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EFFICACY OF METACOGNITIVE THERAPY FOR PATIENTS WITH OBSESSIVE COMPULSIVE DISORDER

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ABSTRACT

Background: *Obsessive Compulsive Disorder (OCD) is considered as one of the most commonly reported disorder. Its prevalence rate is 1.1 to 1.8% (APA, 2013). It is characterized by persistent thoughts or urges that may lead to compulsions (Kring, Johnson, Davison and Neale, 2008). Metacognitive Therapy (MCT) comes under the umbrella of Cognitive Therapies (CT) and it was based on metacognitive model developed by Wells (1997).*
Objectives: *The present study aimed to develop a therapy protocol based on MCT and to investigate the efficacy of Metacognitive Therapy for the patients of Obsessive Compulsive Disorder (OCD).*
Method: *With the help of purposive sampling, participants diagnosed with OCD according to the DSM-IV-TR and who fulfilled the inclusion criteria, were selected for the study. Four participants (men=2, women=2) participated in the study. Assessment was carried out at pre and post-treatment levels. Symptom Checklist-Revised [(SCL-R):Rahman, Dawood, Rehman, Mansoor, & Ali, 2009] was used for the purpose of screening and Obsessive Compulsive Symptoms Checklist [(OCSC); Jabeen & Kausar, 2010)] was used to assess symptoms of OCD. Treatment sessions were conducted with the participants based on the therapy protocol developed by the researchers. Pre and post-treatment assessment was done to find out the outcome of sessions been conducted with the participants.*
Results: *Participants receiving treatment sessions based on MCT showed significant reduction in their symptoms on subscales of depression (p=.05), anxiety (p=.05), OCD (p=.05), obsessions (p=.05) and compulsions (p=.05) at the end of therapy.*
Conclusion: *The MCT was proved an effective mode of psychotherapy in reducing symptoms of OCD.*

Keywords: Meta cognitive therapy, Obsessive Compulsive Disorder

INTRODUCTION

Obsessive Compulsive Disorder (OCD) is one of the most commonly reported disorders. Its prevalence rate is 1.1 to 1.8% internationally (APA, 2013). After mood disorders, OCD is the most prevalent disorder in Pakistani society with prevalence rate of 3% (Gaddit, 2003). The core feature of OCD is the presence of obsessions and compulsions. Obsessions are persistent thoughts or urges that are uncontrollable, intrusive and distressful for an individual. As obsessions are distressful, therefore, an individual feels driven to indulge into compulsive behaviors to neutralize their obsessions (APA, 2013). Most of the individuals tend to have such types of unwanted thoughts or urges but they do not meet the criteria for the diagnosis of OCD (Kring, Johnson, Davison & Neale, 2008). An individual needs to be indulged in these obsessions or compulsions for at least 1 hour per day and there should be a significant impairment in one's functioning (APA, 2013). Cognitive theorists believed that individuals diagnosed with OCD have false beliefs. It is their wrong interpretation of disturbing thoughts that give way to obsessions and rituals. They proclaimed that such kind of invasive thoughts come to everybody's mind but problem occurs when people start giving meanings to these thoughts (Clark & Beck, 2010; Rachman, 1997; Salkovskis, 2007). The dysfunctional beliefs in OCD are inflated responsibility; over importance of thoughts; control of thoughts; overestimation of threat; perfectionism and intolerance of uncertainty (APA, 2013).

When it comes to the treatment of OCD, it can be treated with the help of pharmacotherapy and psychological therapy. Through pharmacotherapy, OCD can be effectively treated with the help of Selective Serotonin Reuptake Inhibitors (SSRIs) and the most effective SSRI for OCD is Clomipramine and it is the most commonly prescribed drug for OCD around the globe (Kring et al., 2008). It is proved that almost 60-70% of patients experience improvement in their symptoms of OCD with the usage of SSRIs (Fenske & Schwenk, 2009).

In psychotherapy, there are different types of treatment modalities for the management of OCD such as Psychoanalytic Therapy; Behavior Therapy; Rational Emotive Behavior Therapy (REBT), Cognitive Behavior Therapy (CBT) and Metacognitive Therapy (MCT). All the therapies have their own cluster of techniques to deal with different types of symptoms of OCD but some are common among all the modalities like Exposure and Response Prevention (ERP) (Wells, 2009). Fisher and Wells (2005) reported that ERP leads to

statistically significant improvements in 75% of patients. The present study targeted the efficacy of meta cognitive therapy in the treatment of OCD patients.

