Review

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Experiential Avoidance in Obsessive-Compulsive Disorder from the Perspective of Acceptance and Commitment Therapy

Kabul ve Kararlılık Terapisi Perspektifinden Obsesif Kompulsif Bozuklukta Yaşantısal Kaçınma

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ABSTRACT

Obsessive compulsive disorder (OCD) is a psychiatric disorder characterized by the persistence of obsessions and compulsions, which negatively impact functionality and may become chronic if left untreated. Although the efficacy of pharmacological treatment and Cognitive Behavioral Therapy (CBT) involving exposure and response prevention techniques has been proven in OCD, treatment discontinuation rates and residual symptoms following treatment have led researchers to explore different therapeutic approaches. One such approach gaining increasing interest is Acceptance and Commitment Therapy (ACT), a third-generation therapeutic model, which is proving to be an innovative and effective treatment for OCD. ACT primarily aims to guide individuals toward leading a life aligned with their chosen values, by accepting the pains that exist in the natural flow of life instead of avoiding them. In the treatment of OCD, with the ACT approach, interventions aimed at enhancing psychological flexibility have been shown to positively impact the prognosis of the disorder. In addition to engaging in compulsions to avoid the anxiety caused by obsessions, OCD patients may follow a wide variety of experiential avoidance strategies. With the ACT approach, these strategies can be reduced and the anxiety caused by obsessions and compulsions can be eliminated through the acceptance of negative internal experiences. This review article addresses experiential avoidance in OCD within the framework of ACT. Based on recent publications, the article discusses how ACT targets experiential avoidance in OCD treatment and the effects of interventions on the relationship between OCD symptom severity and psychological flexibility.

Keywords: Obsessive-compulsive disorder, acceptance and commitment therapy, experiential avoidance

ÖZ

Obsesif kompulsif bozukluk (OKB), obsesyon ve kompulsiyonlarla süregiden ve işlevselliği olumsuz yönde etkileyen, tedavi edilmediğinde kronikleşebilen psikiyatrik bir rahatsızlıktır. OKB'de ilaç tedavisi ve maruz bırakma-tepki önleme tekniklerini içeren Bilişsel Davranışçı Terapinin etkililiği kanıtlanmış görünse de tedavi bırakma oranları ve takip sonrası kalıntı belirtilerin görülmesi, araştırmacıları farklı tedavi yaklaşımlarına yöneltmiştir. Bu bağlamda ortaya çıkan üçüncü kuşak terapi yaklaşımlarından biri olan Kabul ve Kararlılık Terapisi (KKT), OKB tedavisinde yenilikçi ve etkili bir yaklaşım olarak giderek daha fazla ilgi görmektedir. KKT, temelde hayatın doğal akışı içerisinde var olan acılardan kaçınmak yerine onları kabul ederek kişinin yaşamını kendi seçtiği değerler doğrultusunda yönlendirmesini amaçlamaktadır. KKT yaklaşımı ile OKB tedavisinde, bireylerin psikolojik esneklik seviyelerini artırmaya yönelik müdahalelerle hastalığın prognozuna olumlu katkı sağlanabildiği görülmektedir. OKB hastalarında obsesyonların yarattığı kaygıdan kaçınmak için kompulsiyonlara girişmenin yanı sıra çok çeşitli yaşantısal kaçınma stratejileri izlenebilmektedir. KKT yaklaşımı ile, bu stratejilerinin azaltılarak olumsuz içsel yaşantıların kabulü yoluyla obsesyonların yarattığı kaygının giderilmesi ve kompulsiyonların ortadan kaldırılması sağlanabilmektedir. Bu derleme makalesi, OKB'de yaşantısal kaçınmayı KKT çerçevesinde ele almaktadır. Son yıllarda yayımlanan güncel çalışmalar ekseninde, KKT'nin OKB tedavisinde yaşantısal kaçınmayı nasıl hedef aldığı ve yapılan müdahalelerin OKB semptom şiddeti ve psikolojik esneklik arasındaki ilişkiye etkileri tartışılmaktadır.

