ERP + ACT for OCD Treatment Manual

*Proposal Title*: Psychosocial Treatment of OCD

*Principal Investigator* (USU Faculty Member): Michael P. Twohig, Ph.D.

*Date of Online Submission*: 06/03/2011

Therapist Manual for Twice Weekly Acceptance and Commitment Therapy Model of Exposure and Response Prevention (ACT+ERP) Treatment of Obsessive-Compulsive Disorder

# To the Therapist...

This manual describes a cognitive-behavioral treatment program for obsessive-compulsive disorder that includes 16 treatment sessions delivered over the course of 7 and one half weeks. It includes therapist-supervised and self-controlled Exposure and Response prevention (ERP) infused with the principles of Acceptance and Commitment Therapy (ACT). Handouts and homework practice assignment forms are also included for copying and using with patients. The ERP treatment is similar to the cognitive-behavior therapy program described by Foa and Kozak (1997) and Abramowitz (2006). The ACT portions of the treatment were originated Hayes et al (1999) and described in manual form by Twohig et.al. (2010).

During the first week of treatment, three sessions are scheduled. It is preferable to schedule these on a Monday, Wednesday, and Friday. These initial meetings are devoted to gathering information and introducing the ACT and ERP concepts.

Following the three introductory sessions, exposure therapy sessions occur twice each week. It is preferable to schedule these sessions about two to three days apart (e.g., Monday and Thursday, Tuesday and Friday) so that intersession time is never prolonged. These sessions involve exposure and response prevention under the therapist’s direct supervision.

On each day that there is no therapy session, patients are assigned exposure homework for practice. Email exchanges between therapist and patient regarding these homework assignments are permitted, but not required.

Jonathan S. Abramowitz, Ph.D. and Michael P. Twohig, Ph.D

References

Abramowitz, J. S. (2006). Understanding and treating obsessive-compulsive disorder: A cognitive-behavioral approach. Mahwah, NJ: Lawrence Erlbaum Associates.

Foa, E. B., & Kozak, M. J. (1997). Mastery of obsessive-compulsive disorder: Client workbook. San Antonio, TX: The Psychological Corporation.

Foa, E. B., & Wilson, R., (1991). Stop obsessing! How to overcome your obsessions and compulsions. New York: Bantam.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York, NY US: Guilford Press.

Kozak, M. J., & Foa, E. B. (1997). Therapist guide to Mastery of obsessive-compulsive disorder: A cognitive-behavioral approach. San Antonio, TX: The Psychological Corporation.

Twohig, M. P., Hayes, S. C., Plumb, J. C., Pruitt, L. D., Collins, A. B., Hazlett-Stevens, H., & Woidneck, M. R. (2010). A randomized clinical trial of acceptance and commitment therapy versus progressive relaxation training for obsessive-compulsive disorder. *Journal of Consulting and Clinical Psychology*, *78*(5), 705-716. doi:10.1037/a0020508

**Major Components**

The training includes three major components: (a) data collection on the participant’s presentation of OCD; (b) introducing of ACT processes as applied to ones OCD; (c) in-session and instruction on between session exposure exercises incorporating ACT-based exercises. Treatment integrity is maintained by a structured and manualized treatment protocol that describes the specific goals and strategies. To maintain the integrity of the therapy, sessions will be video recorded, and the therapist will explain the purpose and protection of these recordings to Ps, who will be allowed to listen to them. Remember to turn the video recorder on at the beginning of each session.

**SESSION 1 (120 minutes)**

***Materials needed:***

* Information Gathering handout #1 (for therapist)
* Obsessive-Compulsive Disorder: Some Facts (for client)
* ACT+ERP self-monitoring form
* Appointment scheduling sheet-2 copies (for therapist and client)

Overview

The first session will cover these general components: description of OCD and rationale for treatment; informed consent; information gathering; increasing awareness of struggle with OCD symptoms; proposal of acceptance as an alternative to controlling the internal experiences associated with OCD symptoms; and introduction of an acceptance exercise. The therapist will need to be familiar with both ACT and ERP interventions and how these are applied to OCD. ACT is best thought of as a new context where inner experiences are not treated as events that have the ability to directly regulate actions. Therapists will need to be familiar with this therapeutic approach and have the ability to appropriately respond to statements by the Ps in an ACT-consistent manner. At the end of the session, patients are provided with a client manual repeating the contents of this session. This manual also contains information on the homework that will occur between sessions.

**Rationale**

The rationale for acceptance in the treatment of OCD is that the disorder is comprised of three parts: 1) the inner experience of obsessions (thoughts, feelings, and bodily sensation); 2) changes in behavior in response to these inner experiences such as compulsions, avoiding situations, “safety behaviors,” and other private attempts to regulate OCD-related inner experiences (self-soothing); and 3) negative effects on quality of life. It is assumed that regulation of inner experience is generally futile and attempts to do so only exacerbate the OCD and other problems in one’s life. Behaviors such as compulsions, avoidance, safety behavior, or self-soothing are controllable, it is thought that these attempts to regulate the OCD related inner experiences are more damaging to quality of life than the OCD-related inner experiences themselves. Thus, ACT focuses on decreasing attempts to regulate OCD related inner experiences and increasing behaviors that enrich quality of life.

**Informed Consent**

*Treatment will be confusing:* Describe to the Ps that this approach to treating OCD is somewhat contrary to what the Ps have likely been attempting at home. Most Ps come into the sessions hoping that the therapist has some way of making the OCD symptoms stop. That may be possible—but not in the way that the Ps assumes. The way out of OCD symptoms is unlike anything the Ps is familiar with, thus therapy is often experienced as confusing. Warn the Ps of this upfront so that the Ps will be more open to the confusion that is often experienced as a result of ACT. The Ps can also be informed that if the solution to OCD symptoms was more straightforward the Ps would have stopped them on his or her own and would not need therapy.

*Treatment will be difficult:* Describe to the participant that working out of OCD symptoms is likely difficult. There will be times in therapy where the Ps will feel anxious or uncomfortable or there will be times when the Ps is at home and does not feel like engaging in the exercises or doing other work associated with therapy. Tell the Ps that this is to be expected and is perfectly acceptable. Use the examples of therapy being like riding on a *rollercoaster* where there are high points and low points, enjoyable points and scary points. All these experiences are welcome and expected. Another way to describe therapy is to say that it can be like, “Cleaning out a *dirty glass with sludge* in the bottom: the only way to do it is to stir up the dirt.” Things in therapy may be cloudy or messy before they improve. Help the Ps see that this discomfort and confusion is an expected part of therapy.

**Commitment to All Sessions**

Finally, remind the Ps that because of the discomfort that occurs in this treatment, some Ps consider dropping out of therapy. Explain that this is a natural reaction and completely acceptable, but that if the Ps does not make it to the end of the sessions the Ps will never know if this approach is useful. Therefore, ask the Ps if he or she is willing to participate in all 16 sessions, and then decide at the end if it was useful or not. Request that they do not judge the treatment prematurely because it may take all 16 sessions to see the benefit.

OCD Information Gathering

Collect information about the patient's obsessive-compulsive symptoms using the guidelines provided below. Summarize the information on the “*Information Gathering: First Session*.”

*Indicate to the patient that you, as the therapist, need a detailed understanding of the symptoms so that you can individualize the therapy procedures for the patient.*

**Obsessions** (anxiety evoking material)

1. **External Cues**. Specifically elicit information about objects or situations which are sources of high anxiety or discomfort, such as urine, pesticides, locking a door, driving over bumps, hearing a certain word/sentence, etc.
2. **Internal Cues**. Inquire about thoughts, images or impulses that provoke anxiety, shame or disgust, such as images of Christ's penis, certain numbers, impulses to stab one's child, thoughts of being contaminated, thoughts of negligence about the gas burners being left on.

*Inquire about* ***bodily sensations*** *that disturb the patient, such as tachycardia, pains, swallowing.*

1. **Consequences of External and Internal Cues**. Elicit information about possible harm that can be caused by the external object or situation, e.g., disease from touching a contaminated object, burglary if a door is not properly locked.

*Elicit information about possible harm that the patient thinks can be c*aused by internal cues

1. **from thoughts, images or impulses**, e.g., "God will punish me”, or “I may actually stab my child".
2. **from bodily sensations**, e.g., "I'll lose control".
3. **from the long-term experience of high anxiety**, e.g., "This anxiety will never go away and I'll always be highly upset".

**Avoidance Patterns**

1. **Passive Avoidance**. Gather a list of all situations or objects that are avoided - e.g., using public bathrooms, stepping on brown spots on the sidewalk, carrying one's child on a concrete floor, driving. Attend to subtle avoidance practices, e.g., touching doorknobs on the least used surface, driving at times of least traffic.
2. **Rituals**. List all ritualistic behavior including washing, cleaning, checking, repeating an action, ordering objects, requesting reassurance, and cognitive rituals (such as praying, neutralizing thoughts, "good" numbers). Many patients exhibit more than one type of compulsion.

Pay attention to subtle rituals such as the use of "Handiwipes" or lotion to decontaminate hands: wiping is a short version of a washing ritual. Ask patients about behaviors they engage in which they consider to be different from what others do.

Also ask about mental ritualizing- repeating prayers or phrases to oneself, conjuring up a “good” image after seeing or picturing a “bad” one, or any a neutralizing thoughts that are purposely had to reduce distress.

**Relationship Between Avoidance Behaviors and Fear Cues**. Ascertain the functional relationship between the fear cues and the avoidances associated with them. Do the latter reduce anxiety/discomfort elicited by the former?

**Definition and ACT View of OCD**

Give patients the following ACT view of OCD making sure to include examples of the patients’ own repertoire:

“A good way to think about OCD is that it has three parts: First, there are the **inner experiences**—your obsessional thoughts about \_\_\_\_\_\_\_, feelings of anxiety doubt, uncertainty, and distress, and body sensations like sweating, a racing heart, and the like. Second, there are also **your** **attempts to get rid of these inner experiences**, such as your compulsive rituals like \_\_\_\_\_\_, your avoidance strategies such as \_\_\_\_\_\_\_\_\_, and other rituals like \_\_\_\_\_\_\_\_ that you use in response to your obsessional thoughts to try to get out of the anxiety and uncertainty. The third part of OCD is the **negative effects on your quality of life**, such as how your problems interfere with \_\_\_\_\_\_\_\_\_\_. Right now, most of your time is spent on the second part—trying to regulate or reduce the inner experiences of obsessional thoughts, emotions, and feelings. (*This can be illustrated by using one hand to represent the* OCD*-related inner experience and using the other had to represent the compulsions*)*.* In fact, it is this part of OCD that’s mainly causing the reduction in your quality of life. These attempts interfere with your daily routine. The inner experiences—obsessional thoughts, feelings, and anxiety-related body sensations alone don’t interfere with your quality of life.”

*If needed, give more examples of obsessions and compulsions from the patient’s own repertoire to show the relationship between the symptoms.*

*Ask for questions or if the patient needs clarification and then continue…*

“You already know how to control the avoidance and compulsive rituals, and it’s even possible for you to sometimes resist doing these behaviors, even though it might be hard for you. For example, you said that sometimes you’re able to (stop, delay, put off, not avoid \_\_\_\_\_\_\_ if \_\_\_\_\_\_. *Provide an example of a time when the patient was able to resist an avoidance or ritual behavior*). Right now, there is a balanced relationship between the severity of the obsessions and the frequency of the compulsions. But it’s a lot harder to control the inner experiences. So, in this therapy, we’ll be spending time focusing on ways to help you better handle the inner experiences. Specifically, we’ll be working to help you learn a new way to **relate to** these inner experiences that will make it easier for you to reduce the compulsive behavior and avoidance that gets in the way of your life.

*If the Ps has trouble following this rationale the therapist can use the example of trying to not feeling anxious singing the national anthem at a sporting event, versus not touching an object. Most people would feel uncontrollably anxious when singing, but can easily not touch an object. (Another option is to ask “for $1,000 can you not think of your obsession in the next minute versus not touching an object for a minute.”) The therapist then explains that one of these is an inner experience and the other is an overt behavior.*

Engage the patient in a discussion of this conceptualization to help them to understand. Ask for questions. Give the patient the “Obsessive-Compulsive Disorder: Some Facts” handout for the ACT+ERP condition for their future reading. Ask them to review it at home so that they become familiar with this conceptualization.

If the patient wants to know *why* they have OCD, explain that there are several theories about the origin of OCD, but that it is impossible to know for sure how and why it develops in individuals. It is probably a combination of many environmental and biological factors. The important part is that, luckily, our treatment does not depend on knowing what caused OCD. It depends completely on understanding the current obsessions and compulsions.

