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RESPONDING TO COVID-19: LESSONS LEARNED FROM ADAPTING A SPECIALIST OCD SERVICE FOR OCD

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Background

In April 2020, following the introduction of 'lock-down' and national COVID-19 restrictions, it became difficult to provide face-to-face exposure and response prevention (ERP) for people with OCD. Reducing face-to-face treatment was being recommended by many specialists.[1]

In response, the Advanced Interventions Service (a nationally-commissioned specialist service that provides intensive treatment for OCD) was unable to provide standard ERP. Instead, the service adopted Inference-Based Therapy (IBT) as the first-line/ primary treatment.

The AIS had already used IBT in a small number of cases of repugnant obsessions because it does not require as much exposure, which may be distressing. It can also be delivered using videoconferencing.

IBT is a manualised treatment approach which differs from traditional cognitive appraisal methods in that intrusive thoughts are not viewed as 'normal'. Instead, obsessions are considered to be due to doubt, which arises from faulty reasoning systems. The focus of treatment is to help people to identify this faulty reasoning, challenge them, and reduce obsessions and compulsive behaviours.

Characteristic	CBT/ ERP	IBT
Underlying theory	Learning Theory	Reasoning Theory
Nature of intrusions	Intrusions are normal	Intrusions are abnormal
Underlying error	Appraisal of intrusion (and meaning) is faulty	Reasoning is faulty
Target of treatment	Appraisal of thoughts and extinction of feared response (anxiety)	Doubt and inferential confusion
Main interventions	1) Cognitive interventions to challenge thought appraisal / maladaptive thinking styles 2) In vivo exposure and response prevention (ERP) based on hierarchy and repeated trials	1) Cognitive interventions to resolve OCD doubts 2) 'Reality testing' (real-world exposure, but no hierarchy and no response prevention)

Methods

We present a description of our experience of treating the first eleven patients to be treated with IBT as an alternative to intensive ERP.

We wanted to determine if delivery of IBT could offer an alternative and effective treatment for patients with OCD who could not travel because of COVID-19.

Patient characteristics (N=11)

M:F ratio	4:7
Age (mean ± SD)	43.2 ± 17.4
Age (range)	21.1 – 73.1
Baseline Y-BOCS-SR (mean ± SD)	34.0 + 4.8

Delivering IBT and patient progress

Delivery of IBT

All staff members undertook supervision for IBT and the developers of the therapy were available for consultation. All patients who would previously have been considered for ERP were assessed for suitability for IBT.

The treatment programme was offered on a weekly basis, with sessions typically lasting one hour. Additional sessions were offered to support homework tasks and complete rating scales. Family sessions (typically fortnightly) were also used to support the introduction of 'non-OCD' behaviours and enable changes within the family system. The manual was used to guide therapy.[2]

Patient status (All patients, N=11)

Outcome	N
Unable to complete assessment (8 sessions) – IBT not considered suitable	1
Completed a course of treatment, but didn't progress through all stages	1
Completed treatment and all stages	2
Completed assessment and treatment ongoing	7

Treatment characteristics (Exposed to IBT, N=10)

Treatment completers are those that have had ≥ 16 sessions.

Characteristic	Completers (N=3)	Treatment ongoing (N=7)
No. of assessment sessions	7.3 ± 1.2	5.4 ± 2.2
Duration of assessment (hrs)	5.1 ± 1.1	4.7 ± 1.2
No. of treatment sessions	40.3 ± 15.6	18.3 ± 8.3
Duration of treatment (hrs)	23.2 ± 8.1	12.9 ± 5.5
No. of family sessions	7.0 ± 7.5	4.0 ± 4.7
Duration of family sessions (hrs)	5.0 ± 6.2	2.6 ± 3.4

Discussion

We observed that:

1. For patients with chronic and severe OCD, the majority of people will required more than the predicted number of sessions.
2. Not everyone will be suitable due to struggling with the concepts and/ or regular online therapy.
3. There is significant variability in delivery of IBT, with regards to:
   - Time needed for assessment.
   - Total number of sessions required.
   - Amount of therapeutic time spent working with the family.
   - Duration of each session.

We conclude that incorporating a new treatment, and delivering it to a complex and severe population is complicated and affected by a range of patient- and therapist-related factors.

[1] N. A. Fineberg, et al. 2020. *Compr Psychiatry*; 100: 152174. [2] K. O'Connor, et al. 2011. *Clinician's Handbook for Obsessive-Compulsive Disorder: Inference-Based Therapy*