Metacognitive Therapy (MCT) focuses on the metacognition of an individual, which refers to an individual's beliefs about thinking and strategies used to regulate and control the thinking processes (Flavell, 1999). The metacognitive model of OCD specifies two types of metacognitive beliefs (a) beliefs about intrusions i.e., Thought Action Fusion (TAF), Thought Event Fusion (TEF), and Thought Object Fusion (TOF), and (b) beliefs about rituals in response to obsessions. The main focus of MCT is to evaluate how the patient is experiencing and relating with his or her thoughts and person's belief about his or her thoughts. The major techniques used in MCT are Case conceptualization, detached mindfulness, Thought Action Fusion (TAF), Thought Event Fusion (TEF), Exposure and Response Commission (ERC) and relapse prevention (Wells, 2009).

Fisher and Wells (2005) proposed that when Exposure and Response Prevention (ERP) is used in reference to metacognitions, it significantly reduce anxiety linked with obsessional thoughts. Another study conducted by Fisher and Wells (2008) to evaluate efficacy of Metacognitive Therapy for OCD showed significant reduction in symptoms at post treatment assessment level and follow ups. It was claimed that Metacognitive Therapy is time efficient and can be easily delivered to the patients suffering from OCD and they would achieve significant outcome in twelve hour of therapy. Moreover, MCT focuses on the modification of beliefs concerning rituals and it motivates patients to use new stop signals (Solem, Myers, Fisher, Vogel & Wells, 2010). It can be concluded that MCT is effective for OCD patients for reducing their symptoms, modification of their beliefs and thought fusion beliefs (Zahra, Behrouz, Nehaleh & Ashgar, 2012). Thus, in present study, therapy protocol based on metacognitive therapy was developed to assess its efficacy for the patients of OCD.

METHOD

Participants

The subjects of the study were selected from the outpatients of two psychiatry departments of Jinnah Hospital and Mayo Hospital, Lahore. The study remained continued from May 2013 - December 2014.

Purposive sampling was used to select 10 patients diagnosed with OCD from two hospitals of Lahore, Pakistan. During the course of therapy, 6 patients were dropped. Only 4 patients (men=2, women=2) completed the proposed sessions. Only those patients were included who were outpatients. All the patients were taking medicines for at least 2 months. The age range of the participants was between 21-27 years (M = 24.3; SD = 3.20). One of the participants was under-Matric, two were educated up till Intermediate, and one was educated up till Masters. The duration of illness was 3 months to 24 months (M=13.5; SD=8.66).There was no family history of any psychiatric illness among the participants while one of the patients had family history of medical illness. The patients with any comorbid medical or psychological disorder were excluded from the study (See Table 1).

Measures

Data regarding demographic characteristics of the participants were collected through demographic form developed by the researchers. For screening, SCL-R (Symptom Checklist-Revised) was used. For the assessment of symptoms of OCD, the OCSC (Obsessive Compulsive Symptoms Checklist) was used.

Symptom Checklist – Revised [(SCL-R); Rahman, Dawood, Rehman, Mansoor, & Ali, 2009] was used for the purpose of screening and to assess associated anxiety and depressive symptoms with OCD. It is an indigenously developed tool with 139 items originally, the scale has six subscales but only three subscales i.e., anxiety (27 items), depression (24 items) and OCD (15 items) were used in the present study. The values of Cronbach alpha were .84, .86 & .74 for depression, anxiety and OCD, respectively.

Obsessive Compulsive Symptoms Checklist [(OCSC); Jabeen & Kausar, 2010)] in an indigenously developed tool to screen the symptoms of OCD. It has 46 items with two subscales: Obsessive Symptom Scale and Compulsive Symptom Scale. Obsessive Scale has 5 factors: Filth related contamination (7 items); Health related contamination (5 items); Controlling Obsessions (3 items); Obsessional impulses and images (5 items); and Blasphemous/religions (3 items). Compulsive Scale also has 5 factors: rituals related to contamination (8 items); General checking (4 items); safety checking (3 items); Diversion based controlling compulsions (5 items) and controlling compulsion with religious connotation (3 items). The items are to be rated on a five point Likert scale. For

present study, the Cronbach alpha was .89 &.84 for the subscales of Obsessions and Compulsions, respectively.

Intervention

The MCT intervention consists of 11 sessions lasting approximately 40 to 45 minutes. Sessions were provided twice a week. The initial sessions were based on the identification of obsessive thoughts and their interpretation. It was emphasized to help participants discriminate their intrusive and obsessive thoughts so that they would be ready to change those afterwards. They were taught how to remain detached from thoughts without giving meanings to them. Afterwards, they were asked to prevent their compulsions (both either overt or covert) along with it, their thoughts and fusion beliefs were challenged with the help of verbal reattribution techniques. In the termination phase, they were provided information regarding lapses and relapse and how to deal with symptoms of lapse. A therapy blueprint comprising of an overview of techniques being implemented in the whole program was given.

