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### Case Study



# Addicted to Compulsions: A Complex Case Study of Obsessive and Compulsive Disorder Treated with Acceptance and Commitment Therapy (ACT) and Exposure Therapy (ERP)

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### Abstract

Obsessive-Compulsive Disorder (OCD) is characterised by distressing, intrusive obsessive thoughts and/or repetitive compulsive physical or mental acts. OCD negatively impacts patients' functioning and quality of life. Acceptance and Commitment Therapy (ACT) promotes acceptance of difficult sensations, emotions, and thoughts and when doing so facilitates living a values-based life. This study describes ACT for improving functioning and wellbeing for a young 30-year-old woman with complex OCD. She attended fourteen sessions, using Acceptance and Commitment Therapy (ACT) with Exposure and Response Prevention (ERP). Specific measures were obtained between the sessions (Yale-Brown Obsessive-Compulsive Scale; Obsessional Compulsive Inventory and CORE Outcome Measure). Improvements were evident; outcome measures suggest a reduction on the symptoms of OCD and an increase in well-being. Anecdotal comments support these findings and provide additional evidence that ACT and ERP is an effective treatment in Obsessive-Compulsive Disorder.

### Keywords

Acceptance; Commitment; Compulsion; Obsession

### Abbreviations

|     |   |                                   |
|-----|---|-----------------------------------|
| ACT | : | Acceptance and Commitment Therapy |
| CBT | : | Cognitive and Behavioral Therapy  |
| ERP | : | Exposure and Response Prevention  |
| OCD | : | Obsessive-Compulsive Disorder     |

### Introduction

Obsessive-Compulsive Disorder (OCD) is characterized by repetitive and unwanted thoughts (i.e., obsessions) and perseverative and ritualized behaviors (i.e., compulsions) [1]. OCD is ranked by the World Health Organization in the top 10 of the most handicapping illnesses by lost income and decreased quality of life [2]. Obsessive-Compulsive Disorder is one of the most common mental illnesses in Western countries, with an estimated 1.2% of the UK population affected at any one time (OCD-UK, 2016).

OCD may have a major negative impact on social relationships leading to frequent family and marital discord or dissatisfaction, separation or divorce [3]. OCD often interferes with a person’s ability to study or work, leading to diminished educational and/or occupational attainment, and unemployment [3].

The most common obsessions are listed in table 1. The percentages refer to the frequency in a survey of 431 individuals with OCD [4].

Acceptance and Commitment Therapy (ACT) is a trans diagnostic Cognitive Behavioural Therapy (CBT) that emphasises acceptance, mindfulness, values clarification, and enactment skills [9]. ACT is recognised as “empirically supported” by the US Substance Abuse and Mental Health Services Administration (SAMHSA, 2012) in their national registry of evidence-based programmes and practices in the areas of Obsessive-Compulsive Disorder (OCD), depression, general mental health, and rehospitalisation.

| Obsession   | Percent |
|---|---------|
| Contamination from dirt, germs, viruses (e.g., HIV), bodily fluids or faeces, chemicals, sticky substances, dangerous material (e.g., asbestos) | 37.8%   |
| Fear of harm (e.g., door locks are not safe)  | 23.6%   |
| Excessive concern with order or symmetry  | 10.0%   |
| Obsessions with the body or physical symptoms   | 7.2%    |
| Religious, sacrilegious or blasphemous thoughts   | 5.9%    |
| Sexual thoughts (e.g., being a paedophile or a homosexual)  | 5.5%    |
| Urge to hoard useless or worn out possessions   | 4.8%    |
| Thoughts of violence or aggression (e.g., stabbing one’s baby)  | 4.3%    |

**Table 1:** Common obsessions in OCD.

One of the promising novel treatment strategies, which have been developed to improve the efficacy of treatment for patients with OCD, is the Acceptance and Commitment Therapy [5].

