

Effects of Detached Mindfulness on Patients with Obsessive-Compulsive Disorder

ABSTRACT

Objective: The objective of this study was to evaluate the effectiveness of detached mindfulness (DM) in patients with obsessive-compulsive disorder (OCD).

Methods: Seventeen adult patients with OCD, who were receiving psychotropic medication, were included in the study. M.A., a qualified metacognitive therapist at the Metacognitive Therapy Institute in Manchester, conducted DM therapy. The Yale-Brown Obsession Compulsion Scale (Y-BOCS) and the Beck Depression Inventory (BDI) were used to monitor clinical progress.

Results: The mean Y-BOCS scores at baseline and the end of the study were 25.29 ± 5.70 and 13.53 ± 3.41 , respectively, and a paired *t*-test analysis revealed a statistically significant difference between baseline and end-of-treatment scores ($P < .001$). The homework practices were also assessed in sessions 2, 3, and 4. The mean homework scores at the second, third, and fourth homework sessions were 8.70 ± 1.10 , 8.00 ± 0.79 and 8.20 ± 1.1 , respectively. The DM homework completion rate was at an acceptable level.

Conclusion: In conclusion, our study has shown that the DM technique, one of the main techniques used in metacognitive therapy, is significantly beneficial in patients with a certain degree of severity. We are of the opinion that supportive studies with larger sample sizes are necessary for the demonstration of efficacy in patients with significant treatment resistance.

Keywords: Obsessive-compulsive disorder, detached mindfulness, obsession

Introduction

Obsessive-compulsive disorder (OCD) is a psychiatric disorder involving obsessions and compulsions that can last a lifetime, and lead to serious social, occupational, academic, and relationship problems. Obsessions are defined as repetitive impulses, thoughts, and disturbing images that arise unintentionally and are sometimes experienced inappropriately, causing distress to the individual. Compulsions are defined as repetitive behaviors or mental actions that attempt to neutralize the obsessions. Obsessive-compulsive disorder is one of the most common mental disorders in the population. Catchment area epidemiologic studies have shown that the prevalence of this fairly common disorder in the population is approximately 2%-3%.¹ World Health Organization (WHO) recognizes it as one of the 10 most disabling diseases.² Due to the high level of distress and disability it causes, as well as its high incidence, OCD has inevitably attracted a great deal of attention from researchers. The definitive etiology of OCD remains still unclear, despite several studies conducted to elucidate the reasons for its development. A multifactorial etiopathogenesis, including genetic factors, learned behaviors, neurodevelopmental factors, dysfunction in neurotransmission, and structural, and neurochemical changes in the brain, has been suggested in the literature.

Obsessive-compulsive disorder is one of the most challenging psychiatric disorders to treat in clinical practice. Medications that affect the serotonin system are particularly effective in treating OCD. However, only 40%-60% of OCD patients respond to the first-generation serotonergic drugs, and the remainder are resistant to treatment.³ Because treatment resistance



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is a major problem in OCD patients, cognitive-behavioral therapy (CBT) is the preferred psychotherapy for this disorder in both adults and adolescents, in addition to pharmacotherapy with serotonin reuptake inhibitors.⁴ Cognitive-behavioral therapy is considered to be the most established, effective, and evidence-based of all the psychotherapeutic techniques.⁵ Along with cognitive restructuring methods, exposure with ritual prevention (ERP) is the most widely accepted empirical method.⁶⁻⁸ Thus, the first choice of psychotherapeutic approach for patients with OCD is ERP.⁹⁻¹¹ Exposure with ritual prevention is based on learning theory. According to behavioral learning theory, the emergence of obsessions is related to classical conditioning, but the principles of operant conditioning play an important role in the persistence of anxiety and compulsive behavior.¹² Although ERP and cognitive restructuring techniques offer significant benefits in the treatment of OCD, treatment success remains still below optimal levels for a significant proportion of patients.¹³ Moreover, it has been reported that only 25% of patients remain completely asymptomatic in real-life situations.¹⁴