Anahtar sözcükler: Obsesif kompulsif bozukluk, kabul ve kararlılık terapisi, yaşantısal kaçınma

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Introduction

Obsessive-Compulsive Disorder (OCD) is a psychiatric condition characterized by persistent obsessions and compulsions, which may become chronic in the absence of effective treatment. With appropriate interventions, individuals can regain and sustain functional capacity. Although pharmacological treatments and the gold-standard Cognitive Behavioral Therapy (CBT) have demonstrated efficacy in managing OCD, issues such as treatment discontinuation and relapse have prompted researchers to explore alternative approaches (Porgalı-Zayman 2016). In this context, Acceptance and Commitment Therapy (ACT), a third-wave therapeutic approach, has been increasingly supported by evidence for its effectiveness in treating OCD. In the ACT framework, efforts are made to strengthen the core components that constitute psychological flexibility: contact with the present moment, connection with personal values, committed action, self-as-context, cognitive defusion, and acceptance. Enhancing these components aims to increase the individual's overall psychological flexibility (Hayes et al. 2006). According to ACT, psychopathologies emerge from psychological inflexibility, which represents the opposite of psychological flexibility. The main components of psychological inflexibility are: lack of contact with the present moment, lack of contact with personal values, avoidance or impulsivity, self as content, cognitive fusion and experiential avoidance. In the context of OCD psychopathology, the ACT approach suggests that individuals with OCD frequently engage in experiential avoidance strategies. Experiential avoidance, defined as the tendency to avoid or suppress distressing internal experiences, undermines one's capacity for acceptance and leads to psychological inflexibility. In individuals diagnosed with OCD, psychological inflexibility is often evaluated through the dimension of experiential avoidance. Therefore, understanding this concept is essential for the effective treatment of OCD (Hayes et al. 2006).

This review aims to examine the concept of experiential avoidance in obsessive-compulsive disorder from the perspective of Acceptance and Commitment Therapy. A comprehensive literature search was conducted across databases including PubMed, PsycINFO, Scopus, Web of Science, ULAKBİM TR Index, and DergiPark, focusing on studies published in the last 20 years to achieve this aim. Seach terms included "experiential avoidance," "obsessive-compulsive disorder," "psychological flexibility," and "acceptance and commitment therapy." The findings indicate a limited number of studies addressing the impact of ACT on experiential avoidance in OCD. By synthesizing current research on this topic, this article seeks to contribute to the existing literature and offer a new perspective on therapeutic interventions for OCD. Accordingly, the review discusses the general characteristics of OCD, introduces the ACT framework and the psychological flexibility model, and elaborates on the relationship between experiential avoidance and OCD in light of relevant studies.

Obsessive-Compulsive Disorder

OCD is a psychiatric disorder characterized by recurrent obsessions and/or compulsions (APA 2013). Obsessions are defined as intrusive, egodystonic thoughts, impulses, or images that cause significant distress and ritualistic behaviours attempted to eliminate the anxiety caused by obsessions are called "compulsions" (Abramowitz et al. 2008, Rachman and de Silva 2009, Porgalı-Zayman 2016). It is known that the 12-month prevalence of OCD worldwide varies between 1.1% and 1.8% (APA 2013), and the disorder is commonly comorbid with major depressive disorder (Demet et al. 2005, Osland et al. 2018).

Despite decades of research, the etiology of OCD remains unclear, due to the its heterogeneous symptomatology, the presence of subthreshold symptoms and diagnostic overlap with other psychopathologies within the same spectrum, Nonetheless, a range of genetic, neurological, psychodynamic, cognitive, and behavioral factors are thought to contribute to the onset and maintenance of the disorder. From a psychodynamic perspective, OCD is conceptualized as 'obsessional neurosis,' with its origins attributed to a regression from the phallic stage to the anal stage of psychosexual development. In this framework, the ego cannot use sufficiently developed defences because it has to mature early with the conflict of strong impulses, it tries to protect itself with primitive mechanisms such as isolation, undoing and reaction formation (Freud 1926, Topçuoğlu 2003). Cognitive theories, on the other hand, have tried to explain OCD with the Inflated Sense of Responsibility Model (Salkovskis 1999), the Misinterpretation

of Intrusive Thoughts Model (Rachman 1997, Rachman 1998), and the Failure of Thought Control (Clark 2004). In addition, the Obsessive Compulsive Cognitions Working Group (OCDWG), established to clarify the cognitive underpinnings of OCD, identified six maladaptive belief domains believed to play a critical role: inflated sense of responsibility, over-importance of thoughts, emphasis of thought-control, overestimation of threat, intolerance of uncertainty and perfectionism (Obsessive Compulsive Cognitions Working Group 1997, 2001).

