



## Exposure therapy for OCD from an acceptance and commitment therapy (ACT) framework



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### ABSTRACT

This article addresses the use of exposure therapy for OCD as informed by an acceptance and commitment therapy (ACT) framework. The model on which ACT is based is covered, including its philosophy, basic research, targeted process of change, individual treatment components, and general manual. Specific suggestions for how to prepare, select, set up, and conclude exposure exercises from an ACT perspective are included and illustrated using the case of Monica as an example. Empirical support for this approach is briefly covered.

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### 1. Introduction

Acceptance and Commitment Therapy (ACT) is an experiential, contextual approach to psychotherapy that falls within the broad category of cognitive behavior therapies (CBT; Twohig, Woidneck, & Crosby, 2013). This approach is grounded in a philosophy of science known as functional contextualism, based on behavioral theory and research including relational frame theory, with this larger line of work often called contextual behavioral science (Hayes, Levin, Plumb-Villardaga, Villatte, & Pistorello, 2013). ACT promotes *psychological flexibility*, which is defined as being able to be in the present moment, just noticing inner experiences, while engaging in actions that are personally important. In order to increase psychological flexibility, ACT targets six core processes of change, including acceptance, cognitive defusion, awareness of the present moment, self as context, values, and committed action. These processes are described in Table 1. Data exist on ACT for OCD alone (see Twohig, Morrison, & Bluett, 2014), but its incorporation with exposure and response prevention (ERP) is new.

#### 1.1. Exposure therapy from an ACT perspective

Exposure therapy entails the repeated direct confrontation with feared stimuli in the absence of compulsive rituals (i.e., response

prevention). From an ACT perspective, and consistent with the functional contextual philosophy, the goal of exposure is to learn to interact with feared stimuli in new and more functional ways so that the client can move in the direction of values—the things that are important and meaningful in life—which are currently disrupted. As an example, for Monica (described in Conelea & Freeman, 2015), being able to more fully engage in studies, friendships, and activities such as basketball and piano would be the aims of engaging in therapy for obsessive compulsive disorder (OCD). Unlike in some other approaches to using exposure (Kozak & Foa, 1997), reductions in the frequency, intensity, and duration of experiences such as dysfunctional beliefs, anxiety, and obsessions are generally not explicitly targeted when exposure is used from the ACT perspective—although such changes might be observed in the long-term. Rather, ACT explicitly targets helping the client learn how to pursue valued-based living regardless of obsessional anxiety and compulsive urges.

Accordingly, in the treatment of OCD, ERP from an ACT perspective primarily taps into three of the core ACT processes described in Table 1: acceptance, cognitive defusion, and values (with being present and self as context targeted as needed, and behavioral commitments generally engaged in via exposure exercises). ERP taps into acceptance as these techniques are used to help the patient *welcome* unwanted obsessional thoughts, images, doubts, and anxiety. Different than “tolerating” or “enduring” these inner experiences until habituation occurs, *acceptance* means genuinely being open to having them for as long as they occur—without attempting to change them—even if one does not like or enjoy

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**Table 1**  
The six core ACT processes.

Process	Description
Acceptance	Embracing unwanted internal events (i.e., thoughts, feelings, memories, physical sensations, and other internal experiences) without attempting to change them. Acceptance is the opposite of <i>experiential avoidance</i> , which is the tendency to avoid such inner events even when doing so interferes with one's values.
Cognitive defusion	Changing how one interacts with internal events by allowing one to experience such events for what they are, rather than what they present themselves to be.
Awareness of the present moment	The ability to attend non-judgmentally to that which is occurring now, rather than getting lost in thoughts about the past or future.
Self as context	Taking a perspective as the place where inner experiences occur rather than being defined by them.
Values	Statements about areas of life that are meaningful to the individual. Values are life directions that help to guide actions (e.g., "pursuing knowledge") rather than achievable goals.
Committed action	Specific actions taken that produce movement toward values.

them. Thus, as in the inhibitory learning approach to exposure, habituation of anxiety is not a priority in ACT-based exposure. In fact, instead of monitoring ratings of anxiety levels during exposure (i.e., subjective units of distress; "SUDS"), patients are asked to provide ratings of their willingness to experience anxiety and obsessions throughout exposure tasks.