ACT is a third-wave of Cognitive and Behavioural Therapy (CBT) that specifically focuses on decreasing Experiential Avoidance (EA) and increasing psychological flexibility [6]. ACT researchers argue that ACT is not less effective than traditional CBT but that it currently lacks good quality research [7].

ACT employs six core components to attempt to increase psychological flexibility and change the way the person interacts with their thoughts and feelings: Cognitive defusion (recognising thoughts as constructs, not objective facts), Acceptance, Contact with the present moment (mindfulness), Observing the self, Values and Committed action A typical ACT session includes experiential exercises where therapists or facilitators use stories, metaphors, mindfulness and language games to help people gain a different perspective on their thoughts and emotions [8]. ACT commonly combines attention to a person’s life values with concrete goals based on behavioural changes.

Exposure and Response Prevention (ERP) is a method of allowing a client to experience their intrusive thoughts and uncomfortable feelings yet not completing previously used compulsive behaviours (the responses). Therefore graded exposure exercises based on valued actions using ERP are compatible with ACT.

In treating OCD, ACT targets particular constructs including cognitive defusion and decreasing EA. ACT teaches patients to create a new relationship with obsessive thoughts and anxious emotions; for example, helping patients notice that a thought is just a thought and anxiety is an emotion to be felt. ACT also helps patients commit to act in the service of their valued life goals rather than spending large amounts of time trying to decrease the obsession or avoid anxious feelings. ACT helps patients to accept their obsessional thoughts and negative feelings and commit to act in the service of their valued life whether or not obsessions were occurring. Thus, these constructs will increase psychological flexibility, which is the ability to act in accordance with the patient’s meaningful life directions regardless of unpleasant inner experiences [10].

## Case Presentation

The patient is a 30-year-old female, symptoms of OCD started three years ago but she has a history of bullying and anxiety from the age of 16 years old.

She described symptoms of anxiety at her workplace a year before she developed OCD till the point she could not cope anymore and left work completely. Two months later her parents went to South Africa, and she was at home alone, her brother, grandmother, and sister were around and supportive.

Her parents stayed an extra two weeks due to her mother being admitted to hospital with a perforated bowel. At that time,

she remembers getting a bit anxious but coping “fairly well.”

Her mother was unable to work for a few months and due to her previous surgery that she suffered from acid reflux. This occasionally created a small bubble in her throat causing a problem with food intake. The patient described these episodes as the cause of her becoming scared of food and eating.

She experienced strong anxiety a month later whilst watching a thriller TV series and eating her dinner. She experienced a major anxiety attack and described it as: “I got hot, and my heart started racing chest and throat tightening.”

Over the following few months, she experienced more panic attacks and usually whilst eating dinner. She began associating anxiety attacks with eating and food because she just kept getting anxious every time she was eating.

Another triggering on her anxiety was when it was feeling hot, or she felt there was no air, as this sensation reminds her a panic attack sensation. Over time, she was starting eating less and less until some days she was not eating at all.

She developed a belief that she was allergic to everything: food, drink or even things she touched. Moreover, anytime she tried to eat, her throat felt like it was tightening. Over time, she struggled more and more with eating until being able to eat only tomato soup, hot chocolate, and a vitamin shake.

In addition to struggling to eat, she was unable to do anything alone and needed someone to be present in the room. She was unable to watch anything related to illnesses and hospitals. Her coping strategy was constant avoidance and distraction; she mentioned: “I needed to constantly play games on my phone to keep me distracted from my anxiety.”

In ACT terms, she became fused in setting her timer for 15 minutes after eating and drinking. She struggled to go out, everything is done at roughly the same times, and she struggled with change.

## Assessment and Treatment

The patient gave written consent for our therapy work to be written up as an anonymized single case study. We held 14 weekly sessions.

She was diagnosed through a Semi-Formal Interview and Psychological Evaluation, including OCI Questionnaire and Yale-Brow Obsessive-Compulsive Scale, showing in both psychometric test significantly high scores. A differential diagnosis was made using the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition), and the conclusion was that this patient only diagnosed was OCD.

