Author’s response to reviews

Title: A randomised controlled trial comparing active versus control internet-based cognitive bias modification for obsessive compulsive disorder.

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Dear Editor,

Thank you for your positive comments and specific recommendations regarding the manuscript entitled “A randomised controlled trial comparing active versus control internet-based cognitive bias modification for obsessive compulsive disorder. Please find attached a revised manuscript (in ‘track changes’) and a summary of the suggested modifications and responses to each query. We believe that the modifications made address the concerns raised by the Reviewer, and that the helpful suggestions put forth have resulted in a more cohesive summary of our research.

Reviewer's report:

This is a very well written manuscript and very interesting study that will make a useful contribution to the field. I have several comments that I hope the authors will address to improve the clarity and impact of the article.

1.1 The manuscript is rather long and there is some repetition that could be reduced.

- The manuscript is now 4,352 words in length and includes all required information to comply with the SPIRIT guidelines for trial protocols. We would be happy to receive Editorial advice regarding the length of the manuscript.

1.2 The authors need to closely follow/use the headings requested by the Journal.

- The headings have been modified to directly align with the Journal guidelines. We have retained subheadings in order to comply with the SPIRIT guidelines. As per above, we would be happy to receive Editorial advice on this point.
1.3 The introduction would greatly benefit from the authors introducing effect sizes for all reported studies and not just study 30. Where the authors are reporting effects of CBM for other anxiety disorders across a range of studies – a range of ES could be given.

- We thank the Reviewer for this suggestion. We have now included effect sizes (as reported by the original Authors) on Pages 4 and 6.

1.4 On page 7, the sentence starting, "Based on these collective results...." is overly strong given the effect sizes achieved with CBM, largely with non-clinical populations, and very few with individuals high in OC with OCD. I think the sentence should read, "The available literature suggests that CBM produces modest changes in beliefs and emotional processes that may underpin symptom change in Individuals with OC symptoms recruited outside of clinics." To be clear, this trial does not "establish" efficacy. It is rather, proof-of-concept and feasibility - a form of words that would be better used throughout this protocol.

- We have revised this sentence based on the Reviewer’s suggestion (pg. 7).

1.5 The paragraph under the heading Study Objective is partly redundant with the Hypotheses section and can be removed. The second half of this paragraph should be moved to the Methods section and placed in the interventions section. The heading Trial Design and the sentence beneath should be moved to the Methods section.

- We have re-arranged some of the text based on the Reviewer’s suggestion (pgs 7-8).

1.6 I think many readers will be somewhat confused by the hypotheses and greater clarity is needed here. If your intent is show that CBM might be a useful addition to the available treatments for individuals with a diagnosis of OCD, why are you including people with a lifetime diagnosis of OCD? I really see this as muddying the waters and there is no justification for this anywhere in the introduction. The authors need to explain this better.

It seems to me that you could find yourself at the end of recruitment with an imbalanced number of folks in each condition with/without a current diagnosis of OCD, or arguably worse, very few people with a current diagnosis of OCD in the study overall. These are not critical flaws if one is simply wanting to see whether CBM alters processes that might underpin OC symptom change or diagnostic status - but it is potentially critical if the purpose of the study is to demonstrate the ES achievable with CBM for adults with a diagnosis of OCD (i.e. relevant to treatment-seeking clinical populations).

- To clarify, as indicated on pg 8, participants with a lifetime diagnosis of OCD will also be recruited to evaluate whether previously symptomatic individuals demonstrate a negative interpretation bias for OC-specific information. To the extent that a bias is detectable, we predict that CBM-active training, relative to CBM-control training, will result in a bias towards more positive OC-specific targets and bias scores. This is a secondary study embedded within the trial – the primary trial objective is indeed to investigate the potential therapeutic benefit of delivering CBM to participants who
meet current diagnostic criteria for OCD. The power calculations were conducted for this primary aim. We have made this distinction more explicit on Page 7.

I do not understand why you do not predict a change in OC symptoms in individuals with a lifetime diagnosis of OCD? This needs explanation. If you are going to predict changes in OC symptoms in those with current OCD, I think you should specify the amount of change you are expecting (i.e. in line with your power analyses) and say whether these symptom changes correspond to clinically meaningful changes.

- We do not predict a change in OC symptoms in individuals with a lifetime diagnosis (who do not also meet criteria for a current diagnosis). We have clarified this in the text (pg. 8).

1.7 The article would benefit from a brief description of the procedures in place to train the assessors in the use the MINI and to check on the reliability of the diagnoses of OCD (current and lifetime) made by this interview.

- We have added this information to the text (pg. 17).

1.8 The article needs to specify if the post-intervention MINI assessments were conducted blindly and if not why.

- We have now specified that interviewers will be blind to the baseline interview assessment (pg. 17).

1.9 The authors should specify what level of non-completion of the computerized tasks constitutes a drop-out - and what is the longest length of time the authors would permit between computerized training and still consider the participant to be in the trial.

- As the trial is conducted under intention-to-treat principles, all participant data will be included in the analyses (with the exception of patients who elect to formally withdraw from the trial). As indicated on Page 18, complete-case analyses will be conducted on data from participants who complete all 4 CBM sessions.

1.10 The description of the CBM procedure requires greater detail. The reader needs to know how many items are used, a rough overview of content areas, and if they are exactly the same as used in a previous study.

- As indicated on Page 11, there are four separate sessions of the CBM program, each of approximately 20-30 minutes duration. These are completed over the course of five consecutive days (allowing some flexibility to delivery). Both conditions include four days of 164 training scenarios; with each CBM session delivering 41 training scenarios. We have added additional information (pg 11) to clarify the source and breadth of information covered.