Journal of Obsessive-Compulsive and Related Disorders 9 (2016) 24–29

Contents lists available at ScienceDirect

Journal of Obsessive-Compulsive and Related Disorders

journal homepage: www.elsevier.com/locate/jocrd

Metacognitive therapy for obsessive–compulsive disorder: A pilot study

Colin van der Heiden [a,b,*], Kim van Rossen [a], Anika Dekker [a], Marianne Damstra [a], Mathijs Deen [c]

[a] Outpatient Treatment Centre PsyQ, Max Euwelaan 70, 3062 MA Rotterdam, The Netherlands
[b] Erasmus University Rotterdam, Burgemeester Oudlaan 50, 3062 PA Rotterdam, The Netherlands
[c] Parnassia Psychiatric Institute & Leiden University, Kiwistraat 32, 2552 DH Den Haag, The Netherlands

ARTICLE INFO

Article history:
Received 18 December 2015
Received in revised form
18 February 2016
Accepted 20 February 2016
Available online 23 February 2016

Keywords:
Obsessive–compulsive disorder
Metacognitive therapy
Pilot study
Effectiveness

ABSTRACT

The first-line psychological treatment for OCD, exposure and response prevention (ERP), has been shown to lead to statistically significant improvements in 75% of patients. However, as only about 60% of treatment completers achieve recovery, and 25% of patients are asymptomatic following treatment, there is room for improvement. One promising approach is metacognitive therapy, which targets metacognition, a key cognitive process involved in the development and maintenance of OCD. This open trial examined the effectiveness of MCT among 25 consecutively referred outpatients with OCD. At post-treatment and follow-up, MCT produced significant and large reductions across all outcome variables, with high proportions of clinically significant change (patients recovered at posttreatment, 74%; at follow-up, 80%) on the Y-BOCS. In addition, the majority of patients (63% and 80% respectively) no longer fulfilled the diagnostic criteria for OCD. The encouraging results from this open trial justify a controlled trial in which the effectiveness of MCT is evaluated against ERP.

1. Introduction

Obsessive–compulsive disorder (OCD) is characterized by recurrent obsessions and/or compulsions that cause marked distress and interfere with daily functioning (APA, 2013). In the absence of treatment the course of OCD can be chronic. Until the 1960s, this relatively common condition was considered unresponsive to psychological treatments. However, with the introduction of exposure and response prevention (ERP) the prognosis for OCD improved substantially (Meyer, 1966). The procedure is based on learning theory, which suggests that classical conditioning is responsible for the development of obsessions, whereas operant conditioning processes maintain anxiety and compulsive behaviors (Fisher & Wells, 2005). As a consequence, ERP consists of (a) exposure to anxiety provoking stimuli and (b) prevention of compulsive responses that reduce anxiety.

Widely regarded as first-line psychological treatment for OCD (Olatunji, Cisler, & Deacon, 2010; Öst, Havnen, Hansen, & Kvale, 2015), several studies and meta-analyses have shown ERP to lead to statistically significant improvements in 75% of patients, only about 60% of treatment completers achieve recovery, whereas only approximately 25% of patients are asymptomatic following treatment (Fisher & Wells, 2005). As only treatment completers were included in these analysis, and approximately 30% of patients refuse ERP or dropout from treatment, overall recovery rates may be lower (Clark, 2004). Furthermore, there appears to be a clear dose-effect relationship for ERP, i.e., the greater the number of treatment hours, the greater the percentage of recovered and asymptomatic patients (Fisher & Wells, 2005). As such, optimal ERP requires considerable amounts of therapist time, with typically 15–20 treatment sessions of 90 min (Foa & Kozak, 1996). These data show that there is room for improvement in both the effectiveness and cost-effectiveness of OCD-treatment. It has been suggested that progress might be made by basing treatments on key cognitive processes involved in the development and maintenance of the disorder (Frost & Steketee, 2002), such as metacognition (Purdon & Clark, 1999; Wells, 1997).

Metacognition refers to knowledge or beliefs about thinking and strategies used to regulate and control thinking processes (Flavell, 1979). The metacognitive model of OCD specifies two subcategories of belief that are fundamental to the maintenance of the disorder; (a) metacognitive beliefs about the meaning and consequences of intrusive thoughts and feelings, containing themes of thought action fusion (TAF), thought event fusion (TEF),

* Corresponding author at: Outpatient Treatment Centre PsyQ, Max Euwelaan 70, 3062 MA Rotterdam, The Netherlands.
E-mail addresses: c.vanderheiden@psyq.nl (C. van der Heiden), k.vanrossen@psyq.nl (K. van Rossen), anika.dekker@gmail.com (A. Dekker), marianne@damstra.me (M. Damstra), m.deen@parnassiagroep.nl (M. Deen).

http://dx.doi.org/10.1016/j.jocrd.2016.02.002
2211-3649/

and thought object fusion (TOF), and (b) beliefs about the necessity of performing rituals in response to obsessions. Resulting from the metacognitive model, treatment focuses on modifying patients' beliefs about the importance and power of thoughts and rituals using verbal reattribution and behavioral experiments, with the aim to alter the patients' relationship with their thoughts as opposed to challenging the actual content of intrusive thoughts (Fisher & Wells, 2008).

