



**VALUES vs Lack of direction**

Recognising & labelling thoughts for what they are

**COMMITTED ACTION vs Inaction**

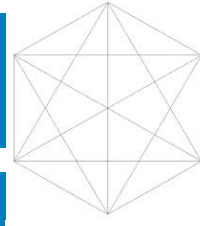
with OCD brain, paying attention to obsessions

**SELF AS CONTEXT vs Content**

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**ACCEPTANCE vs Avoidance**

**MINDFULNESS vs Past Future**



**VALUES vs Lack of direction**

Behavioural commitments to willingness & values

**COMMITTED ACTION vs Inaction**

"I will only do X when I don't feel Y"

**SELF AS CONTEXT vs Content**

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**ACCEPTANCE vs Avoidance**      **MINDFULNESS vs Past Future**      **VALUES vs Lack of direction**

**DEFUSION vs Fusion**      **COMMITTED ACTION vs Inaction**

**SELF AS CONTEXT vs Content**

The observing self noticing all experiences.. Remains unchanged by thoughts and feelings

Over-identifying with experiences. "I am my obsessions"

Refocusing to the present moment. Non-judgemental awareness and observation of obsessions and urges

Being "stuck" in the obsessive mind-time travelling. Operating on auto-pilot and impulses

**ACCEPTANCE vs Avoidance**      **MINDFULNESS vs Past Future**      **VALUES vs Lack of direction**

of emotions (e.g.: anxiety, uncertainty)      Control & avoidance of discomfort & fear (compulsions)      Decisions guided by flexible principles of what is most important to me

Decisions formed by avoiding discomfort: Rigidly held beliefs -> rigid repetitive behaviours

**DEFUSION vs Fusion**      **COMMITTED ACTION vs Inaction**

Recognising & labelling thoughts for what they are      with OCD brain, paying attention to obsessions      Behavioural commitments to willingness & values

**SELF AS CONTEXT vs Content**

The observing self noticing all experiences.. Remains unchanged by thoughts and feelings

Over-identifying with experiences. "I am my obsessions"

"I will only do X when I don't feel Y"

## Assessment & Entry into Program

Clinical Interview:

- Initial assessment and diagnosis by treating psychiatrist

Psychometric Scales:

- YBOCS Checklist & Scale (Goodman, Rasmussen, Price, & Storch, 2006)  
Assesses symptoms of OCD & severity
- DASS-21(Lovibond & Lovibond, 1995)  
Assesses symptoms of depression, anxiety, and stress
- Acceptance and Action Questionnaire II (AAQ-II; Bond et al., 2011)  
Assesses psychological flexibility & experiential avoidance
- MAAS (Mindful Attention Awareness Scale; Brown & Ryan, 2003)
- QOL (The Quality of Life Scale; Burckhardt & Anderson, 2003)

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## Program Structure

- 10 Week Program
- Group meets once a week
- Sessions- 3 hour total (with breaks)
- Group components:
  - Check-in
  - Mindfulness practice
  - Home task review
  - New content (1-2 points of the hexaflex covered per session)
  - Set home tasks (flexible- members can set own tasks)
  - Wind down, session evaluation, check-out

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## Program Structure

Session No.	Topic
1	Introduction to ACT & understanding OCD
2	Control & avoidance
3	Willingness & commitment
4	Defusion and the "observing self"
5	Harnessing Mindfulness
6	Understanding and making room for emotional experiencing
7	Contacting your values meaningfully
8	Values in Action- Harnessing Strengths
9	Wellness planning
10	Review and graduation

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## Experiential Exercises in the Group Space

"Handy Hints" for facilitation

- "Get experiential" in every group session & be creative! Be willing to let go of the session plan (aka our own control agenda's!)
- Maintain beginners mind, and the curious observer stance
- Access your "inner silly". Be the first to model, be willing to "make a fool of yourself". Harness humour- it's very hard for shame to co-exist with laughter.

"Laughter especially laughter around one's transgression as it occurs in a social context, provides the opportunity for the transgressing person to join others in viewing the self. In this way, the self metaphorically moves from the site of the shame to the site of observing the shame with the other"

- Lewis, 1995

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## Pilot Study Research Project

**AIM**

1. To evaluate the effectiveness of an ACT for OCD group program on OCD.
2. To assess the acceptability and feasibility of delivering an ACT for OCD group program.

Ethics Approved for "quality assurance" study, Data Collection Phase  
Collection of Pre & Post-Program data


- outcome measures, information re: demographics/ diagnosis, feedback collected during program

Co- Investigators: Dr. Terence Chong, Dr. Amit Zutshi, Professor David Castle of Epworth Clinic

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## Outcomes- Early Observations

- Trends towards individual improvements in Mindfulness
- Varying responses in individual OCD symptom changes (YBOCS total)
  - Changes in individual obsessions?
- Acceptability
- Anonymous Weekly Session Ratings
  - Mean 8.7/10
  - Overall positive feedback




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## Qualitative Feedback



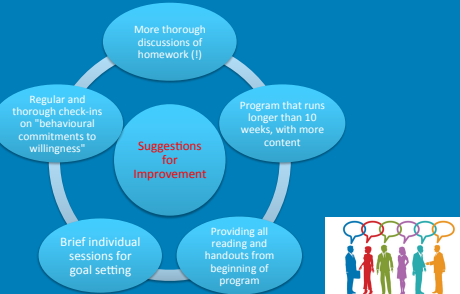
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## Feedback Cont.



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## Feedback cont.



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## Process Issues & Observations

- Initial Fear and Shame at prospect of speaking about intrusions
- Patient Centered Care
  - Balancing the needs of an individual as well as the needs of the group
  - Heterogeneity of population, differences in stages of recovery & change
- Nature of Group Setting Vs Individual Therapy
  - Limitations to working experientially "in the moment"
- Varying Engagement in Home Tasks
- Behavioural Commitments to Willingness
  - Scope to practice in session supported by therapist?
- OCD and Stages of Change- Striking while the irons hot



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## Future Directions- Where to from here?

- Restructuring the program?
- Incorporating both ACT & CBT/ERP
  - Utility of ACT in enhancing engagement in CBT/ERP
- Incorporating intensive inpatient stay
- Involvement of family/ carers



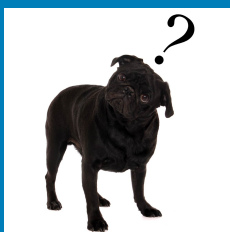
## Proposed Treatment Model?

6-8 week ACT Day Program  
"Assessment, Intro & Commitment"

2-3 week inpatient stay  
"Intensive Exposure Work- ACT & CBT"

6-8 week Day Program  
"Maintaining Treatment Gains"

## Questions?



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