A Newsletter Dealing with Obsessive Compulsive Disorder

NEVER say NEVER

In the midst of the seemingly endless storm,
look to the promise of the rainbow -
the rain shall not prevail!

Winter/Spring 2013

Living With Your Worst Nightmares:

The Role of Mindfulness and Acceptance in Exposure and Response Prevention

By Jonathan Grayson, Ph.D. and Jodi Rosenfeld, Psy.D.
The Anxiety and Agoraphobia Treatment Center
Bala Cynwyd, PA

Acceptance and mindfulness are concepts that have been practiced in spiritual teachings for many thousands of years. More recently, psychologists have begun to apply acceptance and mindfulness techniques to the treatments of many different problems. Unfortunately, when new techniques are adopted, there is often a great deal of misinformation as to how to use them and what to expect from them. Currently, we are beginning to explore the usefulness of these techniques in the treatment of Obsessive Compulsive Disorder (OCD). In this article, we hope to answer three questions:

1. Does it make sense to incorporate acceptance and mindfulness techniques into the treatment of OCD?
2. What is acceptance and what is its role in the treatment of OCD?
3. What is mindfulness and what is its role in the treatment of OCD?

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SPRING PROGRAM, 1:00 SATURDAY, MAY 11, 2013

Dr. Laura Nisenson and Laurie Krauth will speak to us on "Mindfulness and Acceptance: Disengaging From OCD." They explain:

"The gold standard for treating OCD is Exposure and Response Prevention (ERP). ERP helps people with OCD experience their obsessions without doing rituals to bring down the anxiety that comes with confronting their fears. The challenge for OCD sufferers is tolerating that anxiety so that they can fully participate in ERP. Mindfulness strategies can help people with OCD better tolerate and accept anxiety so that they can more effectively succeed with ERP and more fully engage with their lives."

Join us at St. Joseph Mercy Hospital, Ellen Thompson Women's Health Center, Classroom #1A-B, 5320 Elliott Drive, Ypsilanti, MI. See our webpage, ocdmich.org, for flyer and map.

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To submit articles or letters, write or e-mail the OCDFM at the above addresses.

LIST OF SELF-HELP GROUPS

***ANN ARBOR*:**
1st Thursday, 7-9 PM
St. Joseph Mercy Hospital Ann Arbor
Ellen Thompson Women's Health Center
Classroom #3
(in the Specialty Centers area)
5320 Elliott Drive, Ypsilanti, MI
Call Jeannie at (734) 846-9656
E-mail bellajean@sbcglobal.net

***DEARBORN*:**
2nd Thursday, 7-9 PM
First United Methodist Church
22124 Garrison Street (at Mason)
Call Joan at (734) 479-2416

***FARMINGTON HILLS*:**
1st and 3rd Sundays, 1-3 PM
Trichotillomania Support Group
Botsford Hospital
Administration & Education Center, Classroom C
28050 Grand River Ave. (North of 8 Mile)
Call Bobbie at (734) 522-8907 or (734) 652-8907
E-mail rslade9627@aol.com

***GRAND RAPIDS*:**
Old Firehouse #6
312 Grandville SE
Call the Anxiety Resource Center
(616) 356-1614
www.anxietyresourcecenter.org

Anxiety (all forms)
Meets every Wednesday, 7 to 8:30 p.m.
Open to individuals who have any kind of anxiety problems as well as their friends and family members.

Adults Obsessive-Compulsive Disorders
2nd and 4th Tuesdays, 7 to 8:30 p.m.
Open to any adults who have or think they may have Obsessive-Compulsive Disorder.
Friends and family members welcome.

Body Focused Repetitive Behaviors
1st Tuesday, 7 to 8:30 p.m.
A monthly support group for adults who have Compulsive Hair Pulling, Skin Picking and Nail Biting problems.
Open to friends and family members.

Compulsive Hoarding
3rd and 5th Tuesday, 7 to 8:30 p.m.
A monthly support group for people who have trouble with compulsive hoarding.
Open to friends and family members.

Social Outings
3rd Tuesday and 4th Saturday, call for details
Challenge your anxiety in the comfort of others while attending fun-filled events.
Past activities have included: game night, visiting a bird sanctuary, concert and comedy events, sunset strolls on the beach and even canoeing.