Within the behavioural framework, Mowrer's two-factor theory (1951) is one of the most widely accepted models for explaining the development and maintenance of OCD. According to this theory, initially neutral intrusive thoughts become associated with negative emotions such as fear, anxiety, and worry through classical conditioning. In the second stage, behaviours such as avoidance, escape, or compulsions, which are performed to reduce these negative emotions, relieve distress and are negatively reinforced via operant conditioning. This reinforcement process contributes to the persistence of compulsive behaviors and fosters a self-perpetuating cycle.

Clinical Presentation

Although both obsessions and compulsions often seen together in OCD, it is also possible for individuals to experience only obsessions or only compulsions (Porgalı-Zayman 2016). Obsessions can be about contamination, doubt, aggression, sexual, scrupulosity, bodily/somatic, symmetry/ordering and other issues. In response to these obsessions, individuals often develop compulsions such as washing/cleaning, checking, seeking reassurance or approval, undoing actions, and counting. Numerous studies have found that contamination-related obsessions are the most frequently observed type (Tükel et al. 2009, Beşiroğlu 2014). Moreover, the majority of clinical cases involve more than one type of obsession (Beşiroğlu 2014).

OCD significantly disrupts functioning in various areas of life, such as social, professional, academic, and family life, by greatly hindering an individual's ability to adapt to daily life (Gururaj et al. 2008, Ruscio et al. 2010, Morrison 2016). Therefore, early and effective intervention is essential to prevent chronicity and preserve functional capacity.

Treatment Options

Selective serotonin reuptake inhibitors (SSRIs) are the first-line pharmacological treatment for OCD, and the efficacy of these medications has been well-established over the years (Pittenger and Bloch 2014, McKay et al. 2015). However, given the chronic and relapsing nature of OCD, studies have demonstrated that discontinuation of medication frequently results in relapse and a consequent decline in quality of life (Fineberg et al. 2012). Additionally, high rates of treatment discontinuation (Öst et al. 2015) have raised important concerns about long-term adherence and the overall sustainability of pharmacological interventions.

The efficacy of psychological interventions in alleviating OCD symptoms has been consistently demonstrated across numerous studies (Abramowitz 2006, Norton and Price 2007, Hofmann and Smits 2008, Tolin 2010). Many randomized controlled trials have reported the effectiveness of CBT, particularly including exposure and response prevention (ERP) techniques, in the treatment of OCD (Abramowitz 2006). However, factors such as poor patient adherence to treatment (Didonna et al. 2019), significant rates of treatment refusal and dropout (Ong et al. 2016, Leeuwerik et al. 2019), the long duration and cost of CBT (Fineberg et al. 2018), persistence of residual symptoms post-treatment (Fisher and Wells 2005), and post-treatment relapse rates (Eisen et al. 2013) have led researchers to explore alternative treatment options. These limitations of pharmacological treatment and CBT have resulted in the introduction of third-wave therapies (Manjula and Sudhir 2019).

Acceptance and Commitment Therapy

ACT, developed by Steven C. Hayes and colleagues in the early 1980s and originating from cognitive behavioral therapy, is an increasingly widespread third-wave therapy approach that focuses on the effects

of context and language on human behavior, and its effectiveness has been supported by empirical evidence (Hayes 2004). Within third-wave therapies, including ACT, emphasis is placed on the function of these experiences, rather than their content, form, or frequency, and these experiences are evaluated within the context in which they arise, with the goal of improving the behavioral repertoire by altering their functions (Zettle 2005).