**Creative Hopelessness Exercise**

Creative hopelessness is a commonly used ACT exercise. The focus is to help the Ps understand that his attempts at controlling OCD-related inner experiences are by-and-large ineffective and may actually contribute to the overall problem. This phase is done as experientially as possible. The therapist should try to avoid teaching the Ps these things. The Ps should come to realize that her attempts at controlling her inner experiences are ineffective. Ps usually have a realization that what they have been doing to control the inner experience(s) does not work (and that maybe nothing will work). Often therapists make the common mistake of trying to teach this material rather than help the Ps realize it for himself. There are many examples of this exercise in most ACT books. It is suggested that the therapist read up on the use of this exercise.

There are three immediate goals for this exercise:

1. Help the Ps see that attempts at controlling OCD-related inner experiences work in the short-term.
2. Help the Ps see that these attempts do not work in the long-term.
3. Help the Ps see that these attempts may actually be more detrimental to the Ps’ quality of life than just having the OCD inner experiences.

Introduce the exercise as follows:

“So, let’s begin by examining the different strategies you’re using to try to control your OCD-related inner experiences, and how effective these strategies are.”

On a whiteboard write *“Can I control my OCD related inner experiences?”* and explain to the Ps that the two of you are going to make a list of all the ways that the Ps attempted to control her OCD-related inner experiences. Be very clear that you are talking about the OCD-related inner experiences (e.g., feelings of anxiety, obsessional thoughts and images, pounding heart, etc.). We are not referring to OCD, per se. We are just looking at whether the OCD-related inner experiences can be controlled.

Under the heading, “*Can I control my OCD related inner experiences?”* write down all of the Ps’ attempts that the patient and you generate together. Common ones include: avoiding situations, engaging in rituals, seeking re-assurance, mental strategies, praying, medications, etc. Usually Ps can make a list of between 10 and 20 attempts. Because time is limited, it is okay to make suggestions by saying things like, “A lot of people try this… do you?”

After the list is on the whiteboard ask the Ps, *“What do you think of this list?”* Usually there is some level of surprise at the amount of work that has been devoted to controlling these inner experiences. Let the Ps talk about his reaction to seeing the long list.

Ask the Ps, *“Which items on this list work really well in the short term? Which ones work well at controlling the obsessional thoughts and anxiety for a couple minutes or maybe an hour?”* In most cases about half of the items work well at controlling the inner experiences immediately.

Then move to, *“Which ones work well in the long term? For example, which ones work well for a month, or even a week?”* Most likely there are no items on the list that work for a duration of a week or a month. A statement such as, *“Hm. . .this is odd, wouldn’t you think that you would want a solution that works for an extended period of time? For example, if you had a leaky pipe in your basement you would want the plumber to fix it for 20 or 30 years not for a day or two. Are there any items up there that can fix this for a meaningful period of time?”* Most likely nothing on the board will work like that, otherwise the Ps would not need to participate in the study. Allow the Ps some time to discuss these findings.

Finally, ask the Ps, *“Do any of these items have a negative effect on your life?* Usually about half of the items on the list negatively affect the Ps’ quality of life. Rituals and avoidance of situations usually end up being quite problematic in the long run. Allow a couple minutes for the participant to discuss these issues.

This phase usually ends with a review of findings such as, *“It looks like these attempts work pretty well in the short term, are generally unhelpful in the long term, and at some level cause problems in your life.”*  Discuss these findings with the Ps. This needs to be done in a non-blaming way.

Once the Ps is in some level of agreement the therapist can transition into the *Man in the Hole Metaphor.*

**Man in the Hole Metaphor**

 Therapist: *Now, imagine that you’re placed in a field, wearing a blindfold, and you’re given a little bag of tools. You’re told that your job is to run around this field, blindfolded, and live your life. So you start running around, but sooner or later you fall into a big hole. Everyone has a hole—something that gets in the way of your life. Your hole is that you experience these OCD-related inner experiences—the intense obsessional thoughts, feelings of anxiety, doubts, and so on. Now, one tendency you might have would be to try and figure out how you got in the hole—exactly what path you followed. You might tell yourself, “I went to the left, and over a little hill, and then I fell in,” etc. In one sense, that may be true; you are in the hole because you walked exactly that way.*

 *However, knowing how you got into the hole in the first place is not necessarily the solution to knowing how to get out of the hole. And, even if you had not followed the path that led you to this particular hole, you might have fallen into another hole anyway because unbeknownst to you, in this field there are countless widely spaced, fairly deep holes. So for now you’re in this hole, blindfolded.*

 *Another thing you might do in such a predicament is to take the bag of tools you were given and try to get out of the hole. Now suppose that the tool you’ve been given is a shovel. So you start digging, but pretty soon you notice that you’re not out of the hole. So you try digging* ***faster****, or with* ***bigger*** *shovelfuls, or with a* ***different style****.* ***More****,* ***different****, and* ***better****. More, different, and better.* ***You are trying all these difference strategies that we have listed on the board.*** *(Compulsions are one way of digging, reassurance is another, and avoidance is another.)* *But all of that makes no difference, because digging is not the way out of the hole; it only makes the hole bigger. Pretty soon this hole is huge. It has multiple rooms, halls, and caverns. It is more and more elaborate. So maybe you stop for a while and try to put up with it. But it doesn't work—you are still in the hole.*

 *This is like what has happened with your OCD inner experience. It is bigger and bigger. It has become a central focus of your life. You know all this hasn’t worked. But what I’m saying is that it* ***can’t*** *work. You absolutely can't dig your way out of the hole. It's hopeless. That’s not to say that there is no way out of the hole. But within the system in which you have been working--no matter how hard you dig—there is no way out. The things you’ve taught yourself to do aren't working (although they may work perfectly well somewhere else). The problem is not in the tools; it’s in the situation in which you find yourself using them.*

 *Lots of people who come for treatment for their OCD simply want a gold-plated steam shovel from the therapist. But I can’t give it to you; and even if I could I wouldn’t because that’s not going to solve your problem. It'd only make it worse.”*

 *“So, your job right now is not to figure out how to get out of the hole. That is what you have been doing all along. Your job is to accept that you are in the hole. In the position you are in right now, even if you were given other things to do, it wouldn't work. The problem is not the tool—it is the agenda. It is digging. If you were given a ladder right now it wouldn’t do any good. You’d only try to dig with it. And ladders make terrible shovels.*

 *If you need to dig, you've got a perfectly good tool already. You can’t do anything else until you let go of the shovel and let go of digging as the agenda. You need to make room for something else in your hands. And that is a very difficult and bold thing to do. The shovel appears to be the only tool you have. Letting go of it seems as though it would doom you to stay in the hole forever. And I can’t really reassure you about that. Nothing I can say right now would help ease the difficulty of what you have to do here. Your best ally is your own pain from OCD, and the knowledge that none of the strategies you’ve tried using have worked very well. Have you suffered enough? Are you ready to give up and try something else?*

There is a multitude of responses that can occur to this metaphor such as, *“There must be something”* or, *“Maybe I have not tried enough.”* Therapists should read the writings on this metaphor to know how to respond to these types of statements. Generally, let the Ps’ experiences guide this phase. If the Ps thinks she can control the inner experience some other way, let her go home and try to do that. If the Ps thinks his methods work well sometimes, tell him that this training can be used in the situations where OCD can’t be controlled.

**Acceptance**

Like the other phases of treatment, there is a significant amount of writing on this technique. Therapists should read that material prior to seeing participants in this study.

This is a pretty easy transition from the *Man in the Hole* metaphor. The focus of this phase of the first session is to offer an alternative to controlling the inner experiences. Because the inner experiences cannot be controlled in a meaningful way, and because attempting to control them partly explains why the OCD-related inner experiences become a disorder, acceptance is offered as an alternative. The term “acceptance” is usually avoided in therapy because of its many existing connotations. Instead, terms such as “**willingness**” or “**openness**” are commonly used. It is explained in the following way.

**Two Scales Metaphor**

Therapist: *Imagine there are two scales, like the volume and balance knobs on a stereo. One is right out here in front of us and it is called ‘Anxiety- or* OCD*-related inner experiences’* [It may also help to move ones hand as if it is moving up and down a numerical scale]*. It can go from 0 to 10. In the posture you're in, what brought you in here was this: "This anxiety is too high. It's way up here and I want it down here and I want you, the therapist, to help me do that, please.” In other words you have been trying to pull the pointer down on this scale [the therapist can use the other hand to pull down unsuccessfully on the anxiety hand].*

*But now there's also another scale. It's been hidden. It is hard to see. This other scale can also go from 0 to 10* [move the other hand up and down behind your head so you can't see it]*. What we have been doing is gradually preparing the way so that we can see this other scale. We've been bringing it around to look at it* [move the other hand around in front]*. It is really the more important of the two, because it is this one that makes the difference and it is the only one that you can control. This second scale is called ‘Willingness’. It refers to how open you are to experiencing your own experience when you experience it—without trying to manipulate it, avoid it, escape it, change it, and so on. When anxiety of your* OCD *feelings is up here at 10, and you're trying hard to control this anxiety, make it go down, make it go away, then you're unwilling to feel this anxiety.*

*In other words, the Willingness scale is down at 0. But that is a terrible combination. It's like a ratchet or something. You know how a ratchet wrench works? When you have a ratchet set one way, no matter how you turn the handle on the wrench it can only tighten the bolt. It's like that. When anxiety is high and willingness is low, the ratchet is in and anxiety can't go down. That's because if you are really, really unwilling to have anxiety then anxiety is something to be anxious about. It's as if when anxiety is high, and willingness drops down, the anxiety kind of locks into place. You turn the ratchet and no matter what you do with that tool, it drives it in tighter. So, what we need to do in this therapy is shift our focus from the anxiety scale to the willingness scale. You've been trying to control Mr. Anxiety for a long time, and it just doesn't work. It's not that you weren't clever enough; it simply doesn't work.*

*Instead of doing that, we will turn our focus to the Willingness scale. Unlike the anxiety scale, which you can't move around at will, the willingness scale is something you can set anywhere. It is not a reaction—not a feeling or a thought—it is a choice. You've had it set low. You came in here with it set low—in fact, coming in here at all may initially have been a reflection of its low setting. What we need to do is set it high. If you do this, if you set willingness high, I can guarantee you what will happen to anxiety. You can hold me to this as a solemn promise. If you stop trying to control anxiety, your anxiety will be low ...[pause] or ... it will be high. I promise you! Swear. Hold me to it. And when it is low, it will be low, until it's not low and then it will be high. And when it is high it will be high until it isn't high anymore. Then it will be low again. ... I'm not teasing you. There just aren't good words for what it is like to have the willingness scale set high--these strange words are as close as I can get.*

*I can say one thing for sure, though, and your experience says the same thing—if you want to know for sure where the Anxiety scale will be, then there is something you can do. Just set willingness very, very low and sooner or later when anxiety starts up the ratchet will lock in and you will have plenty of anxiety. It will be very predictable. All in the name of getting it low. If you move the willingness scale up, then anxiety is free to move. Sometimes it will be low, and sometimes it will be high, and in both cases you will keep out of a useless and traumatic struggle that can only lead in one direction.*

Make sure the P is clear on what *willingness* is. Explain how therapy will help him or her increase willingness.

*“Willingness is a skill like playing a musical instrument, a sport, or riding a bike. It has to be learned. The exposure and response prevention techniques we’ll be using here are excellent ways to practice willingness, which is why they are so helpful in the treatment of OCD. I’ll also be giving you some other exercises to help you increase your willingness; such as the one we’re going to do next.*

**Rationale for Treatment**

Give the following rationale for treatment:

“The treatment we are about to begin is designed to help you develop a healthier and more effective way of relating to your obsessional thoughts and anxiety so that you feel like you have more options when it comes to engaging in the compulsion or not. Importantly, the goal is NOT to make the inner experiences go away, or to give you a more effective strategy for controlling these thoughts and fears. Rather, we will be working to help you connect with them in a way that will be more helpful for you in the long-run.

#### Tell patients it is important that they understand this explanation. Ask if they have any questions, or if you can clarify anything for them.

**Description of Treatment**

As you can probably see from our discussion, I am not too concerned that you are experiencing obsessions and associated anxiety. This just happens to be the hole that you fell into. I am more concerned with the relationship that you have with your obsessions and anxiety. It is like it is a bully at a school who just keeps bossing you around. I would like to spend time with you creating a new relationship with these obsessions and associated anxiety. Some of this will come from discussions that you and I will have, but most of it will come from work that we will do during the sessions and you do at home between sessions. This will involve coming into contact with things that evoke your obsessions, and then working on forming a new relationship with the thoughts, feelings, and emotions that come up. We don’t need the obsessions or anxiety to go away; we just need to renegotiate who is in charge of your life. I believe you are, but your obsessions also think they are in charge.

We will spend some time in the next couple sessions organizing these exercises, and then the final 14 or so session will really be spent interacting with your obsessions. We will only engage in exercises that you agree too. This is your treatment—not mine. There is no speedometer. We’ll get there at your pace.