***LANSING*:**
3rd Monday, 7-8:30 PM
Delta Presbyterian Church
6100 W. Michigan
Call Jon at (517) 485-6653

***LAPEER*:**
2nd Wednesday, 7:30 - 9 PM
Meditation Self-Healing Center
244 Law St. (Corner of Law & Cedar Streets)
Call Mary at (810) 793-6544

***PETOSKY*:**
2nd Tuesday, 7-9 PM
Northern Michigan Regional Hospital
Community Health Education Center (CHEC)
360 Connable Avenue
Call Kevin P at (231) 838-9501
E-mail Runocd@gmail.com

***ROYAL OAK*:**
1st Wednesday, 7-9 PM
Beaumont Hospital, Administration Building
3601 W. Thirteen Mile Rd.
Use Staff Entrance off 13 Mile Rd.
Follow John R. Poole Drive to Administration Building
Park in the South Parking Deck
Meets in Private Dining Room
(If the building is locked, press the Security button next to the door, tell them you are there for a meeting, and they will buzz you in.)
Call Anu at (248) 835-3400
E-mail anuarumu@umich.edu

What is Acceptance and Commitment Therapy, What is its Effectiveness, and Should I Look Into It?

by Michael Twohig, Ph.D.

Michael P. Twohig, Ph.D. a licensed clinical psychologist in Utah and an assistant professor at Utah State University. He received his Ph.D. from the University of Nevada, Reno, and completed his clinical internship in the CBT track at the University of British Columbia. His research spans a variety of areas including the treatment of obsessive compulsive disorder and OC-spectrum disorders, substance use, mechanisms of action, and multicultural issues. He has published over 50 scholarly works including two books: An ACT-Enhanced Behavior Therapy approach to the Treatment of Trichotillomania (with Woods) and ACT Verbatim for Depression and Anxiety (with Hayes). His research is funded through multiple sources, including the NIMH.

What is Acceptance and Commitment Therapy for OCD?

Acceptance and Commitment Therapy (ACT, said as one word and not spelled out) is a form of Cognitive Behavioral Therapy (CBT) in the same way that Exposure and Ritual Prevention (ERP), Cognitive Therapy, and Dialectical Behavior Therapy are forms of CBT. All of these interventions share certain therapeutic or philosophical elements that put them under the CBT umbrella rather than other umbrellas (such as psychoanalysis or humanistic psychology, for example). Some of the defining elements of CBT interventions, including ACT, involve:

- Viewing behaviors as shapeable or changeable through environmental manipulations, rather than seeing behaviors as solely biological or neurological in nature, and thus responsive to psychotherapy;

- Focusing on the way the client interacts or responds to events (including thoughts and feelings) in his or her life rather than intrapsychic events, developmental milestones, or personality characteristics; and

- Testing the effectiveness of its interventions as well as the processes through which they work. There are some places, though, where ACT may be different than more commonly practiced forms of CBT. The most commonly used and supported forms of CBT for OCD are ERP and ERP with cognitive challenging (the term ERP will be used to cover both in this article). The ultimate goal of ERP is greater functioning of the client, and it appears that most ERP models focus on reducing obsessions and associated anxiety so that greater functioning can be achieved. Subjective Units of Discomfort (SUDS) scores are collected throughout therapy. Measures of OCD severity place equal emphasis on the frequency and severity of obsessions and compulsions. This focus is also evident in ERP where equal time is spent focusing on reducing obsessions and compulsions. ACT is purported to be different than ERP in that it focuses less on the reduction of inner experiences (such as obsessions) and more on altering the way they are experienced. ACT sees inner experiences, such as obsessions and anxiety, as part of our lives. Obsessions and anxiety are not inherently bad events, but they are treated that way by most of society. ACT focuses on finding a way to allow obsessions and anxiety to come and go without interfering with the way one lives his or her life. Thus, greater functioning can be achieved without a change in severity or frequency of obsessions or anxiety. This is a position that is shared with other forms of CBT, but possibly emphasized to a lesser extent.