With regard to defusion, ERP is used to help patients change how they relate to their inner experiences, and to view such experiences as what they *are*, rather than what they *present themselves to be*. More specifically, patients "de-fuse" from their obsessional stimuli when they use exposure to practice viewing obsessions and anxiety simply as streams of words or passing bodily sensations (i.e., mental noise), rather than facts or dangers. Although this goal overlaps to some extent with the use of exposure to modify dysfunctional cognitions about the importance of and need to control thoughts (e.g., thought-action fusion or the importance of thought control), exposure from an ACT perspective is different in that it does not explicitly focus on challenging and modifying irrational beliefs (i.e., there is no Socratic questioning). It is also more "meta-cognitive" in that defusion is about thinking in general rather than being applied to target thoughts only. Defusion is also promoted using metaphorical and paradoxical language (as discussed in detail further below). Metaphors, in addition to being memorable, are less likely to turn into rules—which are avoided in ACT.

From an ACT perspective, exposure touches on values in two ways. Firstly, values are used to provide a rationale for engaging in exposure tasks and resisting compulsive urges. For example, before beginning ERP, patients identify their values and discuss how engaging in the exposures supports moving in valued directions. Secondly, ERP is used to help clients practice and learn that they can, in fact, engage in meaningful activities even while they are experiencing obsessional thoughts, anxiety, body sensations, and other unpleasant inner experiences. This is particularly beneficial as the values-based actions serve as their own reinforcers, maintaining these actions after the conclusion of therapy. Thus, goals for ACT-based ERP are individualistic. ACT-based ERP is a means to an end, with the end being living a life that the client finds meaningful. Learning processes such as acceptance and defusion from inner experiences, and behavioral commitments of within and out of session ERP, is done in the service of the client's values. Thus, there is no concern for the amount of anxiety or the content of thoughts and obsessions that occur; the therapist is largely concerned with how well the client responds to those inner experiences and how often and fully she is engaging in actions she finds meaningful. While the goal of successful living is consistent with most other forms of therapy, it is front and center in ACT. With no additional concern for levels of inner experience,

this approach may be at odds with some other conceptualizations of OCD and some measures of OCD severity.

### 1.2. Preparing the client for exposure

Before using exposure from an ACT perspective, the client should be socialized to the ACT model of OCD and the rationale and description of ERP. Indeed, this model and rationale often diverge from the goals that clients with OCD, such as Monica, initially have for therapy. That is, Monica might approach therapy thinking, "I need to get control of these thoughts" or "I can't be successful if I have anxiety and urges to ritualize—I need to get rid of these things." An important aim of the first few sessions—before beginning to implement exposure—is for the therapist and client to come to an understanding that therapy is about *behaving differently in the presence of obsessions*, and that this does *not* necessarily require changing the internal experience. Accordingly, the initial part of treatment focuses on these goals as described in this section.

## 2. The ACT model of OCD

Throughout treatment, the therapist would help a client such as Monica to see that there is nothing inherently wrong with her experiences of anxiety and obsessions. Rather, the difficulty (and a sign of experiencing OCD) is that she uses ineffective tools (e.g., logic, rituals) to try to address these internal experiences. To normalize her struggle and help develop rapport, the therapist explains that everyone experiences unpleasant internal experiences of one kind or another. It is also common for therapists to share examples of his or her own intrusions when explaining the model of OCD (e.g., "I've had disgusting thoughts too, and I more commonly have general thoughts I really struggle with such as 'Am I a good parent' or such"). The client is informed that, "how we treat these thoughts is what really makes a difference, rather than what thoughts we have."