Between-Session (Homework) Exercises

**Self-Monitoring of Rituals (15 min)**

##### Introduce the importance of self-monitoring rituals in the following way:

“It is very important for the treatment program that we have an accurate picture of your obsessive thinking and compulsive behavior. Part of what we are interested in is how much time you are spending on this, but we are also interested in what these rituals do for you and how they affect your life. It does not need to be filled out after every obsession. It just needs to be filled out a least a few times.”

“It is not easy to report accurately on OCD symptoms, so we’ll spend some time now and in the next session going over how to keep track of them. Here are some monitoring forms on which you will record your OCD-related inner experiences and your rituals.”

*Use two copies of "Self-Monitoring of Rituals in ACT+ERP". Present one copy of each to the patient and retain one for yourself. Specify on the patient's form which obsession(s) you want him/her to record. Go over the instruction form carefully with the patient. Practice with the patient by filling out the form with him/her using an "imaginary day" of his life.*

Scheduling of Future Sessions

Fill out the calendar for future sessions. Have a copy for both the therapist and the client.

**SESSION 2 (120 minutes)**

***Materials needed:***

* Information Gathering handout #2
* ACT+ERP self-monitoring form

**Focus of session:**

After a review of the homework from session 1, this session begins with going over the conceptual model of OCD and treatment rationale. A focus on acceptance of OCD-related inner experiences is also continued. Information gathering and development of the exposure treatment plan occur in this session, and ACT metaphors are woven into these activities. Defusion is introduced toward the end of the session, and related to doing exposure. Defusion, or separation from OCD-related inner experiences, generally results in greater acceptance of these types of inner experiences. The discussion about cognitive fusion will focus in particular on the patient’s anxiety and OCD-related cognitions.

**Review Reactions and Self-Monitoring from Last Session**

The session will start with a brief review and discussion of the self-monitoring form. Help the participant become more aware of their experiences from the last week. It is easy to get out of touch with one’s experiences and hopefully this form, mixed with the discussion from last week, helped the patient get more in touch with the effects of his or her compulsions. The main thing that should be pointed out to the patient is that engaging in the compulsion likely reduced the obsession, but that reduction was only felt for a brief period. In the instance where the patient did not engage in the compulsion the obsession likely stayed around for a while and maybe it was really problematic or it wasn’t. Either way, most patients report that they enjoyed not getting wrapped up in the compulsion. It feels freeing. Help the patient see that there are some positive aspects to not engaging in compulsions.

Therapists may need to explain the concept of willingness as Ps will have likely struggled with it. Therapists will also have to troubleshoot the acceptance exercise.

Again, the therapist needs to be familiar with concepts of acceptance, defusion, and ACT in general to respond to Ps’ questions and concerns.

**Discussing the Model of OCD**

*Ask patients if they have any questions about the**model of OCD discussed at the last session and described in the “Obsessive-Compulsive Disorder: Some Facts” handout. Answer any questions they might have and reinforce the model.* If the patient has no questions, ask them questions to assess their understanding of the model.

**Control as the Problem**

Control as the problem is a commonly used ACT exercise. Therapists can read about this series of exercises in most ACT books. The 1999 ACT book (Hayes, Strosahl, & Wilson, 1999) has a whole chapter on this phase of treatment.

Overall, the focus of this phase of the treatment is to help the Ps experience the utility and the need for acceptance in dealing with OCD symptoms. This phase has a series of experiential exercises that show how difficult and counterproductive it is to attempt to control OCD-related inner experiences. This is done experientially rather than didactically because it is assumed that experiential learning decreases the chances of the client becoming cognitively fused. The patient’s self-monitoring forms are used to provide examples of control as the problem.

**Introduction**

Therapist: *Last week we started to discuss how well attempting to control or regulate OCD-related inner experiences like obsessional thoughts and anxiety works. We found that, for you, strategies such as \_\_\_\_\_\_ (mention some of the patient’s rituals and avoidances) might work pretty well in the short term, but that they are not successful in the long term; and that these attempts may, themselves, be problematic. I certainly don’t blame you for doing what you have been doing. Frankly, you have been doing what any logical person should do. I want to spend a couple minutes today looking at how people get into the situation you are in and why it is so difficult to get out.*

**Control Usually Works**

A discussion on the usual utility of control should take place using the self-monitoring forms as a guide. The purpose is to help the Ps see that control can sometimes work in our lives, but usually not when applied to OCD-related internal experiences. An example of this dialogue is as follows:

Therapist (T): *Pick one of the situations on your self-monitoring form and walk me through what happened. Tell me about the situation you were in, the obsessional thoughts, level of anxiety, and the rituals or other things you did to control your obsessions.*

Patient (P): *Well, when I was about to leave the house, I started worrying that maybe I would leave the doors unlocked. So, I checked them all. Then, even when I was getting in my car, I had to go back to check again just to make sure they were locked from the outside. I guess knew they were locked, but I just had to make sure.*

T: *What do you think was the purpose of the checking?*

P: *To calm those uncomfortable doubts and anxiety that I get.*

T: *OK. I think I understand how that went.*

Make sure the patient understands. If not, use another example from the self-monitoring form to illustrate again. The general point is to remind the Ps of how the rituals are performed to regulate her OCD-related inner experiences.

T: *Right. You know how I was saying last time that most of what you have been doing is quite logical, sensible, and reasonable. The outcome isn’t maybe, but really it seems to me that you’ve done pretty much the normal thing. Remember the digging metaphor from last time? The rituals you kept track of on the forms—aren’t they just exaggerations of the kinds of things people do? Consider this as a possibility: It is similar because what you are doing is what we are all trained to do (check when in doubt, wash when dirty, etc.). It’s just that it doesn’t work here. Human language has given us a tremendous advantage as a species because it allows us to break things down into parts, to formulate a plan, to construct futures we have never experienced before, and to take action. And it works pretty well. If we look just at the 95% of our existence that involves what goes on outside the skin, it works great. Look at all the things the rest of the animal kingdom is dealing with and you’ll see we do pretty well. Just look around this room. Almost everything we see in here wouldn’t be here without human language and human rationality. The plastic chair. The lights. The heating duct. Our clothes. That computer. And so on. So we are warm, it won’t rain on us, we have light - with regard to the stuff non‑humans are struggling with, we pretty much have it made. You give a dog or a cat all this stuff - warmth, shelter, food, social simulation - and they are about as happy as they know to be.*

P: *What’s your point?*

T: *Well, I’m just saying that really, really important things - important to us as a species competing with other life forms on this planet - have been done with human language. There is an operating rule: if you don’t like something, figure out how to get rid of it, and do so. And that rule works great in 95% of our life. But not in the world inside the skin. That last 5%. It is a pretty important 5% because it is where satisfaction lies, but it is only a small proportion of our total lives. But suppose that same rule worked just terribly in that last 5%. In your experience, not in your logical mind, check and see if it isn’t so: in the world inside the skin, the rule actually is,* ***if you aren’t willing to have it, you’ve got it****.*

P: *If I’m not willing to have it, I’ve got it...*

T: *Weird, huh? Just to put a name on it, let me say it this way: in the outside world, conscious, deliberate, purposeful control works great. Figure out how to get rid of what we want to get rid of and do it. But in the areas of consciousness, history, self, emotions, thoughts, feelings, behavioral predispositions, memories, attitudes, bodily sensations, and so on, it often isn’t helpful. In these situations, control isn’t the solution, but the problem. If you try to avoid your own history and the feelings it evokes, you are in an unwinnable struggle. Dig, dig, dig. Let’s use some of the events from your life to see this.*

**Collecting Detailed Information about OCD Symptoms**

Elaborate on the information you have collected in the first session. Get the patient to tell you about *specific* situations, thoughts, or images which evoke discomfort or anxiety. This information will form the basis for generating the exposure treatment plan for the patient and therefore should be detailed. Read the examples provided for each section and use them as a guide. Record all information on Information Gathering Form 2.

As you collect and review the patient’s OCD information, use the ACT metaphors embedded in this section to reinforce the model of OCD and rationale for exposure therapy and response prevention. Weave these metaphors into the information-gathering. It is not necessary to use each of the metaphors below. Choose the metaphors that best fit with the P’s experience. Encourage them to engage in the discussion of the metaphor and apply it to their own experience.

**External Feared Situations**

*Drawing from the information you have collected, choose about 10 to 15 situations which evoke obsessional thoughts and anxiety. Use the following example to guide your inquiry. Examine the examples before proceeding.*

Examples:

1. Touching a person that has just come out of a public bathroom
2. Sitting on the toilet seat in a public bathroom
3. Touching one's own feces

**Fear Evoking Thoughts**

*Elicit specific details about thoughts and images, as well as the circumstances surrounding their evocation.*

Examples:

1. "I am afraid that in a state of sleep, at night, I will unwillingly go to the kitchen, take a knife and kill my baby"
2. "I am afraid that in a state of sleep I will go out the window in our apartment on the 17th floor and jump out and kill myself"

*The Jelly Donut Metaphor*

*Let’s look at your obsessional thoughts more carefully. Suppose I tell you right now that I don’t want you to think about... See? I can’t even tell you because you know what would happen. Well, OK. Let’s see. Don’t think of... warm jelly donuts. Don’t think of them. Don’t think of how they smell when they first come out of the oven. Don’t think of that! The taste of the jelly when you bite into the donut as the jelly squishes out the opposite side into your lap through the wax paper. Don’t think of that! And the white flaky frosting on the top of the round, soft shape? DON’T THINK ABOUT ANY OF THIS!*

For Ps with OCD, this issue should be related to the struggle with their obsessional thoughts, doubts, images, etc. (for example, ask, “What do you think this has to do with your obsessional thoughts?). What their mind tells them is that they should make these thoughts go away; and if they cannot, they will always have OCD. But, of course, it’s impossible. The act of trying NOT to think of an obsession usually makes the obsession stronger.

Ask the Ps whether this strategy has worked. They will usually say that it has worked in a limited sense. However, it has not worked in a real, lasting, fundamental sense, or else the Ps would not be in treatment. It is important to validate the incredible effort the client has invested in controlling urges.

The therapist should also explore the Ps’ actual experience with attempting to regulate these inner experiences to see if trying to regulate them may actually be negatively affecting their lives. The therapist need not insist that this is so. Tentativeness creates less resistance. We might say something like: “Is it possible that this is so?” We also point out that in other areas of their life where they have invested this much effort they have succeeded in making fundamental changes. We ask if it is a bit fishy that this does not seem to have worked out here. Another way to introduce the possibility is to ask the Ps the following:

T: *Does your struggle with your obsessional thoughts seem like it has gotten easier over the last 5-10 years, or more difficult?*

P: *It is a full time job trying to control them.*

T: *How good a job are you doing? Have you gotten better at it or are you finding that you need to work more and more?*

P: *I am not getting any better.*

T: *Are you getting tired and worn out from all this work?*

P: *Yes. Definitely!*

Ps will certainly have his/her own experience. It is important that they make contact with the paradox of control efforts in his/her experience, rather than as a compellingly logical argument. The Ps know quite well that emotional control and avoidance haven’t worked. What Ps have usually not faced is that it can’t work. These various metaphors expose the client to the fundamental unworkability of this system of deliberate, conscious, purposeful (i.e., verbally regulated) control as applied to private events.

 Finally, make sure to tie this back to doing exposure, particularly imaginal exposure. Rather than trying to suppress or control these obsessional thoughts, the patient, through exposure practice, will learn a new way to relate to these thoughts (acceptance), that will be more helpful than trying to fight or resist them. For example, as the patient, “If trying to get rid of these kinds of thoughts isn’t the answer, if that’s only making the OCD worse, what might be a better strategy? What about doing the opposite? What about allowing them to hang out in your brain and learning to relate with these thoughts in a new way?”

**Fear of Bodily Sensations**

*Explore whether patient has fears of body sensations.*

Examples:

1. "Each brown spot on my skin terrifies me (because I think it is skin cancer)."

-Small Spot

-Large Spot

1. When I swallow, I am very aware of my throat and it upsets me (because I'm afraid I'll choke to death)."

*“If you aren’t willing to have it, you’ve got it” Metaphor*

This metaphor is useful with anxiety over unwanted anxiety-related body sensations as well as with unwanted thoughts and other private experiences. The point is that the very act of not wanting to experience something will make you experience it. So, some patients try to hijack this and superficially decide that they *are* willing to have these inner experiences **so that** they won’t have them. But being willing to have an inner experience *just so that you won’t have it* is the same as resisting it (or not really being willing to have it). This metaphor helps patients understand that OCD is smarter than this.

T: *Think about this paradox: “if you are not willing to have it, you’ve got it.” As soon as we tell ourselves that we don’t want to feel a certain way or think a certain thought, we often end up with the feeling or the thought. That’s just how the mind and body work. Now, what could you do with this knowledge? Now let’s see ... “ah, I want to get rid of it, but if you are not willing to have it, you’ve got it. So, therefore, if I am willing to have it, I’ll get rid of it! That’s it! If I am willing to have it, I’ll get rid of it! But if I am willing to have it in order to get rid of it, then I’m not really willing to have it and have it again.” So you can’t trick yourself. “If you are not willing to have it, you’ve got it” can’t be used for the old agenda. You can’t dig with it ... or at least if you do, nothing positive or different will happen.*

It is important to help the patient relate this back to doing exposures, the point of which is to learn to truly be willing to “have the OCD-related inner experiences” over and over, again and again.