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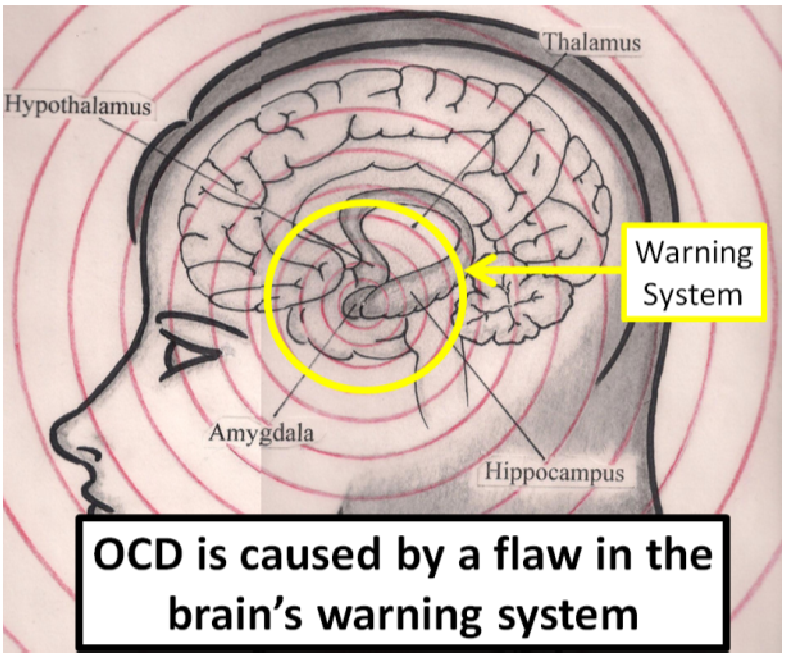
OCD: A Simple Explanation… Why It Happens and How We Get Rid of It

by Alan D. Carriero, MSW

I'm a therapist in Grand Rapids Michigan who specializes in the treatment of OCD and the OC Spectrum Disorders (Hair Pulling, Skin Picking, Body Dysmorphic Disorder, and others). I've had OCD since I was a teenager but thanks to exposure therapy, I defeated it over 25 years ago – it no longer runs my life! Yes!

I'm a strong believer in the idea that if we can maintain a clear and simple understanding of OCD and exposure therapy while we're fighting OCD, we can win the battle all the sooner. So, to help my private clients and the folks that attend the OCD support group that I facilitate at the Anxiety Resource Center in Grand Rapids, I condensed all I know about OCD into the three simple statements that you see below. I've found them to be very helpful. (You can learn more about me at ocdgrandrapids.com and about the Center at anxietyresourcecenter.org)



1. A flaw in the brain's warning system keeps sending **us false warnings** by repeating unrealistic thoughts and producing fear or discomfort.

2. Doing compulsions and avoidances tell the system, "This is a real problem. **Keep** warning **me** by making me feel frightened or uncomfortable whenever this situation occurs.

3. Refusing to do compulsions and avoidances tells the system, "This is *not* a real problem**. Stop sending me these false warnings!"** If we keep sending it *this* message, it will eventually stop sending us false warnings. The result: **You're OCD free!**

Illustration: Alan D. Carriero

Emotional Freedom Technique (EFT) Also referred to as "Tapping"

by Kay Zeaman

EFT is a popular healing technique that consists of tapping on the meridians (energy centers) of the body to restore energy balance, release negative emotions, and create lasting breakthroughs by rewiring your brain with positive affirmations.

Tapping, a combination of ancient Chinese acupressure and modern psychology is an integration of east and west medicine. It has been used to treat anxiety, PTSD, phobias, fibromyalgia, physical pain, addictions, weight loss, self-sabotage, procrastination, abuse, insomnia, stop smoking, and emphysema to name a few.

Tapping gives a way to disrupt the "fight or flight" response very quickly. It accesses the amygdala (the almond shaped part of the brain) to produce a neutral emotional state.

The first step is to rate your anxiety concerning the problem from 0 to 10.

Begin by tapping the outside edge of your hands (the karate chop points) while saying a positive affirmation three times such as "Even though I feel anxiety I deeply and completely accept myself"

Next begin tapping at the top of the head for 5-7 taps while saying a reminder phase such as "my anxiety is lessening."

Continue with each set of taps and repeat the reminder phase. Next with two fingers tap on the inner edge of each eyebrow. Continue tapping with two fingers on side of eyes, then tap under the eyes, under the nose, on the chin (between bottom of lower lip and chin), use four fingers below the hard ridge of the collarbone, then with four fingers tap four inches below each underarm, and lastly tap the side of both wrists together. Go through another round of tapping.

Then rate your level of anxiety again from 0 to 10. If the rate is higher than a "2", begin doing the tapping sequence again.

You want to achieve emotional wholeness and/or physical relief (create an energy change to a more positive flow and positive vibration).