All sessions followed the same pattern: events since the last session and homework were reviewed, the material from the previous session was reviewed, new material was presented, new homework was assigned, and behavioural commitment exercises were agreed upon. Behavioural commitment exercises involved commitments to engage in values-guided behaviour instead of behaviour guided by attempts to control one's private events.

She described having 2 courses of CBT, the first one was 10 half an hour online (text message) sessions that she did not find useful and then 6 more sessions in person, she mentioned: “the therapist only made emphasis in I should have more positive thought”, any of the previous therapists did not diagnosed her. In several occasions she was offered medication, but regarding her fear of swallowing in combination with her allergies she felt unable to take this route. Throughout the whole treatment she did not take any medication.

The first two sessions consisted of developing initial rapport and an assessment carried out. Due to the complexities involved, aspects of her history were gathered throughout the whole treatment. The following two sessions were used as psychoeducation in OCD. The patient mentioned several times feeling understood. She found very useful just going through the outcome measures and noticing statements that could explain the way she was thinking and feeling.

Intervention sessions focused on ACT processes and techniques for increasing psychological flexibility. Throughout the sessions, we used experiential activities to introduce ACT concepts.

Psychoeducation regarding concepts of Acceptance and Commitment Therapy and Obsessive-Compulsive Disorder where introduced from session 3. We began by distinguishing the difference between the obsession and the compulsion; we worked around the vicious cycle of OCD and how attempts to control the obsession might be the problem rather than the solution. This session we also introduced specific strategies to be in the present moment instead of distracting herself.

From session 4, she started introducing graded exposure exercises and response prevention. During previous sessions, we discussed diverse options to introduce other nutrients to her diet. Moreover, we discussed the possibility of baby food and considering that the brand she found had three stages.

Between sessions 4 and 9, she tried four different types of baby food, including the following ingredients: peas, broccoli, potatoes, carrots, kale, pumpkin, sweet corn, squash, sweet potato, and parsnip. It is relevant to mention the flavours, and each of them implied exposure for the patient. She started with two spoons a day until she managed to have the whole sachet. She adds the baby food to her daily diet of the hot

chocolate, tomato soup, and milkshake. The patient struggled between sessions 7 and 9 and she experienced cold symptoms, including a sore throat, which made the tightness in her throat more significant.

From session 10, she started having a whole sachet of the vegetable she started adding 1 fruity one in the mornings, and from session 13, she began with stage 2.

There have been several graded exposures thought-out all the sessions; she has significantly reduced washing her hands, she has challenged herself to use a public toilet, she managed to go by train to the city and to go to a theatre show (previously we did imagination exposures). She cleaned her bedroom being aware of the thing she really needed, walking by herself 20 minutes, eating in public places, and using the dishwasher when someone ate something with nuts.

Furthermore, from session 4, we included and reinforced concepts and diverse exercises involving defusion, contact with the present moment, and self as context work.

The struggle switch [5,11] is an extended metaphor that covers both creative hopelessness and acceptance, once introduced it becomes a powerful interactive tool for acceptance work.

We used the metaphor passengers on a bus in which the participant is the bus driver. This metaphor illustrates that the passengers have had control of the bus (the participant responding to his or her obsessions) rather than the driver, and offers control of the bus back to the driver. The participant is told that the passengers will probably get upset (the obsessions will feel more intense), but the participant will gain control of the bus [5].

From session 7, the patient values where describe by areas including: Family relations, Marriage/couple/intimate relations, Parenting, Friendship/social/relationship, Employment, Education/training/personal growth, Recreation, Spirituality, Citizenship/community, and Physical wellbeing. The patient was asked to rate the importance of each area and to rate her success in pursuing those. She mentioned: "I do not know who I am. I have lived more for what other expected from me". There were even a few areas just blank. We worked during three sessions trying to clarify her values to then increased behavioural commitments to follow those values.

