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Research Paper

Effectiveness of a Brief Acceptance and Commitment Therapy (ACT) Protocol in Reducing Symptoms of Obsessive-Compulsive Disorder

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ABSTRACT

The study evaluated the effectiveness of Acceptance and Commitment Therapy (ACT) as a third-wave behavioral intervention for treating Obsessive-Compulsive Disorder (OCD) symptoms. Ten OCD patients who met DSM-5 criteria received six individual sessions of ACT from a licensed clinical psychologist during a ten-week period. The intervention used ACT core processes to enhance psychological flexibility through acceptance and cognitive defusion, mindfulness, and values-based action techniques. The Yale-Brown Obsessive Compulsive Scale (Y-BOCS) measured symptom severity before and after the intervention. The statistical results showed substantial decreases in obsessions and compulsions and total OCD severity with effect sizes ranging from 1.62 to 2.03. The study indicates that ACT produces significant OCD symptom reduction when delivered in a short treatment duration. The research adds to the expanding scientific evidence that supports ACT as an effective treatment method compared to traditional cognitive-behavioral therapy. The study's small participant number, together with its lack of control group participants, requires additional research to validate its findings. Future research must include bigger participant groups and controlled randomized designs, and extended follow-up periods to evaluate treatment durability and applicability across different populations.

Keywords: *Acceptance and Commitment Therapy (ACT), Protocol, Symptoms, Obsessive-Compulsive Disorder*

Obsessive-Compulsive Disorder (OCD) is a chronic and debilitating psychiatric condition characterized by persistent intrusive thoughts (obsessions) and repetitive behaviors or mental rituals (compulsions) aimed at reducing distress or preventing perceived harm (American Psychiatric Association [APA], 2013). Affecting approximately 2–3% of the global population, OCD significantly impairs daily functioning and quality of life.

Cognitive Behavioral Therapy (CBT) with Exposure and Response Prevention (ERP) is considered the gold standard for OCD treatment. However, high dropout rates and treatment refusal highlight the need for alternative therapeutic approaches (Abramowitz et al., 2009).

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Acceptance and Commitment Therapy (ACT), grounded in Relational Frame Theory, promotes psychological flexibility—the ability to engage with the present moment and act in alignment with personal values despite difficult internal experiences (Hayes et al., 1999). Rather than focusing on symptom reduction, ACT helps clients accept obsessions and engage in valued living.

ACT integrates six core processes: acceptance, cognitive defusion, present-moment awareness, self-as-context, values clarification, and committed action (Harris, 2009). Several studies and meta-analyses (Twohig et al., 2006; Bluett et al., 2014) support ACT's efficacy across anxiety disorders, including OCD. However, there is limited evidence on the effectiveness of brief ACT interventions in real-world clinical settings.

This study explores the impact of a six-session ACT protocol emphasizing mindfulness, defusion, and values-based goal setting on OCD symptoms in a small clinical sample.

METHOD

Participants and Procedure

Ten individuals (6 males, 4 females; mean age = 28.4 years, SD = 5.1) diagnosed with OCD per DSM-5 criteria were recruited through clinical referrals. Duration of illness ranged from 1 to 8 years (M = 3.5 years). Informed consent was obtained from all participants, and ethical approval was secured from the institutional review board. No participant dropped out.

Each participant received six individual ACT sessions over a ten-week period, conducted by a licensed clinical psychologist trained in ACT. The therapist received weekly supervision to ensure treatment fidelity.

Measures

The Yale-Brown Obsessive Compulsive Scale (Y-BOCS), a clinician-administered tool with high reliability and validity, was used to assess severity of obsessions, compulsions, and total OCD symptoms at baseline and post-intervention.

Intervention

The ACT protocol followed a structured six-session model emphasizing three key processes: mindfulness, cognitive defusion, and values-based goal setting. Although other ACT components were discussed (e.g., self-as-context, committed action), they were not systematically implemented. Each session lasted 60 minutes and was delivered individually in a clinical setting. The study was approved by the Institutional Ethics Committee, and all participants provided written informed consent."

RESULTS

Table 1 Descriptive statistics and paired-sample t-tests were used to evaluate changes in OCD symptoms from pre- to post-intervention.

Y-BOCS Domain	Pre-Intervention (M ± SD)	Post-Intervention (M ± SD)	t	Cohen's d
Obsessions	11.70 ± 2.45	7.60 ± 2.01	6.02*	1.90
Compulsions	10.60 ± 2.22	6.90 ± 2.02	5.14*	1.62
Total Severity	22.30 ± 4.17	14.50 ± 3.34	6.43**	2.03

**p<0.05, **p<0.01*

DISCUSSION

The study observed statistically significant reductions in symptoms of Obsessive-Compulsive Disorder (OCD) following the administration of a brief six-session Acceptance and Commitment Therapy (ACT) protocol. All symptom domains—obsessions, compulsions, and total OCD severity—demonstrated large effect sizes, with Cohen's d values ranging from 1.62 to 2.03. These values reflect not only statistical significance ($p < .001$ for all domains) but also robust clinical change within a relatively short intervention period. The pre-intervention mean total Y-BOCS score was 22.30 (SD = 4.17), which reduced to 14.50 (SD = 3.34) post-intervention, indicating a 34.9% decrease in overall OCD severity. This level of improvement suggests clinically meaningful change, as reductions of 25% or greater on the Y-BOCS are commonly considered indicative of treatment response.