**Consequences**

*Record all harm anticipated by patients if they refrain from ritualizing.*

Examples:

1. "If I don't check the stove before I leave, the burners might be on and my home will catch on fire."
2. "If I don't check before I go to bed, then my house will catch fire, my wife and children might suffocate."
3. "If I don't wash my hands thoroughly after using the bathroom, I might get sick."
4. "If I don't wash my hands after using "Endust", I may poison my children."

**Harm from Long-Term Anxiety**

Examples:

1. "I am afraid that if I don't wash, I will get more and more anxious until I'll go crazy".
2. "I am afraid that if I stop checking, I'll be so nervous that I won't be able to do my job and will be fired."

*Chessboard Metaphor*

This exercise helps the Ps see that she is not her inner experiences—specifically the obsessional thoughts and fears of disastrous consequences—and that these experiences occur within her but do not define her. Some transition will be necessary between these two exercises. Saying something like, “*Here is another way to look at thinking,”* can help make the transition smoother.

Therapist: *A chess board is covered with two different colored pieces, black pieces and white pieces. They work together in teams: the white pieces fight against the black pieces and vice versa. You can think of your thoughts and feelings and beliefs as these pieces; they hang out together in teams. For example, “bad” feelings like anxiety and obsessions hang out on one side with “bad” thoughts, such as “I might hurt someone” or “I may be contaminated”, and “bad” memories, such as the memory of your OCD symptoms. We’ll call this “team one”. The “good” pieces (e.g., thoughts expressing confidence that compulsions will not occur, feelings of being in control or relaxed, etc.) hang out on the other side of the board. We’ll call this team “team two”. It seems that the way to win this game is to choose a side we want to win. So, when the knight of the anxiety team attacks, we get up on the back of the other queen, ride to battle, and try to knock the knight out by doing or thinking something to defeat the knight.*

*The problem is that when you become invested in a particular side winning, huge portions of yourself become your enemy. Because in this game, the two opposing teams are really one team: YOU. When you are unwilling to have certain pieces, such as certain physical sensations or bothersome thoughts about the sensations, it is like you are one of the players leading your side into battle trying to defeat the other side by knocking them off the board. As a player with an investment in who wins, it seems logical that if you knock enough of them off the board, that you will eventually dominate over them and win this game. But has that been your experience? Or has it been your experience that the more invested you have become in defeating team one, the more the members of that team take on a central, dominating role in your life? When you take on the role of a player invested in a side, you have no choice but to take up this battle—a battle that can’t be won.*

*Now suppose that you are not the pieces, but instead you are the board. Notice that without the board, these pieces have no place to be. The board holds the pieces. For instance, what would happen to your thoughts if you weren’t there to notice them? The pieces can’t exist without you – but you contain them, they don’t contain you. Notice that if you’re the pieces, the game is very important; you’ve got to win, your life depends on it. But if you’re the board, it doesn’t matter whether the battle stops or not. It makes no difference to the board. As the board, you can see all the pieces, you can hold them, you are in intimate contact with them; you can watch the war being played out in your consciousness, but it does not matter what happens. It takes no effort.*

Some familiarity with this exercise is needed because a number of responses can occur. Commonly Ps will be a little confused and ask if they can really just let the thoughts and feelings occur and not do anything about it. It is important in ACT to not try and convince the Ps of these concepts. They will fit as well as they fit. If the Ps begins questioning whether it is possible to really do nothing about the inner experiences, offer up the other option. Say something like, *We could continue to try and regulate them, but where has that got you? Do you really feel like you are making progress and your life is getting richer? Maybe it is time to try taking a different stance to these inner experiences.*

**Passive Avoidance Behavior**

*Specify 10 to 15 situations the patient avoids because of his/her fears.*

Examples:

1. "I don't use public bathrooms."
2. "I don't let my family eat at home, since it might attract ants."
3. "I don't use my stove to make sure it doesn't get left on."

**Rituals**

*Specify daily routine with each ritual.*

Example:

1. "I get up in the morning and I first use the toilet. Then I clean the toilet and every place around it, just in case some water splashed. I then wash my hands thoroughly up to the elbows. Then I clean the shower and the faucets so I can take a shower in a clean bathroom".

**Defusion and Values Work**

**Passengers on the Bus**

After collecting all this information on the patient’s triggers, the patient is ready to set up her exposure exercises. But to give purpose and meaning to these exercises we will use the example of the patient being the driver of a bus and the passengers being her OCD-related thoughts and feelings. The purpose of this exercise is twofold: 1) to help the patient see her thoughts, feelings, and bodily sensations as just passengers on the bus along for the ride, and 2) to help the patient think about what direction the bus is going in.

Defusion is about seeing thinking as an ongoing process that is neither right or wrong. The poser of thoughts should be based on their utility if followed. Defusion teaches a discrimination between thoughts that are worth following and ones that are not. Help the patient see that the passengers are allowed to yell all the way, and it is up to the driver to listen or not.

Values involve closing which directions one wants to take life. Again, there is no right or wrong direction but the important part is that the patient gets to choose. For most people with OCD, they have not been choosing the direction of life but instead letting their obsessions choose the direction their life goes. Hopefully, this little exercise helps the patient see that she is the driver of the bus and gets to choose where it goes.

**Exercise**

“It’s as if there is a bus and you’re the driver. On this bus we’ve got a bunch of passengers. The passengers are obsessions, feelings, bodily states, worries, and other aspects of your OCD. Some of them are scary, and they’re dressed up in black leather jackets and they’ve got switchblade knives. What happens is, you’re driving along and the passengers start threatening you, telling you what you have to do, where you have to go. “You’ve got to turn left,” “you’ve got to go right,” etc. The threat that they have over you is that, if you don’t do what they say, they’re going to come up from the back of the bus.

 It’s as if you’ve made deals with these passengers, and the deal is, “You sit in the back of the bus and scrunch down so that I can’t see you very often, and I’ll do what you say, pretty much.” Now what if one day you get tired of that and say, “I don’t like this! I’m going to throw those people off the bus!” You stop the bus, and you go back to deal with the mean-looking passengers. Except you notice that the very first thing you had to do was stop. Notice now, you’re not driving anywhere, you’re just dealing with these passengers. And plus, they’re real strong. They don’t intend to leave and you wrestle with them, but it just doesn’t turn out very successfully. “Does this match up with your struggle with your obsessions?”

 Eventually you go back to placating the passengers, to try and get them to sit way in the back again where you can’t see them. The problem with that deal is that, in exchange, you do what they ask in exchange for getting them out of your life. Pretty soon, they don’t even have to tell you, “Turn left”--you know as soon as you get near a left-turn the passengers are going to crawl all over you. Eventually you may get good enough that you can almost pretend that they’re not on the bus at all. You just tell yourself that left is the only direction you want to turn. However, when they eventually do show up, it’s with the added power of the deals that you’ve made with them in the past.

 Now the trick about the whole thing is this: The power that the passengers have over you is 100% based on this: “If you don’t do what we say, we’re coming up and we’re making you look at us.” That’s it. It’s true that when they come up they look like they could do a whole lot more. They’ve got knives, chains, etc. It looks like you could be destroyed. The deal you make is to do what they say so they won’t come up and stand next to you and make you look at them. The driver (you) has control of the bus, but you trade off the control in these secret deals with the passengers. In other words, by trying to get control, you’ve actually given up control! Now notice that, even though your passengers claim they can destroy you if you don’t turn left, it has never actually happened. These passengers can’t make you do something against your will.

The therapist can continue to allude to the bus metaphor throughout deliteralization work. Questions such as, “Which passenger is threatening you now?” can help re-orient the client who is practicing emotional avoidance in session.

 The bus metaphor casts the relationship between a person and thoughts or feelings the way one might cast a social relationship between a person and bullies. This reframe is useful in motivating the patient in seeking freedom from literal language.

* This exercise also sets up exposure work nicely.
* The patient and the therapist can talk about where they would like the bus to be going.
* Exposure exercises, in session and outside, can be used as opportunities to practice driving the bus in the valued direction while allowing the passengers on the bus to yell at the patient.

Generating the Exposure Treatment Plan

*On the basis of the information collected previously, develop a treatment program with the patient. Use the following guidelines:*

**Rules for Selection of Exposure Situations**

Items chosen for exposure (i.e., items or situations or thoughts evoking OCD-related inner discomfort and urges to ritualize) are selected strictly according to patients' report of their discomfort-evoking capacity.

All designated items are arranged hierarchically according distress levels evoked and are presented in ascending order beginning midway. That is, if the top item evokes high distress, a mid distressing item is presented first. Map out the exposures to be practiced at each of the twice-weekly exposure sessions.

Most items should be done first during the office visits (with the therapist), and then practiced for self-exposure.

The most disturbing items should be confronted toward the middle of the treatment, leaving plenty of time for repetitions with minor variations, focusing on those that provoke the most discomfort.

Should some items have been inadvertently omitted previously, they will be incorporated in the remaining sessions.

Exposure to an item may be omitted when it evokes minimal or no discomfort for two successive days.

Study the following examples of in *vivo* exposure to select appropriate exposure items for each session.

Notice that self-exposure practices generally mirror the exposure conducted in session that day, with the patient conducting the exposure in his/her own environment, as opposed to in the therapist’s office.

1. Example for Washer:

The patient, Steve, felt contaminated by feces, urine, sweat and contact with others. He feared contracting a debilitating disease. Each treatment session included exposure to contaminants.

The following hierarchy was constructed for Steve:

1. doorknobs
2. newspapers
3. sweat
4. toilet seats in public bathrooms
5. urine
6. feces

These items all have in common the ability to cause disease.

1. During in *vivo* exposure treatment, the following sequence was pursued:

Session 1 - Steve walked with the therapist through the building touching doorknobs, especially those of the public restrooms, holding each for a period of several minutes. He also held newspapers left behind by people in the waiting room. Between sessions, he practiced with doorknobs at other public places that he frequently avoided (e.g., work, restaurants, bus station).

Session 2 - Steve held newspapers and doorknobs. Contact with sweat was introduced by having him place one hand under his arm and the other inside his shoe. After the session, Steve practiced carrying a dirty sock with him in his pocket and contaminated his hands before eating.

Session 3 - Exposure began with newspapers and sweat. Toilet seats were added by having the patient sit next to the toilet and place his hand on the seat. For home practice, Steve was instructed to sit on a public toilet at various places he had been avoiding.

Session 4 - Exposure began with contact with sweat and toilet seats. Urine was then introduced by having Steve hold a paper towel dampened in his own urine specimen collected that morning. Between sessions, Steve carried the paper towel with him in his pocket each day.

Session 5 - Exposure included urine, toilet seats and sweat with the addition of fecal material (a piece of toilet paper lightly soiled with his own fecal material). Homework practice focused on feces, urine and toilet seats.

Sessions 6 to 15 - Daily exposure to the three items which provoked the greatest discomfort was continued. Self-exposure practice focused on the objects used during that day's treatment session. Weekend practice mirrored Friday's exposure. Periodic contact with lesser contaminants was continued throughout.

1. Example for Checker:

The patient, Mike, feared harming others when driving his car by failing to check appliances, locks, lights, etc., at home. He worried about flushing insects down the toilet and killing them and particularly about his four-year-old daughter, fearing that he would drop her on a concrete floor or that she would fall downstairs. To prevent these catastrophes, Mike checked repeatedly.

Mike's hierarchy was as follows:

1. turn lights and stove on or off without checking
2. opening windows without checking
3. flushing toilet with cover closed
4. daughter playing near open basement gate
5. carrying daughter on concrete floors
6. driving on highways without retracing route
7. Exposure in *vivo* was conducted in the patient's home as follows:

Session 1 - Mike was required to turn the lights on and off once, to turn the stove on and off once, and to open and close doors and windows once. After each action he was required to leave the room immediately and focus his attention on his failure to check these objects. This procedure was repeated throughout the session using different switches and windows. For further practice between sessions, Mike conducted these exposures by himself.

Session 2 - Exposure to situations from Session 1 was repeated with the addition of repeated flushing of the toilet without looking into the toilet bowl.

Session 3 - Exposure to above situations was continued. In addition, Mike was instructed to open the gate to the basement and allow his four-year-old daughter to play near the gate without his supervision.

Session 4 - Mike was exposed to all situations presented on the previous day with the addition of carrying his daughter across the concrete floor.

Session 5 - After initial exposure to previous situations, Mike was instructed to drive alone on the highway without retracing his route. He reported to the therapist every 20 minutes.