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Emotional Freedom Technique (EFT)
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Recently, the Fifth Annual Tapping World Summit took place online from February 4-13, 2013. It was geared to professionals, but anyone interested to learn more about tapping would benefit from it. Access to the 10 videos was free to anyone who registered for it. You can get more information at www.tappingsolution.com. A documentary film entitled "The Tapping Solution" is available for purchase on that website. It depicts a four day tapping retreat attended by ten people. Nick Ortner, an EFT specialist, has a book coming out in April 2013 called *The Tapping Solution: A Revolutionary System for Stress-Free Living.*

Others books available about tapping are:

*Tapping Into Ultimate Success: How to Overcome any Obstacle and Skyrocket Your Results***,** by Jack Canfield and Paula Bruner, 2012

Using EFT Tapping to Release Anger, Heal Pain, Reduce Weight, Attract Abundance, Increase Confidence, by Ruthy Boehm, 2012

The Tapping Cure: A Revolutionary System for Rapid Relief from Phobias, Anxiety, PTSD, by Roberta Temes, PhD, 2006

Discover the Power of Meridian Tapping, by Dr. Patricia Carrington, 2010

Transform Your Emotions with Energy Tapping (EFT), by Cathy Vartuil and Rick Wilkes, 2011

Kay Zeaman is an OCDFM Board member who is always looking for interesting, alternative methods of addressing OCD.

Words of Wisdom

"If you wait for the perfect moment when all is safe and assured, it may never arrive. Mountains will not be climbed, races won, or lasting happiness achieved."

- Maurice Chevalier

Mindfulness and Acceptance
(Continued from page 1)

Exposure and Response Prevention (ERP) is still the core cognitive-behavioral treatment (CBT) of choice for OCD. The majority of sufferers will receive some benefit from ERP, even it is poorly done. However, significant benefit as opposed to some benefit is our treatment goal. Because of this, those who work with OCD are always looking for ways to improve treatment. For example, there has been a great deal of work during the past few years focusing on adapting cognitive techniques from the CBT arsenal to the treatment of OCD. With the growing research and press coverage on acceptance and mindfulness, it makes sense for us to shift our attention to their usefulness in the treatment of OCD.

The answer to the first question is easy: yes. As Hannan and Tolin (2005) point out in a recent book chapter, ERP is already an acceptance-based technique. How is this so? At our Center, we see intolerance of uncertainty as the core problem for most manifestations of OCD. With this in mind, the goal of treatment is to learn to live with uncertainty, that is, to learn to live and cope in a world where your worst fears might come true, i.e., that your house might burn down, that the world will always be dirty or that your loved ones might die. We define treatment readiness as being willing to learn how to accept living with uncertainty. We say learning, because if accepting uncertainty were a simple decision, then we would cure everyone in a single session. Acceptance of feared consequences is hard work, but this acceptance is critical if ERP is to commence. If the sufferer isn't willing to do this, then we won't begin the ERP part of treatment. To put it another way, how can someone get better if the goal isn't to get better?

Despite the fact that ERP is, by its nature, an acceptance-based procedure, further examination of acceptance and mindfulness provides us with an opportunity to improve and refine our use of these in ERP. Hopefully, this will result in better treatment and will, perhaps, help sufferers to choose the goals of treatment over suffering.

Having answered the first question and one-half of the second (what is the role of acceptance in the treatment of OCD), you may be wondering what acceptance is. Acceptance and its opposite, denial, are terms you often hear mental health professionals use, but you rarely hear them defined. Let us start with denial. You may have been accused of this or have heard about someone having lost a loved one and being in denial over the death. Have you ever considered how this is possible? A mourner accused of this might likely challenge us and reply that they aren't in denial, that they know that their loved one has died and isn't coming back. If they didn't know this, we would be talking about psychosis or a break with reality rather than denial. Denial occurs whenever the sufferer is comparing fantasy with reality. So in the case of someone who has lost a loved one, the statement of denial is: life would be better if my spouse were still here. There may be some truth to this. But this is a fantasy; it will never happen again. The problem with comparing fantasy with reality is that fantasy always wins, because we don't include problems or difficulties in denial fantasies. The two major problems with denial are that the fantasies won't or are unlikely to occur and they end up demeaning the present.

To see how this works, imagine the following scene: A man is sitting with his wife by a mountain lake in the Pocono Mountains at sunset. Then he thinks to himself: if we were rich right now, we could be sitting on the beach of a fabulous Caribbean resort, having waiters bring us rum punches at the snap of our fingers, while watching a spectacular sunset over the Atlantic. It's a nice fantasy, but in that moment he has now tarnished a real moment that he could have been sharing with his wife. And if a pleasant experience like this can be turned into sadness, think about how much worse a sad, anxious, or stressful time can be.