The client is then helped to think about OCD as involving three parts: (a) inner experiences of unwanted thoughts, anxiety, doubt, bodily sensations, etc. (i.e., obsessions), (b) behaviors performed to control and reduce the inner experiences (e.g., compulsions, avoidance, neutralizing), and (c) negative effects on quality of life. Using metaphors, the client is helped to see that compulsions are much easier to control than obsessions, and that the negative effects on quality of life are generally the product of attempting to control obsessions and other inner experiences, not these inner experiences themselves. Moreover, through self-monitoring and exploration, the client is helped to see that the compulsive behaviors in "part b" are

not even successful in the long-term even if they provide short-term relief from unwanted inner experiences. The main implication of this model for treatment is that the work should focus on learning new ways to interact with the obsessions, thereby lessening the need to engage in the compulsions and avoidance behavior which produce the functional interference.

### 3. The treatment rationale

The therapist provides a rationale for using ERP that stems from the ACT model of OCD presented previously. It is explained that all work in session is about helping the client move toward what he or she values in life in order to improve overall quality of life. The concept of acceptance (often referred to as “willingness”) is then presented as an alternative manner in which to respond to obsessions. That is, instead of spending time and energy on trying to control obsessions and associated anxiety, the client is offered the option of allowing the obsessions to just “be there,” without fighting against or getting entangled with them; and learning how to live a meaningful life while they are present. An important element of this approach is that the rule that inner experiences can be meaningfully regulated is inaccurate, and that acceptance might actually work better as a way to respond to obsessions. It is simply that the brief successes of control maintain the verbal rule that “controlling obsessions works well.” The following might be used to illustrate this point:

*Really look at your life and tell me how successful you have been at regulating your obsessions in a meaningful way. For example, if you had to give yourself a grade for “obsession regulating” what grade would you get? Do you think this is because you have not tried hard enough or have not tried the right thing, or might this be because this game is rigged and there is no good way to win? What if this was a game you did not need to win? What if you could stop playing this game—that is, stop trying to control the obsessions—and just step over to this other game that is about living your life? What if we could do that right now without changing anything about you, but just learning how to respond to your inner experiences differently? Would you be interested?*

Ways of not getting so caught up in obsessional thoughts and feelings are then presented and discussed. These techniques help set the stage for practicing ERP. Specifically, the “self” is presented as the *context where inner experiences occur*, rather than being defined by those experiences. One method to illustrate this perspective is the *chessboard exercise* (Hayes, Strosahl, & Wilson, 1999, p. 190), in which the client tries to see herself as a chessboard, with the unwanted inner experiences and the anxiety-reducing inner experiences as two teams playing against each other on that board. The board does not really care what the teams do; it simply holds the pieces. Similarly, the board is not affected by the actions of the pieces or who wins the game. This type of exercise is particularly useful if the client has a “self-concept” that is rigidly held. While not explicit in Monica’s case example, she probably has self-concepts such as a “protector of friends and family” and a “cautious and safe person.” These can be helpful self-concepts, but holding them lightly is also important. Metaphors to help the client view obsessions as “just thoughts, and not events with power” are also used. One example is the *passengers on the bus exercise* (Hayes et al., 1999, p. 157), which helps the client see herself as the driver of a bus going toward her values. There are passengers seated on this bus (the obsessions) who yell at her and tell her where to go; yet it is her job to go where she wants, even if the obsessions come along for the ride. During exposure, the client has the opportunity to practice “driving the bus.”

Finally, the concept of values is introduced to provide additional personal meaning for ERP and to help increase motivation for engaging in challenging therapeutic exercises. All work done inside and outside of session is connected to values in some way. In the ACT-ERP program, the therapist and client use a worksheet called the *Bullseye* (Lundgren, Luoma, Dahl, Strosahl, & Melin, 2012) that helps the client clarify her values and examine the extent to which attempts to control obsessions interferes with pursuing valued activities. It might be discussed that pursuing values often means doing so despite difficult situations. This concept is presented through the metaphor of throwing a party in which some guests are being obnoxious. The client can either argue with the unruly guests (i.e., spend time using compulsive rituals to fight obsessional thoughts), or she can keep her eye on what is important to her and interact with the guests she enjoys at the party (i.e., pursue her values), while allowing the unwanted guests (i.e., obsessional thoughts and anxiety) to be there as well.