A more recently introduced model for the treatment of OCD is the metacognitive model, developed by Wells.¹⁵ According to Wells's model, 2 metacognitive dimensions are responsible for the onset and persistence of OCD.¹³ In the first dimension, obsessions are the result of metacognitive beliefs that lead to the interpretation of intrusions as dangerous and harmful.¹⁵ This situation, in which obsessive thoughts are mixed with events, actions, and objects, is called fusion. According to Wells, the system works as follows: after fusion beliefs are activated, the person begins to attach importance to their obsessions and tends to interpret the obsessions as threats.¹⁶ This provoked anxiety activates the second part of the model: The patient feels obliged to perform some rituals to reduce the threat and anxiety (e.g., "If I don't walk around the tree three times, my mother will die"). As a result, the patient is trapped in an overt and covert spiral of rituals, does not know how to stop the spiral, and even believes that stopping the spiral will cause her anxiety to become uncontrollable.¹³ The goal of the metacognitive model is to achieve remission by eliminating the metacognitive beliefs that fuel the intrusions, rather than dealing with and changing the content of the obsessions and compulsions.¹⁴ At present, there is a limited number of studies demonstrating the efficacy of metacognitive therapy (MCT) for OCD. In their case series, Fisher and Wells achieved significant clinical improvement in 4 patients using only MCT techniques, and they reported that 2 of the patients became completely asymptomatic.¹⁴ In another study, Rees and van Koesfeld used the Yale-Brown Obsession Compulsion Scale (Y-BOCS) in 7 of the 8 patients they followed and reported an improvement in Y-BOCS scores.¹⁷ In the study conducted by Fitt and Rees, the investigators observed significant clinical improvement in 3 OCD patients, who underwent MCT via the videoconferencing.¹⁸ In another open-ended study, van der Heiden *et al.* treated

25 OCD patients with MCT and reported that approximately 75% of the patients recovered after therapy, and almost half of the patients became asymptomatic.¹⁹ Interestingly, they also found that well-being continued and even increased during the follow-up period. Metacognitive therapy has also been shown to be effective in childhood OCD in another case series.²⁰

The most basic technique used in MCT is presumably detached mindfulness (DM). As the name suggests, it involves similar aspects to the mindfulness techniques used in mindfulness-oriented therapies. However, DM, first described by Wells and Matthews,²¹ has some unique features. During DM, the patient or client communicates with his/her cognition. Detached mindfulness is characterized by flexible control of attention and thinking and can be defined as the state of being able to remain without reacting to mental events, without trying to control and suppress them, and without showing behavioral reactions. The goal is to increase the patient's meta-awareness.²¹ Instead of dealing with thoughts, especially with mind-blowing thoughts, it is about creating awareness by passively observing them in their place.²² The technique consists of two elements: mindfulness and detachment. The term "mindfulness" refers to mental events, namely thoughts, beliefs, memories, and the sense of knowing. A better definition might be to be aware only of internal events without being attached to thoughts, beliefs, emotions, and memories.²² Detachment, on the other hand, is the ability to passively observe mental events, to separate them from themselves by establishing a new type of relationship. A new way is being developed in DM – a new way of relating to thoughts is being put on the agenda. It teaches not to interfere with mental events, either behaviorally or conceptually. Using DM, the therapist tries to move the patient from the object mode, where thoughts and facts are mixed, to the metacognitive mode, where the two are separated.

Detached mindfulness is a technique that is easy to practice and effective when well described and practiced by the patient. There is a study comparing cognitive restructuring and the effectiveness of DM in OCD patients.²³ In this comparative study, 43 patients with OCD were randomized to DM and cognitive restructuring therapy groups, and all but 3 patients completed the study. Efficacy was compared at baseline, at the end of treatment, and 4 weeks after treatment. The reduction in Y-BOCS scores showed that both DM and cognitive restructuring were effective.²³ As there is a very limited number of studies that have focused only on DM and evaluated its efficacy in OCD patients, we aimed to evaluate the efficacy of DM in patients with OCD in this open study.

Material and Methods

This study was conducted in the outpatient clinics of the Department of Psychiatry, Firat University School of Medicine. Eighteen adult patients with OCD were included in the study, but 1 patient dropped out. The mean age of the patients (11 females and 6 males) was 34.29 ± 7.55 years. The study protocol was reviewed and approved from the Ethics Committee of Firat University School of Medicine Department of Psychiatry (Approval No: 2023/14-01). After a detailed explanation of the study procedure, informed consent was obtained from all participants. Each subject underwent a physical examination and psychiatric diagnostic evaluation. Obsessive-compulsive disorder was diagnosed according to DSM-5 based on a clinical interview using the Structured Clinical Interview for DSM-5.²⁴ The principles of

MAIN POINTS

- Detached mindfulness (DM) is an important technique of metacognitive therapy (MCT).
- In our patient group, the mean Y-BOCS score was 25.29 ± 5.70 at baseline and 13.53 ± 3.41 at the end of the study.
- The DM technique is significantly beneficial in patients with a certain degree of severity.

the Declaration of Helsinki were strictly adhered to throughout the study program.

