

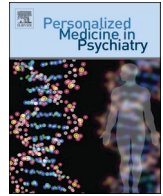


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# Personalized Medicine in Psychiatry

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## Expert opinion in obsessive-compulsive disorder: Treating patients with obsessive-compulsive disorder during the COVID-19 pandemic<sup>☆</sup>

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### ABSTRACT

This commentary outlines assessment and treatment of patients with OCD during the era of COVID-19. The ongoing COVID-19 pandemic has required providers to make important considerations in treatment, including how *usual risk* is defined, as well as the use of personal protective equipment and telehealth services. These considerations have allowed providers to continue using both reliable and valid assessment procedures, as well as previously established and efficacious interventions. These adjustments create a context in which patient care for OCD remains fundamentally unchanged; however, important considerations should still be made because of the COVID-19 pandemic.

### Introduction

Obsessive-compulsive disorder (OCD) is a debilitating condition affecting approximately 1% of adults and youth [6]. Obsessive-compulsive symptoms present heterogeneously, and generally fall into several dimensions including hoarding, contamination/cleaning, symmetry/ordering, unacceptable or taboo thoughts, and doubting/checking [2]. Symptoms of OCD tend to be chronic without effective treatment. Evidence-based interventions include cognitive-behavioral therapy with exposure and response prevention (ERP) and serotonin reuptake inhibitor (SRI) medications [11]. Although most people respond to first-line interventions, a meaningful number of individuals do not achieve clinical remission or respond sufficiently [9,17].

Stressful life events, including public health crises, can exacerbate OCD symptom severity or affect treatment delivery. During the onset of the HIV/AIDS epidemic, uncertainty about transmission and contagion of the virus provoked contamination fears in individuals both with and without preexisting OCD [5,22]. Practical and ethical guidelines for treating patients with HIV/AIDS-specific obsessions were rapidly

developed in response [25]. Similar increases in the prevalence and severity of symptoms have been documented during the current pandemic, leading to questions about how to best approach OCD during a pandemic and whether alterations should be made to pre-existing gold standard treatment modalities [27]. The following article details recommendations for assessing and managing patients with OCD during COVID-19.

### Assessment

Gold-standard assessment of OCD includes interviews, self-report questionnaires, family-report questionnaires, and clinician-administered inventories (for a review, see [26]). Areas to assess include presence of intrusive thoughts, images, and impulses (obsessions), associated compulsions/avoidance, insight, as well as severity, duration, intensity, and functional impairments associated with these symptoms. Fortunately, assessment of OCD during the COVID-19 pandemic remains largely unchanged; diagnostic interviews should include the same assessment areas listed above, and assessment of

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symptom severity continues to revolve around duration, intensity, and distress associated with obsessive–compulsive symptoms.

Complexity in assessment does occur in differentiating adaptive behavioral responses to COVID-19 (e.g., frequent handwashing) from obsessive-compulsive symptoms. We refer to the inherent, everyday risks that humans encounter in daily life as *usual risk*. Thorough understanding of typical behaviors in response to the usual level of risk is essential to the assessment of OCD symptoms. Behaviors that are in meaningful excess of public health guidelines and are motivated by distress may be reflective of obsessive–compulsive symptomology. On balance, the relative level of usual risk has inherently changed during the pandemic, and this change in usual risk warrants certain changes in behavior. Given the worldwide shifts in “normal” behavior, clinicians must take into account factors including community transmission data, patients’ health backgrounds, life stressors secondary to COVID (e.g., economic challenges), and differentiating between good public health vs. excessive behaviors.

Much like any other psychiatric condition, treatment considerations are based on current scientific knowledge; what is unique in this context is that our understanding of the COVID-19 virus has advanced at an unprecedented rate. The Centers for Disease Control (CDC) continues to revise public health guidelines; differentiating between adaptive versus problematic behaviors should reflect these advances.