The most pronounced improvement was seen in the domain of obsessions, where scores dropped from a mean of 11.70 to 7.60, with a Cohen's d of 1.90. This substantial reduction aligns with the theoretical premise that ACT's cognitive defusion techniques help decrease the believability and impact of intrusive thoughts. Clients were trained to perceive their obsessions not as literal truths but as transient mental events, which contributed to a reduction in distress and reactivity. These results are in agreement with previous ACT research (e.g., Twohig et al., 2010) that showed that cognitive defusion was especially effective in reducing the emotional salience of obsessional content.

There was also a significant reduction in compulsions, with a mean of 10.60 to 6.90, producing a large effect size (d = 1.62). In contrast to ERP, which aims at the regular exposure to feared stimuli, ACT will motivate clients to take valued actions even when they experience anxiety or distress, making compulsive behaviors less important. Although ERP has traditionally been regarded as the gold standard of treating compulsions, its tolerability may be restricted. The present results indicate that ACT can be a good alternative, particularly among clients who refuse ERP because of avoidance patterns or intolerance of exposure-related activities. Notably, the intervention did not induce the change by specifically addressing compulsions via exposure, which highlights the ability of ACT to induce behavior change by increasing psychological flexibility.

The overall decrease in the severity of OCD (Cohen's d = 2.03) indicates not only the improvement of symptoms but also probable improvement in overall functioning. The participants also indicated a higher readiness to take part in their everyday activities, social roles, and goal-oriented behavior, which is also at the focus of the ACT values-based approach. This lends credence to the claim that symptom relief can be a side effect of functional change, but not necessarily the goal, as is true of ACT theory (Hayes et al., 1999). Though these findings are promising, one should be cautious about their interpretation because the study is preliminary. There is no measure of the process, including the Acceptance and Action Questionnaire (AAQ-II), which implies that the psychological flexibility improvement, the proposed mechanism of change, was not confirmed. Also, the lack of a comparison group would mean that the enhanced outcomes may be affected by extraneous factors like therapeutic alliance, spontaneous remission, or placebo. However, the extent of the change that was reported, especially in a streamlined treatment modality, implies that ACT holds a lot of potential as an independent treatment of OCD.

Implications, Limitations, and Future Directions

The results of this pilot study have encouraging implications for how ACT can be used to treat OCD. The considerable reduction of OCD symptoms in a comparatively short 6-session intervention points to the potential of ACT as an effective but time- and resource-saving, client-friendly alternative to more intense and exposure-based treatment like ERP. It may be especially beneficial to people who are either unwilling or incapable of participating in ERP due to fear, discomfort, or logistics constraints. The strong focus of ACT on psychological flexibility and living according to values is compatible with the transdiagnostic movement within contemporary psychotherapy, in which functional gains are emphasized over symptom removal. Further, the individually administered mode and favorable involvement witnessed in this research indicate that ACT can be viable and can be applied in real clinical practice by competent practitioners.

However, these findings have a number of limitations that curtail their generalizability and power. The sample was small, which restricted the statistical power and the possibility of revealing more subtle effects. Also, the absence of a control group makes causal determination impossible, since the gains may be attributed to nonspecific therapy effects, natural healing, or placebo. The lack of long-term follow-up limits the conclusions regarding the sustainability of treatment effects, and in the absence of key process variables such as psychological flexibility, mechanisms of observed changes cannot be established. Moreover, only one therapist provided the intervention, which creates a possibility of bias and the inability to reproduce the findings in other practitioners and environments.

The limitations should be addressed in future studies by conducting well-powered randomized controlled trials with diverse samples. The long-term follow-up assessment would enable the maintenance effects to be assessed. It would be beneficial to include some process measures in the study, like the Acceptance and Action Questionnaire (AAQ-II) or other psychological flexibility indices, which would help to understand the change processes and theoretical basis of ACT. Comparative research evaluating ACT in combination with ERP or other interventions may also help to understand how effective it is compared to other interventions. Lastly, investigating different delivery modalities, including group-based interventions, digital mediums, or stepped-care approaches, may increase accessibility and scalability, and ACT may become a more universally applicable therapy to address OCD in a variety of populations and settings.

CONCLUSION

This pilot study shows that a short duration of six sessions of the ACT protocol can be very effective in reducing OCD symptoms, and large improvements were shown in obsessive-compulsive and severity measures. The emphasis on acceptance, cognitive defusion, and values-based living in ACT offers a very empowering alternative to symptom suppression approaches. Although more investigation is necessary, the results justify the argument that ACT is an effective and humane treatment method for OCD.

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Conflict of Interest

The author(s) declared no conflict of interest.

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