Sessions 6 to 15 - Exposure of all of the above situations under various conditions was continued with particular emphasis on the most difficult items. He practiced on his own daily with situations which were introduced during the treatment sessions.

1. For Imaginal Exposure:

Imaginal exposure will involve the patient vividly imagining intrusive upsetting thoughts, the feared consequences of exposure, and situations that evoke their urges to perform rituals.

Six scenes of gradually increasing anxiety evoking potential are prepared in advance of treatment. Each script should create a vivid imaginal picture for the patient with more severe concerns and feared consequences being included in later images. Generally, the greater the detail of these images, the more effective they are in evoking the desired result. Equal emphasis should be placed on including external/situational stimuli and internal/cognitive or physiological responses in the feared scene.

Agreement on the Exposure Plan

Establishing an agreement between patient and therapist is particularly important for this therapy since the patient will be conducting many exposure practices on their own. Describe the rules for treatment to the patient as follows:

*"OK, now I want to discuss our plan for the next several weeks of therapy- beginning with our next visit. As I told you before, we will practice a healthier way of relating to the OCD-related inner experiences (doubts, obsessional thoughts, urges to ritualize, anxiety, etc.) and the situations that evoke these inner experiences. In order to practice, we will be confronting situations that trigger the inner experiences and urges to do compulsive rituals, and to practice the material we are working on in session.*

“I will help you to expose yourself to the situations we planned for each day. When you are here at the office, I will be there to help you, but we will also plan situations for you to practice when at home, on your own or with the help of a family member or friend.”

“You should expect that doing this work will be hard and will sometimes not go how you want. That is Ok. We will work through these situations together and figure it out. Hopefully, interacting with your obsessions and associated anxiety will help you figure out how to live with these events in a way that is much easier for you. When doing this work, we will start with less distressing exposure items and work our way up to the more challenging ones. I won't ever force you to expose yourself to these situations. Everything you do is your choice. Remember, I will be there with you.”

“Besides the exposures, starting at the next session, we will also work on planning for you to decrease your rituals in order to learn how to connect with the anxiety.”

“At our next meeting, I will teach you how to do exposure and response prevention. We will spend a lot of time working on this and will begin with *[the easiest items on the exposure hierarchy]*. Think of me as your coach- someone you will rely on for tips and suggestions about how to overcome OCD.”

***Some ACT thoughts on willingness and exposure***

## Willingness Has an All or Nothing Quality

 The client may begin to promote the idea that willingness can be achieved via sequential steps. Willingness is not measured by the magnitude of the situation the client tackles; it is a “whole act”. As the Zen saying goes, “You cannot jump a canyon in two steps”. The *Jump Exercise* makes this point.

“Willingness is like jumping. You can jump off lots of things. [Therapist takes a book and places it on the floor and stands on it, then jumps off]. Notice that the quality of jumping is to put yourself in space and then let gravity do the rest. You don’t jump in two steps. You can put your toe over the edge and touch the floor but that’s not jumping. [Therapist puts one toes on the floor while standing on the book]. So jumping from this little book is still jumping. And it is the same action as jumping from higher places. [Therapist gets up on the chair and jumps off]. Now this is jumping too, right? Same quality? I put myself out into space and gravity does the rest. But notice from here I can’t really put my toe down very well. [Therapist tries awkwardly to touch ground with toe after getting back up on the chair]. Now if I jumped off the top of this building it would be the same thing. The jump would be identical. Only the context would have changed. But from there it would be impossible to try to step down. There is a Zen saying, “You can’t cross a canyon in two steps.” Willingness is like that. You can limit willingness by limiting context or situation. You get to chose the magnitude of your jump. What you can’t do is limit the nature of your action and still have it work. Reaching down with your toe is simply not jumping. What we need to do here is learn how to jump: we can start small, but it has to be jumping from the very beginning or we won’t be doing anything fundamentally useful. So this is not about learning to be comfortable, or grit-your-teeth exposure, or gradually changing habits. This is about learning how to be willing.”

**Willingness Is Safely Limited Only By The Size Of The Situation**

 Even with the caveat that heroic steps are not required to apply willingness, any notion of letting “monsters” in the room can be frightening to clients. They do not know what will happen if they let go. Clients see the value of willingness, and yet they want to keep it limited. The OCD client might say, “I’m willing to touch the doorknob, but if I start to feel dizzy or sick, I’m leaving”. There are ways to limit willingness safely, but most of the normal actions taken to limit it are destructive. The client cannot learn willingness by changing its quality because then the client is not limiting willingness, but instead is destroying it. Willingness can only safely be limited by situation. When willingness is limited in a way that changes its qualitative nature, it is no longer willingness. Being half willing is like being half pregnant.

Self-Monitoring Form and Wrapping Up

Instruct the patient to continue self-monitoring using the forms provided.

Remind the patient that at the next session, there will be some discussion of the self-monitoring form and then the first exposure. You will also be discussing plans for response prevention—resisting rituals.

**SESSION 3 (120 minutes)**

***Materials needed:***

* Patient’s Bull’s Eye diagram
* Therapist Form (Exposure Sessions)
* Exposure Practice Form
* ACT+ERP Self-Monitoring Form

The session will start with a brief review and discussion of the self-monitoring form and assess general functioning since the previous session. Then another values-based exercise will occur. Following this, the therapist and patient will conduct the first exposure and discuss guidelines for response prevention. The manual for this session presents information about handling exposure sessions and dealing with problems. The therapist should be familiar with this procedure, having watched videotapes of experienced therapists performing the interventions.

**Review Reactions and Self-Monitoring from Last Session**

Begin by inspecting the patient’s self-monitoring form. Help the client see what effects the control versus emotional control strategies are having on the obsessions and associated anxiety. It is likely that control strategies do not work very well to actually control the obsessions. It is also likely that engaging in willingness actually works out better than presumed. It is not so much that there is less anxiety, but that life actually works a little better when the patient does not spend so much energy trying to control the obsessions.

**Adding Meaning to Acceptance**

The therapist will benefit from familiarizing himself/herself with other ACT writings on values work.

There are a variety of exercises that can help foster exposure therapy. First a discussion of the importance of approaching anxiety is needed. Throughout, help the patient tie this in to doing exposure and response prevention.

Therapist: *We’ve talked about how it’s not really worthwhile trying to control OCD related inner experiences, and why letting them occur may be a more helpful way of living with these events. We have also done some work on what these inner experiences really are because they present themselves to be more than they really are. But we have thus far left out the desirable aspects of increasing willingness to experience your OCD related inner experiences.*

*Let’s consider the possibility that there is something meaningful about approaching your OCD-related inner experiences. What if we are not just experiencing these thoughts, feelings, and bodily sensations because we have to, but because we chose to?*

**Values Bull’s Eye**

In this exercise, you will be asking the client to specify areas of her life that she values. It may be useful to organize these areas into four categories (i.e., work/education, leisure, personal growth/health, relationships). It may be useful at this point to make the distinction between goals and values for the P.

Therapist: *When I ask you about your values, I am asking you to tell me what you want your life to be about. Values are constant underlying motives we have in our lives. Goals are not the same as values. Goals are set, attainable mile markers. Values are not attainable, we just continue to live in the direction of a value, but can never say “I have reached my value.”*

Once these categories have been determined, you will write them either on a white-board or paper reflecting a specific quadrant of a bull’s eye image (an illustration is available in appendix). The center of the bull’s eye reflects that the P’s life is exactly where she wants it to be and the outer circle reflects that she is far from where she wants it to be. Go through each category and ask the P to mark on the bull’s eye where she feels she is in relation to that value.

Then have the P identify what stands between her and living her current life as she wants to, from what she wrote down in the areas of value.

Therapist: *When you think of the life you want to live and the values that you would like to put in play, what gets in the way of you living that kind of life? Where do your rituals fit into this? Are they getting in the way of any of these values? How could doing exposure and response prevention help you move in that valued direction?*

Complete values worksheet with the client and go over the results. Help the client find the meaning in doing this work.

**Increase focus on Behavioral Commitment**

 After values have been clarified, it is time to assist the client in shifting the focus to engaging in these behaviors via exposure and response prevention. The client has been making commitments to increase his or her willingness throughout the treatment, and now the commitment should be more focused on engaging in these valued activities. The following exercises will assist the client in engaging in valued activities (i.e., exposure exercises) over slipping back into avoidance and rituals.

**Bum at the Door**

*"Imagine that you got a new house and you invited all the neighbors over to a party, a housewarming. Everyone's invited in the whole neighborhood--you even put up a sign at the supermarket. So all the neighbors show up, the party's going great, and here comes Joe-the-bum, who lives behind the supermarket in the trash dumpster. He's stinky and smelly and you think, God, why did he show up? But you did say on the sign, “Everyone's welcome.” Can you see that it's possible for you to welcome him, and really, fully, do that without liking that he's there? You can welcome him even though you don't think well of him. You don't have to like him. You don't have to like the way he smells, or his life style, or his clothing. You may be embarrassed about the way he's dipping into the punch or the finger sandwiches. Your opinion of him, your evaluation of him is absolutely distinct from you willingness to have him as a guest in your home.*

*Now you could decide that even though you said everyone was welcome, in reality he's not welcome. You could try to kick him out. But as soon as you do that, the party changes. Now you have to be at the front of the house, guarding the door so he can't come back in. Or if you say, OK, you're welcome, but you don't really mean it, you only mean that he's welcome as long as he stays in the kitchen and doesn't mingle with the other guests, then you're going to have to be constantly making him do that, and your whole party will be about that. Meanwhile, life's going on, the party's going on, and you're off guarding the bum. It's just not life-enhancing. It's not much like a party. It's a lot of work.*

Tie this metaphor back into doing exposure therapy by discussing the following:

“What this metaphor is about, of course, is all the situations, thoughts, and feelings that show up and that trigger anxiety—which we were just identifying; they're just bums at the door. The issue is the posture you take with regards to your own “bums at the door.” Are the bums welcome? Can you choose to welcome them in, even though you don't like the fact they came? If not, what's the party going to be like for you? The exposure and response prevention techniques we’ve been talking about are all about helping you see whether choosing to welcome the bums in is a useful choice for you.

This metaphor leads into generating the exposure treatment plan.

**Preparing for the First Exposure**

*Give the following description of exposure and response prevention:*

“The exposure practices that we will begin today, involves confronting OCD-inner experiences (intrusive thoughts, anxiety, urges to ritualize) and the situations that trigger these experiences. We will conduct each exposure practice in the session under my supervision. You will learn how to do exposure so that on the days when we do not meet, you can practice successfully on your own.”

*Explain to patients that therapy will, at times, seem demanding, but that it is in service of larger values. Continue with the rationale:*

“Why is it actually helpful for you to expose yourself to places and objects that will make you uncomfortable, situations that you have attempted to avoid even at much cost? We want to find the triggers that produce anxiety while you are in session so we can practice the techniques we have learned thus far. We mentioned a scale before where one side is willingness and the other side is anxiety. We want to focus on increasing the willingness side and just watch what the anxiety side does. The skill we are teaching is openness to wherever the anxiety scale is. Thoughts and emotions will arise during these exercises. I will be here to help you practice willingness. While these exposures may be difficult, it is in the service of you getting to live the life that matters to you.”

*The Moving Through a Swamp Metaphor helps illustrate how exposure will help the patient move closer to his or her values (e.g., on the bull’s eye). Present this metaphor in preparation for the first exposure as follows:*

“Imagine that there is a swamp in front of you. This swamp is all your OCD-related inner experiences, and the situations that trigger them—all the things on our exposure hierarchy. More than just thoughts, feeling, and bodily sensations; this is also your fears about what might occur if you changed your way of life: fears of failure, memories of obsessions, and so on. Acceptance is what happens when you are willing to go into that swamp without resisting and using compulsive rituals.

But notice also that there is a purpose to it. It is not that we need to wallow in swamps. It is that when we are going somewhere, sometimes there is a swamp there, and we have the choice either to change directions or to open up *[Use an example that fits for the Ps regarding a time when she changed her life by going to great lengths to avoid having obsessional thoughts]*. You can avoid going into the swamp and getting dirty, but you must also stop heading towards some things that are important to you. It is as if the things you want in life are on the other end of the swamp, and the only way to them is through the swamp.

You don’t have to go through the swamp; you may continue to live your life as you are, but if you are going to choose to go towards those things, you are going to have to choose to walk through the swamp. This means getting dirty and muddy, but for a purpose. We are not just wallowing in a swamp to wallow in a swamp.

*Make sure the patient understands the relevance of this metaphor before moving on to each exposure. Review the bull’s eye created at the previous session. Say the following to the patient:*

“Before beginning this exposure, you’ll want to you to take a look at your Bull’s Eye. Think about where you are currently and what direction you would like to be moving in. Know that you might need to go through the swamp to head towards your values. Think of the exposure exercises as part of that swamp.”