## Outcome Measures

The present study has utilized the intensive time-series design [12]. The patient was asked to complete the Yale-Brown Obsessive-Compulsive Scale; Obsessional Compulsive Inventory and CORE Outcome Measure (Table 2).

| Outcome Measure                      | Session administered |
|--------------------------------------|----------------------|
| CORE- Outcome Measure                | 1-4-7-11-14          |
| OCI Questionnaire                    | 02-06-2013           |
| Yale-Brow Obsessive-Compulsive Scale | 04-07-2014           |

**Table 2:** Measures used during therapy.

## CORE-Outcome Measure

The CORE-OM is a 34-item generic measure of psychological distress, which is pan-theoretical (i.e., not associated with a school of therapy), pan-diagnostic (i.e., not focused on a single presenting problem), and draws upon the views of what practitioners considered to be the most important generic aspects of psychological wellbeing health to measure. The CORE-OM comprises four domains: Well-being (4 items), Symptoms (12 items), Functioning (12 items), Risk (6 items) [13].

## OCI questionnaire

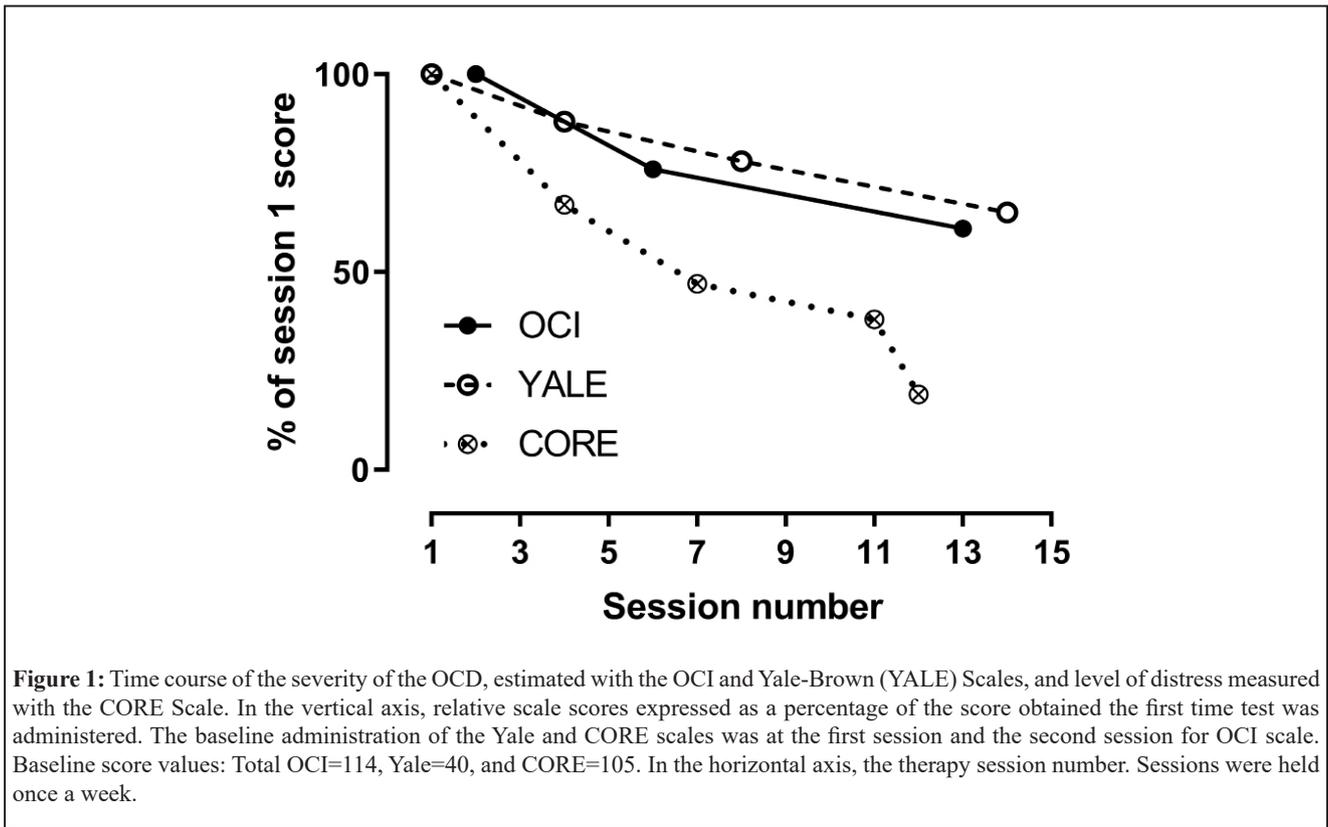
Obsessive Compulsive Inventory [14]. The OCI is a 42-item measure of OCD features. Items are rated on a 0-to-4-point scale for the frequency of the symptom and severity of the associated distress. The OCI is scored by summing the scores from the individual items for each subscale (Washing, Checking, Doubting, Ordering, Obsessions, Hoarding and Neutralising). The scores range from 0 to 168 on each OCI subscale.

