



Shorter communication

A pilot randomized controlled trial of videoconference-assisted treatment for obsessive-compulsive disorder



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ARTICLE INFO

Article history:

Received 20 June 2014

Received in revised form

24 October 2014

Accepted 26 October 2014

Available online 30 October 2014

Keywords:

OCD

CBT

Videoconference

Self-help

ERP

Telepsychology

ABSTRACT

Evidence-based exposure and response prevention (ERP) treatment for obsessive-compulsive disorder (OCD) is not always easily accessible. Long distances from specialist treatment and other practical or motivational difficulties can interfere with ERP access and outcome. Delivery of ERP through telepsychology can help “fill the gap”. The current study included 30 patients with OCD who were randomized to 12 weeks of either videoconference-assisted ERP (VCT; $N = 10$), self-help ERP (S-H, $N = 10$), or a wait-list condition (W-L, $N = 10$). The VCT format included use of tablet-based videoconferencing sessions ($N = 6$) or studio-based videoconference ($N = 4$), as well as telephone calls. Patients rated the VCT format as natural and reported strong working alliances with their therapists. VCT treatment produced significantly greater reductions in obsessive-compulsive symptoms compared to the two control conditions. Treatment outcomes were similar to that of regular face-to-face ERP and improvements in symptom scores remained stable at follow-up. The study indicated that ERP for OCD can be delivered efficiently with videoconferencing technology along with telephone calls. The use of such technology in psychological treatment is likely to become more common in the future and it holds promise as a method to make evidence-based treatment more accessible.

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Several meta-analytic studies and expert consensus guidelines indicate that serotonin reuptake inhibiting medication and cognitive-behavioral therapies including exposure and response prevention (ERP) are effective treatments for OCD (Hofmann & Smits, 2008). The effect sizes (ES, Cohens d , pooled) in controlled studies of CBT for OCD are large (.97) and 48% of patients with intention to seek treatment show clinically significant improvement (Öst, 2008). Medication treatment is widely available, but many patients in routine clinical settings refuse medication treatment (Himle et al., 2006).

There are several important barriers to accessing guideline-concordant ERP-based care for OCD and several methods have been developed to help address this challenge. Perhaps the simplest and lowest cost method is the self-help book focused on

the CBT treatment of OCD. But a controlled trial (Tolin et al., 2007) found that an unguided self-help book for OCD yielded only a 17% reduction in symptoms. Among the first attempts to improve upon book-directed CBT involved the use of a telephone voice interactive approach known as BT-STEPS (Greist et al., 2002). BT-STEPS yielded modest results when delivered without clinician involvement, but outcomes improved when clinician support was added to this model (Gega, Marks, & Mataix-Cols, 2004). However, even with clinician involvement, effect sizes are smaller than typical face-to-face CBT and many people with OCD do not adhere to BT-STEPS and drop out (Gega et al., 2004). CBT delivered with a combination of face-to-face and telephone calls has also shown promise as a way to deliver CBT effectively, especially for those who live far from trained therapists (Lovell et al., 2006). Limitations with telephone treatment include concerns about treating patients with co-occurring depression and difficulties judging progress and tailoring exposure exercises without visual feedback (Taylor et al., 2003).

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One promising method for delivering CBT efficiently over long distances and that addresses the problems involved in self-help and telephone therapy approaches involves the use of videoconferencing from clinic-based studios, or through the use of Wi-Fi connected tablets or smartphones. Videoconferencing was effective and highly accepted in a small open trial of CBT for OCD in the US (Himle et al., 2006) and a second one in Norway (Vogel et al., 2012). No randomized, controlled trials exist involving videoconferencing CBT (VCT) for OCD. Pilot studies revealed several important strengths of the format including strong therapeutic alliances, a strong sense of independent accomplishment for patients performing exposure and response prevention exercises with the therapist at a distance compared to being present in the room, and high levels of overall treatment satisfaction.

Videoconferencing thus far has involved arranging access to expensive teleconferencing equipment and the need for patients to travel to a hospital to gain access to the necessary equipment. The majority of households in western countries now have internet access in their homes and the use of videoconferencing through mobile phones and tablets has also rapidly increased over the past few years and may prove to be a low cost and practical alternative to hospital equipment.