*Elicit and carefully answer any questions patients may have about the program. Then begin.*

Therapist-Aided Exposure

Imaginal and in vivo exposure might be conducted by themselves or together, depending on the exposure hierarchy item being confronted at that particular session. The manual describes them separately.

**Imaginal Exposure**

Many patients may not have experience with imagining scenes as vividly as is necessary to evoke anxiety. It is therefore useful to try a few practice imaginal scenes to ‘warm up’ for the planned exposures. Use the following directions to help the patient learn imaginal exposure skills…

“As I told you, the aim of imaginal exposure is for you to imagine yourself in the situation we are describing and feel as if it were really happening to you. Not like it’s a story being told, but like you’re living through the situation and are aware of the thoughts, feelings, sights, sounds, and sensations. To do this, you have to be good at vivid imagination, and this takes practice. So, let’s start with some easy scenes to get warmed up.”

*Ask the patient to close their eye and focus on what you’re saying...*

“Picture yourself on a beach in the middle of summer. It is very hot and you can feel the sun beating down on your skin- particularly on your shoulders and back (pause). There is a gentile wind blowing off the sea and you smell the salty air. Do you have the scene? How vivid is it? Describe how you feel.”

*Encourage the patient to maintain the scene.*

“Now, you hear the waves crashing against the sand, and you hear people playing and sea-gulls crying out. It is very bright. Do you have the image? Are you there? Just practice keeping the image (pause).”

*Also, use this scene…*

“Imagine yourself outside on a crisp November morning. There is a cold breeze that you feel on your face, and it is very quiet except for the rustling of leaves on the ground. The sun is very bright and you can barely look in the sky. Tell me what you see when you look around. Describe how you feel on the inside.

During imaginal exposure the patient will be asked to sit in a chair and will be given the following instructions:

"Today you will be imagining..... [*describe the scene*]. I'll ask you to close your eyes so that you won't be distracted. Please try to picture this scene as fully and as vividly as possible. Every few minutes I will ask you to rate your level of willingness on a scale from 0 to 100. Please answer quickly and don't leave the image".

*Record the patient’s willingness to experience the obsessions every 5 minutes on the Therapist Form.*

Audiotape/record the imaginal exposure and give the tape to the patient. Listening to the tape will be part of that day's assignment.

**In *Vivo* Exposure** (45 minutes)

*During* in *vivo exposure the following instructions are exemplary:*

1. **Washing Rituals:**

"Today, you will be touching*...[specify item(s)]*. This means that I will ask you to touch it with your whole hand, not just the fingers and then to touch it to your face and hair and clothing, all over you so you feel that no part of you has avoided contamination. Then I'll ask you to sit and hold it, regularly touching it to your face, hair, and clothes during the rest of the session. I know that it is likely to make you upset but I just want you to notice the thoughts and sensations you are experiencing. Don’t try to avoid or alter them. Just notice. I also want you to go ahead and let yourself think about the harm you are afraid will happen (e.g., disease) since you won't be washing or cleaning after this exposure. Remember that this is in the service of larger values (*specify values that were stated previously*). Are you willing to try this? OK, here it is, go ahead and touch it".

Give the patient the object to hold [or ask him/her to touch it] and then ask him/her to touch the object or the "contaminated" hands directly to the face, hair, and clothing. Contact with the contaminant should be continuous throughout the session and touching of face, hair, etc. should be repeated every five minutes throughout the 45-minute session, immediately prior to inquiring about the patient's discomfort level.

At the end of the session, note any unusual events in the section entitled "Remarks".

1. ***Checking Rituals***

The situations to which individuals with checking rituals are exposed are highly variable from patient to patient and from session to session. Instruct the patient as follows:

"Now, I'd like you to...(e.g., write out your checks to pay your monthly bills without looking at them after you've finished. Just put them in the envelope and then we will mail them right away without checking even once after you've done it.). Then we will go on and do.....in the same way (e.g., drive on a bumpy road without looking in the rear view mirror). While doing this, I would like you to worry about what harm might happen because you aren't checking your actions, but don't let the thoughts interfere with actually doing those activities."

Record the patient's level of willingness every five minutes on the "Therapist Form" as noted above.

**In Between Sessions**

At home assignments following session 3 will include exposure exercises outside of the session.

**Instructions for Self-Exposure (15 min)**

Explain self-exposure for patients as follows:

“It is important that you are also able to do exposure on your own, without my help. This means practicing on your own on the days when we don’t have sessions.”

"Each day, I will ask you to do practices which will usually continue the exposure that you did during the most recent session. Prior to the exposure exercises, I want you to check in with yourself on why you are doing this work and what you should be focusing on during the exposures. These exercises are not just a means to an end. They are part of the process of moving forward with your life. Doing this exposure and being open to the inner experiences that show up is in the service of what is important to you in life. This may just be practice, but practice has lots of meaning.

You will be asked to expose yourself as closely as possible to the situations we discussed and planned during the session. I'll ask you to do this for a period of up to two hours each day and it is best if you do it all at one time, rather than splitting it into segments. Sometimes, however, there may be situations to which you can't continually expose yourself for two-hour periods because of special circumstances. In those cases, you and I will devise a plan to be sure that you expose yourself for a long enough period, since a long exposure give you more opportunities to practice the techniques we talk about in session. Sometimes, I may ask you to practice situations that we are not able to do in the office because of the logistics of the situation."

Give an example such as having the patient touch fixed objects at home or elsewhere which can't be brought into the office or easily reached from the office.

"At each session, I will write out for you on your Exposure Practice Sheet what you are to do prior to the next session. You will then keep a record of what you did and when, and how uncomfortable you felt periodically during the exposure so we can discuss it at the next session.”

*Show the patient the “Exposure Practice Sheet” booklet and explain it to them.*

“This is the form you will use. Is it clear to you? Do you have any questions?"

**Exposure Practice Assignments**

With the patient, agree on items from the hierarchy that will be practiced before the next session. Write the assignment on the patient’s form. Continue...

"At home, plan to expose yourself to ..... and ..... just as we did today in the session. Each situation should be done for a one-hour period (or one item should be done for a two-hour period) so you get a total of two hours of actual exposure. I am writing each situation to be practiced here on your practice form. When you are practicing, write down your level of willingness every 10 minutes. Try to pay attention to the time so you don't forget to note your level of willingness. You should repeat at home exactly what we did here in the session. That means long exposures, without any rituals. Again, the useful guideline is to do exposures for one full hour. During that time period, do not try to alter or avoid the emotions or thoughts that arise.”

“If you had any problems or comments about the assignment, you can write a brief note on the practice form so you are reminded to discuss them with me when we talk at the next session. Do you have any questions?”

**Comments and Metaphors During Exposure Sessions**

*The following are examples of comments and metaphors to be introduced during exposure in vivo, after imaginal exposure, and on inspection of self-exposure practice:*

1. If willingness is **low**:

Use the **“Tug-of-war with a Monster”** metaphor: *Your situation is like being in a tug of war with a monster. It is big, ugly, and very strong, and you don’t like it. In between you and the monster is a pit, and so far, as you can tell, it is bottomless – the abyss. If you lose this tug-of-war you will fall into this pit and you will be destroyed – the anxiety monster has won. You don’t want this to happen. So you fight back. You pull and pull, but the harder you pull, it seems the harder the monster pulls back – and all the time, it seems you get a bit closer to the edge of the pit.*

*Most people think there are only two possible endings: either I win by pulling harder than the monster or the monster wins by wearing me out. And so they spend all their energy fighting their monsters seemingly doomed to fight until the end. Yet, there is another alternative here: you could simply drop the rope. The hardest thing to see is that you need not win this tug-of-war. You could simply drop the rope. The fight would stop in an instant. The monster would still be there, but the fight would be over.*

**Other comments**

"Notice how important the thoughts and emotions feel when you are fighting them? This may feel like you are in a game of tug of war with that monster. Try just dropping the rope and looking at the thoughts, but not fighting with them.”

"This may feel like you are trudging through a swamp, but remember that there is meaning in this work."

“I noticed that you had difficulty in opening up to that experience today. What do you think was getting in the way of that?”

“This will take practice. Your mind has been trained to push and fight for so long, that learning to actively open up to feared events will take time.”

1. If willingness is **high**:

"What did it feel like to welcome and accept the anxiety and obsessions?”

"Was that easier or harder than fighting or pushing away your inner OCD experiences?”

Response prevention

Together with the patient, develop specific instructions for response prevention on the first day of exposure. Remind the patient of these rules periodically during treatment. It’s helpful to refer back to the Moving Through a Swamp metaphor to help the patient grasp the rationale for stopping rituals.

*If the patient is unable to end all rituals at once, it is appropriate to discuss gradual response prevention. Following the guidelines set out in Abramowitz (2006) for arranging response prevention to go along with movement up the exposure hierarchy.*

**Common Difficulties During Exposure Treatment**

The following problems may arise during exposure/response prevention treatment for OCD. Methods for handling them are given below:

1. Non-Compliance with Response prevention Instructions

On rare occasions patients actively conceal ritualistic activity which was specifically prohibited by the therapist. The patient should be confronted with this discovery matter-of-factly and without anger. Its implications for treatment outcome should be emphasized:

"I understand from your father that he saw you checking the front door lock five or six times this weekend before you left the house on three occasions. He called to tell me because he felt I needed to be aware of it, since as we agreed, I had told him in our first session to let me know of any problems you had following my instructions. Before we started treatment we agreed you would check only once. If you had a problem, you would tell me or your supervisor (your father) immediately so we could help you expose yourself without ritualizing. What happened?"

"It seems that right now you aren't able to stop ritualizing as we agreed at the outset. I am not here to force you to do any of these. This is your decision. However, as we talked about before these rituals only work in the short term to stop the obsessions. What we are working on is to teach techniques that will be more effective in the long term. While it is easy to fall back into comfortable habits, that hasn’t worked so far. Why don’t we try to something new, even if it feels more difficult right now?

*Although direct violation of response prevention instructions is relatively rare, the replacement of prohibited rituals with less obvious avoidance patterns is quite common. For example, if the therapist learns that the use of hand lotion serves to "decontaminate" a patient almost as successfully as the form washing rituals, its use should be banned. Other examples of replacement washing rituals include brushing off hands and blowing off "germs". Direct questioning of the patient to solicit such information should proceed as follows:*

"Now that you've stopped your rituals, have you found that you are doing anything else to relieve your anxiety that is like a ritual? Sometimes people find themselves doing little things that substitute for the longer compulsive acts. Has this happened to you?"

*If the answer is positive, the need to prohibit this new behavior is emphasized and the rationale for doing so is repeated.*

1. Continued Passive Avoidance

Some individuals who carry out the required exposure without ritualizing may continue to engage in unreported and sometimes unnoticed passive avoidance behaviors. Examples include placing "contaminated" clothing back in the closet for a second wearing but making certain it does not touch the clean garments, and delaying entry or departure from a public bathroom until another person heads for the door, thereby eliminating the need to touch the door knob. Since these behaviors reflect an ambivalent attitude toward treatment and lack of committed action, they are predictors for failure. Failure to give up avoidance patterns also calls for a reevaluation of continuation in treatment.

"Your husband tells me that you don't mix your dirty underwear with other dirty clothes when you do your laundry even when it would be logical to wash them together. Why is this? Would it upset you to wash them together?

*If the answer is "YES", the therapist should assign this as homework and continue as follows:*

"Are there any other little avoidances like this that you are doing?.....It is very important to notice little attempts like this to rid of your obsessions. When you are engaging in these behaviors, you are not moving in the direction of your value to [state specific value]. You continue the pattern that we talked about before that has not worked so far. Did you find that these behaviors worked the same as the other rituals we have decided to not engage in anymore? If they are serving the same function, they are going to work the same way. And we are here working on this because those didn’t work before."

1. Arguments: Balking

The therapist should not engage in arguments regarding what a patient will and will not do during treatment. Both individuals are expected to adhere to the contract agreed upon at the commencement of treatment. If new feared situations are discovered, the therapist should not insist on exposing the patient to unplanned difficult situations without first warning him/her of this plan during the previous session. In turn the patient is expected to expose his/herself to planned situations in the therapists' presence without argument. Should a patient balk at a planned exposure or attempt to reduce the intensity of exposure, the therapist should empathize with his/her discomfort, inquire about the reasons for the hesitation and encourage him/her to proceed by reminding why we are doing this and that it is in the service of chosen values. Only if this fails, should the patient be reminded of the treatment contract. The therapist may say:

"It seems like engaging in this exercise is leading to a lot of distress for you. That is a natural response to have when confronting feared objects. What is it that your mind is telling you right now?...It’s interesting how believable those thoughts are. Those are words, just as milk is (**see the “Milk Milk Milk Metaphor” presented during exposures in sessions 4-15**). However, you are certainly attending to these words more aren’t you? Do you think it would be possible to just notice those words as they are occurring and continue to engage in this exercise? You have control over your actions, but you don’t have control of what your mind is going to do. Let’s try to open up to this experience and just watch what your mind does.”

