CHAPTER I – INTRODUCTION

“I find hope in the darkest of days, and focus in the brightest. I do not judge the universe”

- XIV Dalai Lama
INTRODUCTION

The present study was an attempt to examine the effects of Acceptance and Commitment Therapy (ACT) on psychological flexibility, thought suppression, mindfulness skills and symptoms in patients diagnosed with Obsessive Compulsive Disorder (OCD). This study was planned owing to the researcher’s interest in the area of third wave behaviour therapies, especially Acceptance and Commitment Therapy (ACT). It was found that there is paucity of research in this area, especially in India, wherein the objective was not only to examine the efficacy of ACT on the outcome measures of a disorder, but also to examine the effects of the treatment on the process measures, which would provide more insight about an efficacious therapy for the disorder. The current research entailed the application of Acceptance and Commitment Therapy (ACT) on Obsessive Compulsive Disorder (OCD), to study its effects on the process measures of psychological flexibility, thought suppression, mindfulness skills, and also symptoms in patients diagnosed with OCD. This chapter contains an account of OCD, its main characteristics, epidemiological findings, and psychological treatments for the disorder. This is followed by a descriptive account of Acceptance and Commitment Therapy, its key elements, techniques, and how it differs from conventional CBT approach. Lastly, linking the relevance of ACT with OCD and how its principles work in the treatment of the significant factors maintaining the disorder.

OBSESSIVE COMPULSIVE DISORDER (OCD)

_Obsessive-compulsive disorder (OCD)_ is an anxiety disorder characterized by recurrent, intrusive ideas, thoughts, impulses, or images that induce extreme anxiety in the
individual and lead to the performance of compulsive behaviors that can be either physical (e.g., repetitive hand washing) or mental (e.g., ritualistic praying) in order to reduce the anxiety brought on by the obsessions. OCD is represented by a diverse group of symptoms which are etiologically as well as symptomatically heterogeneous, making it a difficult anxiety disorder to understand and treat. The diagnosis of OCD can be made when the individual has either obsessions or compulsions or both, the person realizes at some point that their obsessions and/or compulsions are excessive or unreasonable, and these obsessions and compulsions significantly interfere with the person’s daily routine (American Psychiatric Association/APA, 2000).

Obsessions are intrusive and recurrent, unwanted ideas, thoughts, impulses or images that are difficult to dismiss despite their disturbing nature (APA, 2000). Obsessions are anxiety provoking phenomenon; however, differ qualitatively from excessive worries about real-life problems. Typical examples include preoccupation with contamination (e.g., “My hands are dirty”), doubts about having caused harm (e.g., “I left the stove on”), unwanted sexual thoughts (e.g., thoughts of having unaccepted sexual encounters), and violent impulses (e.g., images/impulses of violence against loved ones). Compulsions are repetitive behaviours, either physical/observable behaviours (e.g., washing and checking rituals) or mental behaviours (e.g., praying, counting mentally), that are intended to neutralize the anxiety caused by the obsessions. Mataix-cols, Rosario-Campos, & Leckman (2005) summarized factor and cluster analysis studies of obsessive-compulsive symptom dimensions and found strong evidence for contamination/cleaning, symmetry/order, obsession/checking, sexual/religious and saving/hoarding. In addition, Denys, de Gues, Van Megen, & Westenberg (2004) provided evidence for ‘pure obsessions’ subtype which predominantly
contained aggressive, sexual, and religious obsessions without significant loading from overt compulsions. The obsessions and compulsions cause marked distress and are time consuming (more than one hour per day). Insight into the illness is no longer necessary for the diagnosis of OCD provided the excessiveness or senselessness of obsessions and compulsions is recognized at some point during the course of the disorder (APA, 2000).