The present study extends prior work on videoconferencing CBT for OCD by comparing videoconferencing-based CBT to an available alternative treatment (self-help) and to a wait-list control condition. Additionally, this project includes videoconferencing sessions delivered via a tablet computer in addition to treatment involving professional videoconferencing equipment. It was hypothesized that VCT would produce large reductions in OCD symptoms on a par with face-to-face treatment and that VCT would be superior compared to self-help ERP (S–H) and waitlist (W–L).

Method

Participants

Forty-three consecutive referrals for regular OCD outpatient treatment at specialized clinics in Oslo, Kristiansand, and Trondheim, Norway, were contacted by telephone and were pre-screened at the clinics by project clinicians. Inclusion criteria were: having an OCD diagnosis and signing the informed consent form. Exclusion criteria were: suicidality, head injury, co-morbid alcohol/drug dependency, or psychosis. Patients not meeting inclusion/exclusion criteria at pre-screening or in later structured clinical interviews were referred elsewhere. Reasons for exclusion included subclinical OCD or the presence of a primary disorder other than OCD. Thirty-four people met for structured clinical interviews. Thirty of these patients met criteria for a primary diagnosis of OCD. All patients were offered VCT as alternative to waiting periods of more than 3 months for access to regular treatment. VCT completers retained their place on the waiting list for standard face-to-face treatment afterwards if needed. None of the 34 eligible participants refused study participation and all completed pretreatment assessments prior to randomization. See Fig. 1 for a summary of the participant flow. The study was approved by the regional ethics committee for human research and all participants signed informed consent.

A summary of the participants' demographic and diagnostic information is presented in Table 1. There was a significant difference in the three conditions with regard to age and number of children. Participants in the wait-list condition were significantly older and had more children compared to participants randomized to other conditions. Correlations between number of children or age and OCD symptoms (both pre- and post-treatment) were insignificant in all three conditions ($p > .10$). There were no significant differences between the groups with regard to

employment, marital status, gender, or treatment history. The majority (80%) of participants had received previous psychological treatment.

Procedure

The participants were diagnosed using a structured clinical interview by one of three psychologists. The interviews in all but three occasions were conducted via hospital videoconference links or on a tablet computer handed out by the local coordinator prior to this assessment interview. All participants met DSM-IV (American Psychiatric Association, 1994) criteria for OCD. Participants completing the self-report questionnaires were then randomized to one of three treatment conditions. Ten participants were assigned to receive VCT, ten received, free of charge, an ERP-based self-help book (Foa & Kozak, 1997) sent in the mail by the study administrator (S–H), and ten were placed in a wait-list condition (W–L). Participants in the self-help condition and wait-list conditions were not contacted during a 12 week period post-randomization. They could contact the clinic if they had questions about the study or if their condition worsened. In the self-help condition no structured guidance was given, but patients could ask direct questions about the material presented in the self-help book. Such contacts occurred to only a very limited extent, but two of the participants had e-mail exchanges with study investigators regarding understanding the principles described in the book. Self-help ERP was chosen as a control condition as it is the most natural first-line ERP treatment option available to the majority of patients with OCD in Norway. A waitlist condition was also chosen since efficacy of self-help treatment has previously not been explored in Norway. Other potential comparison conditions considered included SSRI medication or internet treatment. However, internet treatment programs for OCD are not readily available in Norway and the patients seeking out help at the OCD clinics used in our study have already tried SSRIs.

No participants dropped out of the videoconference condition. In the wait-list condition, two people did not provide data on the self-report inventories or the telephone Y-BOCS interview at post-treatment assessment. One person in the self-help condition did not provide data at post-treatment assessment. After 12 weeks, all participants were again contacted for reassessment with the ADIS-IV and Y-BOCS interview. Participants were interviewed by a psychologist blinded as to treatment condition.

Therapists

Participants assigned to videoconference treatment received a videoconference therapy appointment with one of six therapists *not* connected to the same clinic that patients had applied to. Assignment to therapist was based only on who had time available for a new case. Therapists included one psychiatrist, one psychiatric nurse, and four psychologists, all experienced with ERP for OCD. Participants were also assigned a local clinical partner who was a clinician from the staff at the same clinic they were on the waiting list to. These clinicians served in a facilitating role, assisting in booking and starting up hospital videoconference sessions and were available for making treatment referrals in case of discontinuation or at the end of the study, but did not otherwise participate in the treatment.

Treatment

The first four videoconference therapy (VCT) participants received an average of six hospital studio-based videoconference sessions and nine telephone sessions. After receiving ethics

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