OCD-NET & BDD-NET therapist resources

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Contents

Chapter 1

Introduction

Welcome to our online therapist resource for *OCD-NET* and *BDD-NET*. This website contains resources to support therapists in their work, both technical and clinical aspects of doing internet-based cognitive behaviour therapy.

We strive to continuously update and improve this material and would appreciate any feedback. You can reach us at ocdnet.support@webcbt.se or talk to us in person at a training session.

1.1 Description of OCD-NET and BDD-NET

OCD-NET and BDD-NET are therapist-guided internet-based cognitive behaviour (ICBT) therapies for OCD and BDD, respectively. In ICBT, patients have an identified therapist providing support and feedback throughout treatment. All contact with the therapist occurs through the treatment platform as asynchronous text messages (like e-mail or SMS).

1.2 Type of treatment

The intended use of OCD-NET and BDD-NET are within a stepped care model as an alternative to brief individual CBT, group CBT, serotonin reuptake inhibitors (SSRIs), or higher-intensity CBT for adults with mild to moderate symptoms. The treatments are expected to be cost-saving compared to individual CBT (10 hours or more intensive treatment) but not compared to group CBT. Crucially, ICBT therapies typically require less therapist time per patient (10-20 minutes per patient each week) and could therefore release therapist time compared to individual CBT or group CBT.

1.3 Background

Both OCD-NET and BDD-NET were initially developed by researchers at Karolinska Institutet in Stockholm, Sweden. OCD-NET has been evaluated in six clinical trials to date with results indicating that it is as effective as regular face-to-face CBT, while requiring less therapist time per patient and with the advantage of being accessible from any device connected to the internet (Andersson et al., 2011, 2012, 2014, 2015; Rück et al., 2018). Similarly, BDD-NET has been evaluated in two clinical trials with comparable results (Enander et al., 2014, 2016). Both treatments were initially developed in Swedish but have been translated to English and evaluated in pilot studies in New York (OCD-NET; Patel et al. (2017)) and an international pilot study (BDD-NET; Gentile et al., 2018, *under review*).

Chapter 2

Using the technology

2.1 Quick start

If you want to explore the platform yourself, you can use test therapist and test patient logins provided to try out the features. We generally recommend that you use the platform while reading this manual, to test features as you go along.

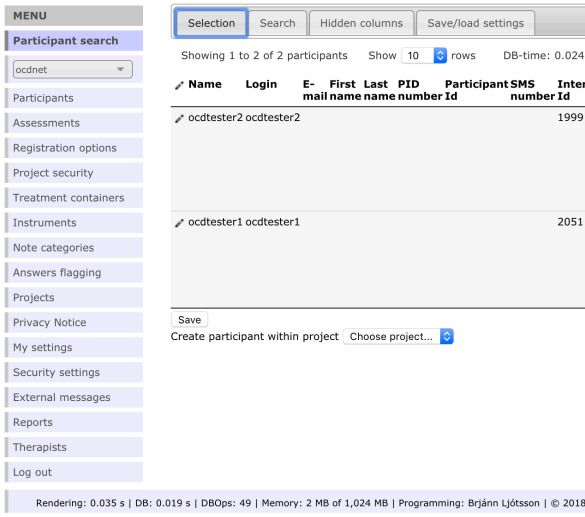
Therapists access the platform via this URL: https://webcbt.tst.ki.se/t1. This is where therapists enter their username and password to enter the treatment platform.

Note that URLs will change once OCD-NET and BDD-NET are used in clinical work, the current ones are for testing the platform only.

2.2 Platform use overview

There are five common scenarios during the course of treatment:

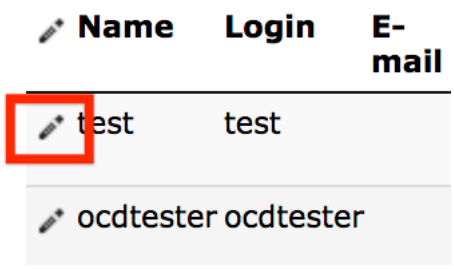
- Responding to messages
- Reviewing homework
- Opening new treatment modules
- Reviewing questionnaires
- Responding to warning flags



These actions can all be accessed in the participant overview, shown below:

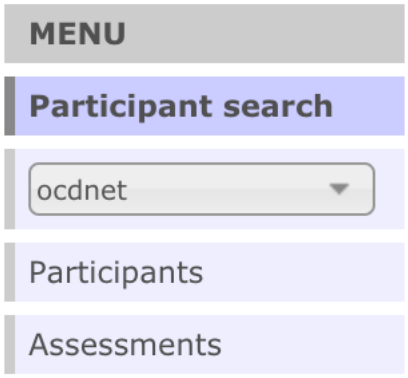
A typical day as a therapist includes responding to one or more messages, reviewing homework and opening up a new module. Once in a while therapists contact inactive patients or assess a warning flag.

The majority of day to day tasks are accessed via the *Participant search* menu. The menu is located at the left-hand side of the browser window. Closing the current participant and clicking *Participant search* will get you back to the participant overview. To access individual participants, click the pencil next to their name.



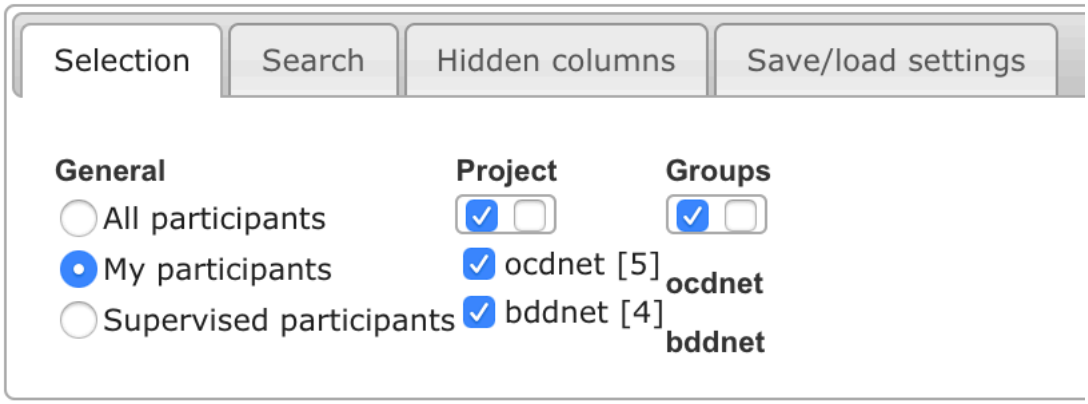
2.3 Navigation

The menu bar on the left may expand depending on administrative rights. Other parts of the menu include administrative settings such as editing treatment content, editing assessments, editing conditions for when participant assessments are flagged, and changing settings to the site itself. These will not be relevant to most therapists and we do not cover them in detail here. Just remember that you can always go back to the default view by closing the current participant and navigating to *Participant search* in the left-hand menu.