Participants were included according to the following exclusion criteria: any Axis 1 disorder other than OCD, except depression; age under 18 years; lack of intelligence within normal limits; refusal to give written informed consent; any organic disease that might prevent the conduct of the interview; history of alcohol and substance use disorder in the past 6 months; active suicidal ideation or suicide attempt in the past 6 months; lifetime bipolar disorder or any psychotic disorder; borderline personality disorder; negative experience with a similar treatment modality, although not previously structured; and refusal to complete the treatment process. Patients on medication were excluded from the study if they had taken irregular doses in the previous 8 weeks. In addition, criteria for completion of the 8-week withdrawal period were defined for those who had stopped any drug treatment and wished to participate in the study. Furthermore, a Y-BOCS score of 16 and above was set as an inclusion criterion to demonstrate treatment efficacy. All patients were assessed with the Y-BOCS at the start of this open-label study.

The DM therapy process was carried out by M.A., who is a qualified metacognitive therapist at the Metacognitive Therapy Institute in Manchester. Treatment consisted of 1 session per week. The initial DM practice involved psychoeducation, discussing the meaning of OCD with metacognitive theory. During the psychoeducation, it was emphasized that there are many intrusions in the minds of healthy people every day. Although they do not turn them into obsessions, patients with OCD turn them into obsessions mainly because of the wrong relationship they have with their thoughts. In particular, the over-emphasis on thinking and the errors of thought-action fusion were meticulously studied. The next stage was to emphasize that thoughts are powerless things that pass through the mind and that there is no need to interfere with them. Later, the free association task was introduced to the patients. For this task, the patients were asked to sit calmly. They were given some words with neutral content such as "tree", "flower", "butterfly", "cloud", "toy", "chocolate", and "sea beach". Then they were asked to allow these words to have some associations in their minds. It may or may not be a form, it may or may not be a memory. They were told that it did not matter, that they just had to let these thoughts circulate freely in their minds. They were asked not to analyze their thoughts, not to try to control them, just to observe passively how their mind reacted to these thoughts. The tiger task, suggested by Wells, was then administered to make the DM a little more tangible. In this task, patients were asked to visualize a tiger and to observe it passively, without interfering with the image.²² Suggestions such as "the tiger may move, it may not matter, it doesn't matter", "the tiger may or may not wag its tail, just watch, don't interfere, we are changing the way you relate to your thoughts" were made to help the patient remain observant. Later, DM training was given to the patient's obsessions. They were instructed to bring the obsession to mind, to leave the obsession in place, to let it go, and to see their obsessions only as thoughts, i.e., to enter into a new style of relationship with their obsessions. Patients were also given homework to do between sessions: they were asked to observe and record their obsessions and to apply the DM to these thoughts as soon as possible after the triggering thought arose. The treatment process consisted of 4 sessions for all patients. Certain

scales (Y-BOCS,²⁵ the Beck Anxiety Inventory,²⁶ and Beck Depression Inventory²⁷) were administered before and at the end of treatment. The patient's compliance with the homework was rated on a scale of 0-100 after each session.

Statistical Analysis

All data were analyzed using the Statistical Package for the Social Sciences (SPSS®) version 16.0 (SPSS Inc., Chicago, IL, USA). Demographic and clinical measurements were reported using descriptive statistics. Initially, normality tests performed to determine whether the data follow a normal distribution confirmed the normal distribution. Then, the scale scores obtained at baseline and the end of treatment were analyzed using paired *t*-tests. Homework scores from the second, third, and fourth sessions were compared using analysis of variance.

Results

The study group consisted of 18 patients with OCD, as mentioned in the "Methods" section. Eleven of the patients were female and 7 were male. The mean age was 34.29 ± 7.55 years. Ten of the patients were university graduates, 5 were high school graduates, and 3 were secondary school graduates. Only 1 of the enrolled patient dropped out after the second session. The reason for dropping out was an organic health problem that the patient experienced and reported on the phone that she could not continue with the study, although she was very willing to continue. All data obtained from the remaining patients were included in the analysis. None of the patients in the study group reported any adverse events related to the ongoing medication or DM practice. All patients attended their sessions regularly. Only 2 patients were unable to attend some sessions due to social problems (1 at the second session and 1 at the fourth session). Detailed sociodemographic and clinical data are presented in Table 1.