In addition to obsessive-compulsive symptoms and subtypes, other significant phenomena are ruminations. Lewis (1966) acknowledged the existence of obsessional ruminations as a subtype of obsessive phenomena that takes the form of endless questioning. Ingram (1960) described a diagnostic category distinct from OCD called phobic-ruminative state, which involved predominantly phobic or ruminative symptoms without motor compulsions. de Silva (2003) defined obsessional rumination as, “A compulsive cognitive activity that is carried out in response to an obsessive thought. The content of the intruding thought determines the question or the theme that the person ruminates about”. Furthermore, a restrictive definition of pure obsessions was proposed which was reserved for individuals with obsessions without any overt or covert compulsions (de Silva, 2003). Clark and Guyitt (2008) defined pure obsessions as “obsessional thoughts, images and impulses that are not accompanied by motor compulsions or very few if any, but can be associated with cognitive compulsions or other forms of neutralizations”. Predominantly, obsessions have high prevalence of cognitive compulsions or neutralization strategies but they are less accessible and more difficult to control (Salkovskis, 1999). Neutralization is defined as any voluntary, effortful cognitive or behavioural response that is directed at removing, preventing or attenuating the thought or associated discomfort. Patients with predominantly obsessions more often use a variety of neutralization strategies including thought suppression,
rationalization, distraction, thought replacement, self punishment, or, do nothing (Freeston & Ladouceur, 1997). In addition, they engage in a number of compulsive or neutralizing behaviours of mental list making, substituting neutral images, mentally rehearsing a particular sequence of numbers, staring at an object or forming its exact mental representation, ritualistic prayer, mental review of conversations, or mentally checking and patterning objects (Einstein & Menzies, 2003).

One of the neutralizing strategies often used by patients with OCD is *Thought Suppression*, that is, the process of deliberately trying to stop thinking about certain thoughts (Wegner, 1989). It is an attempt to ignore or control one’s thoughts that are found to be threatening or distressing. In OCD, one repeatedly (usually unsuccessfully) attempts to prevent or "neutralize" intrusive distressing thoughts centered around one or more obsessions. Research evidence suggests that unwanted target thoughts occur at a higher frequency in those who use the strategy of thought suppression, a phenomenon which has been termed as the ‘rebound effect’ (Wegner, 1989). According to Wegner (1989), individuals distract themselves using environmental items which then become retrieval cues for the thought causing the rebound effect. In OCD, thought suppression is a form of experiential avoidance in which an attempt is made to suppress, change or control internal experiences (thoughts, feelings, bodily sensations, memories, etc.) (Hayes et al., 1996; Kashdan et al., 2006). This process of experiential avoidance is maintained in OCD though negative reinforcement, that is, short-term relief of discomfort is achieved through avoidance, thereby increasing the likelihood of the undesirable thoughts (Hayes et al., 1996).
Another important cognitive process in OCD is the way thoughts or images become fused with reality, in turn, aggravating the obsessive-compulsive symptoms. This process is called ‘Thought–Action Fusion’ (TAF) or ‘magical thinking’ (Rachman, 1993). Thought action fusion can be understood as two types, likelihood TAF and moral TAF. Likelihood TAF is the belief that having an unacceptable or disturbing thought will increase the likelihood that the thought (or situation) will occur in reality; and moral TAF which is the belief that having unacceptable thoughts, images, or impulses are as bad as actually carrying them out (Shafran, Thordarson, & Rachman, 1996). Thought–action fusion (TAF) refers to a set of cognitive biases involving faulty causal relationships between one’s own thoughts and external reality, thereby increasing the sense of personal responsibility (Shafran et al., 1996). Evidence suggests that thought-action fusion further triggers thought suppression, while thought suppression, in turn, promotes obsessive compulsive symptoms (Rassin, Muris, Schmidt, & Merckelbach, 2000).

