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Randomized-controlled trial on a novel (meta-)cognitive self-help approach for obsessive-compulsive disorder ("myMCT")

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ABSTRACT

Effective treatment strategies exist for obsessive-compulsive disorder (OCD), however, many individuals do not receive professional help. Media-delivered self-help is increasingly sought to narrow the treatment gap. Previous studies included personal contact with a clinician, making it difficult to delineate the specific effect of the medium. We developed "myMCT" for OCD, a (meta-)cognitive manual for self-application. We conducted a randomized-controlled trial with 128 OCD participants receiving myMCT versus psychoeducation, adopting low-threshold recruitment approaches without any face-to-face contact. Diagnoses were verified with telephone interviews paralleling online surveys at pre, post (4 weeks) and follow-up (6 months). Participants benefited significantly from both interventions. MyMCT showed stronger reduction of OCD symptoms on Y-BOCS total score ($p=.023$, η^2partial$=.04$), obsessions ($p=.002$, η^2partial$=.07$), depression (BDI: $p=.022$, η^2partial$=.04$), and cognitive biases (OBQ: $p=.016$, η^2partial$=.05$) after 4 weeks. After 6 months, individuals with myMCT showed decreased levels of cognitive biases (OBQ). The current study provides further evidence that myMCT is a promising approach to target OCD-related psychopathology as mere self-help. Although effect sizes were below those usually found in (therapist-)guided self-help, myMCT could be of value for the large subgroup of individuals without treatment.

1. Introduction

1.1. OCD and its treatment

Obsessive-compulsive disorder (OCD) is characterized by intrusive and upsetting thoughts and/or compulsive behaviour aimed at neutralizing the distressing thought content and accompanying negative emotions (American Psychiatric Association, 2013). OCD has a high lifetime prevalence (2–3%; Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012) and causes significant distress to afflicted individuals, strongly interfering with their quality of life (Hauschildt, Jelinek, Randjbar, Hottenrott, & Moritz, 2010; for a review see Macy et al., 2013). To date, cognitive-behaviour therapy (CBT) with exposure and response prevention (Ex/RP) is considered gold standard with convincing empirical evidence across numerous clinical trials (for a meta-analysis see Olatunji, Davis, Powers, & Smits, 2013). Despite this, numerous individuals with OCD do not receive (Jacobi et al., 2014; Marques et al., 2010; Torres et al., 2007; Wahl et al., 2010) or even seek help (Voderholzer, Schlegl, & Külz, 2011;), reject, or drop out prematurely from Ex/RP treatment (Mancebo, Eisen, Sibrava, Dyck, & Rasmussen, 2011).

1.2. Treatment gap and role of self-help

Studies have shown that in up to 70% of cases OCD remains unrecognised (Torres et al., 2007). According to the authors, less than 10% receive evidence-based treatment (see also Blanco et al., 2006; Marques et al., 2010; Wahl et al., 2010). It has been estimated that only 35–40% receive psychological intervention at all (Goodwin, Koenen, Hellman, Guardio, & Struening, 2002; Mayerovitch et al., 2003).

Reasons for this dramatic treatment gap are manifold. In addition to generic treatment barriers such as poor availability of treatment, particularly in rural areas (Wootton, & Titov, 2010) and non-Western countries (Moritz, & Russu, 2013), specific reasons have been identified for OCD. There is still an insufficient provision of qualified OCD-specialized treatment (e.g., Gunter, & Whittal, 2010; Olatunji, Deacon, & Abramowitz, 2009). In a study by Külz et al. (2010), only 1.7% of the surveyed psychotherapists in outpatient treatment ($N=177$) claimed to be specialists for OCD. More than 50% admitted that they do not provide CBT with Ex/RP, mostly due to lacking skills or experience with OCD patients.

Meanwhile, individuals with OCD seek treatment late, if they

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do at all (7–10 years after first symptom occurrence, Demet et al., 2010), which has been ascribed to subjective shame, guilt, or feared consequences, for example, to be stigmatized as insane or dangerous (Simonds & Thorpe, 2003; Voderholzer et al., 2011). Alarmingly, without treatment, OCD symptom severity usually deteriorates and is likely to become chronic (Abramowitz, Taylor, & McKay, 2009; Skoog, & Skoog, 2015).

Consequently, there is great need for novel approaches targeting this undertreated patient group. Self-help is being ascribed an increasingly important role (e.g., review by Moritz, Wittekind, Hauschildt, & Timpano, 2011; meta-analysis by Haug, Nordgreen, Öst, & Havik, 2012). In order to overcome the above described treatment barriers, evidence-based interventions should be provided via low threshold delivery channels, such as the Internet, books, or other media (see also review by Mataix-Cols, & Marks, 2006).

1.3. Self-help: approaches and empirical evidence

In this article, we refer to self-help following Cuijpers and Schuurmans (2007, p. 284) definition as a "standardized psychological treatment protocol comprising guidance for applying a generally accepted psychological treatment to a mental health problem". Typically, information and exercises for self-application are delivered through media, such as written books, computer software, or the Internet while there is either no or only minimal contact with a therapist. Most self-help approaches in literature are based on CBT treatment protocols, most often applied to either depression or anxiety disorders (see review by Eells, Barrett, Wright, & Thase, 2015; meta-analysis by Grist, & Cavanagh, 2013). While there is accumulating empirical evidence for media-delivered CBT targeting depression and several anxiety disorders (meta-analysis by Cuijpers et al., 2009), the empirical foundation suggesting its utility and efficacy in OCD is rather sparse. In a meta-analysis by Haug et al. (2012), among the 56 publications on self-help for anxiety disorders, only a single study (Greist et al., 2002) targeted OCD. For an overview on the existing media-delivered approaches for OCD, see review by Herbst et al. (2012).