Relational Frame Theory

Relational Frame Theory (RFT), which underpins the theoretical basis of ACT, posits that humans acquire symbolic abilities in a developmental sequence from birth, which over time evolve into a complex language system that regulates behavior. Central to this theory are relational frames, basic patterns of relating events and stimuli such as "i-you," "here-there," and "then-now." From a limited set of these relational frames, an almost limitless and complex symbolic system, namely language, emerges. Through this linguistic system, relational frames gradually acquire the capacity to regulate behavior (Barnes-Holmes et al. 2001, Hayes et al. 2006).

At its core, relational frame theory proposes that human language and cognition depend on the individual's capacity to relate events to one another (Hayes 2004). According to this theory, names and objects are learned in a reciprocal relationship independent of their form (Fletcher and Hayes 2006). For instance, hearing the word "flower" may evoke a mental image of a flower, just as seeing a flower might bring the word itself to mind. Over time, individuals develop the capacity to form complex associations between abstract concepts, even in the absence of direct sensory input.

According to relational frame theory, learned associations are formed within the contexts in which they occur. Consequently, contextual features influence and regulate how events are related (Fletcher and Hayes 2006). For example, a person who senses movement in a wooded area and runs away in fear, they may associate the wooded area with a snake, and the snake with a sign of danger. Even if the person has never directly experienced such an event, they may have heard about it, seen depictions, or formed associations throughout their life. As a result, the pairing of the wooded area and the snake, although meaningless under normal conditions, can still elicit various responses, including a flight reaction. In summary, although the person did not learn to fear snakes directly, they have indirectly associated the snake with fear (Blackledge 2003).

Relational Frame Theory and Psychopathology

From the ACT perspective, individuals learn to transfer the function of a stimulus to other stimuli through specific relational frames such as similarity, temporality, and comparison. In this way, neutral stimuli can acquire anxiety-evoking functions even if the individual has never directly experienced them before. For example, in a person with OCD who experiences contamination-related obsessions, dirt is perceived as threatening, and gradually acquires a threat function that sustains compulsive behaviors. When internal experiences are appraised negatively as dangerous, the urge to suppress or control these experiences arises, contributing to the development and maintenance of psychopathology. According to RFT, psychopathology refers to the predominance of relational networks over behavioral regulation. When a thought is activated, it triggers other events related to that thought, influencing behavior accordingly. As a result, treating a thought merely as a thought becomes increasingly difficult (Fletcher and Hayes 2006).

Psychological Flexibility Model

Acceptance and commitment therapy focuses on the psychological flexibility model, which consists of six core components, when addressing symptoms. The primary goal of the ACT model is to assess verbal and cognitive processes contributing to distress in a more contextually adaptive manner, while facilitating the individual's engagement with the consequences of their actions in accordance with personally chosen values. This approach encourages individuals to live in alignment with self-determined values by embracing both internal and external experiences with present-moment awareness, thereby avoiding entanglement in past- or future-oriented thoughts.

The six core components of the ACTS's hexaflex model that underpin psychological flexibility include contact with the present moment, contact with chosen values, committed action, self as context, cognitive defusion, and acceptance (Figure 1). Contact with the present moment refers to the individual's ability to flexibly focus attention on here and now. Contact with chosen values and committed action involve connecting with personally meaningful values and engaging in behaviors consistent with those values. The concept of self as context highlights that individuals are not defined by their inner experiences. Cognitive defusion entails distinguishing between inner experiences and external reality, recognizing thoughts, feelings, and impulses as merely mental events or bodily sensations. Acceptance involves approaching all internal experiences with an open and flexible stance, without attempting to suppress or alter those (Hayes et al. 2012).