Changes in scale scores and homework ratings by session are summarized in Table 2. Regarding the clinical changes that occurred during the treatment period, the mean Y-BOCS scores at baseline and end of the study were 25.29 ± 5.70 and 13.53 ± 3.41 , respectively. Comparative analysis of the baseline and end-of-treatment scores using the paired *t*-test showed a statistically significant difference ($t = 10.92$; $P < .001$). As mentioned in the "Material and Methods" section, a Y-BOCS score greater than 16 was required. Fourteen of the patients (82.35%) scored below 16 on the Y-BOCS.

We also analyzed homework performance in sessions 2, 3, and 4. The mean homework scores for the second, third, and fourth sessions

Table 1. Demographic and Clinical Characteristics of the Patients

	Patients with OCD (n = 17) mean \pm SD
Age (years)	34.29 \pm 7.55
Gender (F/M)	11/6
Y-BOCS score	25.29 \pm 5.70 (range, 17-7)
Beck Anxiety Inventory score	30.53 \pm 6.19 (range, 21-42)
Beck Depression Inventory score	24.24 \pm 7.51 (range, 10-38)
Duration of illness (years)	9.53 \pm 3.86 (range, 3-18)

Y-BOCS, Yale-Brown Obsession Compulsion Scale; OCD, obsessive-compulsive disorder.

Table 2. Scale Score Changes and Homework Ratings

Patients with OCD (n = 17) mean ± SD	
Y-BOCS	
Session 1	25.29 ± 5.70
Session 2	21.18 ± 5.20*
Session 3	19.18 ± 4.32*
Session 4	13.53 ± 3.41*
Beck Anxiety Inventory	
Session 1	30.53 ± 6.19
Session 2	26.00 ± 4.89*
Session 3	23.47 ± 4.54*
Session 4	15.94 ± 3.44*
Beck Depression Inventory	
Session 1	24.24 ± 7.51
Session 2	21.06 ± 6.39*
Session 3	18.59 ± 5.27*
Session 4	12.41 ± 3.76*
Homework ratings	
Session 2	8.70 ± 1.10
Session 3	8.12 ± 0.86
Session 4	8.00 ± 0.79

Y-BOCS, Yale-Brown Obsession Compulsion Scale; OCD, obsessive-compulsive disorder.
* $P < .001$, compared to baseline using a t -test.

were 8.70 ± 1.10 , 8.12 ± 0.86 , and 8.00 ± 0.79 , respectively. There was no statistically significant difference between sessions for the homework scores ($P > .05$). The DM homework completion rate was considered quite satisfactory.

Discussion

Our study is one of the very few studies on this topic, and we think that it is important because it is the first study that we know of in our country. In this respect, we think it would be useful to summarize some important results of our study. First, only one patient dropped out after the second session due to an organic health problem that the patient reported on the phone as not being able to continue with the study, although she was very willing to continue. Second, the mean Y-BOCS score was 22.65 ± 3.24 at baseline and 14.41 ± 2.18 at the end of the study. The analysis of the baseline and end-of-treatment scores using the paired t -test showed a statistically significant difference ($t = 5.34$; $P < .001$). We also analyzed the homework at sessions 2, 3, and 4. The mean homework ratings at the second, third, and fourth sessions were 9.10 ± 0.5 , 8.80 ± 0.8 , and 8.20 ± 1.1 , respectively. The DM homework completion rate was quite satisfactory.

Although serotonin reuptake inhibitors lead to significant improvements in a considerable proportion of people with OCD, a remarkable proportion (almost 50%) require a combination of medication or psychotherapeutic approaches and advanced somatic treatment methods.³ Although ERP and cognitive restructuring techniques offer significant benefits in the treatment of OCD, the success rate of treatment is still below the optimal levels in a noteworthy proportion of patients.¹³ It has also been reported that only 25% of patients remain completely asymptomatic in real-life situations.¹⁴ It should also be noted that conducting regular structured CBT sessions with

a group of patient represents a pressing workload. As DM exercises and techniques are very practical and easy to practice, we decided to conduct this study and determine the efficacy of DM in patients with OCD. As mentioned at the beginning of the discussion section, to our knowledge, there has been no study in our country, Türkiye focusing on the effects of DM in patients with OCD. It should be noted that different populations may respond differently to any psychotherapeutic intervention.