To date, two studies have provided support for the efficacy of MCT for OCD. Using single case methodology in four consecutively referred patients with OCD, Fisher and Wells (2008) found clinically significant improvements for all patients treated individually with MCT, whereas Rees and van Koesveld (2008) found that all eight participants in an open trial of group metacognitive therapy for OCD demonstrated improvements on all outcome measures, with even recovery achieved for seven of the eight patients on the Y-BOCS. Together, these findings suggest that MCT might be an efficacious treatment for OCD. However, it should be acknowledged that the evidence is only preliminary given the small sample sizes in both studies and the lack of control groups. Given the promising potential for the treatment of OCD, the present study was conducted to further evaluate the efficacy of MCT in a larger sample of clinically referred patients with OCD. It was hypothesized that MCT would result in significant and large reductions in both symptoms of OCD and comorbid depression, and in metacognitive beliefs about intrusive thoughts. If effective, the next step would be to conduct a large study comparing MCT with ERP, the current treatment of choice for OCD, in an outpatient clinical sample of patients with OCD.

2. Method

2.1. Participants and design

Patients were recruited between January 2013 and March 2014 from consecutive referrals to PsyQ, an outpatient community mental health center in the Netherlands, for anxiety disorder treatment from clinical services. Diagnosis was established using the Dutch version of the Structured Clinical Interview for DSM-IV axis-I (SCID-I) (First, Spitzer, Gibbon, & Williams, 2001), which was administered by an independent trained assessor. Inclusion criteria are 1) primary diagnosis of OCD, and 2) age 18–65. To enhance the clinical representativeness of the sample, exclusion criteria were kept to a minimum. Patients were only excluded if they currently 1) met DSM-IV-TR criteria for severe major depressive disorder that requires immediate treatment, psychotic disorder, or bipolar disorder, 2) had mental impairment or evidence of organic brain disorder, 3) had substance abuse requiring specialist treatment, 4) had a change in medication type or dose in the six weeks before assessment or during treatment, or 5) received a concurrent psychological treatment for any Axis I or II disorder. The presence of other comorbid disorders or the continued use of psychopharmaca patients already used longer than six weeks before assessment were not exclusion criteria. Eight of the 34 potentially eligible patients did not meet inclusion criteria, of which 3 refused to take part in the study. One patient met exclusion criteria (use of an SSRI for only 2 weeks at the pretreatment assessment), leaving 25 entering the treatment program.

At the end of the clinical screening eligible patients received extensive information about the design and procedures of the study. After they provided informed consent, patients were assigned to one of the MCT therapists. Each treatment consisted of up to 15 weekly sessions of 45 min. Treatment could be terminated earlier when patient and therapist agreed that recovery had occurred. A detailed manual was used, which was based on publications of the researchers who developed MCT for OCD (Wells, 1997; 2009).

Table 1
Demographic characteristics ($N=25$).

	M	*SD*
Age in years	32.3	11.4
	n	%
Gender (female): *n* (%)	17	68
Married/partnered	13	52
Living alone	12	48
Tertiary education	8	32
Current employment	21	84
Use of psychopharmaca	11	44
≥ 1 comorbid axis I disorder	13	52

Of the 25 patients entering the study, 6 (24%) dropped out in the active treatment phase, 3 for unknown reasons, the other 3 started using a SSRI. Another 3 patients (12%) were lost to follow-up, due to receiving additional treatment (for other problems) during the 3-month follow-up period. Demographic characteristics of the participants are displayed in Table 1.

2.2. Measures

Questionnaires were administered one week before treatment (pretest), after the last treatment session (posttest), and three months after treatment had ended (follow-up). No additional treatment was provided after posttest.

Treatment outcome was evaluated by means of the Dutch versions of both a standardized self-report scale (Padua Inventory; Burns, Keortge, Formea, & Sternberger, 1996) and a semi-structured interview (Y-BOCS; Goodman et al., 1989) conducted by an independent clinician (at all assessment points) for measuring the core symptoms of OCD (primary outcomes). In addition, the Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996) was administered to assess comorbid symptoms of depression (secondary outcome). To study changes in the cognitive process as targeted by MCT, the Thought Fusion Instrument (TFI; Wells, Gwilliam, & Cartwright-Hatton, 2001) was employed.

2.3. Therapist characteristics, recruitment and training

Seven staff psychologists (1 male, 6 female) of the participating mental health care center participated in the study. All of them were certified cognitive-behavioral therapists, who were familiar with the provision of cognitive-behavioral treatment protocols. The mean age of the therapists was 35.0 years (range 27–42), and they had on average 9.1 years of clinical experience (range 5–15). The participating therapists were trained in MCT in a three-day workshop by prof. Adrian Wells and Dr. Peter Fisher, experts in the field of MCT. During the project, all therapists were supervised monthly by the first author (CH). At these group meetings all active cases and therapy notes were reviewed to ensure adherence to protocols and treatment quality.

2.4. Treatment

Following the rationale of the metacognitive model, MCT proceeds with increasing patients' awareness of the role that metacognition plays in maintaining their symptoms by developing an idiosyncratic case formulation, socialization strategies, and 'detached mindfulness', a strategy in which patients are asked not to engage with their obsessional thoughts in any way, but instead to simply notice them and choose to let the thoughts naturally decay (Wells, 2000). The goal is to enable patients to move from treating