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Mindfulness for OCD? No evidence for a direct effect of a self-help treatment approach

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ABSTRACT

Background and objectives: Many patients with obsessive compulsive disorder (OCD) go untreated due to a large treatment gap and fear of engaging in cognitive behavioral therapy. The present study investigated the effectiveness of mindfulness based training delivered as a bibliotherapeutic self-help approach, as an alternative and accessible intervention.
Methods: Eighty-seven participants with OCD anonymously completed an online baseline assessment that included measures of OCD and depression. Subsequently, they were randomly assigned to either mindfulness training or progressive muscle relaxation and received manuals accompanied by audio files. All participants were approached for reassessment six weeks later.
Results: No changes on any of the scales could be found in either the experimental or control group at post-assessment, even though all participants exercising mindfulness found the manual to be useful.
Limitations: Due to the mode of application, the study leaves open the possibility that mindfulness training is beneficial for OCD patients when delivered as a therapist guided intervention.
Conclusions: The effectiveness of mindfulness training as a self-help intervention was not supported in this study. Further work is needed to clarify whether mindfulness is feasible as a treatment for OCD.

1. Introduction

Obsessive–compulsive disorder (OCD) is characterized by intrusive, recurring and disturbing thoughts causing distress (obsessions) usually followed by ritualized behaviors (compulsions) that are aimed at neutralizing the obsessive content and negative emotions. Even though the prevalence of OCD is high (2–3% ; Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012), only 40–60% of those suffering from OCD receive professional treatment (Marques et al., 2010). Several reasons that prevent patients from seeking treatment have been identified, including environmental barriers (e.g. treatment not available or too expensive; Mancebo, Eisen, Sibrava, Dyck, & Rasmussen, 2011). Therefore, accessible and low-threshold interventions such as self-help or online treatment are urgently needed to reach patients less likely to seek treatment through the traditional mental healthcare system (e.g. Andersson et al., 2014; Wootton, Dear, Johnston, Terides, & Titov, 2013). Self-help has been shown to be effective in treating depression and anxiety; with meta-analyses revealing medium to large effect sizes (Van't Hof, Cuijpers, & Stein, 2009). Similar findings have been shown in patients with OCD (see Sarris, Camfield & Berk, 2012) and the acceptability of treatments delivered online is high in patients with OCD (Wootton, Titov, Dear, Spence, & Kemp, 2011).

First-line treatments for OCD include cognitive behavioral therapy (CBT). Despite impressive effect sizes ($g=1.39$; Olatunji, Davis, Powers, & Smits, 2013) and guideline recommendations, a quarter of the individuals with OCD fail to initiate CBT and another 30% who initiate treatment, drop out prematurely, stating fear of engaging in CBT as one of the main reasons (Mancebo et al., 2011). Thus, it is worth investigating other methods of treatment.

Several researchers have proposed alternative therapies including mindfulness techniques in the treatment of patients with OCD (Fairfax, 2008). Mindfulness is defined as paying attention in a particular way – on purpose, in the present moment and non-judgmentally. This is considered to counter the effects of excessive orientation toward the future (Kabat-Zinn, 2013) and to support patients in distancing themselves from negative thoughts (Kuyken et al., 2010), facilitating a flexible and adaptive coping response. Mindfulness-based training is moderately effective in treating anxiety and depressive symptoms, and has been associated with

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improvements and relapse preventions in a range of psychiatric disorders (see e.g. Hofmann, Sawyer, Witt, & Oh, 2010). Practicing mindfulness reduces rumination and enhances emotion regulation (Goldin & Gross, 2010). These components could be beneficial in improving OCD symptoms (Cisler, Olatunji, & Lohr, 2009). Mindfulness training lead to improvements on the obsessive–compulsive subscale of the Symptom Check List 90 Revised in patients with panic disorder or generalized anxiety compared to a psychoeducation control group (Kim et al., 2009). In a pilot study on mindfulness and OCD, participants reporting symptoms of OCD received eight one-hour sessions of mindfulness meditation. They showed a reduction of OCD symptoms compared to a waiting-control list ($d=0.63$; Hanstede, Gidron, & Nyklícek, 2008). However, due to the small sample size and the lack of an active control group, no firm conclusion on the effectiveness of mindfulness in OCD can be reached (Sarris et al., 2012).