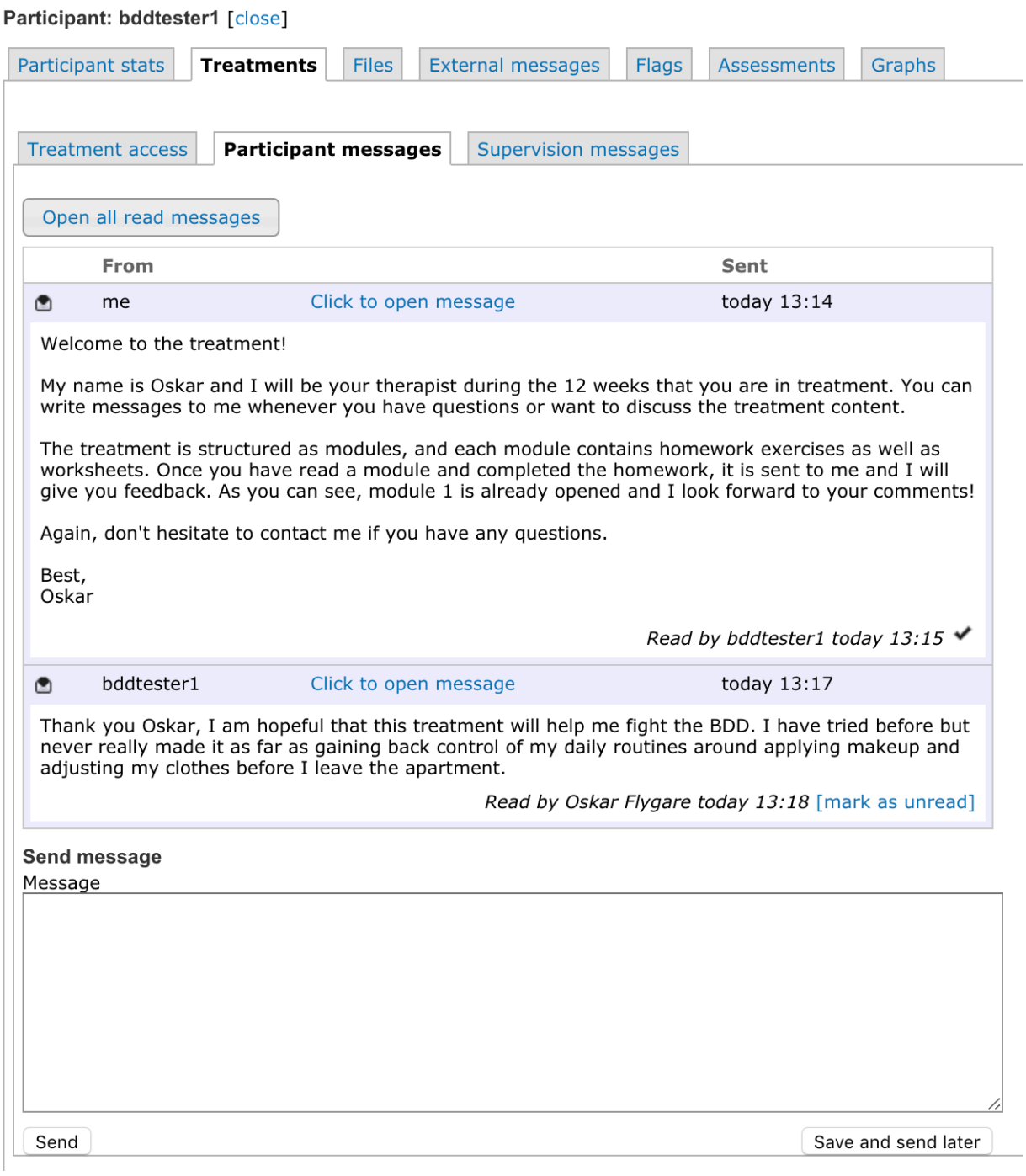
2.4 Filtering the participant overview

To get a quick overview of a long participant list, filter patients that meet certain criteria, for example belonging to certain groups in treatment of certain treatments. There is a button called *Selection* above the participant list. We recommend that therapists use the "My participants" filter to show only patients assigned to them.



2.5 Writing and responding to messages

A new message from a patient will be indicated by this icon  in the participant overview. Click the pencil next to the participant's name to access that patient. Navigate to *Treatments -> participant messages* to view the message and write a response. See the chapter Being an effective ICBT therapist for guidelines on how to write messages.



2.6 Homework review

A completed homework assignment is shown in the **Homework** column in the participant overview. Click the pencil next to the participant and navigate to *Treatments -> Treatment access* to review the homework and mark it as completed.

Please note that patients are not notified if you mark the homework as incomplete. Write a message to explain what additional information you need from the patient when they send it in again.

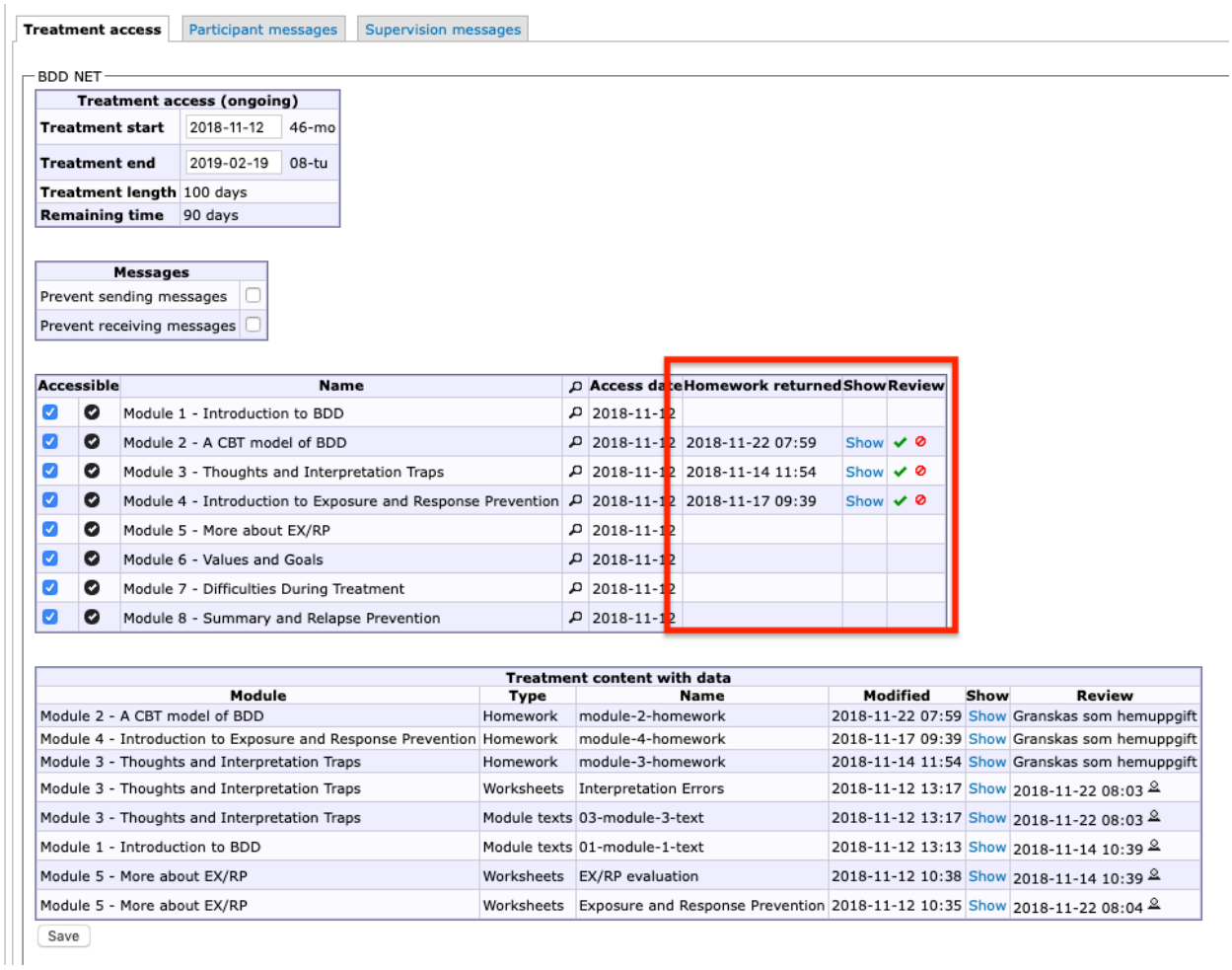


Figure 2.1: Completed homework assignments will show up for review in the treatment overview, click the checkmark or red button to mark it as completed or send back to the participant.