**Epidemiological Research on OCD**

*Prevalence of OCD:* According to the National Epidemiological Catchment Area (ECA) survey, OCD was found to be the fourth most common psychiatric disorder in the United States (Pigott, 1998). Epidemiological studies estimate lifetime prevalence rates in the range of 2 to 3% (Hollander, 1997). OCD has a lifetime prevalence rate of approximately 1-2% in the general population, with one year estimates ranging from 0.7 to 2.1% (Regier, Narrow, Rae, Manderscheid, Locke, & Goodwin, 1993; Andrews, Henderson, & Hall, 2001; Kessler, Berglund, Demler, Robertson, & Walters, 2005). In the DSM-IV field trial 2% of OCD sample had pure obsessions without compulsions (Foa, Kozak, Goodman, Hollander, Jenike,
& Rasmussen, 1995). In a more inclusive criterion (e.g., Clark & Guyitt, 2008), approximately 25% of the OCD cases come under the category of pure obsessions (Ball, Baer, & Otto, 1996; Frost & Steketee, 2002). Prevalence of OCD appears to be quite consistent across countries, although cultural differences probably affect rates of symptom presentation in different countries. For example, religious obsessions are more prevalent in cultures with strict religious ideologies; washing/cleaning compulsions may be more prevalent in Muslim countries which emphasize the importance of cleanliness (Okasha, Saad, Khalil, El Dawla, & Yehia, 1994; Tek & Ulug, 2001). In India, an epidemiological study on OCD conducted by Khanna, Gururaj and Sriram (1993) found lifetime prevalence of 0.6%.

Course of OCD: The disorder tends to exhibit a waxing and waning course over the lifespan, with periods of symptomatic exacerbation and relatively good functioning (Goodman, 2006). OCD may have one of the lowest spontaneous remission rates among the anxiety disorders (Foa & Kozak, 1996); majority of patients retain significant obsessive symptoms (Steketee & Barlow, 2002). In a long term Swedish study that spanned almost 40 years, 20% of the sample exhibited complete symptoms recovery (Skoog & Skoog, 1999).

Gender Differences and Age of Onset in OCD: Evidence of differences in symptom expression appear between genders, with women displaying more washing and cleaning rituals and men reporting more sexual obsessions (Lenski, Cassano, Corredu, Ravagli, Kunovac, & Akiskal, 1996; Rachman & Hodgson, 1980). The disorder is approximately equally common in males and females, although men typically have an earlier age of onset than women, and so men tend to begin treatment at a younger age (Lenski et al., 1996; Rasmussen & Eisen, 1992). However, the average delay in initiation of treatment is between
2 to 7 years (Lensi et al., 1996). Age of onset is typically late adolescence; however, childhood onset is not uncommon. Young adults between 18 to 24 years are at a higher risk for developing OCD (Karno, Golding, Sorenson, & Burman, 1988). According to Rasmussen and Eisen (1992), 65% individuals develop the disorder before 25 years of age, with less than 5% reporting onset after 40 years.

**Effect of Stressors:** There is evidence to support presence of significant stressors prior to the onset of OCD, e.g., loss of a loved one, severe medical illness, or financial loss (Lensi et al., 1996); within 12 months period before the onset of illness as compared to the non clinical comparison group (McKeon, Roa & Mann, 1984). A significant number of women are reported to have initial onset of OCD during pregnancy (Neziroglu, Anemone, & Yaryura-Tobias, 1992).