Since the pandemic began, clinical assessment of OCD symptoms has continuously adapted as understanding of the virus improves. During the early stages of the pandemic, even reliable sources, such as public health websites and announcements from government officials, conveyed a message of panic and uncertainty to the community. Many patients sought information from these sources, and in doing so had their fears and compensatory rituals reinforced. For instance, in March 2020, news outlets recommended sanitizing any surfaces that grocery bags and delivery boxes touched, leaving cardboard delivery boxes outside for 24 h before bringing inside, and wiping down groceries, among others. In the spring and early summer of 2020, many of these behaviors were taking place because the public was being directly instructed to do so, and as such, were consistent with normative behavior. As understanding of the pandemic progressed, research revealed that transmission of the virus through surfaces was significantly lower than originally believed. Behaviors that reflect difficulty adapting as understanding of the pandemic improves (for example, continuing to engage in ritualistic sanitizing with groceries, leaving containers outside for ritualized periods of time, etc.) may be indicative of obsessive–compulsive symptomology, and difficulty accepting contrary evidence may reflect reduced OCD symptom insight.

Another unique aspect of assessing OCD during the pandemic is the need to assess COVID-19 specific obsessions and compulsions designed to “prevent” contraction or spread of COVID-19 to others. These symptoms have typically presented as contamination concerns (i.e., fears of oneself or loved ones getting sick) or aligned with harm obsessions (i.e., harming others by spreading COVID-19). Finally, the extent to which the patient is following specific, ritualized rules should be assessed. Lack of flexibility with rituals is a hallmark feature of OCD, including during the pandemic. Questions to facilitate clinicians’ assessment of adaptive versus pathological behaviors are presented in [Table 1](#).

**Exposure and response prevention**

Exposure and response prevention is an efficacious cognitive-behavioral intervention for OCD, including during the COVID-19 pandemic [14,19]. ERP works through systematic and graded exposure to fear-provoking triggers, while patients actively resist compulsions/avoidance designed to neutralize distress. Patients learn that feared outcomes do not happen and/or is within their ability to cope if it does.

Largely, the intervention involves engaging in normative, day-to-day activities while purposefully resisting compulsive behaviors designed to

**Table 1**

COVID-19 specific questions for assessing pathological vs. non-pathological behaviors.

Questions for Clinicians	Example of Pathological Behavior
1. Does the behavior go above and beyond national (i.e., CDC) or local guidelines?	A patient who washes hands for a ritualized amount of time, which is longer than the standard recommendation of 20 s.
2. Is there scientific evidence supporting the behavior during this time?	A patient who wipes their body with disinfecting wipes.
3. Do the patient’s medical history or other unique risk factors make the behavior adaptive? Or is the behavior excessive, even given the individual’s risk factors?	A patient with a newborn baby at home asks guests to wear masks when they come over. <i>(non-pathological example)</i>
4. Does the patient avoid learning new information about COVID-19? Do they have difficulty adapting to new guidelines?	A patient avoids the CDC.gov website or other news sources, due to fears of seeing information which contradicts their current rituals.
5. Has the patient been presented with contradictory evidence? Is limited insight preventing behavior change?	A patient learns about minimal risk of virus transmission through food items and continues with rituals for sanitizing groceries.
6. Is the behavior taking place in a ritualized way?	A patient leaves groceries, packages, or other contaminated objects in a separate part of their home, for a specified number of hours.

neutralize distress (e.g., handling “contaminated” household items and resisting urges to wash hands). Awareness of usual risk is paramount for effective implementation of ERP, especially in the context of COVID-19. During COVID-19, application of ERP was challenged by an understanding of usual risk. While the suggestion of pausing ERP for contamination related OCD was surprisingly made (e.g., [4]), this broad proposal should not be adopted and would be detrimental to patients (see [19] for full review). Rather than using alternative interventions, adept clinicians should be aware of what usual risk entails and use this to inform patient care. More clearly, ERP should be used during the COVID-19 pandemic, with providers and patients adhering to guidelines set by governmental agencies (i.e., CDC), rather than guidelines determined by a patient’s OCD symptoms [12]. A list of contamination related exposures used by the authors during the pandemic are provided in [Table 2](#).

ERP for other OCD presentations that may exhibit COVID-19 specific content (e.g., fear of harm coming to others, intrusive concerns related to financial stability) should mirror treatment as it would occur during a non-pandemic context. Providers and patients should identify feared

**Table 2**

COVID-19 specific exposures for contamination-related OCD presentation.