Marks et al. (1998) developed the first computerized CBT ("CCBT") program for OCD, called "BT Steps", in which instructions for self-administered Ex/RP are provided by a computerized telephone administration system. A first RCT compared self-administered vs. therapist-administered BT steps vs. systematic relaxation guided by an audio-tape and manual in 218 OCD patients (Greist et al., 2002). Whereas systematic relaxation yielded no effect, both BT conditions proved effective, although clinician-guided BT was superior to computer-guided. However, a more recent study (Kobak, Greist, Jacobi, Levy-Mack, & Greist, 2015) compared BT steps self-applied vs. lay coach-guided vs. therapist – guided and found good and comparable effect sizes for change scores on the Yale-Brown Obsessive Compulsive Scale (Y-BOCS, Goodman et al., 1989) for all three conditions. Similarly, Tolin et al. (2007) compared clinician-administered with self-administered Ex/RP. Participants in the latter condition were instructed to self-conduct Ex/RP exercises with the help of the book *Stop Obsessing!* (Foa, & Wilson, 2001). Patients in both conditions showed statistically and clinically significant symptom reduction but therapist-administered Ex/RP was superior. Importantly, all of the above studies did include face-to-face contact with a clinician or investigator at one point of the study (e.g., for clinical interview, instruction for Ex/RP self-application).

The self-help approach receiving most attention in recent literature is CBT delivered via the Internet, often referred to as "ICBT" (e.g., Andersson, 2009). In ICBT, a patient logs on to a website and works with instructions and homework assignments, often closely monitored by a clinician ("guided self-help"). While a plethora of studies have shown efficacy for ICBT programs for several psychiatric disorders (Hedman, Ljotsson, & Lindefors, 2012), only a few uncontrolled studies (Andersson et al., 2011; Wootton et al., 2011, Wootton, Titov, Dear, Spence, Kemp, 2011; Wootton, Dear, Johnston, Terides, & Titov, 2014; 2015) and recent RCTs (Andersson et al., 2012; Andersson et al., 2014; Herbst et al., 2014; Wootton, Dear, Johnston, Terides, & Titov, 2013) tested IBCT for OCD. These studies obtained satisfactory effect sizes and good acceptance among individuals with OCD.

Haug et al. (2012) concluded in their meta-analysis though self-help seems effective for anxiety disorders, a major restriction lies in the fact that studies involved therapist contact, making it impossible to delineate the specific contribution of the self-help medium.

In their recent Cochrane review on media-delivered CBT (e.g. Internet, books) for anxiety disorders including OCD, Mayo-Wilson and Montgomery (2013) also found evidence for the efficacy of media-delivered interventions compared with no intervention. However, they pointed out that the number of individuals who responded and recovered when using media-delivered interventions alone was small. Thus, the authors concluded that for people who seek treatment, face-to-face interventions are superior to media-delivered interventions whereas media-delivered self-help could be useful for people who are not seeking other services, which is true for a large number of individuals with OCD (e.g., Torres et al., 2007). In line with Haug et al. (2012), the authors criticized that many of the reviewed studies on self-help approaches included therapist input for research and/or treatment purposes (averaging about an hour) which likely affected compliance and efficacy above the effect of the self-help medium. They further argued that many studies demonstrated efficacy of very particular and inaccessible interventions in highly selective populations. Consequently, in order to increase generalizability and utility of the results, they demanded further research examining publicly available interventions (e.g., self-help books) which could be widely disseminated.

1.4. MyMCT, a novel self-help approach for OCD

As one attempt to narrow the described dramatic treatment gap for OCD, we developed *my Metacognitive Training* ("myMCT"), a self-help book for individuals with OCD, in the tradition of the *Metacognitive Training* (MCT) approach, which has been developed in 2003 (e.g., MCT for psychosis, see Moritz et al., 2014). In accordance with our understanding of metacognition (thinking about thinking, particularly "cognitive traps"), myMCT targets disorder specific thought distortions, both on the level of thought process and content. Thus, myMCT can be considered an eclectic approach, which pursues three overarching aims: (i) to educate individuals about core features of OCD, (ii) to help individuals become aware of and detect cognitive biases, dysfunctional (metacognitive) beliefs and coping strategies that underlie or maintain OCD symptomatology; (iii) to convey new strategies to reduce OCD cognitive styles contributing to its pathogenesis. Thus, the book aims at raising awareness for and modifying the six (meta-) cognitive biases that have been identified to contribute to the pathogenesis of OCD by the Obsessive-Compulsive Cognitions Working Group (OCCWG, 1997, 2003, 2005), namely (1) control of thoughts, (2) importance of thoughts, (3) responsibility, (4) intolerance of uncertainty, (5) overestimation of threat, and (6) perfectionism. Additionally, it addresses thought-action-fusion, low self-esteem, depressive thinking style, and fear of being insane, as these biases have high relevance to OCD psychopathology. The thought distortions are targeted with a variety of exercises and techniques in the tradition of CBT (e.g., behavioral experiments, Ex/RP) and newer metacognitive strategies based on approaches