At our Center, we call the act of engaging in the denial, the wishing ritual. Like all OCD manifestations, people without OCD also use this. If you examine your own behavior you may recognize some of the following wishing ritual statements: "There should be an easier way to get over my OCD;" "I have to get rid of this image in my head;" "I can't live with this anxiety;" "If only my boyfriend would be nice to me all of the time." Can you identify the fantasy in each statement?

In the first, the sufferer is comparing the work of ERP to an easy imaginary treatment. In the second, the sufferer is comparing life with the image to life without it. The last two wishing statements aren't exclusive to OCD. In the first, the person is comparing their current life with anxiety to one without it. In the last, the lover is actually imagining a boyfriend who is a different person than the one she has.

In each of the above, the problem with giving up denial is that you have to suffer a loss. Treatment will be hard. You will

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have to use ERP to learn to live in peace with the image. You will have to coexist with the anxiety. And the lover will have to leave her boyfriend and find herself alone for an unknown amount of time. No one wants to have a loss. However, to stay in denial is to go in an endless circle of not confronting a problem and having it torture you forever.

Mourning is the process of moving from denial to acceptance. You can't do it instantly. For example, we noted above that for the death of a loved one, the statement of denial is that life would be better if your loved one were alive. If mourning takes place, you will still miss your loved one. But when you are engaged in some activity, you will enjoy that activity as opposed to thinking about how much better it could be. However, two weeks after losing your partner, no matter how self-aware you are, you will be in denial. You can't stay in denial forever, but there is an upper limit as to how fast you can mourn. Mourning is work.

To go through the work of mourning is to be able to live in the present. Think about someone you love. If they aren't with you at this moment, then they are no more than a memory and a hope, that is, a memory of the good times in the past and a hope that they will alive for the future. The only real time you have them is when you are with them. And, as you know, with OCD, you don't even have that. You are forever in OCD land, wishing your rituals could make the impossible true and that you could know something with absolute certainty.

The first steps of treatment is deciding that you want to learn acceptance. We believe that for most forms of OCD, the core is intolerance of uncertainty. Thus, your first goal needs to be wanting to learn how to live with uncertainty. Again, this is a process. You can't just decide that you accept uncertainty, you have to go through the work, the ERP. But if learning to live with uncertainty isn't your goal, then how can treatment work? Remember, the true reason you can't be certain is that for every logical answer, there is a "what if." It may be an unlikely "what if," but if you want absolute certainty, unlikely isn't good enough.

To decide to live with uncertainty means you want to learn to live in a world where your worst fears can come true: you may contract a horrible illness, you may cause the death of your family, you might run someone over and not know it, you may be gay, or you might go crazy. The reason for choosing this potentially scary vision is that there is no other; the alternatives are wishes and the problem is that you know this. That is why you go in endless circles. On the other hand, we know you can learn to live with uncertainty, because for all of the parts of your life your OCD doesn't focus upon, you do so. You get in a car, knowing it might crash; and if this isn't your OCD problem, your plan is to deal with it if the crash happens. You risk death just to see a movie! And if you look at the above feared consequences we raised, you know they are all possible, but you don't care about the ones that aren't your specific OCD fears. The goal of treatment is to help you treat your feared consequences like all of the disastrous consequences that you accept.

Before moving to the role of mindfulness in facilitating acceptance, we would like to suggest a way to encourage you to move towards acceptance, both of the possibility of facing feared consequences and of experiencing the sensations of anxiety that arise during treatment. Think about what you have lost to OCD, but do it in detail. Think about times you have humiliated yourself, about jobs and relationships that were lost, events that you missed. The more painful you can make this the better, because when you are confronted with having to accept the risk of uncertainty and the work of exposure, you will want to remember these to spur you on. In addition, think about the harm you have done to your families with your anger, your forcing them to ritualize, making your children late to events, questioning them endlessly, and whatever else you can think of. These are real. This pain can motivate you to accept the work of treatment, so that you can live without being ruled by OCD. Remember without acceptance, there is no hope of recovery.