### 4. Describing exposure

In addition to the treatment rationale, the therapist and patient also discuss that (in accord with the rationale) they will agree to activities for exposure that seem meaningful and worth doing on the basis of the client’s values. This diverges from traditional exposure procedures in which tasks are chosen on the basis of how much discomfort or fear they provoke. From the ACT perspective, inner experiences are difficult to control, and if the client is willing to experience whatever occurs during the exposure exercise, it is less important whether the feeling of fear or anxiety is high or low. How open can the client be to what shows up during the exercise is more important from this model. From this approach, the strength of the internal response is not the issue but, rather, the way the client responds. The client can choose the difficulty of the exposure, but not the internal reaction that may or may not occur. It is the client’s job to be as open as possible to what shows up internally when engaging in the exercises. If one is “toughing it out” until time runs out, then acceptance needs to be higher prior to the exercise.

Finally, the focus on different ACT processes is determined by what is needed overall for the client, as well as what is needed in the given exposure. For example, the therapist might spend time on defusion prior to the exposure exercise, and then help the client engage in that process while that exposure is occurring. Similarly, the therapist might notice that the client is losing motivation and in turn make a values based comment such as, “this moment is also practice for other events such as going out on a date with a person you are interested in.”

#### 4.1. Selecting exposure tasks

As in other approaches, the therapist and client collaboratively develop an exposure list that serves as a roadmap for subsequent exposures and includes a variety of stimuli (e.g. items, situations, thoughts) that have traditionally been difficult for the client because they evoke OCD-related inner experiences. In this way, all of the exposures on the list allow the client to practice engaging with these inner experiences in a more open and flexible manner while moving toward things that are important in life. For Monica, this includes specific situations that she would like to engage in based on her values, but that she currently avoids as a result of OCD (e.g., eating with friends at a restaurant). Table 2 includes a sample exposure list for Monica. While developing the exposure list, the purpose of each item and its connection to Monica’s values are explicitly discussed. It is important to note that choosing items for the list is a client-driven process, with the therapist simply assisting her in determining

**Table 2**  
Sample exposure hierarchy: Monica.

Willingness (0–100)	Exposure exercise/behavioral commitment linked to a value
100	Talking or reading about diseases like cancers or Parkinson's disease, without reassurance, so that she can be more open to conversations with friends
90	Allowing family members to use whatever soap they choose so that she can have stronger relationships with them
80	Eat an organic apple that touched a non-organic apple so that she can more easily share foods with friends
70	Washing hands with soap from public restroom so that she can get better at being social
60	Eating a food that the therapist chooses, that has no label, so that she can be more spontaneous
50	Visiting a medical center where cancer is treated so that she can learn to be more present with friends who are ill rather than worrying about herself
40	Washing face nightly with non-organic or non-natural soap so that she could practice being more flexible in related situations where she cannot choose soaps
30	Eating a non-organic apple so that she can eat at friends' homes
20	Letting a friend cook for her without checking on what is in the food
10	Eat at a restaurant that she finds disgusting so that she can be more flexible and spontaneous with friends
0	Going on a date and being open to desired level of intimacy

Note: willingness=client's level of willingness to experience whatever internal experience shows up during exercise; 0=none at all, 100=totally confident that she can maintain openness to whatever occurs during exercise

potentially useful exposure tasks, and highlighting the purpose of the exposures.

