I. Introduction
   A. Therapy must be tailored to the patient, not the patient to the therapy.
      1. The alternative is a manualized treatment program suitable for research, but not the real
         world.
      2. Acceptance and commitment therapy (ACT) can play a role in OCD treatment, but the
         question becomes: Is exposure and response prevention (ERP) the primary treatment with
         ACT contributing or is it primarily ACT with ERP contributing.
   B. Historically, cognitive therapists mistakenly applied a treatment based on depression to anxiety
      without taking into account the critical differences.
      1. Treating the cognitive distortion, Intolerance of Uncertainty.
      2. Improper use of behavioral experiments.
   C. Many practitioners of ACT are repeating history.
      1. As ERP is currently practiced, it is an acceptance based therapy: exposure is acceptance.
      2. However, the extensive work of Hayes and his cohorts has added to our understanding of
         acceptance.
   D. Six psychological processes targeted by ACT.
      1. Acceptance
      2. Defusion
      3. Values
      4. Committed Action
      5. Self as Context
      6. Contact with the Present Moment.
   E. ACT is a top down approach
      1. For OCD it is thought that by targeting these processes, ERP will still take place, but that
         changes in the sufferer resulting from ACT make this, a more natural process.
      2. In this model, the power of meaning and thought has been defused, acceptance of
         experiencing anxiety, the committed action of trying to strive for values that are truly
         important for the sufferer, make following an ERP protocol the obvious choice.
   F. Our current belief is that this is an attempt to adapt the client to treatment. In the treatment of
      OCD, we ultimately include the goals of ACT, but believe a bottom up approach is necessary.
   G. First and foremost, for most sufferers of OCD, the desperate attempts to obtain certainty are so
      overwhelming, that it is difficult to try to make the macro-changes proposed by ACT. It is akin
      to working on an alcoholic's life problems while s/he is drunk.
   H. Instead, we will target the same processes as ACT, but OCD, the presenting problem, is the
      starting point.

II. The 6 ACT processes and ERP
   A. Acceptance
      1. The language of ACT is undermined by the sufferer's view of the world and how they use
         language.
         a. Accepting pain, but learning how to not suffer makes perfect sense, but exactly what
            is the sufferer accepting?
         b. Even in ACT, the painful work of ERP is a part of treatment.
c. We tell our clients that the goal of treatment in OCD is learning to live with uncertainty, or alternatively, to learn to accept the impossibility of ever obtaining absolute certainty.

d. To help them accept this, their OCD is explained from a point of view consistent with their experience.

e. Accepting uncertainty = accepting the possibility of life disasters taking place and deciding that should they occur, the sufferer will hope to cope with the disaster as opposed to giving up in the face of it.

1) The decision to live with potential disaster rather than running from it that makes it possible accept uncertainty.

f. Accepting uncertainty sets the stage for defusion; however, just with regard to OCD.

B. Defusion

1. Defusion is the process of detaching our thoughts from the meanings and importance we give to them. Successful defusion does not mean that the thoughts go away or that the positive or negative emotions associated with the thought are absent. However, how the person relates to those thoughts changes. Rather than experiencing the thought/feelings as truths, they are seen as hypotheses that can be rejected. Part of this process is learning to think without judgment and to see thought just as thoughts.

2. It is here that many ACT therapists run into trouble with OCD and accidentally violate their own rules. For an OCD sufferer, the statement that a thought is just a thought is a judgment. Because if this is true, then they don't have to worry about any potential consequences.

3. When intolerance of uncertainty is the cognitive distortion, then living with potential consequences, regardless of the probability is the goal.

4. Defusion will be accomplished through techniques fostering living with uncertainty.

a. When the nature of thoughts and feelings are accepted as uncertain and therefore not facts, and when rituals are no longer seen as a way to obtain certainty, defusion has taken place.

5. As Hayes notes, there are many paths to defusion.

a. By using language that is consistent with the sufferer's relational frame; i.e., the impossibility of definitely avoiding disaster or of ever being sure, the sufferer's view of their own thoughts changes.

b. When there is no certainty to a thought or its absolute meaning, defusion is taking place.

c. Their obsessions become hypotheses that are impossible to test, i.e. defusion has taken place.

6. However, this is still just with regard to their OCD, not to their conception of all of their thinking; however, the seeds for such changes are being planted.

C. Values

1. ERP is very frightening. Overcoming OCD means accepting the possibility of one’s greatest fears and still feeling the anxiety - coping with it rather than eliminating it.