In some ways, we have already provided you with the beginnings of a definition of mindfulness. It is living in the present and experiencing only the moment. More specifically, mindfulness means paying attention to the present moment on purpose and without judgment (Kabat-Zinn). Often the only thing wrong with the present is that our minds are elsewhere, worrying about the future in a "normal" way or in an OCD ritualistic way. Or we may even be thinking about something pleasant in the future. Either way, when we do this, we are not in the present. One problem people have when talking about mindfulness is that they assume mindfulness feels good and is pleasant. This isn't true. Mindfulness feels however the real present feels. If I'm sick, it won't feel good. If I'm in an OCD ritual and I'm feeling anxious, the rituals may be in my head, but the unpleasant physical sensations of anxiety are real. The present won't feel good.

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For many people, their willingness to learn to accept the possibility of their feared consequences is enough to enable them to go through treatment. However, there is another group of sufferers for whom this acceptance is not enough. They find themselves halted by the intense anxiety they feel during exposure. They will report that it feels like they can't stand another moment. Probably many of you have felt this way at one time or another. Imagine the worst time you have ever had. How would you feel, if at that moment, we could guarantee that it would only last for 10 more minutes?

Most sufferers report that they feel they could easily tolerate their anxiety if they knew it was only going to last for ten minutes. Think about what this means if you feel the same. In both situations, the first two minutes of the remaining ten minutes or ten hours of anxiety are the same. The reason is that your anxiety has two components: the present experience of uncomfortable sensations and thoughts, and the judgments about these sensations and thoughts. These judgments come swiftly and can often be difficult to tease apart from the present experience itself. They take the form of thoughts such as, "Oh, not again! What if this never ends? What if I'm really going to have a complete breakdown this time? There is no way I can tolerate these thoughts and feelings!" What mindfulness provides us with is a way to see clearly what we are experiencing in the present versus what we are adding to the experience by judging it. It helps us to tease apart what initially feels like an overwhelming wave of anxiety into present moment sensations (heart palpitations, sweating, etc.), present moment thoughts ("I'm shaking!", "I'm thinking about those violent thoughts."), and the judgmental thoughts about these experiences ("I should not have these thoughts," "Something bad is going to happen if I don't fix this."). In a mindful moment, we will drop the commentary about what we are experiencing and will instead simply notice what we are experiencing, whether this is pleasant or unpleasant.

The work of learning to do this involves practicing in both stressful and non-stressful times. Perhaps the most successful way of learning mindfulness in a non-stressful situation is practicing mindfulness meditation. Mindfulness meditation is not a technique used to relax anxiety away. Rather, the goal of this practice is to learn to focus on your physical and cognitive present without judgment. "What am I feeling now," as opposed to "Am I feeling what I am supposed to be feeling" or "This would be better if …" Learning to do this takes time and patience; practicing mindfulness through meditation during times that are not necessarily stressful allows you to be better prepared to apply mindfulness techniques during specifically anxious moments. You are not suppressing judgmental thoughts, but you are focusing your attention upon the present and allowing judgmental thoughts to be noise in the background in the same way you focus upon a conversation you are having in a restaurant despite the fact you can hear others talking.

The next step would involve setting up a small exposure and then using mindfulness to focus on all the physical and cognitive components of your anxiety without judgment. Again, this does not mean suppressing thoughts nor does it mean reasoning them away. More important, the goal is not to get rid of your anxiety. It is to learn to be able to stay with it and function with it. Imagine someone you loved needed you to rush him or her to the hospital in a life or death situation. We are assuming you would rather be in the middle of an OCD mess than in the actual emergency. However, in which one would you better cope with your anxiety? For most people, the answer is the emergency. They may feel anxious and panicked, but they allow those feelings and instead focus on the job at hand. If they are worried, it is about their loved one, not their feelings. You would actually cope better in the situation that you don't want to be in. This is because you are accepting your anxiety and functioning side by side with it rather than fighting it. The fact that you don't like it doesn't interfere. The practice of mindfulness will help you to become better able to do this in any given moment.

Coping with anxiety this way is not the same as saying just put up with your anxiety and suffer. Instead you are working on getting rid of another wishing ritual. In this case, you are accidentally saying that life without this anxiety would be better and as a result are comparing every moment to the fantasy moment in which anxiety doesn't exist. Remember, whenever you do this, you are making the present worse. By using mindfulness as a way to expose yourself to living with anxiety, your willingness to tolerate anxiety changes and your judgments change from "this is intolerable" to "I don't like this, but I can get through this and not have it control me."

