Need CE credit for this session?

Please don’t forget to scan in to have your attendance tracked.

Expanding our Therapeutic Tools in the OCD Toolbox: “ACT for OCD”

Group Therapy
Candice Fieg M.Psych
Epworth Clinic
Melbourne Australia

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?

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

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

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
**Treat OCD- The Literature**

Gold Standard/First Line Treatments:
- Psychotropic: Selective serotonin reuptake inhibitors-SSRIs (Fineberg & Gale, 2005)
- Exposure and Response Prevention (ERP) (CBT)
  - Consistently found to be efficacious in improving OCD symptoms (Leen et al., 2014; Ponniah et al., 2013; Gava et al., 2007; Abramowitz, 2001)
- Gold Standard, "One Size Fits All"?
  - Refusal to undergo exposure work due to the confronting nature of exposures
  - Early dropout (Manefield et al., 2011)
  - Poor treatment motivation
  - Inadequate response to treatment (Steincox et al., 2001)
  - Persistence of residual symptoms
  - Relapse
  - Questionable efficacy in predominantly obsessional presentations and hoarding (Rufer et al., 2006)

**ACT for OCD- The Literature**

ACT processes effective in increasing willingness to experience obsessive thoughts
- Marks & Woods 2005
- ACT effective in reducing self-reported compulsions in adolescents with OCD, maintained at follow up.
- Armstrong et al., 2013

A meta-analysis of ACT for anxiety & OCD found positive and significant relationships between psychological flexibility and general measures of anxiety & OCD
- Ruett et al 2014

**ACT for OCD- The Literature**

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

N=1 Case study: ACT led to reductions in symptoms of OCD, depression and anxiety. Gains were maintained at 3,5,6 month follow-up
- Vakili & Gharey, 2014

**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 in compulsive frequency, psychological flexibility, & thought suppression.
  - Individual improvements in OCD symptoms (36%), though, group statistics not significant.

**Group Therapy**

Becoming increasingly more common. Benefits include:
- Increased cost effectiveness
- Therefore increased accessibility for individuals
- Increased social support
- Accountability
How Can ACT and OCD Fit Together?

**Mindfulness vs Past/Future**

**Acceptance vs Avoidance**
- Non-judgmental awareness and observation of obsessions and urges.

**Defusion vs Fusion**
- Refocusing to the present moment.
- Non-judgmental awareness and observation of obsessions and urges.
- Being "stuck" in the obsessive mind-traveling. Operating on autopilot and impulses.

**Self as Context vs Content**

**Values vs Lack of Direction**
- Decisions guided by flexible principles of what is most important to me.
- Decisions formed by avoiding discomfort: rigidly held beliefs → rigid repetitive behaviours.
- "I will only do it when I don't feel Y".

**Committed Action vs Inaction**
- Behavioural commitments to willingness & values.
- "I will only do it when I don't feel Y."
Assessment & Entry into Program

Clinical Interview:
- Initial assessment and diagnosis by treating psychiatrist

Psychometric Scales:
- PROS Checklist & Scale (Goodman, Rasmussen, Price, & Storch, 2006)
- DASS-21 (Lovibond & Lovibond, 1995)
- IAAS (Obsessive-Compulsive Cognitive Therapy Scale)
- QOL (The Quality of Life Scale; Burns & Anderson, 2003)

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

Experience Exercises in the Group Space

"Handy Hints" for facilitation:
- "Get experimental" 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 transgressions as it occurs in a social context, provides the opportunity for the transgressing person to join others in seeing the self, in this way, the self metaphorically moves from the role of the shame to the role of liberating this shame with self-kind laughter."

Lewis, 1995
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

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

Qualitative Feedback

More setting to fit with discomfort
Less stress and anxiety
More setting to fit with discomfort
Less stress and anxiety

What members learnt/gained

Less stress and anxiety

Less stress and anxiety

Support provided by facilitators and group members
Learning helpful tools from co-members
The bringing together of ppl with similar issues, welcoming environment
Attendance of group-prompt to utilize skills

Feedback cont.

More thorough discussion of homework

More thorough discussion of homework

Regular and regular feedback on homework submissions to encouragement

Suggestions for Improvement

Real individual sessions for group setting

Real individual sessions for group setting

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 iron is hot
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/carer

References


References


Acknowledgements


Need credit for this session? Please don’t forget to scan out.

What did you think?.... complete the 3 question quickeval for this session at https://contextualscience.org/quickeval

This was presentation was session #123