**Co-morbid conditions in OCD:** Individuals with OCD frequently have additional co-morbid psychiatric disorders or at some time during their lifetime (Angst et al., 2005). A sub-classification of OCD has been proposed based on co-morbid conditions (Nestadt et al., 2009). The three classes solution was characterized by: (1) an OCD simplex class, in which major depressive disorder (MDD) is the most frequent additional disorder; (2) an OCD co-morbid tic-related class, in which tics are prominent and affective syndromes are considerably rarer; and (3) an OCD co-morbid affective-related class in which panic disorder (PD) and affective syndromes are highly presented (Nestadt et al., 2009). Membership within a class is differentially associated with other clinical characteristics. Depression is the most frequent complication of OCD (El-Mallakh and Hollifield, 2008); up to 60–80% of patients
diagnosed with OCD experience a depressive episode in their lifetime. Research suggests that at least one-third of patients with OCD have concurrent MDD at the time of evaluation (Perugi et al., 1997; Tükel et al., 2002). Obsessive–compulsive morbidity is also one of the most disabling co-occurring conditions in bipolar disorder (BD) (El-Mallakh and Hollifield, 2008), and has clinically significant influence on the symptomatology and complications of the disorder (D’Ambrosio et al., 2010). There is growing evidence that patients with co-morbid OCD and schizophrenia (recently termed “schizo-obsessive”; Hwang and Hollander, 1993; Zohar, 1997) appear to have distinct patterns of psychopathology, course of illness, psychiatric co-morbidity, neuro-cognitive deficits, and treatment response, compared to their schizophrenic counterparts, suggesting the existence of a separate subgroup on the schizophrenia spectrum (Poyurovsky et al., 2004; Lysaker and Whitney, 2009). The US National Institute for Mental Health Epidemiologic Catchment Area Study estimated 12.2% prevalence of co-morbid OCD and schizophrenia (Karno et al., 1988). Obsessive–compulsive disorder has also been found to be a co-morbid condition with temporal lobe epilepsy (TLE). About 10-22% patients with TLE show a high rate of obsessions of washing, symmetry/exactness, and ordering, with greater preoccupation concerning certain aspects of religion, compared with controls or patients with idiopathic generalized epilepsy. Furthermore, discrete anatomic lesions in these pathways, or their surgical removal, may induce (or conversely) improve OCD in TLE patients (Kaplan, 2010). Many other neurological conditions are co-morbidly present with OCD, e.g., Tourette’s syndrome, Sydenham’s chorea, Huntington’s disease, and von Economo’s encephalitis (Miguel et al., 1997), Parkinson’s disease (Pallanti et al., 2010). Lifetime co-morbidity between OCD and other anxiety disorders has been identified as 22% for specific phobia, 18% for social anxiety disorder (social phobia), 12% for PD (Pigott et al., 1994), and 30% for GAD. Therefore, it is
clear that an accurate assessment of OCD and anxiety co-morbidities is necessary to achieve a proper treatment and a good response to it. The non-response to treatment often involves the presence of co-morbid conditions. Non-responsive patients are more likely to meet criteria for co-morbid axis I or axis II disorders and the presence of a specific co-morbid condition could be a distinguishing feature in OCD, with influence on the treatment adequacy and outcome (Pallanti and Quercioli, 2006). For the treatment of OCD, pharmacotherapy involves the use of serotonergic antidepressants, such as selective serotonin reuptake inhibitors (SSRIs) and the tricyclic antidepressants, in particular, clomipramine.

**Impact of OCD on Functionality:** According to the World Health Organization (WHO, 2001), OCD is the 10th most disabling of all medical disorders, and has a significant negative impact on occupational and social functioning, as well as educational attainment (Antony, Downie & Swinson, 1998; Kano et al., 1988). Patients diagnosed with OCD were found to have significant impairment in Quality of Life (QOL) as measured using a variety of instruments in different studies (e.g., Akdede, Alpeterkin, Akvardar, & Kitis, 2005; Masellis, Rector, & Richter, 2003; Rodriguez-Salgado et al., 2006). QOL in patients diagnosed with OCD was found to be even lower than those diagnosed with schizophrenia or depression (Stengler-Wenzke et al., 2006; Gururaj, Bada Math, Reddy, & Chandersekhar, 2008).