In the end, all of us only have the present. Without acceptance, we are trapped in a fantasy world that ruins us. Mindfulness helps us to remain in the present and to experience it even when it is unpleasant. Initially, this sounds crazy, but the willingness to stay in the present allows us to cope with the moment rather than making it intolerable. Obviously a short article can't teach you all there is to know about these concepts or how to implement them. If it were that easy and involved so little work, all of you would have already done this. We do hope that the ideas we've presented to you will help to change the way you approach treatment, so that you can reach the goal of freeing yourself from the chains of OCD, enjoying the life you have and working to improve your life in all of the ways that will make it full.

This article appeared in the OC Foundation (now International OCD Foundation) Newsletter, Fall 2006.

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Individuals diagnosed with OCD or therapists who work with these clients may have a "negative" reaction to the idea of living with obsessions and anxiety. If you experienced the same reaction when you read the last paragraph, just notice that reaction and answer these questions:

- Has attempting to control or regulate obsessions and anxiety worked over the long-term?
- Has this lessened the obsessions and anxiety in a meaningful way?
- Finally, has your life become more open and fulfilling as a result of these attempts to regulate obsessions and anxiety?

If you answered "yes" to all of these questions, then keep doing what you are doing. Follow your experience; it is more honest than your mind. If you answered "no" and what you are doing is not lessening these obsessions, your life feels more restricted, and you are getting further from where you want to be, then some of the concepts from ACT might be useful for you.

One of the central concepts of ACT is that there is a big difference between what one thinks or feels and what one does. ACT is based on the model that the things people think and feel, or the bodily sensations that one has, are not under that person's control in any meaningful way. But, what a person does while thinking, feeling, or experiencing a sensation is under his or her control. To illustrate this, answer these two questions: 1) For $1,000, could you prevent yourself from having an obsession over the next 24 hours, and 2) For $1,000, could you stop yourself from engaging in your compulsion(s) over the next 24 hours? Most people would probably experience their obsession, but would find a way to avoid engaging in the compulsion(s). This exercise illustrates that while obsessions and compulsions often occur together, they are not technically tied to each other. We can experience obsessions and not engage in compulsions. Also, compulsions are much easier to control than obsessions. This is partially why ACT focuses on what one does and less so on what one thinks or feels.

People generally work to control obsessions and related anxiety because they are experienced as dangerous, threatening, uncomfortable, or some other "negative" evaluation. But there is another aspect to obsessions and anxiety that is overlooked—they are just thoughts in one's head and are feelings that one experiences. Humans are constantly thinking and feeling, but most of the time we do not grab on to any of these events. ACT aims to teach us ways to experience obsessions and anxiety as just thoughts and feelings that we may or may not respond to. When obsessions and anxiety are experienced in this way, it is much easier to respond flexibly to these experiences.

The focus of ACT for OCD is to help clients get to a place where they can openly experience thoughts, feelings, or bodily sensations, not be overly impacted by them, and continue to move in directions in life that are meaningful. The benefit of this approach is that a reduction in obsessions and anxiety is not necessary to begin changing one's actions. From the ACT point of view, the problem with OCD is not that obsessions and compulsions occur, but that every time an obsession occurs the compulsion follows. ACT aims to teach the flexibility to engage in an unlimited number of responses when the obsession is there. There is a way to keep working, play with the kids, eat dinner, talk with a friend, or engage in whatever the chosen activity is while experiencing the obsession. This involves experiencing obsessions for what they are (just words in one's head, and words are not dangerous), making room for them as just another experience, and moving forward in directions that are meaningful while the obsessions are there. If this is practiced enough, eventually it becomes easy, and the precise thought or feeling that shows up does not interfere with one's actions. There is a way to experience obsessions AND do what is important in life.

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Is ACT for OCD Effective?