1. Emotional Overload

Occasionally during treatment a patient becomes overwhelmed by fear or other emotional states, as typically evidenced by crying, shaking, extreme lethargy, etc., which is not directly related to his/her exposure practices. For example, patients may be upset by a recent event (such as a phone call from a spouse threatening to leave if he/she doesn't improve), from fears of facing future plans (such as living on one's own, getting a job), or other concerns. When the patient exhibits such reactions, further exposure is inadvisable since it is unlikely that the patient can adequately attend to the exposure stimulus and anxiety is unlikely to decline. Instead the therapist should encourage the patient to talk about the source of this response and only when he/she is calmer, proceed with the exposure. Depending on the patient's reaction, exposure may be postponed altogether until the next day's session.

1. Family Reactions

Since family members have typically experienced years of frustration with the patient's symptomatology, it is not surprising that some are impatient, expecting treatment to progress smoothly and result in total symptom remission. Disappointment and anger may result when this doesn't occur. When needed, the therapist should reassure family members that occasional strong anxiety reactions are to be expected and do not reflect failure, and encourage them to respond as calmly as they are able, should this occur. Some family members may continue to try to protect the patient from upsetting situations. Years of accommodation to the patient's peculiar requests have established habits that are hard to break. For example, the husband who has been accustomed to entering his home through the basement, immediately removing his clothes and showering for his wife's sake may need encouragement to enter through the front door and toss his overcoat on the couch. Similarly, family members may find themselves continuing to perform a variety of household activities that they have come to regard as their responsibility because of the obsessive-compulsive patient's wishes to avoid feared contexts. Since such familiar patterns may hinder progress in treatment, the therapist should inquire about such habits from both the patient and family members and prescribe appropriate alternative behavior which maximizes the patient's exposure and minimizes avoidance.

**SESSIONS 4-15 (120 minutes each)**

***Materials needed:***

* Therapist Form (Exposure Sessions)
* Exposure Practice Form

The 4th through 15th sessions are conducted according to the format used for Session 3: Progress is reviewed, one or more ACT metaphors are presented and discussed, and then exposure and response prevention are practiced at each visit with increasingly difficulty. Generally, the hierarchy is addressed in an ascending fashion at the highest rate that the participant will agree too.

Response prevention remains in effect throughout therapy. The therapist should inspect the assigned practice work and self-monitoring forms at the start of each session.

**Reviewing Progress**

At each session inquire about success with not attempting to alter or avoid obsessions, response prevention, and inspect exposure practice forms.

Periodically, take time to review overall progress the patient has made. What differences does the patient notice in his or her own behavior, acceptance of obsessional thoughts, ability to function in various arenas.

If little improvement has been made, try to address reasons for this. Has there been difficulty completing self-supervised practice exposures? Have response prevention rules been broken? Point out the various areas where overcoming barriers might lead to more noticeable gains. Use the “ACT Advisor” to determine which ACT process is lacking and may be leading to lacks in improvement. Before each exposure, choose specific metaphors or exercises to use or review based on where the participant is struggling.

**ACT Metaphors for Use During Exposure Sessions**

*The therapist can choose from the following metaphors to present at the start of each exposure session. Metaphors can also be presented and discussed* ***during*** *exposure practices.*

* **Choosing: Coke versus 7-UP**

*This metaphor can be used to help the patient think about making choices regardless of what his/her obsessional thoughts, doubts, and anxiety might be telling him/her about the choices.*

Ask the client to imagine being given a choice between two kinds of soft drinks: Coke and 7-Up (can also be done with two types of juices, coffee and tea, two flavors of ice cream, etc.). Ask the client to choose. Whatever the client says, ask why. If a reason is given, attack the reason, point out that the choice could have been different even with that reason, and ask the client once again to choose. And anyway, the issue is which do you choose, not which do your reasons choose. Continue until it is clear that any reason the client gives can be argued, and that reasons, per se, aren’t necessary. Tell the client the issue isn’t even doing things because you want to do them, because there are many things in life we do whether we want to do them or not. Rather, the issue is choosing simply because you choose. Say, “You have the capacity to take a course of action for no other reason than that you choose to take it.” It’s not necessary to defend or explain.

* **The Polygraph Metaphor**

*This exercise targets anxiety directly.*

Therapist: Suppose I had you hooked up to the best polygraph machine that's ever been built. This is a perfect machine, the most sensitive ever made. When you are all wired up to it, there is no way you can be aroused or anxious without the machine knowing it. So I tell you that you have a very simple task here: all you have to do is stay relaxed. If you get the least bit anxious, however, I will know it. I know you want to try hard, but I want to give you an extra incentive, so I also offer you 1000,000 dollars if you can accomplish this. If you just stay relaxed, I will give you the money, but if you get nervous (and I'll know it because you're wired up to this perfect machine), then no money … So, just relax! ... What do you think would happen? Guess what you'd get? How could it work otherwise? The tiniest bit of anxiety would be terrifying. You'd be going "Oh, my God! I'm getting anxious! Here it comes!"

*This metaphor can be used to draw out several paradoxical aspects of the control and avoidance of OCD-related inner experiences. As the following scripts suggest, modifying the language within the metaphor keeps the impact of the exercise intact while allowing the client's different issues to be addressed.*

***1****. The contrast between behavior that can be controlled, and behavior that is not regulated very successfully by verbal rules.*

Therapist: Think about this. If I told you, "Vacuum up the floor or no money," you'd vacuum the floor. If I said, "Paint the house or no money," you'd be painting. That's how the world outside the skin works. But if I simply say, "Relax, or no money," not only will it not work, but it's the other way around. The very fact that I would ask you to do this would make you damn nervous.

***2.*** *How this metaphor maps to the client's situation.*

Therapist: Now, you have the perfect polygraph machine already hooked up to you: it's your own nervous system. It is better than any machine humans have ever made. You can't really feel something and not have your nervous system in contact with it, almost by definition. And you've got something pointed at you that is more powerful and more threatening than anything—your own self-esteem, self-worth, the workability of your life. So you actually are in a situation very much like this. You're holding the gun to your head and saying, "Relax!" So guess what you get?

* **The Fall in Love Metaphor**

*This metaphor helps show how weak deliberate control is when applied to the world of private events. Use it if the patient is struggling with wanting to control intrusive obsessional thoughts. Depending on what the client is struggling with, it might be helpful to develop this point with regard to doubts and uncertainty, upsetting images, anxiety, or other domains of psychological events.*

*This metaphor is also useful to deal with positive emotions, which need to be considered because often the client has the idea that even if negative emotions can’t be controlled, it is quite possible to control positive emotions; and thus by putting positive emotions into the situation, the negative emotions will disappear.*

Therapist: Here’s a test. I come to you and say, “See that person? If you fall in love with that person in 2 days, I’ll give you 10 million dollars.” Could you do it? What if you came back to me in 2 days and said, “I did it.” And then I said, “Sorry, it was just a trick. I don’t have 10 million dollars.” What are you going to do next? In other words, eliminating negative emotions may be difficult, but creating an emotion, even one that seems likable, is equally difficult to in any kind of predictable, systematic and controllable way.

* **The Chinese Finger Trap**

*When the patient is having difficulty with acceptance, use this metaphor to demonstrate how attempts to control OCD-related inner experiences are unproductive, and in fact, maladaptive.*

Therapist: Did you ever play with a Chinese finger trap as a child? A Chinese finger trap is a tube of woven straw about five inches long and half an inch wide. You slide both index fingers into the straw tube, one finger at each end. If you attempt to pull the fingers out, the tube catches and tightens. The harder you pull, the smaller the tube becomes, and the stronger it holds your fingers. The more you try to pull your fingers out, the tighter it grabs hold of your fingers. Conversely, if you push into the tube, you regain some freedom and some space. Your fingers are still in the tube, but at least you’ll have enough room to move around.

Suppose that life itself is like a Chinese finger trap. Perhaps it’s not a question of getting free from the tube. Perhaps it’s a question of how much “wiggle room” you want to have in your life. The more you struggle, the more constricted your movements will be. If you let go of the struggle, the more freedom you have to make new choices.

Can you relate this to the struggles you’re having with obsessional thoughts and doubts?

* **Milk, Milk, Milk Metaphor**

*The purpose of this metaphor is to help the patient see that their intrusive thoughts are just thoughts; rather than the big powerful events they present themselves to be.*

Therapist: As a species, language, including thoughts and words, gives us the blessings and the curse of knowledge. The power of language has pros and cons: there is a "light side" and a "dark side". On the positive side, we can influence the environment and create a comfortable life. Just look around in this room. Lights, chairs, central heating, and clothes we are wearing… Without language and our thoughts (i.e, logical thinking), these would not be here. On the dark side, however, we are the only species that worries. In the extreme case, we are the only species that commits suicide.

The dark side becomes dominant when we believe that our thoughts are literally what they say they are, especially thoughts that really push us around like OCD-related thoughts. For example, "I am going to die." And we tend to think of our thoughts, of what they say, as the reality or as the criteria of the reality. For example, you are what your thoughts say who you are, what you are, and how you are. However, are you really what your thoughts say you are?

What if I say that thoughts are simply what they are (thoughts are just thoughts), rather than what they say they are. OR you are not what they say you are. It might be difficult to get this point, so let's do a little exercise.

As I said, this exercise sounds silly. I'm going to ask you to say a word. Then you tell me what comes to mind. I want you to say the word, "Milk."

P: Milk.

T: Good. Now tell me what comes to mind when you said it?

P: (I have milk at home in the refrigerator).

T: O.K. what else? What shows up when we say "Milk".

P: (I picture it—white, a glass).

T: Good what else? Can you taste it? Can you feel what it feels like to drink a glass of milk? Cold, creamy, coats your mouth…right?

T: O.K., let's see if this fits. What came across your mind were things about actual milk and your experience with it. All that happened is that we made a strange sound — Milk (say it slowly!) —and lots of those things show up. Notice that there isn't any milk in this room, not at all. But milk was in the room psychologically. You and I were seeing it, tasting it, and feeling it. And yet, only the word was actually here.

T: Now, here is another exercise. The exercise is a little silly, and you might feel embarrassed doing it, but I am going to do it with you so we can all be silly together. What I am going to ask you to do is to say the word, "Milk," out loud, over and over again, and as rapidly as possible, and then notice what happens. Are you ready?

T: O.K., Let's do it. Say "milk" over and over again!

[30 seconds pass]

T: O.K. now stop. Tell me what came to mind while you kept repeating it?

P: (e.g., Gone, it sounds funny, it was just a sound)

T: Did you notice what happened to the psychological aspects of milk that were here a few minutes ago?

P: They are not the same; they are not really here.

T: Right, the creamy and cold stuff just goes away. When you said it the first time, it was as if milk was actually here, in the room. But all that really happened was that you just said that word. The first time you said it, it was "psychologically" meaningful, and it was almost solid. But when you said it again and again and again, you began to lose that meaning and the words became just a sound.

T: What I am suggesting is that… What happens in this exercise may be applied to OCD-related thoughts. Imagine that such thoughts are like smoke. When you say things to yourself, like “I am going to die”, that is much like inhaling the smoke and believing it’s the air. But the thoughts are not air—they’re just thoughts, a cloud of smoke over your mind.

*Intervention*

T: Let’s try this same thing with one of your powerful OCD-related thoughts. Let’s use a good one like ‘contamination’ [Let the Ps choose the thought and then shorten it down to one word so that it can be easily repeated].

T: Now, your task here is to say the thought "XXX (one-word thought)," out loud, over and over again, as rapidly as possible until I say "stop". Do you have any questions?

P: [The participant may or may not ask questions about the procedure]

T: O.K., are you ready? Now, begin [Therapist may repeat the thought with the participant initially to prompt him to follow the protocol AND then provide a prompt every 10 seconds, by saying “louder” or “faster” etc].

T: [Let 30 seconds pass]

*The therapist and the Ps continue the discussion about what happens to the functions of the thought. The therapist should help the Ps notice the experience that the verbal functions of that thought were less present during that exercise. Help the Ps notice that the thought has a lot less power when noticed as just a sound. Help the Ps realize that many of the functions of that thought are verbally derived and context dependent. When thoughts are taken literally they pull many powerful functions, but when a thought can be noticed as just a thought then its functions are greatly lessened. This is not meant to be an answer to OCD-related thoughts, or even practiced when an OCD-related thought occurs. The purpose is to help the Ps see that these thoughts are just thoughts in addition to the big powerful events they present themselves to be.*

*The client can be assigned this exercise as homework. The client should find a place in his or her home where he or she will not be interrupted, get centered, and observe what occurs.*

**Exposure Practice**

Assignments for practicing exposure are given at each session. If the patient demonstrates good skills and can advance up the hierarchy by themselves, items not covered in session may be assigned for practice.

However, if the patient has difficulty with in-session exposure, it is best to assign the patient exposures that have already been confronted in sessions.

