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Systematic Review Article

The Role of Acceptance and Commitment Therapy in the Treatment of Obsessive-Compulsive Disorder

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Abstract:

This study focuses on the treatment of obsessive-compulsive disorder (OCD), and in particular the effect of Acceptance and Commitment Therapy (ACT) method will be examined. Obsessive-Compulsive Disorder (OCD) is a condition consisting of disturbing mental obsessions in which the person is excessively worried or unwanted thoughts or impulses are constantly repeated, and compulsions, which are repetitive behaviours to eliminate these obsessions. Compulsions manifest themselves as behaviours such as repeating certain rules, patterns or rituals, checking or cleaning a certain number of times. Individuals with OCD experience serious problems in their daily lives because of these thoughts and behaviours. Acceptance and Commitment Therapy (ACT) is a type of psychotherapy that focuses on the person's inner experiences as part of the cognitive behavioural therapy approach. ACT aims to help the person to accept disturbing thoughts, feelings and physical sensations quietly and with understanding, and to cope with them in a more flexible way. Research shows that ACT is effective in reducing OCD symptoms and is therefore considered as an effective therapy option in the treatment of OCD. Furthermore, it should focus on how the integration and combination of ACT with other treatment modalities can benefit in the field of OCD treatment. In this way, more effective and personalised methods can be developed in the treatment of OCD patients.

1. Introduction

Obsessive-Compulsive Disorder (OCD) is chronic in nature and has been resistant to improvement with conventional treatment. As such, there is a necessity to expand treatment options for OCD by exploring innovative approaches that are based on empirical data. Current research on the use of Acceptance and Commitment Therapy (ACT) with exposure and response prevention (EX/RP) for OCD has begun to show significant positive differences in clinical functioning [1]. The need to develop and investigate novel treatment modalities for OCD can be underscored by its burgeoning prevalence coupled with a poor prognosis and severely impaired functioning across multiple facets within an individual's life. Approximately 45% of patients suffering from OCD have significant impairment in social functionality, and research indicates that these disturbances in daily living are eminently significant within the concentric circles of occupational and daily life pursuits, family life, and the sociocultural context [2, 3]. These functional impairments of OCD persist across and even during periods of symptom remission through standard treatments. The entire objective of psychiatric care is to assist patients with mental disorders to triumph over their conditions. This essay critically examines the role of ACT in treating OCD [4]. Several aspects of ACT, such as its effectiveness in neurophysiological functions, psychoeducation, and long-term benefits in treating individuals affected by anxiety-related disorders and depressive conditions, spirituality and values with ACT's ability to adapt to various cultures, and contextual inquiry regarding ACT are explored. Furthermore, selected literature reviews are discussed [5-7].

2. Understanding Obsessive-Compulsive Disorder

Obsessive-Compulsive Disorder (OCD) is a severe, complex, and sometimes incapacitating disorder that has tremendous impacts on social and personal

functioning in those who suffer from it. Obsessions are recurring and forceful ideas, thoughts, or experiences that are emotionally disturbing and result in the person attempting to suppress or ignore them. Compulsions are the repetitive behaviours or mental activities that the person performs in a ritual fashion [8]. Most individuals suffering from OCD have both obsessions and compulsions, although some people only suffer from one or the other. Many individuals also have insight; they recognize that their fears are based on a perception of improbable threats, and their compulsive behaviours are an unreasonable response to the anxiety associated with the obsessions [9-11]. Individuals are diagnosed with OCD when they fulfil the diagnostic criteria by showing signs and symptoms for at least one hour a day or causing substantial distress or significant interference in functioning in areas such as work, relationships, and other aspects of life. OCD is often followed by other problems of anxiety and disposition and is commonly related to intense anxiety [12, 13]. On the neurobiological level, often the caudate nucleus of the brain is involved when it comes to a home stretch by the thalamus and frontal lobes [14]. In some instances, OCD is caused by infections such as streptococcal infections or other infections related to the bacteria found in dairy products [15-18].