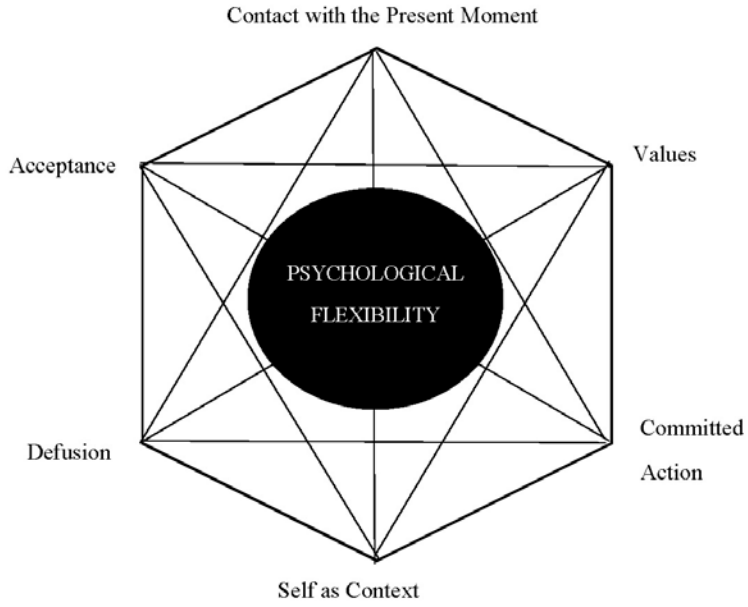

Figure 1. The hexaflex model of ACT for psychological flexibility

Psychological Inflexibility Model

The core components of psychological inflexibility, which is the opposite of psychological flexibility, include lack of contact with the present moment, lack of contact with personal values, avoidance or impulsivity, self as content, cognitive fusion and experiential avoidance. (Hayes et al. 2012, Ruiz 2010). Numerous studies have consistently demonstrated that psychological flexibility is inversely related to various psychopathologies, including OCD, and that increases in psychological flexibility are associated with symptom improvement (Hayes et al. 2006, Twohig et al. 2006, Allen and Barlow 2009, Wersebe et al. 2018).

From the ACT perspective, psychological suffering is considered a natural aspect of human existence. However, psychological inflexibility limits individuals' ability to adapt to internal and external contexts, contributing to the development of diverse psychological difficulties. Psychological suffering becomes problematic when verbal and cognitive processes narrow the behavioral repertoire through cognitive fusion and experiential avoidance, reflecting psychological inflexibility (Yektaş 2020).

ACT in OCD Treatment

Many studies have shown that psychological flexibility is closely linked to various mental health conditions, including obsessive-compulsive disorder, and that increases in flexibility are associated with better treatment outcomes (Hayes et al. 2006, Twohig et al. 2006, Allen and Barlow 2009, Wersebe et al. 2018). Acceptance and commitment therapy does not primarily aim to reduce or modify the intensity or frequency of intrusive thoughts, images, or urges in individuals diagnosed with OCD (Philip and Cherian 2021), rather,

it seeks to modify the individual's functional relationship with these internal experiences. It aims to help individuals view these experiences merely as "thoughts." Rather than reducing or eliminating distressing thoughts, urges, and images, the focus is on enabling individuals to engage in committed actions that are consistent with their chosen values, regardless of whether obsessions are present or not (Philip and Cherian 2021). Thus, the aim is to work towards increasing psychological flexibility.

The effectiveness of ACT in treating OCD has been supported by various research methods, including case studies, single-subject designs, and randomized controlled trials. Consistent evidence highlights ACT's efficacy in OCD treatment. For example, Davazdahmami et al. (2020) investigated ACT's impact on eight Iranian adult women experiencing death anxiety and OCD. Participants attended weekly 40-minute sessions for eight weeks. Following the intervention, reductions of 60–80% in death anxiety and 51–60% in OCD symptoms were observed.

ACT has also been found to significantly reduce OCD symptoms when combined with Exposure and Response Prevention (ERP). For instance, Thompson et al. (2021) conducted a study with three participants who received individual sessions of either ACT or ERP, with weekly assessments throughout the treatment. All participants experienced a reduction in OCD symptoms along with improvements in psychological flexibility. Similarly, Chacin-Fuenmayor et al. (2019) applied a combined ACT and ERP approach in 14 sessions with a 30-year-old woman diagnosed with OCD, reporting a notable decrease in symptoms by the end of the treatment.

Significant improvements have been reported when ACT is added to pharmacological treatment for OCD. In a study by Akhouri et al. (2023) with 62 individuals diagnosed with OCD, participants were randomly assigned to either an experimental or control group. Both groups received pharmacological treatment, while the experimental group also participated in eight weeks of ACT sessions. The experimental group showed a significant reduction in OCD symptom severity, and follow-up assessments three months later indicated that these gains were maintained. These results further support the growing evidence that ACT is a promising and effective treatment option for OCD.