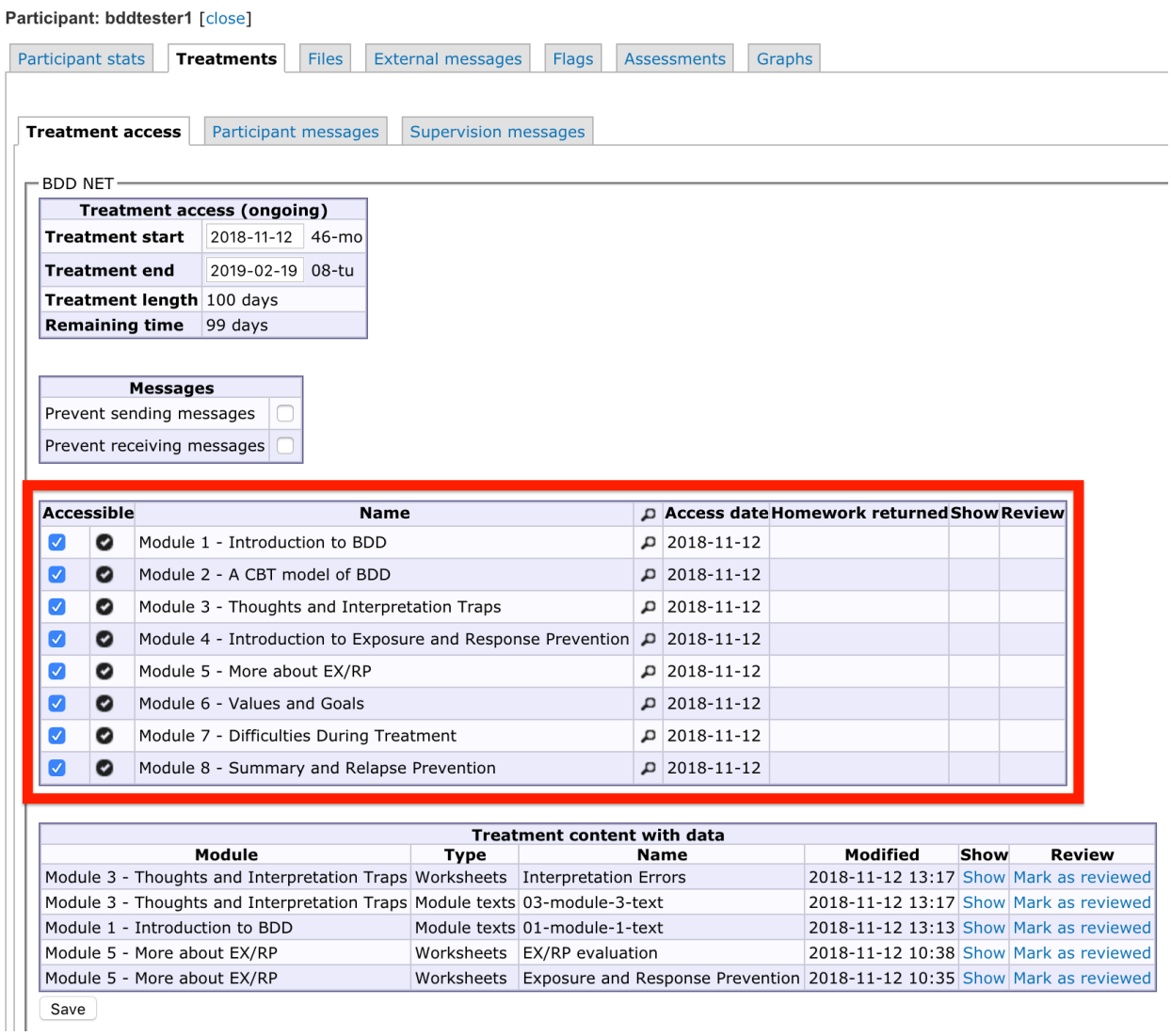


Figure 2.2: Check the box to the left to open a new module

Internet-based CBT relies heavily on self-directed activities and homework review is a good time to check whether the patient has grasped important concepts and are able to apply them to their own situation.

2.7 Treatment modules

When a patient has read a module and completed the corresponding homework assignment(s), they are ready for the next module. To grant access to a new module, navigate to *Treatments -> Treatment access* and check the box next to the next module. A date will appear next to the module indicating when the module was activated.

The number of modules and weeks in treatment varies between treatment protocols but a rough guideline is that patients should progress through one module per week. Some treatment techniques, like exposure with response prevention, are spread out across several modules to emphasise their importance and give participants sufficient time to get started on the technique.