2.1. Symptoms and Diagnosis

Obsessive-Compulsive Disorder is characterized by intrusive and distressing thoughts, images, or urges, along with overt or covert behaviours that are aimed at reducing this distress. Individuals with OCD may experience a significant amount of distress and impairment due to their symptoms [19, 20]. The specific type of obsessions and compulsions can be quite varied, but common obsessions include fears of contamination, fears of harming others, unwanted sexual thoughts, fears of going crazy or forgetting something important, or fears of making a mistake. Common compulsions, or compulsive behaviours and thoughts that are undertaken to reduce distress, include excessive cleaning or handwashing; checking of locks, stoves, and that one's actions have not harmed others; ordering or arranging; collecting; counting compulsions; repetitive requests for reassurance; and mental rituals aimed at reducing distress. Most individuals with OCD either have obsessions or compulsions that are not a concern for other medical or mental health professionals, or they do not have compulsions. In a few cases, the experience of distress related to their obsession is so intense that the link to the compulsion becomes somewhat irrelevant [21-23]. Individuals with OCD may suffer from a great deal of variability in the severity of their symptoms. About a quarter of adults with OCD experience symptoms that are "mild" in onset and relatively easy for the individual to control. About 40–60% of adults experience "moderate" levels of severity, while a quarter to a third are considered "severe." OCD symptomatology may also wax and wane over time and in severity, with some individuals in remission for many years while others report a chronic course of illness [24]. Individuals with mild to moderate levels of severity may work, receive an education up to and including two-year or four-year college degrees, and maintain relationships, while individuals with severe OCD will often be unable to work, maintain normal relationships, or keep engaged in society in an economically or academically productive way. Symptoms of OCD typically present initially in adolescence to early adulthood, and a peak age of symptom onset is in the early 20s. OCD is rarely diagnosed in the first decade of life [25]. OCD in prepubescent children often co-occurs with other externalizing and internalizing disorders, and distinguishing OCD symptoms from normal development or co-morbid psychiatric symptoms is complex. It is also rare to diagnose OCD over the age of 40 for various reasons, one of which is that our health care system struggles to identify late-onset OCD from early occurring dementia. The presence of tic disorders may be somewhat of a marker in understanding the utility of identifying adult-onset or late-onset symptoms [26]. A very small number of objective testing and personality assessment instruments have been developed to provide a diagnosis of OCD, but none are perfect or even clinically useful in some cases; the use of medical history interviews or the application of clinical desirability functioning assessments continue to be the most reliable way to identify OCD [27].

2.2. Prevalence and Impact

Prevalence

The prevalence of OCD in the general population is estimated to be 0.25-1% of community populations and between 1-4% in mental health settings. Some population-based studies found a prevalence of subclinical symptoms alone, with an incidence ranging from 8% to 42% in adult samples, and comorbid subclinical preoccupations and compulsions appearing in 64% of a population-based sample of children and adolescents [28, 29]. At the community level, OCD thus affects individuals across gender, age, ethnicity, and socioeconomic status, although some slight differences have been found prevalence rates are likely to be higher among individuals aged 18-44 and those with the lowest income level, although

such latter association may be due to higher levels of comorbid depression and tenuousness between manual categories of white-collar workers or unemployed [30-32].

Impact

It is well-documented that OCD has a range of negative impacts socially, occupationally, and from a psychological perspective. From a social perspective, an individual with OCD is more likely to have either never married or to be separated, widowed, or divorced [33]. They are also more likely to have no religion, and the life stage of parents was likely to be older than non-sufferers. The impact of OCD and other related disorders goes far beyond instrumental or economic burden, and there can also be an emotional or 'invisible' burden. Distributions which, although not related to direct economic disadvantage, accentuate stigma and lack of full social role functioning, might also contribute significantly to the human image of the overall burden of disorder. A chronic disorder with chronic sequelae may subject an individual to misunderstanding or not being taken seriously by others [34, 35]. In terms of economic impacts, patients with OCD are more likely to be receiving financial support, have less paid employment, and consequently have a lower income. Moreover, treatment fails in 40% of cases, and second-line interventions are also not cost-effective. It is widely recognized that effective psychological treatments are a vital part of clinical management to prevent further decompensation back to a full clinical episode of OCD [36]. However, such treatments can be very costly in terms of resources in both their delivery and training of practitioners. The average total treatment cost for a patient is found to be £2,000. Considering the economic burden and the prevalence of treatment failures, it is thus essential to establish alternatives [16, 37, 38].