## Yale-Brow Obsessive-Compulsive Scale

The Yale-Brown Obsessive-Compulsive Scale was designed to remedy the problems of existing rating scales by providing a specific measure of the severity of symptoms of the obsessive-compulsive disorder that is not influenced by the type of obsessions or compulsions present. The scale is a clinician-rated, 10-item scale, each item rated from 0 (no symptoms) to 4 (extreme symptoms) (total range, 0 to 40), with separate subtotals for severity of obsessions and compulsions [15].

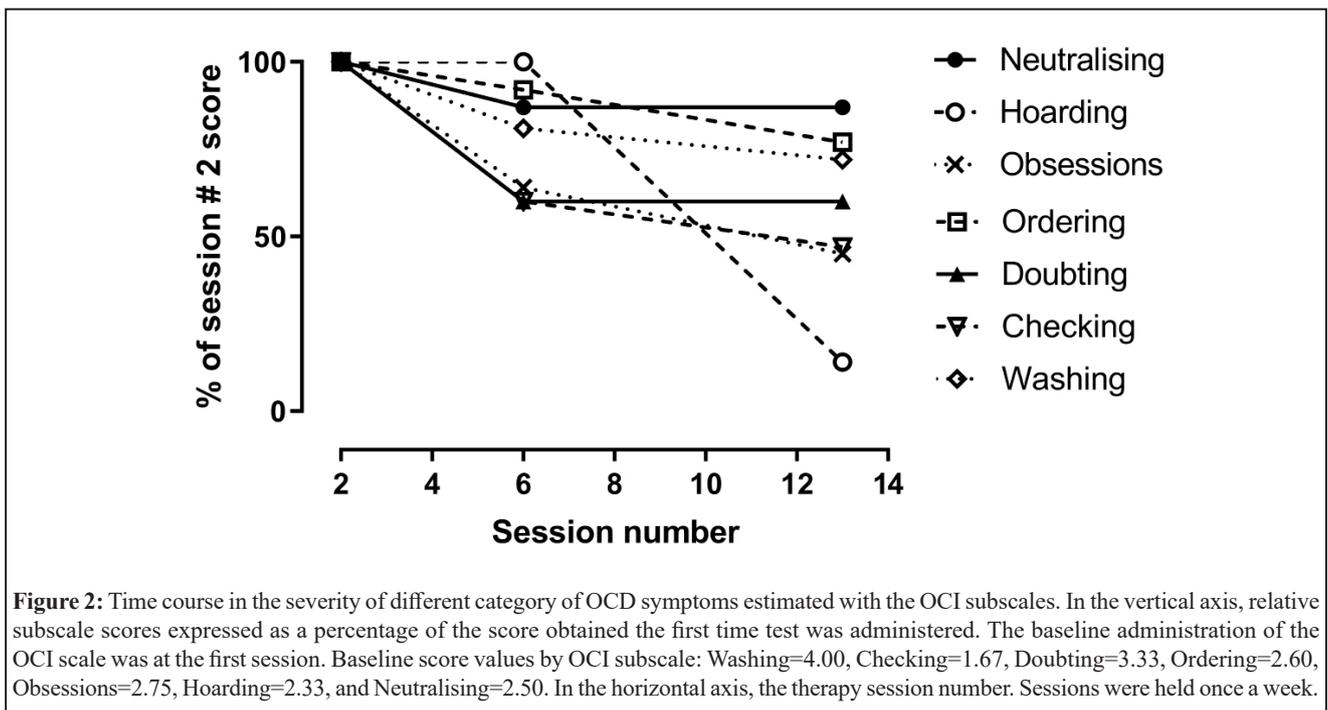
## Results

The scores of the OCI, Yale-Brown, and CORE scales progressively fell throughout the therapy sessions (Figure 1). The time courses of the OCI and Yale-Brown scores were comparable and correlated. OCI and Yale scores fell to 61% and 65% of their baseline values, respectively, at the last 14th session. CORE scores had the highest drop, being only 19% of the baseline value at the