As written previously, as the client and therapist identify exposure tasks, they are rated based on Monica's willingness to experience the obsessional thoughts, doubts, fear, and whatever else might "show up" internally while engaging in the task while also resisting compulsions and other kinds of avoidance strategies. *Willingness* can be rated on a 0–100 scale, with 100 indicating complete willingness, and 0 indicating no willingness. In contrast to traditional approaches to ERP, distress or discomfort is not the focus of the exposures and does not dictate the order of exposure tasks. Instead, the client is able to flexibly determine the order of exposures based on her values and goals for treatment and what she is willing to experience. While the order of exposures is client-driven, the therapist may encourage the client to attempt different types of exposure tasks throughout treatment, as different exposures might be most useful to the client at that time; for example, to address certain valued areas of life.

Monica's therapist, for example, might work with her to choose the first exposure task from any place on the list, as long as Monica is willing to feel what shows up during the exercise and fully engage in the task. For instance, she might decide that she would like to begin with exposure to eating organic food that has touched non-organic food. Such an exposure would allow her to come into contact with her OCD related thoughts and feelings regarding chemicals and diseases, and is also connected to her broader goals of wanting to increase her social and interpersonal connections because it would facilitate eating in social settings. It is best to conduct this first exposure during a session, rather than as homework, in order for the therapist to serve as a facilitator. Accordingly, the therapist "checks in" often to see the levels of acceptance, defusion, and so on in order to assure useful processes are being practiced.

#### 4.2. Introducing exposure

It is important for the therapist to recognize that clients often come to therapy because their anxiety level is high and they are seeking skills and strategies for reducing it. From an ACT

perspective, as discussed, the focus is on increasing willingness to experience anxiety and obsessional distress, not to reduce them. Put another way, rather than developing better strategies for *controlling* anxiety, ERP from an ACT perspective helps the client learn to have a different *relationship* with anxiety (and intrusive thoughts, etc.) so that she can more easily pursue what she values in life regardless of whether the inner experiences are there or not. With these goals in mind, before beginning the initial exposure, the rationale would again be discussed with Monica in greater depth, perhaps as follows:

*So next I want to talk with you a little bit about why we are doing exposure therapy, because purposely confronting thoughts and situations that you have been avoiding is going to be difficult and may seem counter-intuitive. Think about the ways your struggle against your obsessions has been pulling you away from meaningful parts of life. For example, your obsessions about whether or not something you touched or ate may lead to a terrible illness are still there and your struggles against them take up hours a day. I am not going to try and do the impossible and make these inner experiences "go away" completely, or to give you a more effective strategy for controlling them. Maybe obsessive thoughts, anxiety, and uncertainty get evaluated negatively, but they are also a part of life... like rain, for example. We are going to take a different approach and work on finding ways that you can be willing to have these experiences so that you can accomplish what you want in life whether these thoughts are present or not. This might be new and confusing, but we'll be working together to help you connect with these thoughts and feelings in a new way that will hopefully be more helpful for you in the long-run. Are you game to take on this challenge?*

As long as Monica is open and interested in the treatment, the therapist would then define and discuss the concept of *willingness* in more depth:

*Instead of using anxiety as a gauge for whether or not to do something, we are going to be focusing on willingness, which is how open you are to experiencing anxiety, doubt, and obsessions without trying to change, avoid, or escape them. Willingness is a*

skill that can be learned, and exposure is a way to practice increasing willingness and changing your relationship with obsessions. During exposures, we will focus on keeping willingness high so you can get good at letting anxiety fluctuate while you practice re-engaging with important activities you have been avoiding. Instead of basing your decisions on the “emotional weather,” we will be practicing doing things when the emotional weather is “calm” or “stormy.” So, during our exposure practices I will be asking you how “willing” you are to experience OCD-related inner experiences on a scale from 0 (completely unwilling, which means you are fighting with the obsessions and engaging in rituals and avoidance to try to control them) to 100 (completely willing, which means you are not fighting the obsessions or pushing them out of your mind at all; you are welcoming them in). During the exposure, pay attention to anything you do to bring your anxiety down, and practice just letting the unwanted thoughts, anxiety, and uncertainty “be there” without fighting them. That fight against anxiety might not be a fight you need to engage in.

