# Exposure and Response Enhancement:

## A Reply to ACT vs. ERP for OCD: Is It War or Marriage

Hank Robb, Ph.D., ABPP

Private Practice

4550 SW Kruse Way, Suite 225

Lake Oswego, OR 97035

503 635-2489

robbhb@pacificu.edu

Exposure and Response Enhancement:

A Reply to ACT vs. ERP for OCD: Is It War or Marriage

I was interested to read “ACT vs. ERP for OCD: Is It War or Marriage” by Jonathan Grayson (2013) and wish to offer some responses to his views. Grayson makes some important points about the inability of “behavioral experiments” to address the fundamental problem of uncertainty, the importance of embedding Exposure and Response Prevention (ERP) in a larger context and that Acceptance and Commitment Therapy (ACT) has helped further draw “mindfulness” into the mainstream of behavioral practice. However, Grayson fails to correctly present aspects of ACT and seems completely unfamiliar with Relational Frame Theory (RFT), the behaviorally oriented analysis of verbal behavior that informs a significant portion of ACT practice. I especially detail errors related to defusion as well as Functional Contextualism and values in the remainder of this paper.

Preliminarily, I think it unfortunate that in several places Grayson makes assertions about the views of ACT practitioners but provides no citations. For example, in the seventh paragraph of his article Grayson makes two such assertions, “On the other hand, there are those ACT therapists who fail to view ACT as part of the CBT framework …” he then continues, “… and make the mistake of applying ACT principles to the treatment of OCD without understanding the intricacies of OCD (p. 85).” Regarding the first, maybe there are ACT therapists who fail to view ACT as part of CBT, but on what basis does Grayson make this claim? None is offered and the basic ACT text (Hayes, *et. al.* 2012) is not even in his bibliography. The kind of confusion to which Grayson refers might occur if individuals interchangeably use the names of particular approaches, *e.g.* "Cognitive Therapy" (CT), and Cognitive Behavioral Therapy (CBT). CT, like many others, is a particular CBT approach. CBT is a broad umbrella with many approaches under it though I am hardly the first to point this out **(**Herbert & Forman, 2011; Herbert & Forman, 2013 **).** Yes, ACT and other CBT approaches may be quite different in some ways, yet all would fall under the more general CBT umbrella. Regarding the second assertion, I am sure there are practitioners of every approach who wrongly, or mistakenly, apply the approach they are using including those practicing ACT. However, those errors are not necessarily the fault of the approach itself. But again, Grayson offers no evidence of the kind of mistake he attributes to ACT practitioners and the lack of evidence for various claims about ACT and its practitioners continues throughout his paper.

In his summary, Grayson hopes that his paper has achieved two aims. First, he does not want the baby to the thrown out with the bath water. "The directed effort of Hayes and his colleagues has been vital in expanding our understanding of mindfulness and ways of helping clients free themselves from their maladaptive schemas and mind-sets. But ACT is not a replacement for learning behavioral and cognitive principles" (p.88). The first edition of Acceptance and Commitment Therapy (Hayes, *et. al.* 1999) stated, "Its theoretical basis is drawn from behavior analysis. … But the content of this theory is all about cognition and emotion, even though the model is not cognitive in an information processing sense" (p. 79). What Grayson seems to have failed to realize is that RFT, the "cognitive theory" nested with ACT and resting on the philosophic foundation of Functional Contextualism, is not a replacement for behavioral principles, it is an extension of them (Dymond & Roche, 2013; Hayes, *et. al.* 2001; Törneke, 2010). Yes, the information processing model of cognition is being moved to the side, but only because behavioral analysis has been extended into the realm of human cognition by RFT. Perhaps Grayson can actually demonstrate the superiority of information processing models to RFT but in claiming that ACT is, "helping clients free themselves from their maladaptive schemas," he shows that he is not in contact with RFT principles since they have nothing to do with "schemas," maladaptive or otherwise.

Secondly, Grayson hopes his article will serve to remind readers that "… the treatment needs to be tailored to the client (p. 88)" as if, somehow, ACT practitioners would disagree. When Grayson states that in the process of successful ERP treatment, "'Can't' becomes 'I choose not to' and successful therapy means that just because I'm afraid to choose, doesn't mean that I have to let fear make my choices" (p. 88) he is not demonstrating that having achieved these changes sufferer's are now "… ripe and ready to learn the principles of ACT" (p. 88). Instead, he is demonstrating that they have already been learning those principles. When it comes to tailoring treatment to the client, which clients does Grayson believe can be exempted from learning, in his words, "… that the only thing they have is the moment and running from potential fears is impossible" (p. 88)? When Grayson states he does not "… believe that head-to-head comparisons of ACT to a 'pure' ERB protocol (i.e. the way ERP was practiced in the early 1980's) are ultimately useful in improving our treatment," he is indicating that, when it comes to tailoring treatments to individual clients, it is important to nest particular treatment techniques in a larger context. ACT is such a context. Admittedly, the context provided by ACT is less one of exposure and response prevention and more a context for exposure and response enhancement in the service of chosen values; but that hardly means ACT has forgotten, or neglects, to tailor treatment to specific clients.