**Psychological Intervention for OCD**

Although OCD has a strong neurobiological etiology, research has recognized the critical role of psychological factors in the development and maintenance of the disorder. Much research on the psychotherapeutic treatment of OCD has focused upon Exposure and Response Prevention (ERP) and Cognitive Therapy (CBT) as efficacious treatments for OCD.
(e.g., Abramowitz, 1997, 1998; van Balkom et al., 1994). According to Eddy, Dutra, Bradley, & Westen (2004), although psychological treatments often produce substantial decrease in symptomatology, the majority of treated patients remain symptomatic. In understanding this phenomenon, Frost & Steketee (2002) note the importance of illustrating the key cognitive processes involved in the development and maintenance of the disorder in order to develop a more efficient and cost effective psychological treatment for OCD. An important concept that has been proposed in the understanding of OCD is meta-cognition, or the cognition and beliefs about one's thinking and the strategies used to regulate and control thinking processes (Wells, 1997, 2000). According to Wells (1997, 2000), two aspects are fundamental to the maintenance of OCD, i.e., meta-cognitive beliefs about the meaning and consequences of intrusive thoughts and feelings (for e.g., belief about the obsession as being unacceptable or beliefs about the consequence of the emotion/discomfort; thought-action fusion), and beliefs about the necessity of performing rituals and the negative consequences of failing to do so (for e.g., belief about controlling the thought). This further leads to increasing anxiety, which is reduced by engaging in distraction, suppression, avoidance, or performing the ritual; in other words by engaging in experiential avoidance. According to Hayes, Wilson, Gifford, Follette, & Strosahl (1996), OCD is a disorder that is characterized by unacceptable experiences and ineffective change strategies designed to avoid them; unpleasant events that the patient seeks to avoid or escape, for e.g., contamination fears, doubts, aggressive or blasphemous thoughts. The patients with OCD react to the thoughts by ignoring, avoiding or suppressing them, thus distracting themselves, or may they develop elaborate rituals that are thought to undo the danger and experientially reduce anxiety connected to the intrusive thoughts. Compulsions, in turn, become mechanisms of experiential escape. The process of deliberate control contradicts the desired outcome; as experiential avoidance, either by ritual,
distraction, or suppression maintains the problem. Thus, therapy for OCD should focus on the meta-cognitive processes that maintain the disorder; thus, enabling the patient to develop adaptive ways of processing obsessional stimuli for guiding subsequent behavior (Fisher & Wells, 2008). One such therapy is Acceptance and Commitment Therapy.

**ACCEPTANCE AND COMMITMENT THERAPY (ACT)**

*Acceptance and Commitment Therapy* (ACT; Hayes, Strosahl, & Wilson, 1999) is amongst the third wave of behaviour therapies, which draw from a combination of Eastern meditation and Western psychology. The third wave of behavioral and cognitive therapies is particularly sensitive to the context and functions of psychological phenomena, not just their form, and thus tends to emphasize contextual and experiential change strategies, to improve both the understanding and the outcomes. Acceptance and Commitment Therapy (ACT) is a unique empirically based psychological intervention that uses acceptance and mindfulness strategies, together with commitment and behavior change strategies, to increase psychological flexibility (sometimes referred to as acceptance). *Psychological flexibility* means contacting the present moment fully as a conscious human being, and based on what the situation affords, changing or persisting in behavior in the service of chosen values. It Based on Relational Frame Theory, Acceptance and Commitment Therapy illuminates the ways that language entangles clients into futile attempts to wage war against their own inner lives. Through metaphor, paradox, and experiential exercises clients learn how to make healthy contact with thoughts, feelings, memories, and physical sensations that have been feared and avoided. Clients gain the skills to re-contextualize and accept these private events, develop greater clarity about personal values, and commit to needed behavior change (Hayes, n.d., ACBS).
Relational frames allow one to think about events that are not present, compare possible outcomes and then have these verbal relations alter how analyzed events function; for e.g., “If I kill myself, I will stop suffering, which is good”. These verbal rules or evaluations tend to narrow the range of behaviour available to make contact with here and now experience and more direct contingencies (Hayes, 1989). Furthermore, relational frames increase the reach of aversive events leading to avoidance of stimuli similar to painful events of past. Psychopathology results from substituting perceptions and cognitions (cognitive fusion) for having direct experiences, and avoidance of private events or experiences (experiential avoidance) that have been judged or evaluated to be negative, based on thoughts of what might take place, or in an attempt to avoid repeating painful experiences (Hayes, Follette & Linehan, 2004).