Because MCT is a relatively new therapy, only a few studies have examined its effects in people with OCD. One of these studies demonstrated the efficacy of MCT in 4 patients using MCT techniques alone and reported that 2 of these patients became completely asymptomatic.²⁸ In another study, remission was achieved in 7 out of 8 patients with OCD.¹⁷ The investigators reported significant improvement as measured by Y-BOCS scores. Another study reported a significant clinical improvement in 3 patients with OCD using MCT via videoconferencing.¹⁸ In their study, van der Heiden *et al.* treated 25 OCD patients with the MCT techniques and found that about 75% of the patients recovered after treatment and that almost half of the participating patients became asymptomatic.¹⁹ They also found that well-being persisted and even increased during the follow-up period. In addition, the effectiveness of MCT in childhood OCD has been demonstrated in another case series.²⁰ However, it should be underlined that almost all of these studies were conducted with very limited sample sizes.

As mentioned in the "Introduction" section, DM is an easy technique to use and is effective when well-described and practiced by the patient. Our literature search revealed only one study comparing cognitive restructuring and its effectiveness in patients with OCD.²³ In this study, 43 patients with OCD were randomized to DM and cognitive restructuring therapy groups for comparison, and almost all but 3 patients completed the study. Effectiveness was assessed at baseline, at the end of treatment, and 4 weeks post treatment. The comparative analysis showed that both DM and cognitive restructuring were effective, as measured by reductions in Y-BOCS scores.²³ In our study, the mean Y-BOCS score decreased from 22.65 ± 3.24 at baseline to 12.41 ± 2.18 at the end of the study, with a statistically significant difference. The results of our study were consistent with those of the aforementioned study. These results support the efficacy of DM alone in patients with OCD. In general, although MCT is a relatively recently introduced therapy, it appears to be effective for many psychiatric disorders, including OCD. However, DM, which is one of the most effective techniques in MCT, stands out because it is relatively easy for patients to understand and has a more concrete application. In this context, we conducted this study because we believed that it was important to demonstrate the effectiveness of MCT by using only the DM technique, depending on its convenience and applicability, and to reduce the dropout problem in psychotherapy. From this point of view, the usefulness of such an easy-to-apply method is gratifying at least for OCD patients. As far as the homework completion rate is concerned, the rate of patients doing homework in different sessions seems to be quite satisfactory. The question here is how long this state of well-being lasts in OCD patients, and perhaps future longitudinal studies should seek answers to this question. Another point to emphasize is that this effective method, which focuses on direct thinking, points to the importance of cognitive change in the treatment of OCD.

The limitations of our study should be taken into consideration in the evaluation of its results. The first and probably the most important limitation is the relatively small sample size. Future studies with larger samples are needed to confirm our findings. The second major limitation of our study is the lack of a control group, which is important to demonstrate the efficacy of DM and to control for confounding factors. As a next step, we are planning a study to compare DM with different treatment modalities. It would be appropriate to accept our findings as preliminary to this planned study. The third important limitation was that the patients were on anti-obsessive medication during enrollment. However, we chose a cut-off score and selected patients at least with a certain severity of illness. On the other hand, the homework completion assessment showed that the patients' compliance with treatment was quite satisfactory. In our opinion, this is critical in showing the power of the therapeutic correlation. It is also worth mentioning this as a strength of the study. In addition, comparing scores from multiple measurements with baseline data may increase the likelihood of type I. This should also be taken into consideration when reading the article. Finally, the conclusion of the research results is not only influenced by intervention factors but also by repeated collection of questionnaires, which could have affected the reliability of the results.

In conclusion, our present study has shown that the DM technique, one of the main techniques used in MCT, is significantly effective on patients with a certain degree of severity. In this context, DM seems to be one of the important instruments that should be in the clinician's toolbox when treating patients with OCD. We conclude that our findings strongly indicate that studies with larger samples to elucidate DM practice and demonstrate its efficacy in cases with significant treatment resistance are needed.

Availability of Data and Materials: All data that support the findings of this study are available in the paper.

Ethics Committee Approval: The study protocol was reviewed and approved by the Ethics Committee of Firat University (Approval number: 2023/14-01, Date: October 14, 2023).

Informed Consent: Informed consent was obtained from all participants who agreed to take part in the study.

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