## Defusion

In my view, Grayson's misunderstanding of the concept of defusion begins with his failure to make a distinction between "events," whatever those "events" may be, and an individual's thoughts about them. Thus he states, "We believe that exposure is acceptance; however, ACT practitioners would correctly point out that in our usage, acceptance is narrowly targeting the feared consequences of the obsession and the resulting anxiety …" (p. 85). However speaking as a therapist, he then states, "It is impossible to be 100% certain of anything" (p. 85). This is not just speaking for therapeutic effect. In fact, it is always possible that we could be in error when it comes to our thoughts about how things “are,” “were” or “might be.” Thus, if “exposure is acceptance” as he claims, then all of us, including those living with OCD, are already “accepting uncertainty,” since we are constantly “exposed” to uncertainty by simply being alive. However, living with uncertainty can be distinguished from thoughts about living with uncertainty and ACT simply posits the importance of making that distinction in the service of living a more fulfilling life.

Grayson rightly points out that no “behavioral experiment” will help overcome living with uncertainty and he nicely demonstrates this point with the client who thinks her thoughts might kill others. Notice an important aspect of this case. Namely, the client first has thoughts and then she has thoughts about those thoughts. Grayson’s entire approach to this client is not based on ending, or even changing, either the former thoughts or the latter ones. Instead, it is based on developing alternatives to “trying to prove thoughts right or wrong” when those thoughts show up. Such a treatment aim, namely finding ways of living with thoughts (and with images and bodily sensations for that matter), is a key aspect of the ACT approach rather than an alternative to it.

When it comes to defusion, the issue for ACT is not so much that thoughts are “right or wrong,” or “true or false,” but rather that thoughts can be discriminated as thoughts. The question is, “What shall we do when certain thoughts (or images or bodily sensations) show up in our lives?” At least part of the answer for ACT includes, “noticing that thoughts, and whatever the thoughts are about, can be distinguished from one another.” Simply stated, they are not “the same thing.” That kind of “noticing” is what ACT calls “defusion (Hayes, *et. al* 2012). Let me underline that making this discrimination is, explicitly, NOT about thinking more thoughts. ACT is simply pointing out that there are many behaviors in which human beings can engage other than thinking. “Noticing” is one of them. Of course if I “think” about my noticing, then I will be having “thoughts” about my noticing and, once again, the two can be distinguished from each other.

Grayson correctly notes that clients will easily misconstrue what therapists, including ACT therapists, intend. “In the mind of the sufferer this [recognizing thoughts as thoughts] is translated to the idea that there is no reality basis to the thought, so they don’t have to worry” (p. 86). However, the fact that clients do not readily respond as therapists would wish they would is not, necessarily, evidence that there is some flaw in the therapist’s approach. It may only show that making therapeutic headway can turn out to be both tricky and difficult.

When Grayson writes, “The sufferer will obsess about whether the current thought is really just a thought or a real concern” (p. 86), he is demonstrating that people often treat their thoughts about things as if the thoughts were the things themselves. This is why defusion can be useful. I may have a “real concern” about my physical health. And my thought, “I have a real concern about my physical health,” or even, “Damn! This pain may mean I am dying!” can both be discriminated as thoughts, rather than “my concern.” There may be a possibility that I will be in a wreck when I drive my automobile and my thought, “there is a possibility that I will be in a wreck when I drive my automobile” can be discerned as a thought, rather than the possibility.

If an individual were having difficulty determining what s/he actually gives a darn about versus their thoughts, an ACT practitioner, as I imagine many practitioners, would help the individual make the discrimination. For example, many individuals have thoughts about what they should care about though, as a practical matter of fact, they do not care. When such individuals pursue what they think they should care about, they find themselves unfulfilled and wonder why. An ACT practitioner, as I imagine many other practitioners, would help such individuals discriminate their thoughts about caring from their actual caring.