Remind the patient to bring the exposure practice forms to the sessions with them.

**SESSION 16 (120 minutes)**

**Return to Normal Behavior**

At the final session, take some time to review progress that has been made. Evaluate the success or lack thereof.

A reassessment of values and committed action can be done at this point to solidify the reasons to continue moving in a valued direction and not relapsing. Discuss what to do if relapse occurs.

Therapist: *In the future, you may give in to your mind and engage in some rituals. The best thing to do at that point is to just notice what happened and continue to move forward in a direction that matters to you. Your mind will try to take you back to that moment, and that’s okay. That’s what it does. Your job from there will be to work on being in your present moment and behave in a way that is consistent with what you want your life to be like. If you fall down 100 times, just notice it and get back up 100 times. This takes practice. I have no doubt that you can do this as long as you remember what is important to you.*

**INFORMATION GATHERING #1: First Session** Name of Therapist Date

Name of Patient

Address

Telephone number

Age of Patient

Marital Status

Number of Children and Ages

Living Arrangement

Current Work Situation

Obsessions (Anxiety/Discomfort Evoking Material)

 External Cues: Sources of anxiety/discomfort (e.g., feces, urine,

 parents, hometown)

 Internal Cues:

 Thoughts, images, impulses, doubts (e.g., "God is bad")

 Internal Cues:

 Bodily Sensations (e.g., heart palpitations, sweat)

 Consequences

 Harm from external sources (e.g., V.D. from using public toilets)

 Harm from internal cues (e.g., "I will go crazy")

 Harm from experiencing long-term high anxiety

Avoidance Patterns:

 Passive Avoidance

 Rituals

 Relationship between Avoidance and Fear Cues

Events Surrounding Onset of Problem

Historical Course of Problem

History of Psychiatric Treatment for Obsessive-Compulsive Problems and Other Problems

General History

 Medical History

 Educational History

 Employment History

 Previous and Current Relationship with Parents

 Previous and Current Relationship with Siblings

 Previous and Current Relationships with Friends

 Dating Sexual History

 Previous and Current Relationship with Spouse

Obsessive-Compulsive Disorder:

Some Facts

About six million people in the USA are estimated to have obsessive-compulsive disorder (OCD). Men and women develop OCD at similar rates and it has been observed in all age groups, ranging from school-aged children to older adults. OCD typically begins in adolescence, but may start in early adulthood or in childhood. As a rule, the onset is gradual, but in some cases, OCD starts suddenly. Symptoms fluctuate in severity from time to time, and this fluctuation might be related to the occurrence of stressful events. Because symptoms usually worsen with age, people have difficulty remembering when OCD began, but can sometimes recall when they first noticed the symptoms were disrupting their lives.

As you probably know, the symptoms of OCD may include unwanted or upsetting doubts, or other thoughts about harm, contamination, sex, religious themes, or health. Rituals may include excessive washing, re-checking, praying, repeating routine activities or actions, or special thoughts designed to counteract negative thoughts. You are probably also aware of certain situations, places, or objects (that you may even avoid) which trigger the distressing thoughts and urges to ritualize.

What causes OCD? The reasons why some people develop obsessions and compulsions, while others don’t, are unknown. OCD certainly has to do with your thinking and your actions. Many researchers also feel that people with OCD have abnormal brain chemistry involving serotonin, a chemical that is important for brain functioning. There is also evidence that OCD is more prevalent in some families than in others. It is difficult to know how much of this is a result of what children learn from their family while growing up, and how much is hereditary.

Why do *you* have OCD? Many people would like to know what causes this disorder, or how they developed it. There are a number of guesses, some better than others, but there is no satisfactory theory of its development. Most likely, there is a combination of factors (such as biological/genetic and environmental aspects) that contribute to the development of OCD. It is tempting to be overly concerned with the lack of information about how OCD develops. Fortunately, despite our lack of knowledge, there are effective treatments available that do not require an explanation for why or how a person developed OCD.

continued...

Luckily, scientists *do* understand a great deal about the *symptoms* of OCD and this is very important for treatment of the disorder. In fact, *your* learning more about your OCD symptoms will help *you* get more improvement from of this treatment. In this treatment, we will think about OCD as having three parts: First, there are **inner experiences**. These are the recurring intrusive thoughts, ideas, images, or impulses (*obsessions*), along with intense feelings of fear, anxiety, uncertainty, and doubt, and the associated body sensations like a racing heart, sweating, muscle tension, and feelings of breathlessness.

The second part of OCD is your **attempts to get rid of these inner experiences**. This includes compulsive rituals, avoidance behaviors, seeking reassurances, and anything else you do to try to make you feel safe or reduce anxiety and uncertainty. Because these behaviors sometimes work to remove the unwanted inner experiences temporarily, people get into the pattern of doing them over and over and they become “compulsive.”

Unfortunately, trying to get rid of the inner experiences (obsessional thoughts and anxiety) by using avoidance and compulsive rituals doesn’t work that well: you might reduce the inner experiences for a short time, but they come back again. Often, you find yourself doing more and more avoiding and ritualizing to try to get rid of the anxiety, but, even then, it does not reduce the inner experiences permanently, and before long, you’re putting so much time or energy into rituals that other important areas of your life get seriously disrupted. So, the third part of OCD is how it reduces **your quality of life**, such as at work or school, in your relationships, and in your social or leisure life.

In order to treat OCD, we will be working on helping you find new and healthier ways to relate to the inner experience part if OCD so that you don’t feel the need to fight them or get away from these thoughts and feelings. This, in turn, will reduce your urges to perform rituals and avoidance, which will improve your quality of life. Your therapist knows exercises that will be helpful in achieving these goals. These exercises are called Acceptance and Commitment Therapy or ACT (say the word, not the letters), *exposure therapy, and response prevention*; and you will learn more about them in the next session. **For now, it is important that you understand the three parts of OCD and the associations between them**.

SELF MONITORING of OBSESSIONS and RITUALS

Please complete this form after you experience your obsession. This form need not be completed after every obsession. The form only needs to be completed a couple times. Please bring your response to the following session.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date | Time | What was the experience? What were your feelings, thoughts, or bodily sensations while it was happening? | What did you do to in response to your feelings, thoughts, or bodily sensations? | What was the result of that response on the obsession and your life? |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Appointment Schedule

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Wk. | Monday | Tuesday | Wednesday | Thursday | Friday |
| 1 | \_\_| | \_\_| | \_\_| | \_\_| | \_\_| |
| 2 | \_\_| | \_\_| | \_\_| | \_\_| | \_\_| |
| 3 | \_\_| | \_\_| | \_\_| | \_\_| | \_\_| |
| 4 | \_\_| | \_\_| | \_\_| | \_\_| | \_\_| |
| 5 | \_\_| | \_\_| | \_\_| | \_\_| | \_\_| |
| 6 | \_\_| | \_\_| | \_\_| | \_\_| | \_\_| |
| 7 | \_\_| | \_\_| | \_\_| | \_\_| | \_\_| |

**INFORMATION GATHERING: Second Session**

Name of Therapist Date

Name of Patient

Comments about Patient's Self-Monitoring

Obsessions (Anxiety/Discomfort Evoking Material)

 External Cues (specific situations, circumstances and/or objects):

 Situation Treatment Session

 1.

 2.

 3.

 4.

 5.

 6.

 7.

 8.

 9.

10.

11.

12.

13.

14.

15.

 Internal Cues: thoughts, images or impulses (e.g., "God is bad", "I feel an urge to stab my daughter") or bodily sensations that cause fear:

 Cue Treatment Session

 1.

 2.

 3.

 4.

 5.

 6.

 7.

 8.

 9.

10.

 Consequences: harm from external source (e.g., "I will get V.D. if I use public toilets in restaurants), from internal cues, or from long-term anxiety:

 Type of Harm

 1.

 2.

 3.

 4.

 5.

 6.

Avoidance Behavior

 Passive Avoidance (specific situations):

 Situations

 1.

 2.

 3.

 4.

 5.

 6.

 7.

 8.

 9.

10.

11.

12.

13.

14.

15.

 Rituals (describe in detail the daily routine):

1.

2.

3.

Treatment Plan

 Next to each external cue listed previously, specify which day of treatment it is scheduled for exposure. All items must be included during the first five sessions of treatment.

**THERAPIST FORM**

 **Exposure Sessions**

Name of Patient Date

Name of Therapist Session Number

Initial Depression Initial Anxiety Initial Urge to Ritualize

Response prevention: Were there any violations? Yes No

 If yes, describe

Inspection of Self-Exposure Practice Assignment: How much time was spent on practice?

Describe Patterns and Urges to Ritualize

Description of Imaginal Exposure

Description of Exposure in vivo

 **THERAPIST FORM**

 **Exposure Sessions (continued)**

**Imaginal Exposure In-Vivo Exposure**

 Willingness Willingness

Beginning \_\_\_\_ Beginning \_\_\_\_

 5 minutes \_\_\_\_ 5 minutes \_\_\_\_

10 minutes \_\_\_\_ 10 minutes \_\_\_\_

15 minutes \_\_\_\_ 15 minutes \_\_\_\_

20 minutes \_\_\_\_ 20 minutes \_\_\_\_

25 minutes \_\_\_\_ 25 minutes \_\_\_\_

30 minutes \_\_\_\_ 30 minutes \_\_\_\_

35 minutes \_\_\_\_ 35 minutes \_\_\_\_

40 minutes \_\_\_\_ 40 minutes \_\_\_\_

45 minutes \_\_\_\_ 45 minutes \_\_\_\_

Remarks:

Self-exposure practice instructions:

**EXPOSURE PRACTICE FORM** Session Number Date

1) The situation to practice:

Time to Practice:

 Willingness Willingness

Beginning \_\_\_\_ 40 minutes \_\_\_\_

10 minutes \_\_\_\_ 50 minutes \_\_\_\_

20 minutes \_\_\_\_ 60 minutes \_\_\_\_

30 minutes \_\_\_\_

2) The situation to be practiced:

Time to Practice:

 Willingness Willingness

Beginning \_\_\_\_ 40 minutes \_\_\_\_

10 minutes \_\_\_\_ 50 minutes \_\_\_\_

20 minutes \_\_\_\_ 60 minutes \_\_\_\_

30 minutes \_\_\_\_

Tape Practice

 Tape # Willingness

 Pre Peak End

#1 45 minutes \_\_\_\_ \_\_\_\_ \_\_\_\_

#2 45 minutes \_\_\_\_ \_\_\_\_ \_\_\_\_

Comments or Difficulties:

 **BULL’S EYE ILLUSTRATION**

*My life is far from how I want it to be* beifrån det jag önskar

*My life is just as I want it to be*

**Work/ Education**

**Leisure**

**Relationships**

**Personal growth/**

**Health**

***ACT ADVISOR* Psychological Flexibility Measure**

In this diagram there are six double-headed arrows, each with contrasting statements at either end. The arrows represent sliding scales, numbered 1-10, between each set of statements. For each scale, choose whereabouts your client would place him/herself (i.e., at which number), depending on how closely, or otherwise, s/he feels the statements applies to him/her. If you feel that the statements apply equally, or that neither statement applies to him/her, score 5. Enter the scores in the box below, then total them to give a Psychological Flexibility score.

Developed by David Chantry

*My thoughts tell me how things really are, and determine*

*what I do next*

*I constantly struggle with my thoughts and feelings*

*I spend*

*most of my time lost in thought about the past or future*

*I don’t know what I want from life*

*I don‘t manage to act on the things I care about*

*Deep down, my thoughts and feelings are the real me*

*I spend most of my time paying attention to what is happening in the present moment*

*I am clear about what I choose to value in life*

*I work out what I need to do about the things I care about, and*

*I see it through*

*My thoughts and feelings come and go, but deep down the real me doesn’t change*

*I see each of my thoughts as just one of many ways to think about things – what I do next is up to me*

*I willingly accept my thoughts and feelings even when I don’t like them*

ACCEPTANCE SCALE

ATTENTION TO PRESENT SCALE

VALUES IDENTIFICATION SCALE

COMMITMENT & TAKING ACTION SCALE

DEFUSION

SCALE

SELF AS OBSERVER SCALE

10

9

8

7

6

5

4

3

2

1

1

2

3

4

5

6

7

8

9

10

4

5

6

9

10

1

1

1

1

2

2

2

2

3

3

3

3

4

4

4

5

5

5

6

6

6

7

7

7

7

8

8

8

8

9

9

9

10

10

10

SCORES

**A**cceptance scale ...…............. \_\_\_

**C**ommitment &

**T**aking action scale ……….… \_\_\_

**A**ttention to present scale ….... \_\_\_

**D**efusion scale ………..…….… \_\_\_

**V**alues

**I**dentification scale ……….…. \_\_\_

**S**elf as

**O**bserver scale ….................. \_\_\_

**R**esulting psychological

 flexibility (TOTAL SCORE) ... \_\_\_