It is important that Monica understands the concept of willingness, because her openness to experiencing obsessions will be a continual discussion throughout the exposure exercises. Given that it is easy to fall back into traditional emotional control strategies (self-soothing or checking on the level of discomfort), we have found that it is worth reviewing the concept of willingness at most sessions. For example, our clinical observations suggest that, on occasion, willingness negatively correlates with anxiety level, indicating that the client is using willingness scores as a rating of difficulty. When this occurs, we have worked with the client to separate one's *openness* to the experience from the *severity* of the experience.

The therapist would also explicitly discuss how a given exposure is helping Monica move toward her values:

*One more thing I want to emphasize is that you are doing these exposures to help you get back to doing the things that are important to you. To illustrate this, I would like you to imagine that there is a swamp in front of you. In this swamp are all of your OCD-related inner experiences (and the situations that trigger them) that you will confront during treatment. It includes the concerns about toxicity and chemicals, doubts about someday developing a serious or deadly illness, and fears that you will be unable to live an independent and fulfilling life. We are going practice willingness to enter that swamp without resisting or using compulsive rituals. I want to emphasize that we are not doing exposures just to “wallow in the swamp.” We are getting dirty and muddy for a purpose, because walking through this swamp is in the service of things that are important to you. You mentioned that OCD gets in the way of your friendships, your ability to have romantic relationships, and your school work. You emphasized that one big motivator for doing this treatment is that you want to live in the college dorm next year. Moving through the swamp will definitely be a challenge, AND getting dirty might also be about these things that are important to you in life. We are learning to handle whatever comes up while still moving forward through the swamp. How does an exposure to eating organic food that has touched non-organic food move you closer to the things you value?*

During the initial phases of therapy, the values that are often discussed are often more concrete and shorter or smaller. Things like spending time with friends or eating meals with one's family are often discussed. As the sessions progress and the client begins to show more psychological flexibility, the size and duration of the values discussed can grow. Now values such as education, relationships, employment, and spirituality start being discussed. Having more clearly defined larger values can be useful because they can

serve to motivate actions well into the future, after therapy has ended.

Finally, the therapist would clarify her role during exposures. The therapist should acknowledge that treatment will be a collaborative process in which the two will work as a team. There will be no surprises, and the therapist will never force Monica to do exposures she is not willing to try. In fact, most exercises are offered to the client as a choice in the service of fostering acceptance. The therapist will, however, encourage Monica to push herself to select fear-provoking exposures so that she can practice developing a new relationship with her anxiety. This will help her prepare for anxiety triggers in her daily life. In the next section, helpful tips (and interfering behaviors) for exposure will be covered.

#### 4.3. Exposure dos and don'ts

It is recommended that several sessions are taken to prepare for and “set up” the exercises. It is important that Monica understand that the goal of exposure is to help her practice skills that allow her to engage in behaviors that more closely align with how she wants to live her life. Thus, the in-session exposures are used to guide Monica through behaviors that are more consistent with her values and provide a different perspective on her experience. Using the example exposure of eating at a fast food restaurant, the focus would be increasing her ability to eat in a restaurant so that she may engage in valued activities (e.g., spend time with friends and romantic interests, live and eat in a college dormitory). There would be no expectation of her level of distress before, during, or after the exposure.

Internal experiences can seem intolerable to the client during exposures. If, during the exposure, Monica states that she “cannot take a bite of the food because the chemicals in the fries will cause [her] to develop a disease,” the therapist can choose several routes to address this. A response targeting her relationship with this thought might be, “Wow, that thought seemed to really grab your attention. I wonder what it would be like to hold that thought lightly, take a bite of your fries, and see if you can just watch that thought.” Alternatively, the therapist could direct the focus toward values after initially addressing the intolerance concern. This technique is more often used when the client has the necessary skills to engage in the exposure but does not see the purpose. The therapist might say,