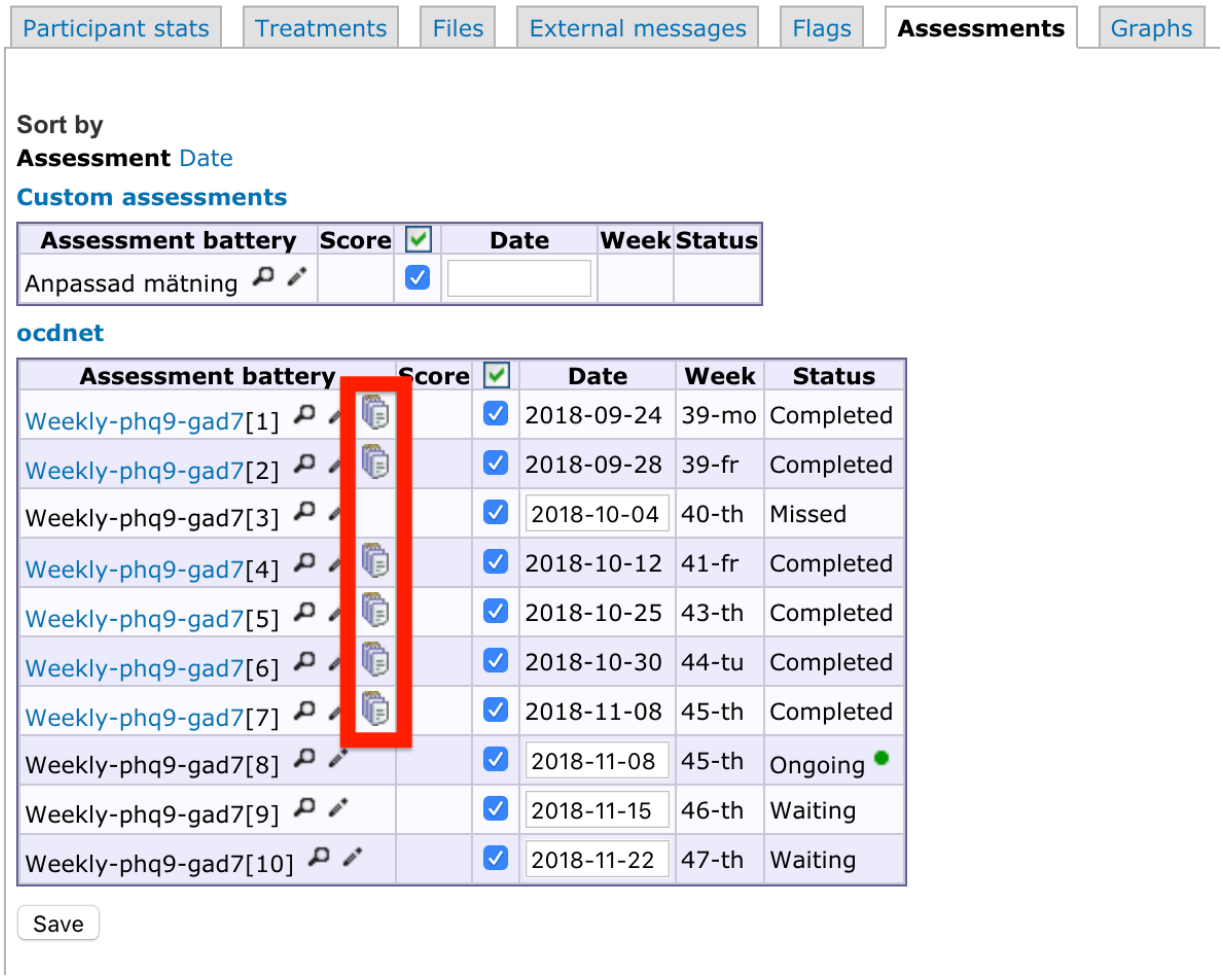


Figure 2.3: Click the paper icon to view responses

2.8 Questionnaires

Before, during, and after treatment, patients are asked to fill out questionnaires. When new questionnaires are activated they appear as the patient logs onto the platform. Therapists can review and change which questionnaires should appear at which day in *Assessments* but we recommend that therapists stick to the standard schedule whenever possible. Questionnaires for each patient are listed in this view, click the paper icon to view responses.

2.9 Warning flags

The ICBT platform will display a *warning flag* next to a patient's name for certain events. The most common flags are due to non-response to questionnaires. These serve as prompts to therapists to take further action, for example reaching out by phone to a patient or sending them another text message reminder.

Once a warning flag has been noticed and dealt with, indicate the action taken in the *temporary flag text* box

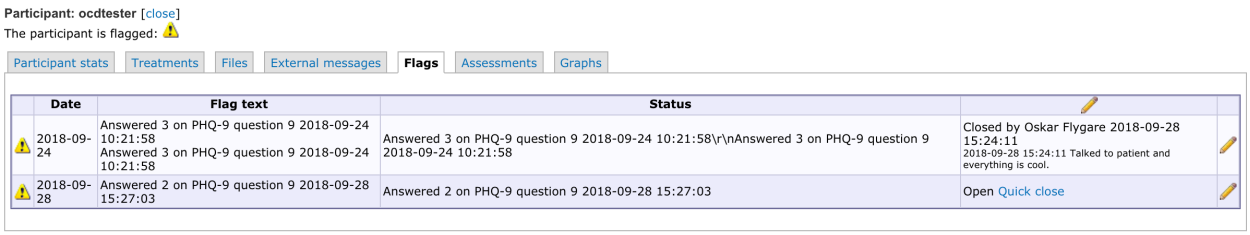
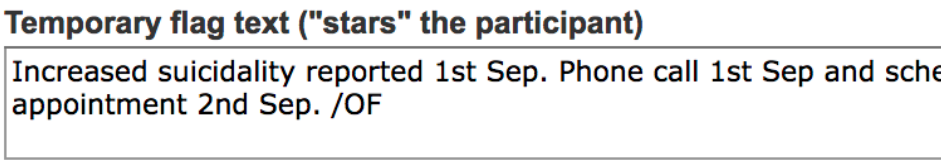


Figure 2.4: Click on the pencil to edit a flag.



in the *Participant stats* tab (shown below).

- Patient has not responded to measurement in time: 

2.9.1 Suicidality warning flags

The most important type of warning flag is due to heightened suicidality. The platform is configured to display this flag if a patient responds 2 or 3 on the suicidality question in PHQ-9.

- Warning flag to indicate suicidal ideation: 

Therapists should refer to local clinical guidelines when performing suicidality assessments and taking action. We recommend that therapists ask for guidance of their supervisors if there are any uncertainties.

Once the level of suicidality is deemed to be low enough to not require further attention, therapists can remove the warning flag under the *Flags* tab for the participant. Flags are listed under the Flags tab, click on the pencil to edit a flag.

2.10 Supervision

Supervision through the platform makes it easy to connect feedback from the supervisor to specific therapist messages and actions. The supervision page is found at *Treatment -> Supervision messages* for each participant. It will look different for the therapist that is supervised and the supervisor.

The notes are only visible to the supervisor, so that he/she can write comments about the supervision for future reference. If you are a supervisor, new messages to review are indicated by an icon for messages. 

2.11 Assign new therapist

The most typical scenario is that each patient is treated by one therapist throughout treatment, but it is not uncommon for a second therapist to act as backup if the primary therapist is not available.

To assign another therapist or change therapist, navigate to the patient in question and click the *Participant stats* tab. At the bottom of that page, there is a list of therapists and those assigned to the patient will have

Figure 2.5: Once you have managed a flag, you can make a note that lists actions taken, and remove the flag.

a checkmark next to them. Simply un-check whoever is to be removed and check whoever is to be assigned the patient.

2.12 Create new patient login

To create a new patient login on the platform, go to the participant overview by selecting *Participant search* in the left-hand menu. Select *Create new participant* at the bottom of the participant list. Therapists can use the "change password" button to generate secure passwords for patients.

Fields not needed are:

- Temporary flag text: Usually not needed at creation but might come in handy later for communicating between therapists
- Temporary notes: Usually not needed but can be used to store information

2.13 OCD-NET and BDD-NET for patients

We encourage therapists using OCD-NET and BDD-NET to login with one of the test patient accounts to see what the platform looks like for patients. See below for a quick overview of the registration process.

2.13.1 Access

Patients access the platform from the Patient-URL, which is different from the therapist URL.