Although the effectiveness of ACT in treating obsessive-compulsive disorder has only recently begun to gain recognition, an increasing number of systematic reviews have been published on the topic. Both Philip and Cherian (2021) and Evey and Steinman (2023) report that most studies included in their reviews support the efficacy of ACT for OCD treatment. Nevertheless, they highlight the need for further research to more conclusively establish these findings.

Experiential Avoidance

As a component of psychological inflexibility, experiential avoidance is defined as an individual's tendency to avoid or disengage from aversive internal experiences such as distressing thoughts, emotions, and bodily sensations (Hayes et al. 1996). Through such avoidance, individuals attempt to protect themselves from psychological pain and to prevent or suppress negative reactions to painful memories. However, rather than alleviating distress, these avoidance strategies often become part of the problem over time (Bennett and Oliver 2019). Consequently, individuals progressively restrict their lives, incurring various costs. Attempts to control, suppress, or prevent unwanted internal experiences (Hayes et al. 2011, Manlick et al. 2013), as well as efforts to alter the frequency, intensity, or form (Bach and Moran 2008, Yavuz 2015), all fall under the umbrella of "experiential avoidance" (Hayes et al. 1996).

In the ACT framework, acceptance is conceptualized as an alternative to experiential avoidance (Harris 2009). Rather than signifying passive resignation, acceptance involves a willingness to experience internal events -such as thoughts, emotions, and bodily sensation- as they are, with an attitude of openness, curiosity, and nonjudgmental awareness (Aydın 2017). Individuals are encouraged to reduce efforts aimed at controlling unpleasant internal experiences and instead to engage in nonjudgmental awareness, observing emotions simply as emotions, thoughts as thoughts, and to notice these experiences as they arise without trying to change them (Blackledge and Hayes 2001). Acceptance does not mean submitting

to symptoms, rather, it means recognizing that the internal processes one experiences are not the self but products of mental events (Gaudiano and Herbert 2006).

Experiential Avoidance and Psychopathology

Experiential avoidance has been identified as a key factor in the development and maintenance of various psychopathological conditions, such as anxiety, depression, and obsessive-compulsive disorder (Eifert and Forsyth 2005, Marx and Sloan 2005, Roemer et al. 2005). Studies across diverse clinical populations have shown that experiential avoidance is linked to impaired functioning, heightened psychological distress, and reliance on maladaptive coping strategies (Hayes et al. 2006, Bond et al. 2011). Furthermore, experiential avoidance has been reported to negatively impact quality of life and well-being in multiple areas, including pain tolerance, overall mental health, job satisfaction, and work performance (Hayes et al. 2006, Chawla and Ostafin 2007).

When individuals struggle to cope with negative internal experiences, they may engage in avoidance behaviors. These can take many forms, for example, avoiding reviewing bank statements due to financial worries or steering clear of social situations because of feelings of shyness (Hayes et al., 1996). Persistently avoiding such experiences can interfere with one's ability to focus on meaningful activities, making avoidance ultimately harmful (Kashdan et al. 2006). Research suggests a strong connection between experiential avoidance and OCD-specific avoidance behaviors (Abramowitz et al. 2009, Manos et al. 2010, Wetterneck et al. 2014). However, because experiential avoidance is viewed as a broader dimension influencing psychological flexibility, it is not seen as directly linked to the specific obsessions and compulsions characteristic of OCD (Bond et al. 2011).

The Role of Experiential Avoidance in OCD

Experiential avoidance, defined as the struggle to tolerate distressing internal experiences, has been shown to play a significant role in the development and persistence of OCD (Arabatzoudis et al. 2017, Blakey et al. 2017, Angelakis and Gooding 2020, Angelakis and Pseftogianni 2021). According to Eifert and Forsyth (2005), compulsions in OCD may arise as attempts to avoid intrusive and unwanted thoughts or feelings. From this perspective, behaviors like washing, checking, or ordering may be maintained through avoidance processes and can be reduced by targeting experiential avoidance in therapy. However, the results of studies on this topic have been inconsistent. While some findings support a relationship between compulsions and experiential avoidance behaviors (Wetterneck et al. 2014), others have failed to support this connection in both clinical and non-clinical samples (Abramowitz et al. 2009, Manos et al. 2010).