Procedure

The present study was comprised of two phases. In first phase, the protocol of therapy was developed and forwarded for expert's opinion. For the development of the protocol, initially the MCT material was translated into Urdu by three language students of psychology. After translation, it was thoroughly reviewed by two practicing clinical psychologists of Lahore with more than 10 years working experience with OCD clients for their worthy comments and suggestions on therapeutic sessions. After making corrections according to the given feedback, the protocol was ready to administer on the participants of the study.

In second phase of the study, the protocol was administered and sessions were conducted. It was started with the meetings with psychiatrists of the selected hospitals for the purpose of referrals of patients. For this, the introduction and main objectives of the study were shared with them to get referrals from them. The referred participants were informed regarding their participation and cooperation required by them by providing an information sheet to each participant. After taking their consent, the participants were called for pre-treatment assessment. After that therapeutic sessions were started. Therapeutic sessions were conducted twice a week and each session was

conducted for 40 to 45 minutes. After the completion of therapeutic sessions, the participants were assessed again for the purpose of post-treatment assessment.

Statistical Analyses

SPSS (Statistical Package for Social Sciences) 17.0 version was used to analyze the data. Descriptive statistics were used to explore demographic characteristics of the sample. To calculate the values of Reliable Change Index (RCI), Jacobson-Truax (1991) was used to see the efficacy at post-treatment level.

RESULTS

Table 1
Demographic Characteristics of the Sample (N=4)

	M	*SD*	*f*	*%*
Age (in years)	24.30	3.20		
Duration of OCD(in months)	13.50	8.66		
Education				
Matriculation			1	25
Intermediate			2	50
Graduation/Masters			1	25
Occupation				
Student			1	25
Non-working			2	50
Working			1	25
Psychiatric Illness in Family				
Present			0	0
Absent			4	100
Medical Illness in Family				
Present			1	25
Absent			3	75

When comparisons were made between pre and post-treatment scores at the termination phase, participants score on anxiety, depression and OCD were reduced (see Table 2). To find out the significance of change of scores, Reliable change index (RCI) was calculated. It showed significant decrease in the symptoms of depression; anxiety and OCD at post-treatment score suggesting that MCT significantly reduced participant's symptoms (see Table 3).

Table 2

Descriptive Statistics for the Subscales of SCL-R and OCSC at Pre and Post-treatment levels (N = 4)

Scales	**Levels**	***M***	***SD***
Symptom Checklist-Revised			
Depression	Pre	30.50	12.87
	Post	6.75	6.24
Anxiety	Pre	31.75	13.96
	Post	09.25	08.99
OCD	Pre	19.75	06.85
	Post	2.50	2.38
Obsessive Compulsive Symptom Checklist			
Obsessions	Pre	28.5	12.34
	Post	2.25	3.30
Compulsions	Pre	20.75	12.26
	Post	3.25	2.98

Table 3

Showing values of Reliable Indices of Jacobson and Truax (1991) against SCL-R and OCSC for the Participants of the Study (N=4)

		Participants			
Subscales	**Variables**	**I**	**II**	**III**	**IV**
Symptom Checklist-Revised					
Depression	SEM	5.15	5.15	5.15	5.15
	S.D.	7.28	7.28	7.28	7.28
	RCI	-4.21*	-3.02*	-1.92	-3.98*
Anxiety	SEM	5.22	5.22	5.22	5.22
	S.D.	7.39	7.39	7.39	7.39
	RCI	-2.98*	-1.35	-5.14*	-2.71*
OCD	SEM	3.49	3.49	3.49	3.49
	S.D.	4.94	4.94	4.94	4.94
	RCI	-3.04*	-1.82	-5.06*	-4.05*
O C S Checklist					
Obsessions	SEM	4.09	4.09	4.09	4.09
	S.D.	5.79	5.79	5.79	5.79
	RCI	-2.59*	-3.97*	-8.12*	-3.46*
Compulsions	SEM	4.90	4.90	4.90	4.90
	S.D.	6.94	6.94	6.94	6.94
	RCI	-2.16*	-2.31*	-5.34*	-0.04

*RCI<-1.96, p<.05. RCI=Jacobson & Truax Reliable Change Index (1991), SEM=Standard Error of Measurement, SD=Standard Difference