last 14th session. These changes suggest that the effect of the behavioral intervention was more substantial on the psychological distress than on the severity of OCD.



Most of the categories of symptoms comparably lessened across the sessions although the decline was more pronounced for the hoarding category (Figure 2). Indeed, hoarding scores fell up to just 14% of the initial baseline score in contrast to the rest of the OCI subscales scores, which declined more moderately up to 45-87% of their baseline values. At the session 6th

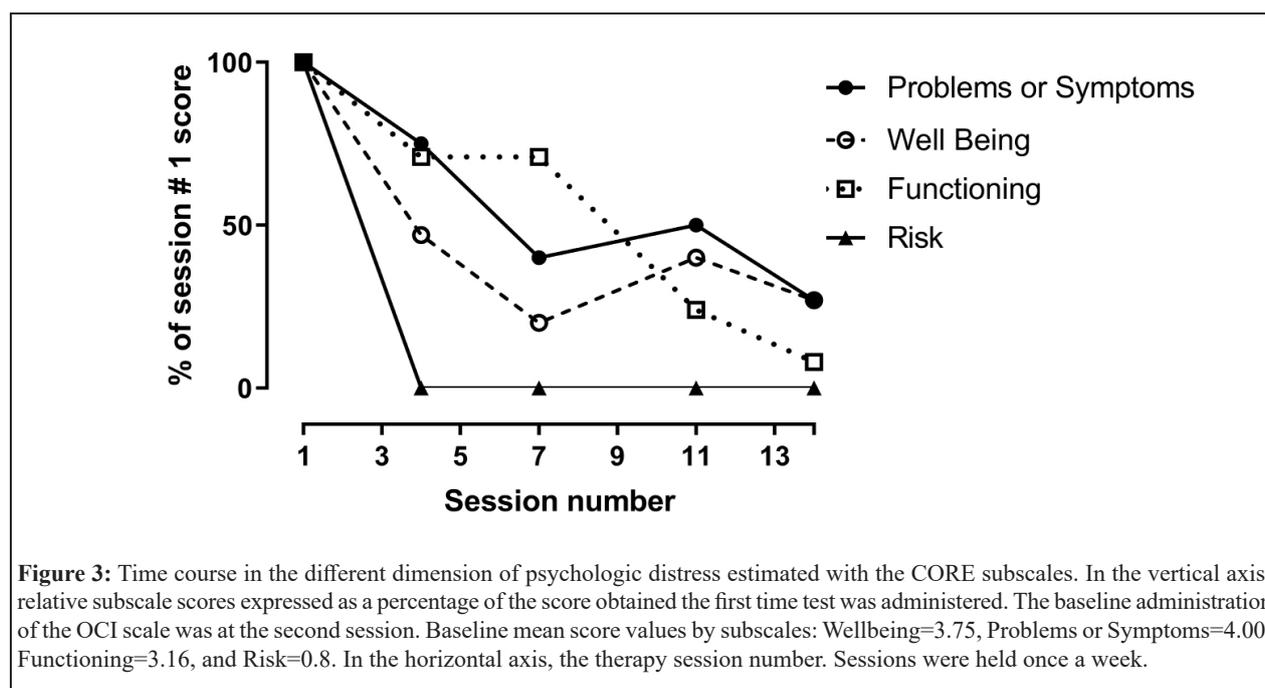
(five weeks since the first session), intervention effects were noticeable in most of the categories except for hoarding, ordering, and neutralising, which exhibited no change or only subtle changes. At the end of the intervention process (session 14th, 13 weeks since the first session), the best improvements (> 50%) occurred in hoarding, obsession, and checking.