Acceptance and Commitment Therapy (ACT) is conceived as the treatment of ‘Experiential Avoidance Disorder’. Experiential Avoidance is the phenomenon that occurs when a person is unwilling to remain in contact with particular private experience (e.g., bodily sensation, emotions, thoughts, memories, behavioural predispositions) and takes steps to alter the form or frequency of these events and the contexts that occasion them. (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). According to Harris (2006), ACT does not have symptom reduction as a goal; the aim is to transform our relationship with our difficult thoughts and feelings, so that we no longer perceive them as ‘symptoms’. Instead, learn to perceive them as harmless, even if uncomfortable, transient psychological events, with symptom reduction as a byproduct. Unpleasant and unwanted ‘private experiences’ (thoughts, images, feelings, sensations, urges, and memories) act as barriers, the attempt to control private experiences can lead to a paradoxical increase in the intensity and frequency of those
experiences, and may even result in psychopathology (Hayes, 2004). Thought suppression in OCD is a form of experiential avoidance (Hayes et al., 1996). Further, cognitive fusion, which supports experiential avoidance, occurs when an individual’s verbal processes (i.e., thoughts) markedly regulate overt behaviour in ineffective ways due to the inability or failure to notice the process of thinking (context) over the products of thinking (content) (Hayes, Luoma, Bond, Masuda, & Lillis, 2006).

ACT views psychological inflexibility as a major causal factor underlying clinical problems; thus, increasing psychological flexibility is a main goal of the therapy. Psychological flexibility, as described earlier, is an individual’s ability to connect with the present moment fully, as a conscious human being, and to change or persist in behavior that is in line with identified values (Hayes, Strosahl, & Wilson, 1999). Psychological inflexibility is argued to emerge from experiential avoidance, cognitive fusion or entanglement, attachment of a conceptualized self, loss of contact with the present, and the resulting failure to take needed behavioral steps in accord with core values. Increasing psychological flexibility involves helping clients to disentangle themselves from the cycle of experiential avoidance and cognitive fusion, not by challenging or changing their thoughts and emotions, but by learning to react more mindfully to such experiences, so that they no longer seem to be barriers (Ciarrochi & Blackledge, 2006). ACT enables one to handle these private experiences effectively utilizing an eclectic mix of metaphor, paradox, and mindfulness skills, along with a wide range of experiential exercises and values-guided behavioural interventions (Harris, 2006). According to Hayes, Strosahl, and Wilson (2011) six key processes are involved in cultivating psychological flexibility: cognitive defusion, acceptance, attention to the present moment, self-awareness, values, and committed action.
These processes are linked to an alteration of the core language processes that interfere with such flexibility. According to Hayes, Follette and Linehan (2004), these six processes can be divided into two groups. The four on the left (acceptance, defusion, contact with the present moment, and self-as-context) together delineate acceptance and mindfulness skills from an ACT perspective. The four on the right (contact with the present moment, self-as-context, values, and committed action) together delineate commitment and behaviour change skills from an ACT perspective (Fig. 1). Together these larger sets of skills unite into a coherent whole in the “acceptance and commitment therapy” approach (Hayes, Follette & Linehan, 2004).

*Figure 1. The facets of psychological flexibility according to the model of change underlying ACT. Note. From Mindfulness and Acceptance: Expanding the Cognitive-Behavioral*
Mindfulness is the practice of consciously bringing awareness to one’s here-and-now experience, including your thoughts, with openness, interest, and receptiveness (Harris, 2006). Marsha Linehan (1993), while integrating mindfulness in the treatment of patients with borderline personality disorder, broke down the practice of mindfulness into the ‘core skills’. There are three ‘what’ skills (observing, describing, participating) and three ‘how’ skills (taking a nonjudgmental stance, focusing on one thing in the moment, being effective). The mindfulness ‘what’ skills include learning to observe, to describe and to participate, the goal of which is to develop a lifestyle of participating with awareness. The first ‘what’ skill is ‘observing’ – that is, attending to events, emotions, and other behavioral responses, even if these are distressing ones. What the patient learns is simply to allow oneself to experience with awareness, in the moment, whatever is happening, rather than leaving a situation or trying to terminate the emotion. Generally, this ability requires a corresponding ability to step back from the event; observing an event is separate or different from it. The second ‘what’ skill is that of ‘describing’ events and personal responses in words, non-judgmentally. The ability to apply verbal labels to behavioural and environmental events is essential for both communication and self control. Learning to describe requires that the individual learn not to take emotions and thoughts literally – that is, as literal reflections of environmental events; for e.g., feeling afraid does not necessarily mean that a situation is threatening to one’s life or welfare. The third ‘what’ skill is the ability to ‘participate’ without self-consciousness. Participating in this sense is entering completely into the activities of the current moment, without separating oneself from
ongoing events and interactions. Mindful participation is participation with attention. The first ‘how’ skill is ‘non-judgmental acceptance’, i.e., accepting things ‘just as they are’ without judging them as either good or bad. It involves observing even painful experiences, but not attaching a label of ‘bad’ to them. This is the action of describing the facts, and not thinking about what’s “good” or “bad”, “fair”, or “unfair.” These are judgments because this is how you feel about the situation but isn’t a factual description. Being non-judgmental means to get one’s point across in an effective manner without adding a judgment, and fully contacting the present moment and the thoughts and feelings it contains without needless defense. In the concept of mindfulness, ‘acceptance without judgment’ refers to allowing thoughts to come and go without struggling with them. The second skill is to learn to focus the mind and awareness on the current moment’s activity only, ‘one-mindfully’. Skill of ‘participation’ when combined with this can also be referred to as ‘acting with awareness’. The last ‘how’ skill of ‘being effective’ is directed towards reducing patient’s tendency to be more concerned with what is ‘right’ than with doing what is actually needed in a situation.