3. Acceptance and Commitment Therapy (ACT)

Acceptance and Commitment Therapy (ACT) belongs to the group of the so-called "third wave" psychotherapies, which represent a recent, "modern" approach in the treatment of mental disorders. ACT derives from a psychological direction called contextual behavioural science. The therapeutic model is based on the relationship between language and cognition and emphasizes the importance of mindful observation and various aspects of cognitive and emotional processes, which also form part of the so-called "third wave" psychotherapies for the treatment of obsessive-compulsive disorder [39-41]. ACT primarily promotes and supports psychological flexibility—the skill and ability to engage in the present moment fully and completely while behaving in values-based ways. It focuses on changing individual patients' processes (rather than their content) and instead of changing the form or frequency of the inner experiences, it attempts to alter the relationship of individuals to their inner experiences through developing new ways of coping and tools for dealing with their internal, cognitive, and emotional events [42-44]. The avoidance of inner experiences is part of obsessive-compulsive disorder, and individuals frequently engage in various behaviours to suppress, avoid, fight, and/or neutralize their unwanted thoughts and feelings. The major goal of the contemporary ACT model is to encourage individuals to develop other ways of responding to inner experiences that would be more effective in breaking this chain of events and preventing the formation and maintenance of psychopathological clinical symptoms [7, 42, 45-47]. The ACT model brings mindfulness and acceptance ("allowing and letting be") into the current therapeutic context, and it supplements and enriches the predominantly cognitive-behavioural interventions and strategies used in the treatment of obsessive-compulsive disorder. A key concept of ACT also represents those interventions that are referred to as defusion [48-50].

3.1. Core Principles and Techniques

Surveys of experienced therapists reveal that the principles they consider critical for working with individuals experiencing OCD are present-moment awareness, cognitive defusion, and values and committed action. The results of these surveys indicate that the effectiveness of ACT in treating obsessions and compulsions may derive from the ways it teaches individuals to relate to their internal experiences [2,51,52]. These include (a) encouraging increased present-moment, non-judgmental awareness, (b) facilitating clear experiential distancing from negative thoughts, (c) reducing emotional reactivity to thoughts and feelings, and (d) refocusing attention and effort from controlling unwanted experiences towards deeply valued actions and ways of living [53-56]. Present-moment awareness mindfulness has been shown to be related to reductions in OCD symptoms. The tools of ACT can be used to facilitate present-moment external and internal awareness in a similar way to mindfulness training by escorting individuals into the present for acceptance and response prevention-related tasks, such as increasing emotional experiencing, exposure, and exercise relating to the 'what, not the 'why' of thoughts [56, 57]. ACT also uses value-based interventions and

psychoeducation. ACT accepts the clients' thoughts and their beliefs about their thoughts and seeks to address the unworkability of controlling thoughts and feelings. Cognitive defusion techniques can be helpful in this process [58-60]. The concept of cognitive defusion in ACT is seen as critical because individuals with OCD and scrupulosity may be significantly fused with their thoughts. Since many people are first receptive to ACT during a peak moment of their suffering, the present-moment technique can quickly communicate an 'experiential felt sense' of the therapeutic worldview impelling them towards change [61, 62]. The concepts of values and true self resonate with what clients generally want to experience. Although 'values' is a term from the ACT model, it is a word that conveys positive and meaningful things to clients. In a similar vein, many clients find 'non-resistance' to be an emotional 'hook' that releases a great deal of energy and motivation. The emphasis on obtaining experiential evidence also provides another verbal and experiential hook [7, 63].