Experiential avoidance is closely related to the "acceptance" component of the psychological flexibility model. This component is most commonly assessed using the Acceptance and Action Questionnaire-II (AAQ-II) and its adaptations, which are widely accepted as indicators of psychological flexibility. In this context, higher scores typically reflect greater levels of experiential avoidance. Research indicates that individuals diagnosed with OCD tend to report elevated levels of experiential avoidance (Xiong et al. 2021).

From the ACT perspective, OCD psychopathology is explained by the individual's attempts to suppress obsessions or engage in compulsions as a means of avoiding contact with them through experiential avoidance. According to this view, OCD symptoms arise not from the intrusive internal experiences themselves, but from efforts to control, suppress, or organize these experiences in terms of their intensity, frequency, or form (Hayes et al. 2006).

Related Studies

Studies examining the relationship between OCD and experiential avoidance highlight that low levels of acceptance and psychological flexibility may exacerbate OCD symptoms. In a review by Bluett et al. (2014), a weak to moderate association was found between OCD and experiential avoidance. Theoretically, experiential avoidance is considered to reflect compulsive behaviors in OCD, supporting the potential for a transdiagnostic conceptualization. The review included five studies conducted with individuals

diagnosed with OCD. In one of these studies, Twohig et al. (2010) applied ACT interventions to two adult patients with OCD, resulting in a significant reduction in symptoms and an increase in psychological flexibility. In another study by Twohig et al. (2006), eight sessions of ACT, delivered without exposure exercises, were provided to four OCD patients, leading to reductions in both OCD symptoms and levels of experiential avoidance. Similarly, ACT sessions conducted with five adult OCD patients with scrupulosity yielded symptom improvement (Dehlin et al. 2013). A study conducted with adolescents diagnosed with OCD also reported comparable results (Armstrong et al. 2013).

Table-1 Studies included in the review

Study	Study Group	Measures	Results
Xiong et al. (2021)	118 individuals diagnosed with Obsessive-Compulsive Disorder (OCD), 109 healthy controls	Cognitive Fusion Questionnaire Acceptance and Action Questionnaire–II Yale-Brown Obsessive Compulsive Scale (Y-BOCS) Hamilton Anxiety Rating Scale Hamilton Depression Rating Scale	The study results indicated that the levels of cognitive fusion and experiential avoidance in the OCD group were significantly different from those in the healthy control group. Additionally, experiential avoidance levels in participants diagnosed with OCD were found to be positively associated with OCD symptom severity.
Twohig et al. (2010)	6 adult participants with a primary diagnosis of OCD	Yale-Brown Obsessive Compulsive Scale (Y-BOCS) Process measurement tools developed by the authors	Participants were divided into three groups to have Acceptance and Commitment Therapy (ACT), Cognitive Therapy (CT), and Exposure and Response Prevention (ERP) for OCD interventions implemented. At the end of the treatment, a significant decrease in OCD severity and an increase in psychological flexibility levels were observed in the ACT group.
Twohig et al. (2006)	4 adult participants diagnosed with OCD	Obsessive-Compulsive Inventory (OCI) Beck Anxiety Inventory Beck Depression Inventory-II Acceptance and Action Questionnaire	8 sessions of ACT were implemented with the participants, resulting in significant improvements in OCD symptom severity and experiential avoidance levels. It was reported that these improvements were maintained during a three-month follow-up period.
Dehlin et al. (2013)	5 adult participants diagnosed with scrupulosity-based OCD	Structured Clinical Interview for DSM (SCID) The Obsessive Compulsive Inventory-Revised, (OCI-R) Penn Inventory of Scrupulosity (PIOS) Yale-Brown Obsessive Compulsive Scale (Y-BOCS) Beck Depression Inventory-II Quality of Life Scale (QOLS) Santa Clara Strength of Religious Faith Questionnaire (SCSORF) Acceptance and Action Questionnaire-II	ACT was implemented in a total of 8 weekly sessions, each lasting 1 to 1.5 hours, with the participants. Reductions in OCD symptom severity were observed, and these improvements were reported to be maintained during the follow-up period.