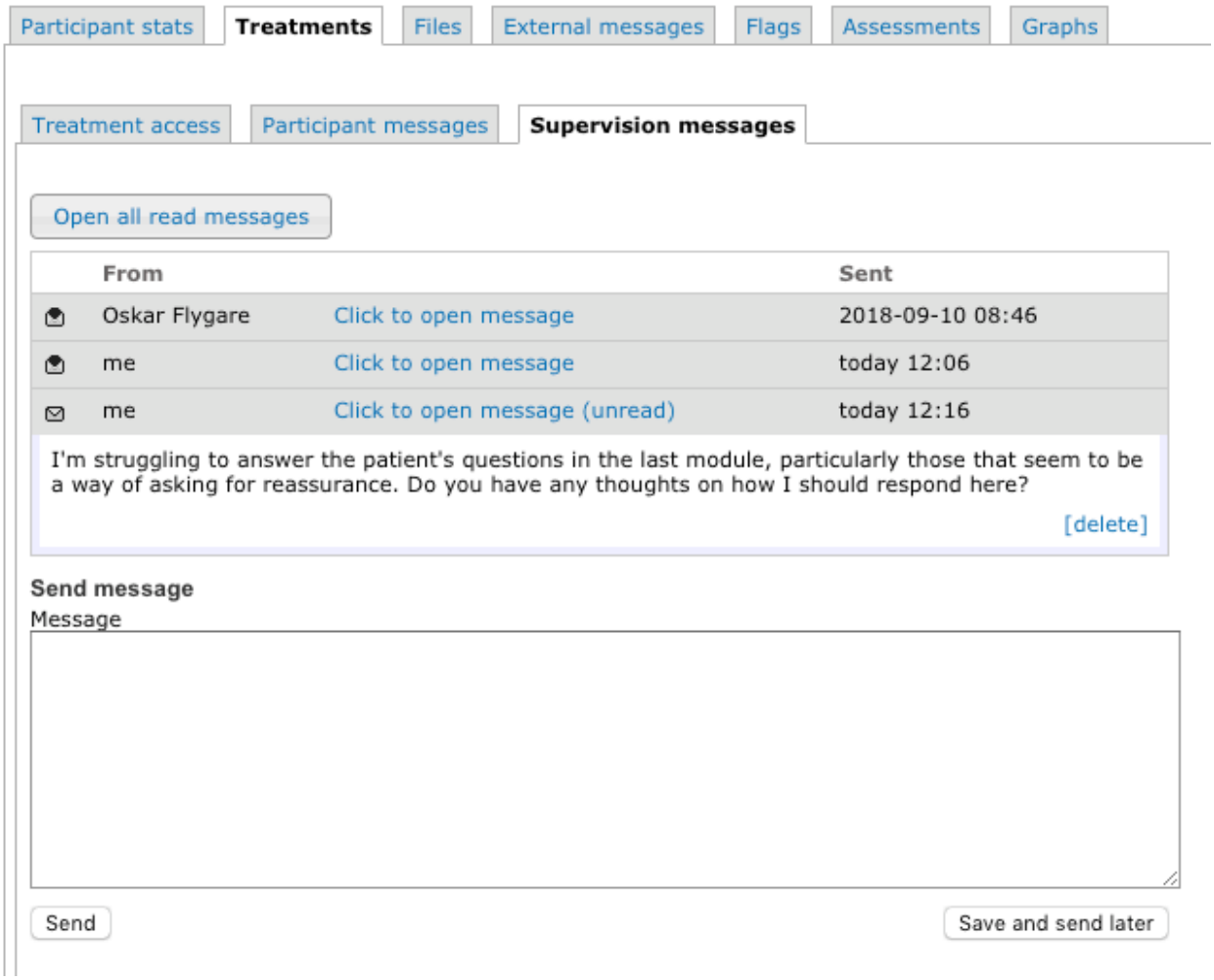


Figure 2.6: Therapists have a simple interface to write and receive messages from their supervisor

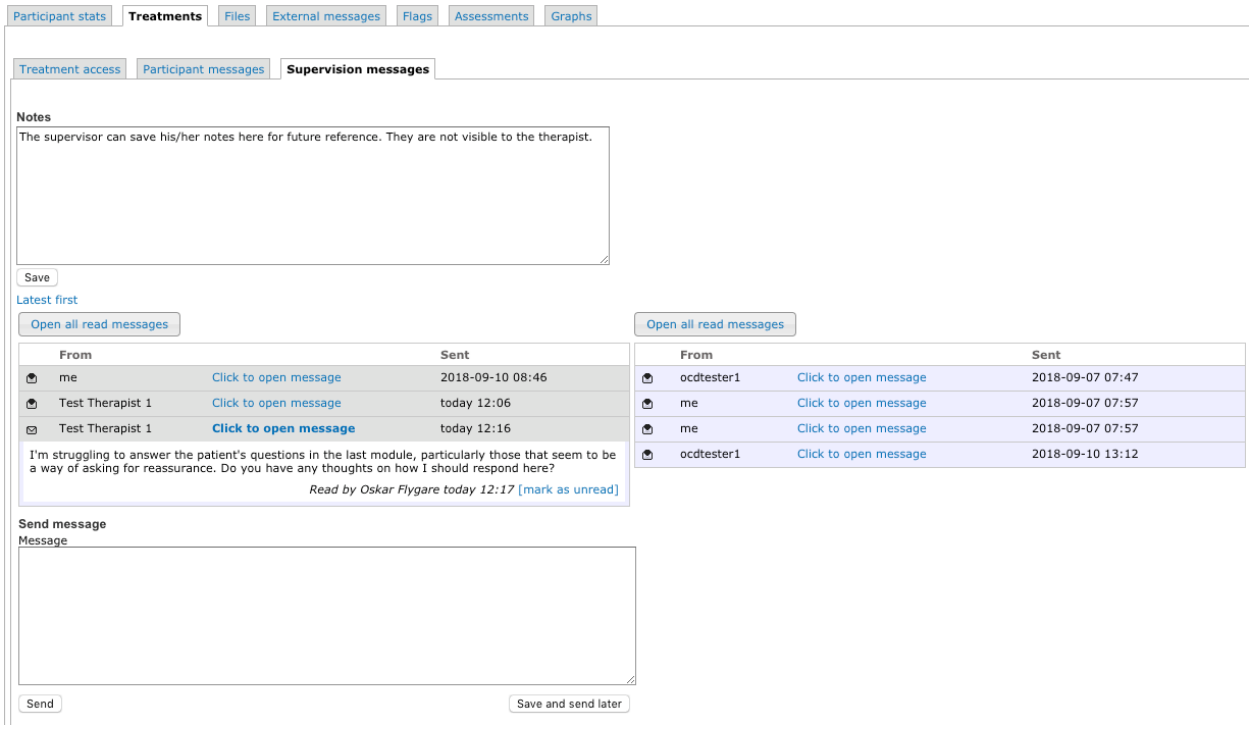


Figure 2.7: Messages between therapist and supervisor to the left, participant messages to the right for reference

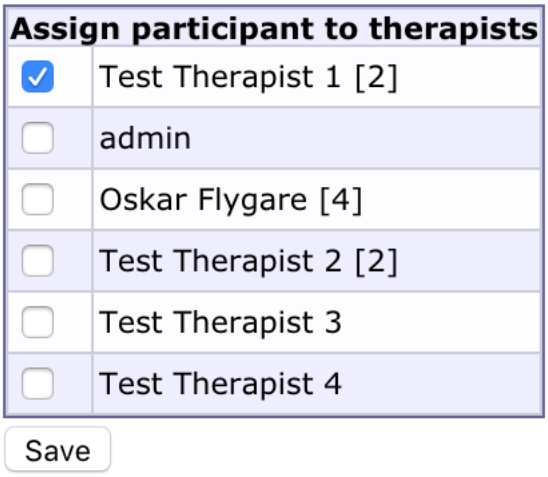


Figure 2.8: The numbers next to therapists indicate how many patients they are assigned to

Stats

Last login	never
Login count	
Privacy consent	No consent
Internal Id	90000001

User information

Login	Username
E-mail	Enter valid e-mail
First name	
Last name	
PID number	Personal identification number
Participant Id	Used to connect other data sources
SMS number	Enter valid phone number
Group	(no group)

Password

Participant has no password

Change password

Temporary flag text ("stars" the participant)

Temporary notes

Assign participant to therapists	
☐	admin
☐	Oskar Flygare [4]
☐	Test Therapist 1 [2]
☐	Test Therapist 2 [2]
☐	Test Therapist 3
☐	Test Therapist 4

Save

Figure 2.9: Therapists can generate secure passwords for patients using the “change password” button

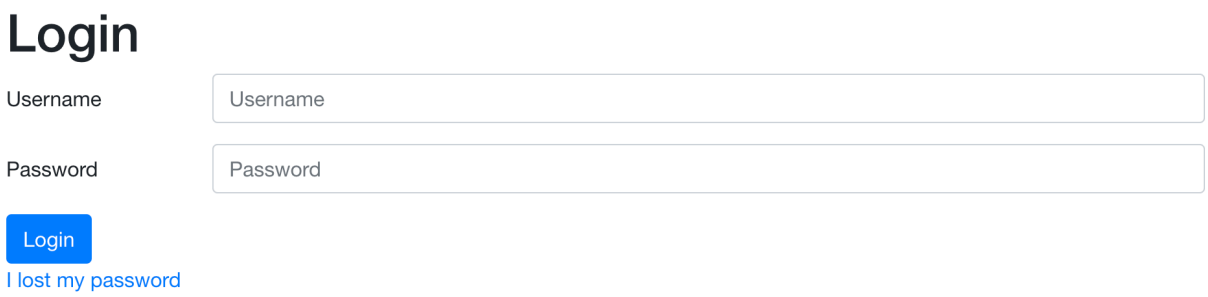


Figure 2.10: Patients can click the "I lost my password" text to receive a new password.