When Grayson writes, “By using language that is consistent with the sufferer’s relational frame (i.e. the impossibility of definitely avoiding disaster or of ever being sure) the sufferer’s view of their own thoughts changes. Their obsessions become hypotheses that are impossible to test – that is, defusion has taken place. (p. 87)” he is demonstrating that he has both misunderstood the way the term “relational frame” is used in Relational Frame Theory (RFT) (Hayes, *et. al* 2001), as well as the process of defusion (Hayes, *et. al* 2012). What Grayson seems to be describing is something that ACT writers have called “creative hopelessness;” namely the experience described by phrases like, “This just isn’t going to work” (Hayes, *et. al* 2012). Indeed, on the way to living more fulfilling lives, many individuals move on from things that have not worked. But neither being in that psychological place encapsulated by phrases like, “I’ve had enough of this,” or moving on from it, is what ACT practitioners mean by the term “defusion.” Defusion is not about treating thoughts as “hypotheses,” either testable or untestable. Defusion is about responding to thoughts as thoughts (Hayes, *et. al.* 2012).

## Functional Contextualism & Values

I would suggest that part of Grayson’s difficulty, as is the difficulty for many, is the failure to take seriously certain aspects of what has been called “Functional Contextualism,” (FC) the philosophical approach on which ACT rests (Hayes, *et. al.* 2012). In particular, there is the failure to take seriously that FC adopts a pragmatic, rather than a correspondence-based, theory of “truth.” Pragmatically, “truth” is successful working and fulfilling that criterion requires being “up to something” in the first place. That is why “values” are important in ACT. Said non-technically, values are verbal abstractions that help direct behavior. Thus, for an individual, “successful working” mostly turns out to be acting in accordance with that individual’s chosen values and doing so even in the presence of thoughts, images and bodily sensations that the individual would rather not experience. This kind of approach is uninterested in a search for “Truth” as an accurate description of reality. FC, and hence ACT, is agnostic on the subject of ontology. Adopting a pragmatic approach to truth, i.e. successful working, is often disorienting when one has been operating with a commitment to the notion of “reality.” However, it has the big advantage of allowing an adherent to a pragmatic notion of truth to be laser focused on what is, and is not, working for the purposes one has in view as well as highlighting the importance of making clear what those purposes are.

What I find so interesting along this line is how close Grayson comes to stating his purpose in working with clients as being something quite different from "no longer meets criteria for OCD." Instead, he implies that the whole point of putting one's self in contact with certain thoughts, images and bodily sensations is not to make them go down, but to make participation in a more fulfilling life go up. Placing it, oddly to me, under the section on defusion, he writes, "Or as we put it: 'The saddest thing is that for all your pain and agony, you don't even get the prize. You are not living your life and the disasters you fear may still occur" (p.86). Never the less, he also writes, "In our bottom-up approach, values are used to motivate and transform the meaning of ERP" (p. 87). Grayson apparently fails to appreciate that ACT is doing precisely that. ACT does not ask individuals simply to "prevent" avoidance responses but to establish approach responses consistent with their chosen values. ACT does not ask individuals to make contact with thoughts or images about events they do not want to happen, or risk the occurrence of such events, or to make contact with bodily sensations they would prefer not to experience simply so they will no longer meet criteria for OCD. ACT asks individuals to do these things because they are the price to be paid for the life those individuals deeply desire, that is; a life instantiated by systematically acting consistently with, or in the service of, one's chosen values.

References

Dymond, S. & Roche, B. (Eds.). (2013). *Advances in relational frame theory: Research & application*. Oakland, CA: New Harbinger Publications.

Grayson, J. Act vs. erp for ocd: is it War or marriage? *the Behavior Therapist*, 36, 84-89.

Hayes, S. C., Barnes-Homes, D., & Roche, B. (Eds.) (2001). *Relational frame theory: A post-Skinnerian account of human language and cognition*. New York: Kluwer/Plenum Press.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (second edition). (2012). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Gilford Press.

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

Herbert, J. D. & Forman, E. M. (2011). The evolution of cognitive behavior therapy: The rise of psychological acceptance and mindfulness. In J. D. Herbert & E. M. Forman (Eds.), *Acceptance and mindfulness in cognitive behavior therapy: Understanding and applying the new therapies* (pp. 3-25). Hoboken, NJ: Wiley.

Herbert, J.D., & Forman, E. M. (2013). Caution: The differences between CT and ACT may be larger (and smaller) than they appear. *Behavior Therapy*, *44*, 218-223.

Törneke, N. (2010). *Learning rft: An introduction to relational frame theory and its clinical application*. Oakland, CA: New Harbinger Publications.