2. A focus on values is imperative to motivate the client to undertake treatment.
a. The source of these values will be derived from what have they lost to OCD. This is still a 'bottom up' approach.
b. How has OCD alienated them from their most important values
   1) E.g., Would you do anything for your children example.
3. The meaning of ERP is transformed from confronting their fears to living their values.

D. Committed Action
   1. Committed action is simply living your values. Like so many ideas and techniques, simple is not the same as easy.
   2. ACT urges us to stop delaying our lives and work towards being the person we choose to be.
   3. For many diagnoses, the most reasonable place to start is with the core problems that make committed living, let alone living almost impossible.
   4. Time-consuming rituals and a mind consumed by trying to avoid uncertainty leave the client little time to devote to their broader goals.
   5. Here we focus on bringing the concepts of acceptance, defusion, and values together by urging the client to do ERP and learn to live with uncertainty.
   6. Both ACT and ERP suggest sitting with anxiety, but to do so when the client is faced with dealing with uncertainty and deciding how to cope with potential disasters is not unlike telling the client, "don't worry", or it's just your OCD, as if this is an idea that hasn't occurred to them.
   7. ERP is the initial action to be committed to.
      a. For OCD, ACT without ERP as the primary tool, is getting the cancer patient to eat healthy while ignoring chemotherapy.

E. Self as Context
   1. According to Hayes' Relational Frame theory of language that underlies ACT, there are at least three senses of self that emerge from our verbal abilities.
   2. The conceptualized self – This is the verbal "I am self".
      a. The categories and evaluations that we hold verbally about self: I am old; I am nice; I am anxious; etc. This is made with verbal content.
      b. This content forms your idea of who you are and how you fit into this life including: thoughts, feelings, bodily sensations, memories and behavioral predispositions that make up your integrated stable idea of self.
      c. This is the self that you are most likely familiar with.
      d. Hayes says that while we are most familiar with the conceptualized self it is the most like part of self to create suffering.
         1) It is the source of beliefs, rules, durable ideas about self that influence how we will act and feel and in some cases regardless of what reality dictates.
         2) E.g., seeing yourself as a depressed person rather than feeling depressed.
   3. Self as Ongoing Process of Awareness
a. Your fluid continuous appraisal of verbal self experiencing the present moment.

b. It is descriptive rather than summary evaluative statements. For example one would notice that I am feeling this, I am thinking this, I am smelling that, I am remembering something. These categories are descriptive non-evaluative, present and flexible.

c. Being unable to connect with an ongoing process of awareness will result in problems.

4. The Observing Self
   a. The observing self is not the object of verbal relations. Meaning that the observing self is not a content based sense of self (not I am smart, pretty, etc.) it is not ongoing process of awareness self (I am tired, hot etc.) but rather it is the place from which observations are made.
   b. ERP sets stage for follow up treatment to expand role of the observing self.

F. Mindfulness
   1. Mindfulness is paying attention on purpose in the present moment as if your life depended on it non-judgmentally.
   2. It is a difficult task to train oneself to be present in this moment and accept all that is here to be faced. A sufferer is primed to step into acceptance through learning to tolerate uncertainty. We choose a specialty practice for a specific problem instead of using a generalist model and wait for it to work on the specific problem.
   3. Living with uncertainty sets stage for further mindfulness, because the client is no longer lost in understanding past disasters or preventing future ones.
   4. Modified mindfulness for special anxiety issues in some OCD patients.

III. Summary
   A. Ideas of ACT in some form has been used by CBT therapist for some time.
      1. The directed effort of Hayes and his colleagues has been vital in expanding our understanding of mindfulness and ways of helping patients free themselves of their maladaptive schemas and mind sets.
      2. ACT is not a replacement for learning behavioral and cognitive principles. Those ACT therapists who seem comfortable narrowing their training and therapy do a disservice to the field.

   B. The second is that treatment needs to be tailored to the patient.
      1. Every patient and presenting problem has its own special language that a good therapist will use and approaches that have solid research behind them.
      2. The suggestions we've made for incorporating ACT into OCD treatment are not new or even original to my center. Hopefully my suggestions reflect the role ACT can play within our framework as opposed to those who present it as the replacement.

   C. Ideas presented here are research hypotheses. If one is going to incorporate ACT into treatment for OCD:
      1. What is the best way to do it and is there a reason to use language focusing on the intolerance of uncertainty
      2. Does the initial focus have to be primarily upon OCD related issues or can ACT concepts and training be done earlier in treatment.
3. The importance of seeing ACT as a part of our CBT universe is to have research focused upon real questions instead of creating an industry of GIGO (garbage in - garbage out) studies.