Techniques of Acceptance and Commitment Therapy (ACT) (Hayes, Follette & Linehan, 2004).

Confronting the System: Creative Hopelessness - Involves evaluating the workability of client’s ways of solving problems and bringing to their awareness how it may not be a faulty technique, but the faulty purpose behind it, for e.g., using the “Person and the Hammer” metaphor.
Control is the Problem – Making clients experience how conscious, deliberate, and purposeful control may not work well with regard to private experiences that one may be targeting, for e.g., using “Don’t think of x” exercise.

Cognitive Defusion and Mindfulness Techniques – Defusion involves working towards changing the contextual function of events in order to decrease the impact and importance of difficult private events. These techniques serve to enable a person to see thoughts as what they are, not what they say they are; thus, eroding the stimulus functions that occur through relational learning (Hayes et al., 1999). For e.g., using the defusion technique of “Milk, Milk, Milk” exercise (Titchener, 1916, p.425) which helps clients notice the process of thinking in the moment; and the “Soldiers in the Parade” exercise which helps to enhance mindfulness skills. ACT sessions often initiate with mindfulness exercises and they are regularly used throughout the therapy to help clients cultivate the ability to look at thoughts as thoughts rather than looking at the world through thoughts, and to learn how to detect the difference.

A Transcendent Sense of Self – This involves enabling clients to develop the “Here Now” perspective of directly experiencing events and thus preventing them from feeling threatened by the difficult nature of psychological content. For e.g., using “The Observer” exercise and “Chess Board” metaphor that helps explain self as context.

Acceptance and Willingness – Acceptance involves undefended ‘exposure’ to thoughts, feelings, bodily sensations as they are directly experienced to be; and the active nonjudgmental embracing of experience in the here and now. For e.g., using the “Jumping versus Stepping Down” metaphor to explain the ‘letting go’ quality of acceptance.

Values – Values are chosen qualities of action that can be instantiation in behaviour and determine the path to achieve concrete goals identified as significant by the client. The barriers to these actions (often psychological than situational) are also identified and are dealt
with through acceptance, exposure, mindfulness, and defusion. For e.g., various evocative exercises such as the “Message on the Tombstone” exercise is used to enable clients to develop more clarity about fundamental values and goals.

*Commitment* – ACT is as much a change-oriented strategy as an acceptance-oriented one, focusing on areas that are readily changeable. It involves making specific commitments with the bigger goal of psychological flexibility and taking full responsibility for behavioural patterns: changing when change is needed, and persisting when persistence is needed. This involves use of concrete homework and behavioural exercises to build larger patterns of effective action.