The effectiveness of ACT for OCD has recently been tested in a large trial funded through the National Institute of Mental Health (Twohig et al., 2010). In this study, eight one-hour sessions of ACT for OCD with no in-session ERP were compared to Progressive Muscle Relaxation (PMR) with assessments taken at pre-treatment, post-treatment, and at a three month follow-up. PMR was viewed as a control condition in this experiment, so most of this review will focus on the results for the ACT condition. In this study, 79 adults (41 in the ACT condition) diagnosed with OCD were treated. All types of OCD were included in this study (hoarding, primary obsessions, checking, cleaning, etc.) and there were very few exclusion criteria, thus hopefully representing a fairly realistic sample of participants. The treatment was found to be highly acceptable. Only 12% of the sample in the ACT condition refused or dropped out, which is quite low for OCD treatment trials. All participants in the ACT condition rated the treatment as a 4 or greater on a 5 point scale, with 5 being the most positive score. These findings are meaningful because low drop-out and high acceptability are difficult to achieve in the treatment of OCD. ACT was more effective than PMR in the treatment of OCD, with clinically significant change in OCD severity occurring more in the ACT condition than PMR using multiple criteria and including all participants, even those who dropped out (clinical response rates: ACT post=46-56% and ACT follow-up 46-66% vs. PMR post=13%-18% and PMR follow-up 16-18%). ACT also had a greater effect on depression and resulted in greater improvements in quality of life than PMR. These findings are in addition to previous smaller studies showing that ACT's effectiveness for OCD (Twohig, Hayes, Mausda, 2006a), skin picking (Twohig, Hayes, Mausda, 2006a), and ACT plus habit reversal in the treatment of trichotillomania (hair pulling) (Twohig & Woods, 2004; Woods, Wetterneck, & Flessner, 2006).

Should I Look into ACT for OCD?

ACT for OCD is a newer treatment and the research is quite limited compared to the work that has been done on ERP and ERP with cognitive procedures (often referred to as CBT). ERP with or without cognitive procedures should be the first line of treatment someone seeks out. ACT procedures integrated into exposure therapy may be useful for people who are struggling with ERP. Finally, if exposure procedures are not useful, ACT may be considered as an alternative treatment. ACT is especially appropriate for people who have been unsuccessful at regulating or controlling obsessions and anxiety—especially after full trials of other treatments. It is also well-suited for people who are very tied into their obsessions and feel like they have very little control over their reactions to obsessions. There are a growing number of therapists who are trained in the use of ACT for OCD. If someone is interested in seeking out one of these therapists refer to the "Find an ACT Therapist" link at www.contextualpsychology.org.

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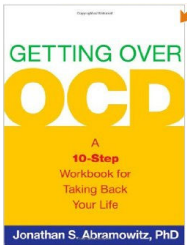
From The International OCD Foundation, ocfoundation.org/EO_what_is_act.aspx

SUGGESTED READING



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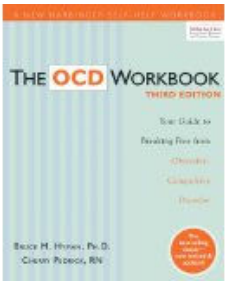
The Guilford Press, 2009
ISBN 978-1-59385-999-2



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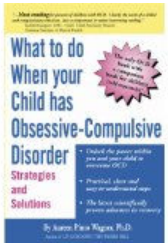

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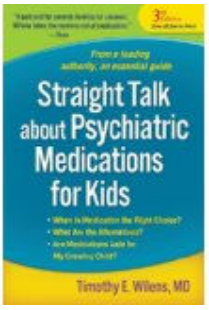

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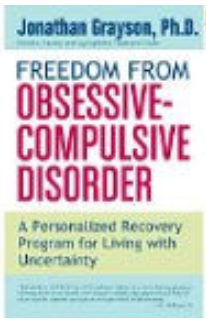

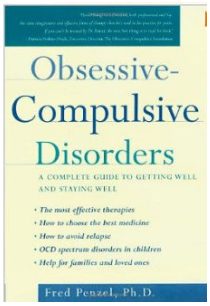

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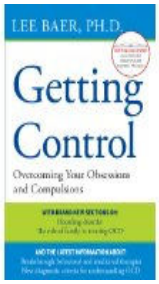

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(These books are all available from amazon.com)

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Know a Good Therapist??

Are you working with a therapist that you like, that knows a lot about OCD and how to treat it? Have you had good success with your treatment professional?

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The International OCD Foundation Annual Conference, July 19-21, 2013, in Atlanta, GA. Info at www.ocfoundation.org/conference

Help is Still Wanted

The OCD Foundation of Michigan is still looking for individuals who would like to serve on the Board of Directors. Have you ever felt the desire to help out your Foundation? Are you passionate about helping others with OCD? Have you been helped by the Foundation and want to give back? The commitment is small. The Board meets only once a month. Beyond that, you can put in only as much time as you wish. If you're interested, call (734) 466-3105 or e-mail OCDmich@aol.com.

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The OCD Foundation of Michigan
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- To recognize that Obsessive-Compulsive Disorder (OCD) is an anxiety-driven, neurobiobehavioral disorder that can be successfully treated.
- To offer a network of information, support, and education for people living with OCD, their families and friends, and the community.

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