Exposure	Anticipated Distress (0–10)	Feared Outcome
Wash hands, without cleaning under fingernails	6	“I will contract COVID-19, become sick, possibly die.”
Touch kitchen floor with hands and rub face	8	“I will Contract COVID-19.”
Resist urge to wash hands and wash dishes	9	“COVID-19 will spread to dish, and I will contract while eating.”
Handle doorknob inside home, breathe with hand near face	8	“I will inhale COVID-19 after handling the door.”
Handle package recently delivered to home without barriers/gloves	7	“I will contract COVID-19 and might become ill.”
Resist urge to shower after driving in vehicle	8	“COVID-19 will be on my body, and I will eventually become sick.”

*Note.* These exposures have been pulled from exposure hierarchies from patients treated at the Baylor College of Medicine Department of Psychiatry. Identifiers have been removed.

outcomes, and design both imaginal and *in-vivo* exposures to practice resisting engagement in compulsive behaviors. While special considerations should be made to account for this new context (e.g., use of PPE or telehealth services, and a new level of usual risk), the intervention itself is fundamentally the same.

### Telehealth

Over the course of the last decade, the OCD community was one of the first to empirically study the efficacy of treatments (e.g., ERP) provided via telehealth [1,21]. Results from clinical trials and meta-analyses have shown that ERP is comparably effective when delivered in person, via telephone, or through telehealth [7,23]. Furthermore, initial reports from the start of the pandemic show that when transitioning to telehealth, either via telephone or video mediated, patients continued to engage in treatment with no significant difference in outcomes [20]. Additionally, home-based exposures have become easier to conduct through telehealth [18].

Despite the efficacy of telehealth ERP, transitioning to telehealth was difficult for some clinicians with more limited experience. Prior to the COVID-19 outbreak, most training programs (e.g., psychology, psychiatry) did not provide training in how to engage in telehealth, and clinicians looking to obtain training had to seek seminars and workshops independently [13]. However, providers were able to quickly, and often at no cost, obtain additional telehealth training through large scale organizations [16].

As the one-year anniversary of transitioning to providing almost solely telehealth services passes, there are benefits of the transition. Clinicians have described increased ability to provide services to rural and underserved communities, cost effectiveness, and decreased no-show rates [18]. It is likely that when the COVID-19 pandemic has abated, many clinicians and organizations will continue to use telehealth as a means to reduce previous barriers to treatment, such as travel time, childcare, time off from work, etc., thereby improving the dissemination of empirically supported treatments for OCD.

### Deep brain stimulation

While deep brain stimulation procedures were initially delayed at the onset of the pandemic given their elective status, this has shifted as safety protocols for elective procedures were implemented. Gross et al. [10] provide recommendations for addressing potential neurosurgical risks during COVID-19 and as such, will not be reviewed here. Patients receiving DBS are carefully selected given symptom severity and ability to adhere to the treatment protocol. Since there are a limited number of sites providing DBS for OCD, this often requires the patient to travel for care, complicating programming adjustments needed post-implant. At the same time, travel is complicated by risk of infection. While programming still requires in person visits at this time, some elements of care can be managed remotely. However, this may be complicated by limitations in patient report and/or technology challenges [24]. Some providers have adopted adjunctive approaches to monitor symptomology in real-time [8], as well as smart phone applications that help to estimate device battery life [15].

Like many individuals with pre-existing psychiatric problems [3], many DBS patients may be experiencing exacerbated symptomology due to fear of COVID-19, potentially compounded by the social isolation and reduced ability to cope. This requires enlisting the individual in adjunctive telehealth treatment, including ERP, behavioral activation, and pharmacotherapy, as well as increased monitoring.

### Conclusion

This report outlines assessment and treatment considerations for patients with OCD during the era of COVID-19. We highlight that the gold-standard procedures for addressing OCD remain largely the same

but require consideration of local risk conditions for personalized treatment. Mental health professionals are trained in navigating ethical dilemmas and are well-equipped to treat OCD during ‘usual’ times and times of unrest. Clinicians should continue to use clinical judgement in assessing symptom severity, duration, and functional impairment, while placing emphasis on local guidelines and the current level of usual risk.

### Conflict of interests

The authors report no conflicts of interest with this article.

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