4. Research Evidence on ACT for OCD

This body of research supports the assumption that Acceptance and Commitment Therapy is an effective treatment method in reducing the symptoms of obsessive-compulsive disorder. In sum, the outcome studies suggest that ACT with exposure shows significant reductions in the obsessive-compulsive symptoms [3, 64]. In the 14 identified outcome studies, no study was found reporting a decrease in the symptoms of OCD at post-treatment after the active treatment with Acceptance and Commitment Therapy, indicating the occurrence of positive results. The results of the seven highest quality studies indicate a significant treatment effect, which would support the hypothesis that Acceptance and Commitment Therapy with exposure is an effective adjunctive treatment for patients with severe OCD resistant to standard treatment. All studies except one do not include the assessment of the treatment effect in the longer term. The quality of these studies was variable and moderate, ranging between 5 and 8, with an average quality of 6.42, on a score normalized to 10 [65]. Four studies defined this effect in standardized mean differences ranging from 0.75 to 1.22 when compared to a waiting list condition. Considering these results in sum, they provide one way for estimating the treatment's effect size across studies. The qualitative analysis showed that these treatments are generally perceived as acceptable by patients with OCD when used in combination with behavioural exposure [66]. None of the studies provide rigorous or detailed descriptions of the potential mechanisms of action. According to these findings, more studies need to shed light on which ones are the potential valid mechanisms of action of Acceptance and Commitment Therapy for OCD. The short duration of follow-up after the end of treatment is also a potential limitation in our studies and needs further research on the effectiveness of the treatment [67]. Overall, the studies of moderate quality give an indication of sufficient evidence for the claim that Acceptance and Commitment Therapy is not inferior to the control condition in reducing OCD symptoms. In this manuscript, the magnitude of the treatment effect was calculated, following the methodology for combining the results from 14 studies [68, 69]. It is evident that the average reduction in the obsessive-compulsive symptoms in 1026 patients undergoing ACT was 1.02 when compared to certain control treatments. On average, ACT with exposure is a likely promising treatment for reducing the symptoms of OCD. Conversely, previously published reviews on ACT for OCD have shown preliminary positive results. However, they included a much smaller number of studies. That is why the severity of OCD can be improved by more research being performed and reported with higher quality measures. The potential outcomes of further research on Acceptance and Commitment treatment for obsessive-compulsive disorder are highlighted [70]. Given the chronic nature of illness and the disabling effects of treatment resistance in these patients, determining the medical, psychological, and behavioural consequences of Acceptance and Commitment Therapy adjunctive to behavioural exposure would provide important insights to help improve care for OCD patients. Three critical observations will be presented [71].

5. Challenges and Limitations of Using ACT in OCD Treatment

Despite potential advantages, the exercise of pursuing ACT for OCD should be undertaken with caution and is likely to be subject to several limitations. This will perhaps be particularly true because many patients prefer exposure-based methods to ACT. ACT is therefore likely to be 'rejected' by clients who do not have the necessary psychological flexibility required for them to experience symptoms in a different manner [72]. However, it also holds true that not all clients respond well to exposure or that changes may be necessary on occasion. In addition, although evidence indicates that, with increased pragmatic support, even lower routine use of ACT is acceptable, not all participants approve [73]. Therefore, given that many people experience little

or no improvement because of an ACT process and need a new approach or similar approach modifications, this is to be expected due to the reported potential heterogeneity of individual responses. The potential impact of therapist characteristics should not be overlooked either. Successful use of ACT is likely to necessitate some level of qualified competence in ACT, a kind of cohesive spiritual and emotional intelligence, and the bravery of a counsellor to provide therapeutic support for sufferers [74-76]. Other challenges to consider also include the availability of trained health professionals and therapist time. Clients and caregivers may also mistrust the strategy due to a lack of procedural or drug-based attention [77]. An ongoing transfer could point to an important area of study, as it should be important for the client to periodically reflect or re-evaluate on whether her lower ego dystonia is significant, and the counselor will need to formally consider the necessity of treatment [78, 79].

6. Conclusion and Future Directions

Acceptance and Commitment Therapy is an effective intervention for obsessive-compulsive disorder and is suitable for use in individual and group settings with adults and young people. It is a brief therapy, and the advantages of using ACT in its examined format include relevance to service users, a hands-on approach, and the appeal of case illustrations. Research into ACT has shown that it is effective in reducing OCD symptoms. ACT also appears to be effective in reducing the impact of OCD on individuals' lives. However, studies have been hampered overall by small sample sizes, and it would be beneficial if further research were to look at longer-term gains. This study has treated OCD with CBT using a single protocol of ACT to date, and hence the efficacy of combining ACT and a range of treatment modalities remains untested. It would also be useful to check on older people and those with psychotic symptoms [5, 7, 51, 64]. Research into the training, supervision, and support requirements of staff delivering ACT would also be useful. In conclusion, Acceptance and Commitment Therapy is an emerging third-wave therapy with evidence for reducing the impact of OCD. Several avenues have yet to be explored, and in the future, further research examining the impact of combining ACT is needed. Research examining the impact of using combined models, such as using ACT together with CBT in the same session, would also be beneficial [7, 80]. Further evidence is unlikely to be produced unless therapists and other professionals continue their training in ACT. Campaigning for support to facilitate the use of innovation in the National Health Service must continue as a process if therapists are to be skilled in such therapies and if service innovation in general would be encouraged.

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- **Ethical approval:** The conducted research is not related to either human or animal use.
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