2.13.2 Using the technology as a patient

The landing page for patients includes basic information about the treatment, whether they have been granted access to new modules or have received new messages.

In the menu bar at the top of the page, patients can easily navigate the platform, view treatment content, report problems, and see the *Privacy Notice*.

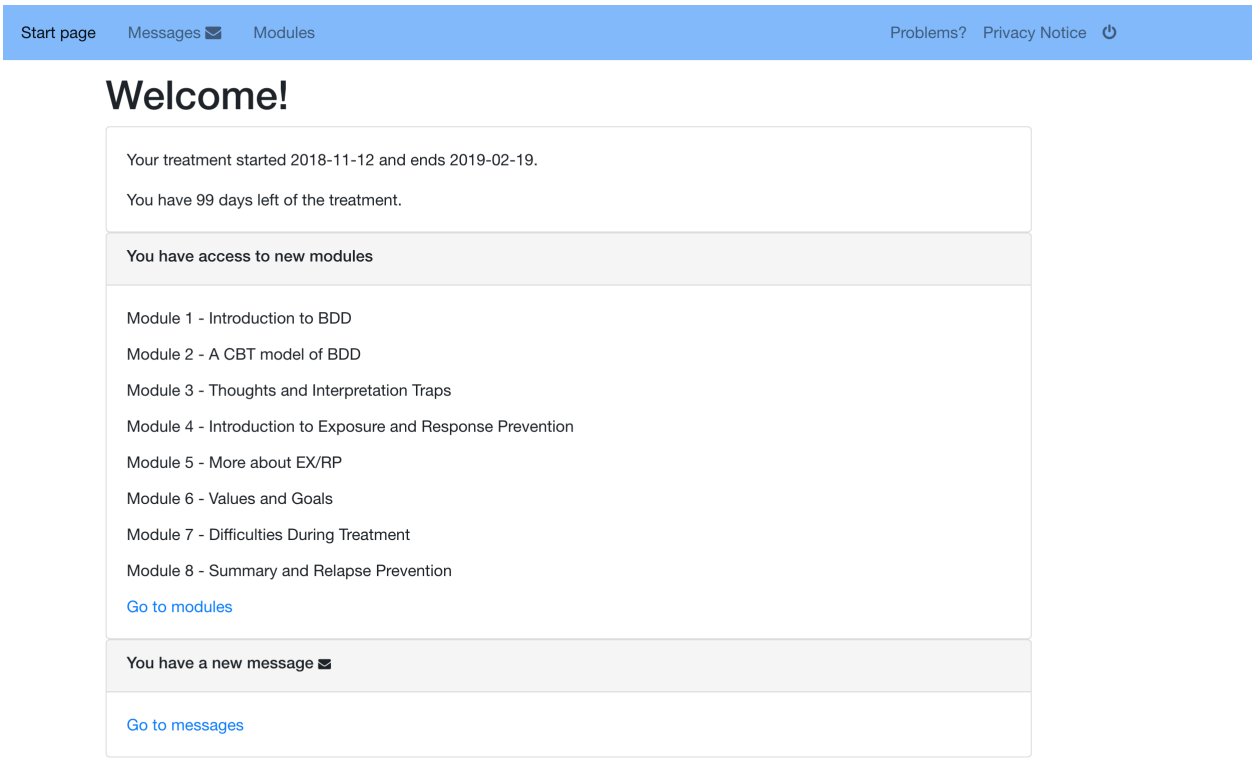


Figure 2.11: Landing page for patients

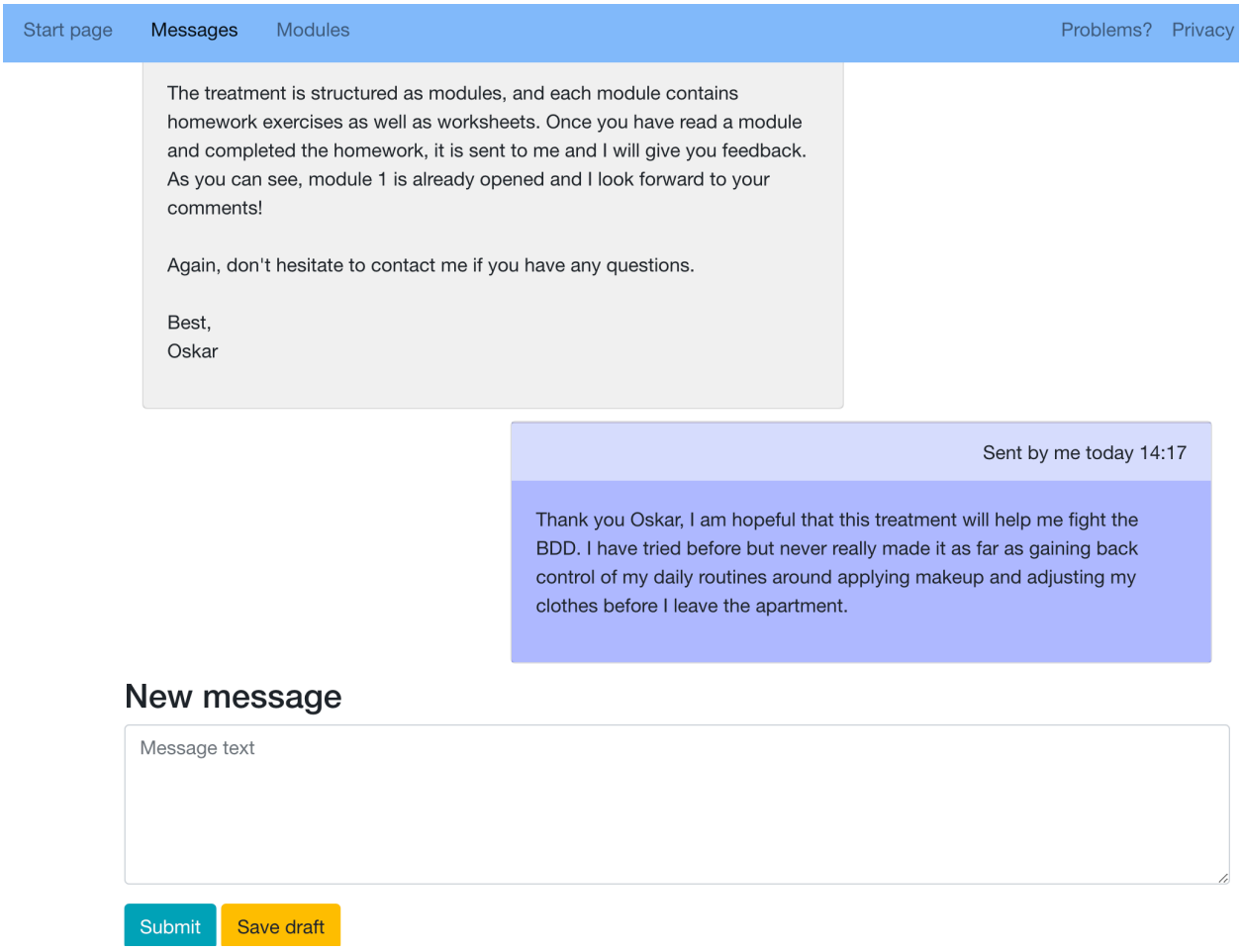


Figure 2.12: Messages in the patient platform

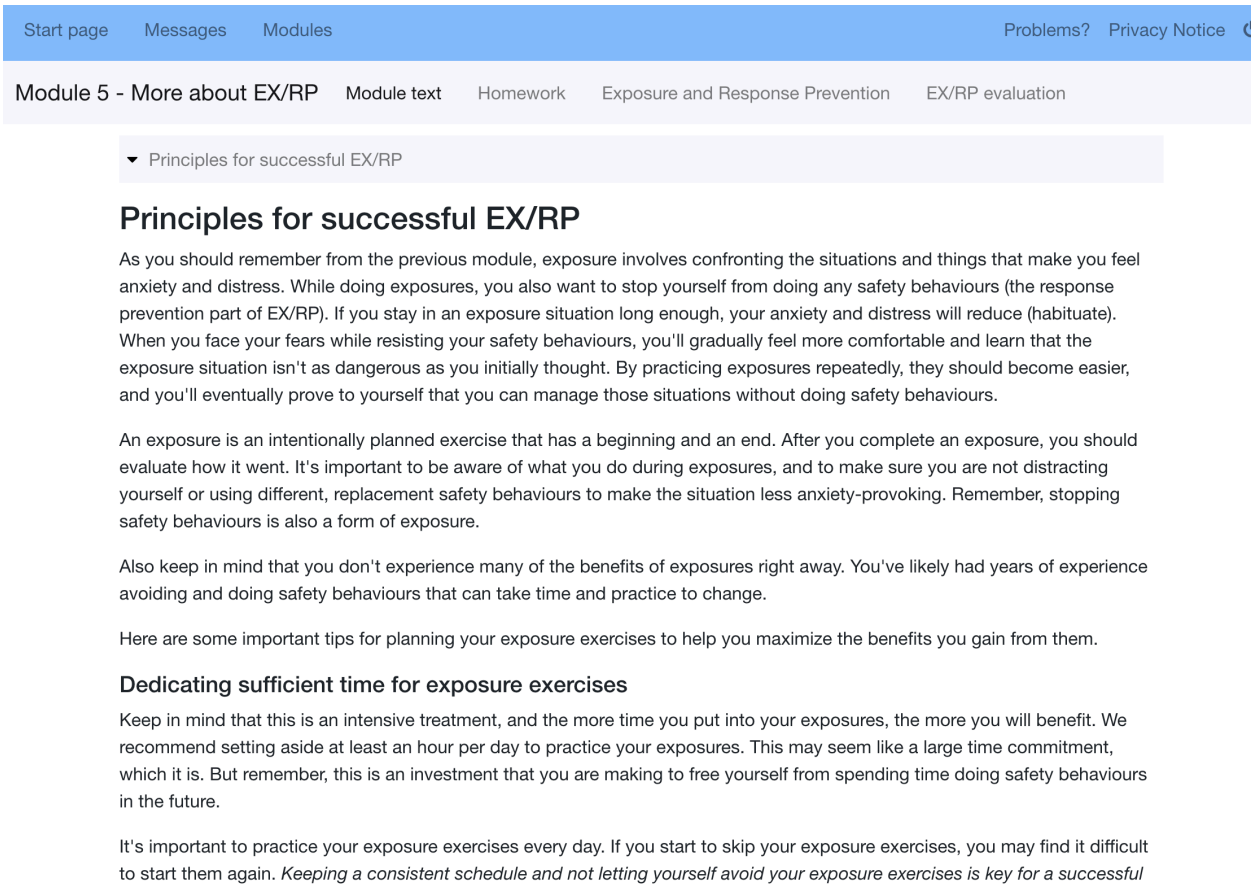


Figure 2.13: Module text

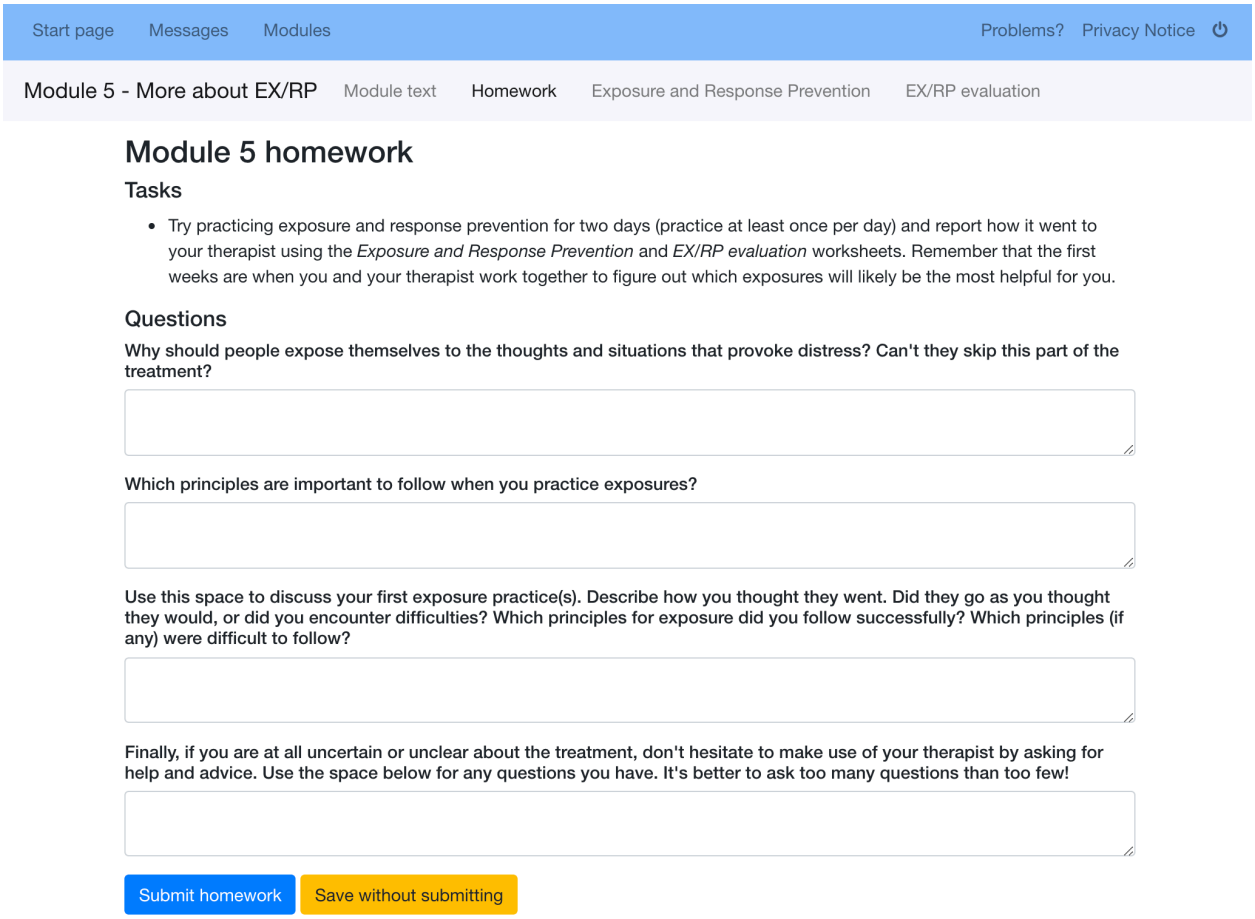


Figure 2.14: Homework assignments