All of the categories of psychological distress declined across the sessions with noticeable intervention as early as in session 4th (3 weeks since the first session) (Figure 3). At the end of the intervention process (session 14th, 13 weeks since the first session), the best improvements (> 90%) occurred in the functioning and risk categories, although the improvement in the other categories (wellbeing and problems/symptoms) was also remarkable (> 30%).

In practice, ERP is conducted in the context of a conceptual framework, and there is evidence that the rationale and goals provided for exposure-based therapy (such as ERP) can affect adherence and outcome [19].

The outcome measures reflect reliable changes and significant reduction of OCD symptoms, especially regarding areas of obsessions and checking that correspond directly with her



## Discussion

There have been multiple randomized trials of ACT, which included exposure exercises, showing that it is a useful treatment for a variety of disorders including mixed anxiety groups, which included OCD [16].

Acceptance and Commitment Therapy (ACT) is a form of psychotherapy that attempts to change how a person views their thoughts and feelings. This is in contrast to challenging those thoughts directly as in Cognitive Behavioural Therapy [17]. These could also explain why CBT did not work with this client.

ACT does not aim to eliminate psychological distress but helps people to choose to live how they want to despite difficult feelings. However, this is expected to lead to a reduction in psychological distress as people learn to accept their thoughts and feelings, seeing them as constructs rather than objective facts. ACT may currently be of interest due to the recent surge in popularity of mindfulness-based interventions in schools to enhance Doctorate in Educational and Child Psychology Imogen Hagarty 3 mental health [18].

diagnosis. To date, very little has been done with ACT and ERP for OCD, and as ERP is the “gold standard” treatment for OCD, it seems logical to see these two approaches can support each other [20].

The decreased of the areas of well-being and functioning between session 7 and 9, could be explained the patient had cold symptoms, what was a triggering of her anxiety, especially regarding swallowing the food while having a sore throat. Even though, it was relevant to observe that after this event, the patient continued her progress and recovered well after the episode.

The hoarding subscale, involves the accumulation of personal possessions to the point at which these accumulations interfere with your quality of life to a significant degree. This subscale, dropped significantly after she tidied her bedroom up and confronted herself with the things she really “needed”. This was also seen as an exposure of her OCD symptoms, that one she went through this her Well-being was also increased. Even though, at the present moment the patient is not totally ready to go back to her normal life. It can be clearly seen, that the patient improved significantly during these

sessions. And she is planning to continue is Psychotherapy, as a reinforcement of achievements and exposures to gain again her total independency.

This study illustrates the effectiveness of individual Acceptance and Commitment Psychotherapy in combination Exposure and Response Prevention can make an major chance in the funtionality of the life of a patient suffering with a complex OCD. This case could serve as an model of psycoptherapy and example for other complex cases of OCD, where the effectiness and reduction of the symtoms could be seen in a relative short period of time, specially in comparison of the leght of time the patient was suffering with the OCD symtoms.

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