Armstrong et al. (2013)	3 adolescent participants aged 12-13 diagnosed with OCD	Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS)	ACT was implemented in 8 to 10 sessions with the participants. A reduction in OCD severity was observed, and the improvement was reported to be maintained throughout the follow-up period.
Rohani et al. (2018)	46 adult female participants diagnosed with OCD currently using SSRIs	Structured Clinical Interview for DSM (SCID) Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) Beck Depression Inventory-II Ruminative Responses Scale (RRS) Acceptance and Action Questionnaire-II	Participants were divided into two groups: one receiving only selective serotonin reuptake inhibitors (SSRI) and the other receiving ACT in addition to SSRI treatment. The treatment process and outcomes were assessed using relevant scales. Experiential avoidance levels, measured by the Acceptance and Action Questionnaire-II (AAQ-II), were found to significantly decrease in the ACT + SSRI group.
Vakili et al. (2015)	32 adult participants diagnosed with OCD	Structured Clinical Interview for DSM (SCID) Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) Acceptance and Action Questionnaire-II	Participants were divided into three groups receiving SSRI, combined treatment (SSRI + ACT), and ACT only. Improvements in OCD symptoms and reductions in experiential avoidance levels were observed in all three groups at the end of the treatment. These effects were greater in the ACT and combined treatment groups compared to the SSRI-only group.

It has been suggested that individuals' levels of experiential avoidance may predict the severity of OCD symptoms (Wetterneck et al. 2014, Stockton et al. 2018). Accordingly, targeting experiential avoidance has been emphasized as a key component in alleviating OCD symptoms (Eifert and Forsyth 2005, Twohig et al. 2010). The demonstrated effectiveness of ACT in treating OCD also supports the notion that reducing experiential avoidance is central to symptom improvement (Rohani et al. 2018). Consistent with these findings, a study by Vakili et al. (2015) found that combining ACT with SSRI treatment resulted in reductions in both OCD symptom severity and experiential avoidance.

Conclusion

Although pharmacological treatments and CBT have long been established as effective approaches in the treatment of OCD, relapse rates and treatment dropouts highlight the importance of exploring alternative therapeutic models. In this context, ACT, a modern intervention approach, has gained increasing empirical support for its effectiveness in treating OCD. Rather than aiming to eliminate symptoms directly, ACT focuses on increasing psychological flexibility by reducing experiential avoidance and promoting greater acceptance of internal experiences. This approach helps individuals move toward a meaningful life aligned with their values, not by avoiding distressing thoughts and emotions, but by learning to engage with them in a more adaptive and open way. By decreasing experiential avoidance, ACT may reduce OCD symptoms and improve overall functioning. Despite the growing interest in ACT globally, research on the relationship between OCD and psychological flexibility in Turkey remains limited, particularly studies examining the role of experiential avoidance from the ACT perspective. This review aims to contribute to the national

literature by clarifying these concepts and emphasizing their clinical relevance. A better understanding of experiential avoidance and its role in OCD may inform the development of more effective intervention strategies, ultimately supporting improved prognosis and quality of life for individuals affected by OCD.

To further elucidate the relationship between OCD and psychological flexibility, future research could examine the specific effects of individual components of psychological flexibility on OCD symptoms. In particular, more detailed investigations into the long-term impact of experiential avoidance strategies may offer valuable insights. These strategies could be explored in relation to relapse rates and treatment-resistant forms of OCD. Furthermore, levels of experiential avoidance in individuals with OCD may vary based on demographic and personal factors. Exploring these individual differences could support the development of more tailored and effective interventions. Given the heterogeneous nature of OCD and its diverse symptom dimensions (e.g., contamination, checking), future research might also explore how experiential avoidance manifests across different OCD subtypes. Comparative studies assessing the role of ACT in reducing experiential avoidance could further clarify how this component interacts with other facets of psychological flexibility. Such research would contribute to a more nuanced understanding of ACT's therapeutic mechanisms and its potential benefits in treating OCD.

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