*“Let's take a moment to notice what is happening in your body right now. You're experiencing thoughts, your heart is beating faster, and you have the feeling of being worried. Do any of those physically stop you from taking a bite of your fries?...Yes, it might be easier to just avoid those fries. What usually happens when you avoid eating fries? Do your worries go away?...Ah, your worries go away for a little bit, but keep coming back. Because these worries keep showing up, is avoiding eating fries and, really, avoiding things you care about, worth it? We're practicing something bigger here. Walking away from these fries may mean a brief break from your worries right now, but it also means that you'll be walking away from time with your friends and a college experience you want to have. Are you willing to take a bite of those fries, with all of that worry, with the purpose of being able to eat out with your friends and form new relationships, or being able to live in the dorms when you go to college?”*

The therapist looks for markers that indicate progress in the desired directions and reinforces those markers. Monica may take a bite of her fries and say, “My body feels really tingly right now,” and the therapist could respond with, “Great job noticing what it feels like to eat a fry while worrying about its impact on your body. What else do you notice?” Other indicators of progress deserving

**Table 3**  
Prescribed and proscribed therapist behaviors during exposure from an ACT framework.

Therapist “Dos” Prescribed behavior	Therapist “Don’ts” Proscribed behavior
Target relationship with internal experiences so that the client interacts differently with the experiences rather than trying to control them	Directly target change in internal experiences
Aim for improvement in daily functioning and reduce the client’s expectation that unwanted internal experiences should change	Target change in internal experiences in order to change behavior
Define goals for the patient in terms of how functional they are for the client	Specify right or wrong behaviors
Increase nonjudgmental awareness of internal experiences. The goal is for the client to have obsessional thoughts without appraising them as “unacceptable”, etc.	Give value to internal experiences as “good,” “bad,” “scary,” “motivational,” etc.
Increase awareness of consequences of compulsive behavior and avoidance using metaphorical discussion and experiential exercises	Directly tell the client about the consequences of the behaviors; use didactic explanations of concepts

**Table 4**  
Prescribed and proscribed client behaviors during exposure from an ACT framework.

Client “Dos” Prescribed behavior	Client “Don’ts” Proscribed behavior
Guide behavioral decisions by individual values, decreasing impact of internal experiences. The goal is that the client chooses to act more in line with her values, regardless of whether obsessions are present	Guide behavioral decisions by changes in internal experiences
Encourage refraining from compulsive rituals even when distress is high so that the client can practice willingness to have unwanted inner experiences without judging them	Give value to internal experiences, compare behaviors to others, follow internal rules and allow the client to perform rituals to escape from very strong distress
Increase awareness of opportunities to spontaneously engage in values based actions	Follow internal rules and perform rituals to escape from distress
Start/continue with exposures even if the client is experiencing distress. The goal is for the client to learn that distress is acceptable and that she can function while experiencing it	Stop exposures because of distress

reinforcement are when she (a) speaks about internal experiences lightly, almost humorously, as an experience that is simply happening (“Whoa, that was a random thought! Isn’t it funny how my mind does that?”), (b) choose to engage in behaviors that are more likely to induce distress, (c) state the valued reason for a behavior (“Going to college is important to me. Let’s practice this and see what happens.”), and (d) describe a shift in the believability of their thoughts (“My mind said, ‘this might kill me.’ I am realizing my mind says often says things like that.”). Throughout the exposure session, the therapist should occasionally inquire about the client’s increases in willingness to have whatever inner experiences show up.

ACT places an emphasis on learning flexibility, and therefore discourages rigid patterns of thinking and behavior (including verbal behavior) in much the same way that a cognitive therapist would discourage dysfunctional cognitions such as “musts,” “should” or “all-or-nothing” thinking. If the therapist observes that Monica is becoming rule bound even within the ACT model, he or she would try to keep the learning flexible and experiential in nature. For example, if Monica says, “I just have to allow that thought to be there and not fight against it,” the therapist might say, “that is one option, how has that worked in following your goals?” A response like this keeps the client thinking flexibly, but lessens the likelihood that what was stated turns into a rule that would be rigidly applied. Tables 3 and 4 provide specific “dos” and “don’ts” for therapists and clients.