Graphical Abstract

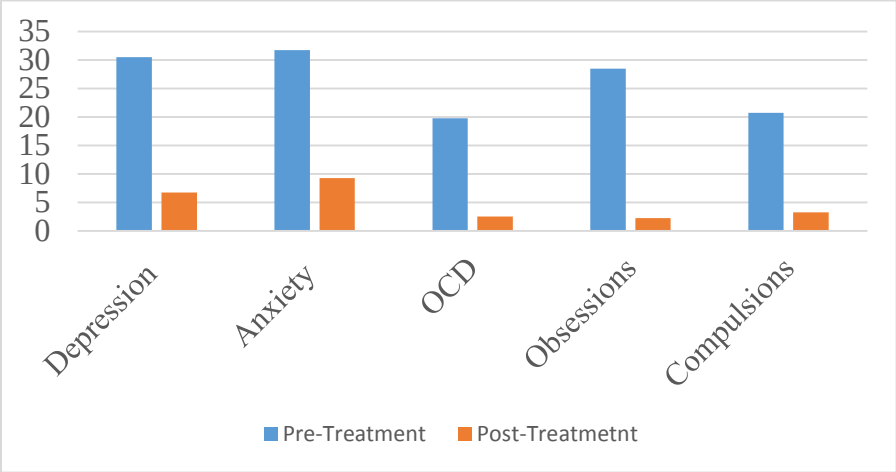

Figure 1: Showing difference in Obtained Scores on SCL-R and OCSC at Pre and Post-Treatment Levels

DISCUSSION

The first case of a male participant, 22 years old, educated till Intermediate. He used to run a general store along with his brother. He was having symptoms of OCD for last fifteen months. The most prominent symptoms of OCD were related to religious (blasphemous) thoughts "whether Allah exists or not; He is the only one or more than one"; and he used to place the things in his store (ordering compulsions). The participant 2, 27 years old male, studied till MBA and suffering from thoughts about harm to others (mother and brother) and religious thoughts. His symptoms started with the thoughts about death but afterwards it changed into uncontrollable thoughts about inflicting harm to his family members. The participant 3 was 27 years old woman, educated till Intermediate. Her symptoms were obsessions related to cleanliness for which she took hours while taking bath or washing her hands. She did not allow anyone from her family to use her things because if they do, then she would not use those things again as she would not stop her anxiety about it. She used to wash three times with soap after urination. She also suffered from sexual thoughts. The participant 4 was 21 years old woman, under matric, having obsessions regarding religion, sexual content and uncontrollable thoughts to become naked in public

place or dance in front of them. Her cluster of symptoms made her the most complicated case of the present study. Her symptoms started after her break-up with her fiancé to whom she had been involved in physical relationship. Descriptive analysis showed that all 4 participants showed reduction in the symptoms of anxiety, depression and OCD.

The Jacobson and Truax RCI was calculated which showed significant improvement in the symptoms. It showed that symptoms of depression, anxiety and OCD were significantly improved after the implementation of MCT plan. It can be supported with the help of previous researches. Previous researches have also showed that Metacognitive Therapy significantly reduce anxiety, metacognitive beliefs and desire to neutralize obsessions (Fisher & Wells, 2005). Another study (Solem, Haland, Vogel, Hansen &Wells, 2009) suggested similar findings that MCT can reduce the metacognitive beliefs of the participants related to perfectionism (orderliness) and responsibility. They further reported that when a therapist worked on metacognitive beliefs, it effectively reduced the symptoms of OCD. Further, Rees and VanKoesveld (2008) also reported that MCT plays a significantly effective role in reduction of symptoms of OCD i.e., obsessions, washing, checking, counting and sexual or some other violent thoughts. Further, Zahra, Behrouz, Nahaleh and Asghar (2012) showed MCT is also effective therapy for patients suffering from pure obsessions.

Conclusion

In the present study, all the participants showed significant reduction in the obsessions and compulsions at the post treatment assessment. Thus, it can be concluded that MCT is an effective therapy for the treatment of Obsessive Compulsive Disorder (OCD).

Limitations and Suggestions

For some techniques, it was difficult for the participants to relate with its effectiveness. Therefore, other participants' feedback was shared with them repeatedly to motivate them to practice it. A major limitation was the reduced number of participants. 4 participants of the study stopped coming to sessions on their own. 2 women participants dropped from sessions because they had conveyance issues as they were dependent on to take them to hospitals.

The therapy protocol developed for present study can be used for training and education purposes. It also devised standard protocol to ensure homogenous implementation of Metacognitive Therapy across all settings. Future studies need to be conducted based on this protocol to see its efficacy on large sample to increase its generalizability.

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