As training in mindfulness seems to be promising for patients with OCD, we sought to examine the effectiveness of mindfulness compared to an active control. To reach patients outside the traditional health care system, the techniques and exercises were provided in the form of self-help manuals and the assessments were conducted as anonymous online surveys. Although internet studies are criticized for questionable validity due to lack of a formal diagnosis (for an overview see Hancock, 2007), the possibility to fake a diagnosis is considered low (Whitehead, 2007) and online administration of OCD measures has been shown to be equivalent to paper-and-pencil versions (Coles, Cook, & Blake, 2007).

For the primary outcomes (OCD symptoms and symptoms of depression), we hypothesized that participants receiving the mindfulness manual would show a greater decrease in symptoms than participants receiving the progressive muscle relaxation (PMR) manual. A secondary goal was to assess the acceptance and feasibility of the manuals.

2. Methods

This study was conducted as part of a larger study examining the effect of self-guided relaxation on cognitive biases in samples with different psychiatric disorders. The study was set up as an online study with random allocation of participants to either the experimental group (mindfulness manual) or the control group (PMR manual) according to date of participation after completion of baseline questionnaires.

2.1. Participants

Participants were former patients who had given consent to participate in subsequent studies or were recruited through OCD-specific discussion forums, whereby consent was sought from administrators before posts were published. In our invitation the following inclusion criteria were emphasized: age between 18 and 65 years, consent to participate in two anonymous (internet-based) surveys, and a verified diagnosis of OCD.

For a flow chart of participants through the study, please see Fig. 1. Eighty-seven subjects who reported having a confirmed diagnosis of OCD were randomized to the two conditions. Randomization into the mindfulness or the PMR group (1:1) was conducted via an automated filter-function in the survey program. Exclusion of the participants was later conducted manually, thus leading to different group sizes. A diagnosis of OCD had been established by a psychiatrist (42.5%), a psychotherapist (40.2%), any other physician (16.1%) or as part of a study (1.1%). Presence of OCD was further verified using the *Web Screening Questionnaire* (see below), in which 100% of the participants screened positive for OCD; 89.7% of the participants stated having had intrusive thoughts daily and 65.5% more than an hour daily during the previous week. About three quarters of the participants (72.4%) had an estimated total score[1] of 21 or more on the OCI-R (described below). More than half (57.5%) of the participants stated they were undergoing or waiting for psychotherapy at the time of the assessment.

2.2. Procedure

Individuals interested in the study were directed to the online baseline survey where a summary of the study rationale including the inclusion and exclusion criteria was given. Participants were informed that they would either receive a PMR or a mindfulness manual (see below) after the baseline measurement and the respective other after the post-assessment. Next, they were asked to provide electronic informed consent. Subjects who did not approve the procedure were excluded. The baseline survey consisted of the following parts: demographic variables, medical history (e.g., psychiatric diagnosis and profession of the person who had diagnosed the disorder), assessment of psychopathology (see questionnaires section for details), request of email address (to match baseline and post-survey data), truthfulness of the answers and opportunity to leave comments. After completing the baseline assessment, subjects received a link to download either the mindfulness or PMR manual and the corresponding audio files. The software program EFS survey (www.unipark.de) that was used to set up the survey did not store IP addresses.

Six weeks after the baseline assessment, all participants were asked via email to take part in the post-assessment. To allow identification, they were requested to first enter their email address when starting the survey. For individuals who had not participated in the post-assessment, up to two reminders were sent. The post-assessment consisted of the following parts: introduction, questionnaire on psychopathology (POD questionnaire only), evaluation of the respective manual (in case subjects endorsed that they had read the manual; see Table 1) or reasons for not reading the manual (in case subjects endorsed that they had not read the manual). At the end, the truthfulness of the answers was asked and participants were given the opportunity to leave comments. After completing the post-assessment participants received a link to download the second manual and audio files and were thanked for their participation.

The manuals were the only form of compensation given for participation. The study was approved by the local ethics committee and has been registered on the ISRCTN registry (trail registration number: ISRCTN86762253).

2.3. Self-help manuals

We prepared two self-help manuals for the study as pdf-files that were accompanied by audio files.

Mindfulness is defined as a process of deliberately focusing attention on the present moment in a non-judgmental and non-reactive way (Kabat-Zinn, 2013). The mindfulness manual consisted of 15 pages and comprised an introduction into the concept of mindfulness and its effectiveness, explaining that mindfulness can lead to emotional stability and prevent relapse in psychiatric disorders. The manual further offered an explanation on how mindfulness can be used, including ten exercises (see Table 2). Participants were proposed to try all exercises, in order to decide

[1] The estimated total score is based on the ten items of the OCI-R used in this study. The mean score was multiplied by 1.8 to create an estimated total score of the OCI-R (18 items).