#### 4.4. Ending exposure

Each exposure can be concluded after the client has had an ample opportunity to function while the obsessions are present and

interact with a situation that was usually avoided. For example, exposure to eating at a fast food restaurant would end when Monica could finish a meal without any rituals and report willingness to experience the corresponding obsessional thoughts and anxiety without trying to avoid or reduce them. In contrast to habituation-based ERP, there is little concern for the client’s subjective level of distress (e.g., habituation of anxiety) at the end of the session in ACT-based exposure.

Upon ending each exposure, it is useful to discuss with the client what it felt like to welcome and accept anxiety and obsessions. For example, the therapist could ask Monica, “Was that easier or harder than fighting or pushing away your inner OCD experiences?” or “Does this seem like a process that will work for you in life?” Although willingly accepting anxiety and obsessions may be difficult at first, it is expected that the client would become more skilled at it over time; as such, the conversation should also acknowledge times when Monica struggled. For example, “Where did you feel stuck, what held you back?” During this conversation, Monica and the clinician can jointly uncover difficult spots for her to focus on during at-home practice. A discussion about how the exercise was or was not linked to values can be worthwhile.

After each in-session exposure, it is useful for the clinician to work with the client to set up similar practice tasks for homework. Ideally, the client should practice a version of the in-session exposure daily. The clinician and client could agree to exposures that may only be feasible outside of the therapy room (e.g., with family members, in specific rooms at home). The client can also be coached about moment-to-moment situations where the pull to avoid or escape occurs, and where it may be helpful to use ACT processes to engage with those situations.

Finally, one of the useful aspects of ACT is that it is based in six process of change. Therefore, these processes can be applied to any issue that at least partially is brought on by psychological inflexibility. This is useful because new and complicated situations show up in most therapy cases. Detection of these processes can be aided by one of many case formulation measures (as presented in Hayes, Strosahl, and Wilson (2012)); a case formulation measure for OCD also exists (Twohig et al., 2014). If the ACT-based ERP approach is being used, then the therapist can refer back to it to partially address the issue. For example, if one of Monica's family members asks how to not give in to Monica, the therapist might stress emotional acceptance and following values by encouraging the family member to just notice the fear of upsetting Monica and behave in a way that supports both their values. The same model of applying ACT principles to new situations can occur for issues such as doubting or client reassurance. For example, if Monica says, "I'm doing well in life but I can't shake the fear that I might contract something," instead of addressing the content of that thought, the therapist would see what ACT process underlies it. The therapist might say, "what do you do with that thought while it is there?" or "does that thought affect your actions?" The answers to these questions will tell the therapist how accepting and fused the client is with that doubt, as well as her ability to follow values while it is present.

## 5. Conclusion

Previous research has found ACT without in session exposure exercises to be a useful treatment for OCD and related disorders (Twohig et al., 2014). 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 (Arch et al. 2012), social anxiety disorder, (Craske et al., 2014), as well as effectiveness studies (Forman, Herbert, Moitra, Yeomans, & Geller, 2007). Additionally, other authors have presented methods for such work (Eifert & Forsyth, 2005). 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 if these two approaches can support each other. We believe the two models can fit very well.

The use of exposure therapy procedures is consistent with ACT, as it offers the ultimate experiential form of practicing acceptance and other ACT processes. The ACT framework, however, offers the exposure therapist new tools and a modified model for discussing with clients the processes involved in OCD and the goals and processes of ERP. ACT also focuses on the client's values more explicitly than do other implementations of exposure. Although ERP is a highly effective treatment for OCD, we believe that the

approach described in this article can offer new directions for improving the acceptability, adherence, and outcome of this empirically supported intervention for certain clients. We are in the beginning stages of empirically examining exposure therapy from an ACT framework: its efficacy, mechanisms, and the degree to which it might confer any benefits over more traditional means of implementing exposure. We hope to have helpful data to share with readers in the near future.

## Author note

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