**Comparing Acceptance and Commitment Therapy (ACT) with Cognitive Behavioural Therapy (CBT)**

ACT differs from traditional cognitive behaviour therapy (CBT) in that rather than trying to teach people to better control their thoughts, feelings, sensations, memories and other private events, ACT teaches them to “just notice”, accept, and embrace their private events, especially previously unwanted ones and to act in ways consistent with chosen values (Hannan & Tolin, 2005). ACT helps the individual get in contact with a transcendent sense of self known as “self-as context” – the aspect of the self that is always there observing and experiencing and yet distinct from one’s thoughts, feelings, sensations and memories. ACT aims to help the individual clarify their personal values and to take action on them, bringing more vitality and meaning to their life in the process and increasing their psychological flexibility. ACT relies heavily on paradox, metaphors, stories, exercises, behavioural tasks, and experiential processes; with limited role of direct instruction, logical analysis, and persuasion. The goal is not to create a new belief system, but to establish a more flexible
repertoire, allowing change when change serves and persistence when persistence serves (Hayes, Follette & Linehan, 2004).

The key goal of ACT is to support clients in feeling and thinking what they directly feel and think already, as it is, not as what it says it is, and to help clients move in a valued direction, with all of their history and automatic reactions. ACT tends to use relatively nonlinear form of language to prevent the pathology which may emerge from psychologically rigid repertoires. The process of ACT involves facing costs of psychological inflexibility and its sources, particularly cognitive fusion (figuring it out, treating oneself as a verbally evaluated object) and avoidance (suppression, passivity in face of needed action); and learning to accept and defuse in areas where psychological inflexibility is dominant (emotions, self, thoughts, sensations); in an attempt to build larger patterns of effective behaviour linked to goals and values of one’s’ life (Hayes, Follette & Linehan, 2004).

THE PRESENT RESEARCH

The present research was undertaken to study the efficacy as well as the effects of Acceptance and Commitment Therapy (ACT) on the process measures of Obsessive Compulsive Disorder (OCD). Acceptance and Commitment therapy seems extremely viable in the context of OCD as ACT aims to teach patients ways to experience obsessions and anxiety as ‘just’ thoughts and feelings that they may or may not respond to. ACT utilizes processes such as acceptance, values, and mindfulness in the treatment to foster willingness to experience obsessions and related anxiety (Hayes et al., 1999). When obsessions and anxiety are experienced in this way, it is much easier to respond flexibly to these experiences. The core principles of ACT are extremely relevant in the treatment of OCD by
way of working on the behavioural and psychological flexibility and in turn working on the processes that maintain OCD. The principles of mindfulness and acceptance in ACT counteract the experiential avoidance in patients diagnosed with OCD, thus, working on a key element that maintains OCD. They also work on the underlying meta-cognitive beliefs that in turn cause avoidance or thought suppression. Thought-action fusion (TAF) is an extreme form of cognitive fusion experienced by people with OCD. Patients diagnosed with OCD tend to identify with their thought, over-value them and even fear them. Cognitive defusion, another significant principle in ACT, means to be able to step back from one’s thoughts and observe them without being caught up in their content, enabling patients with OCD to break the cycle of TAF. The principle of self as context works to enable persons to view themselves as separate from their thought, thus, counteracting the underlying meta-cognitive processes that maintain OCD. Lastly, values and committed action enable people with OCD to withstand the initial discomfort of anxiety to be gradually able to emerge out of the vicious cycle of OCD symptoms and lead a more desired and meaningful life. Hence, ACT seems a relevant treatment option for OCD in the way of working towards developing psychological flexibility, mindfulness skills, counteracting thought suppression, and thereby reducing symptoms in patients diagnosed with OCD.

This study was undertaken as there is paucity of research in this area, especially on the process measures of OCD subsequent to the application of ACT. This research was an attempt to gain more insight into the effectiveness of Acceptance and Commitment Therapy (ACT) on patients diagnosed with Obsessive-Compulsive Disorder (OCD), and more specifically to investigate the impact of ACT on the processes of psychological flexibility, thought suppression and mindfulness skills in a clinical sample of Obsessive-Compulsive
Disorder. Also, in India, there has been very little emphasis on and application of
Acceptance and Commitment Therapy with hardly any published work. Therefore, in the
present study, an attempt was made to examine the effects of Acceptance and Commitment
Therapy on psychological flexibility, thought suppression, mindfulness skills, and
symptoms in patients diagnosed with Obsessive-Compulsive Disorder.