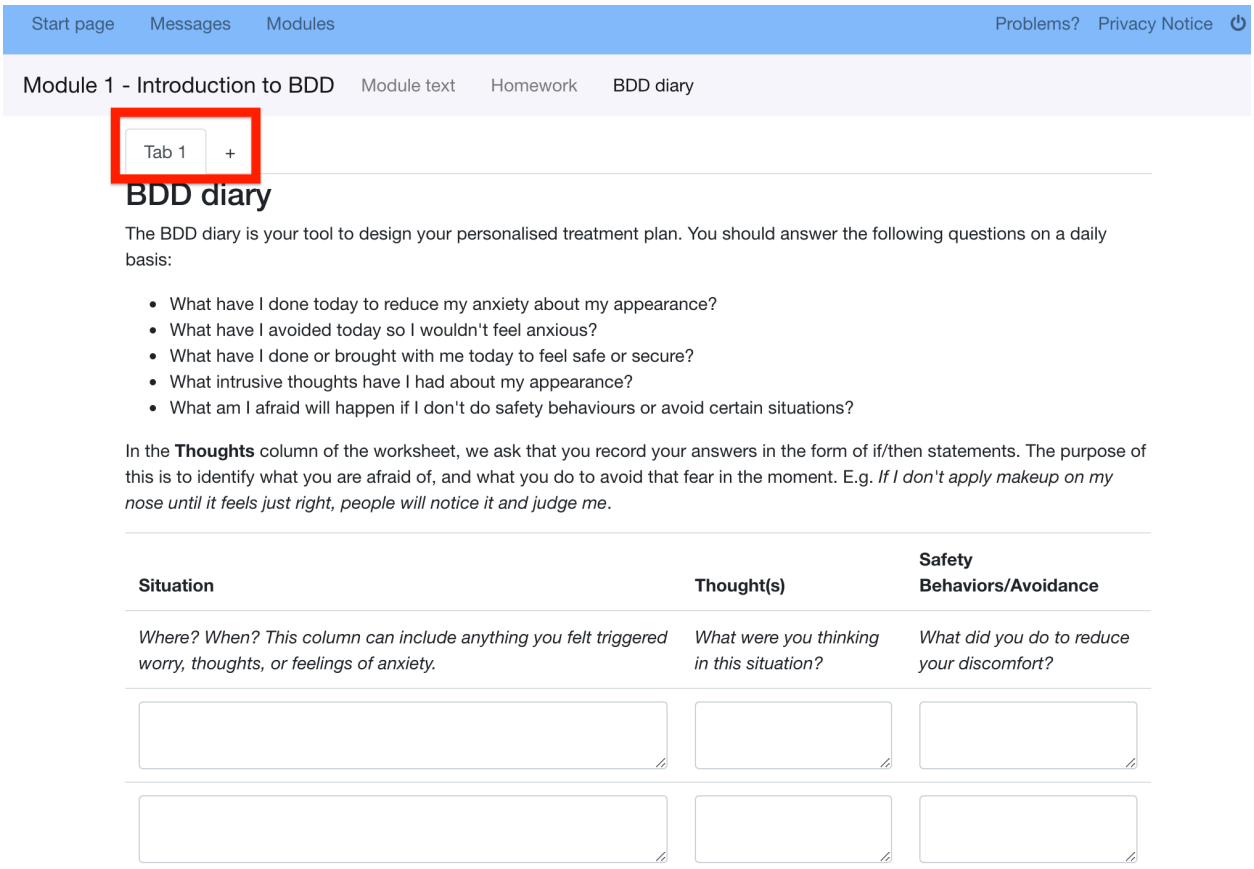


Figure 2.15: Worksheets, patients click the + sign to add new tabs with information

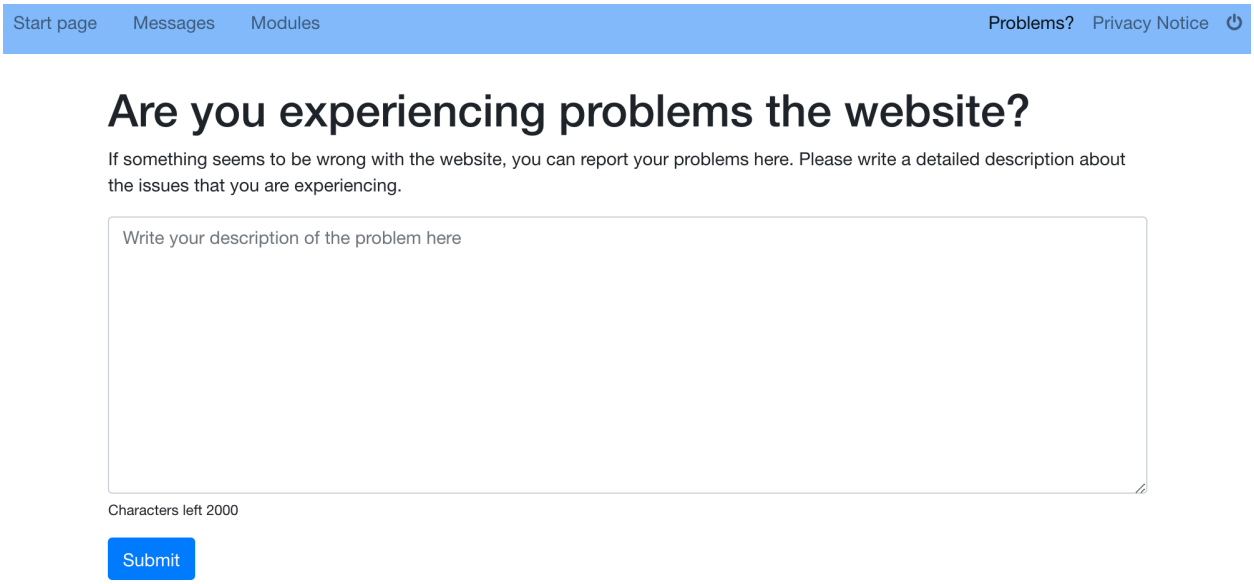


Figure 2.16: Patients can report problems, which will display as a flag in the therapist view

Chapter 3

OCD-NET therapist manual

3.1 What is OCD-NET?

The treatment in OCD-NET is based on established treatment protocols for OCD (Foa et al., 2012), and focuses on exposure with response prevention (ERP). This means patients do most of the active treatment work away from their computer or mobile device, for example when they are performing exposure and response prevention exercises.

3.2 Who is suitable for OCD-NET

OCD-NET has been developed to treat adult patients with OCD. In previous trials evaluating OCD-NET, participants have had comorbid conditions such as depression and anxiety. Patients may also take antidepressant medication during the course of treatment. We recommend that patients do not change the dose during the course of treatment. OCD-NET may also be delivered to patients with any level of OCD symptom severity. OCD-NET is text-based and requires sufficient reading skills and understanding of English. The intended use of OCD-NET is within a stepped-care model where patients are offered low-intensity treatments as a first step, see the NICE-guidelines.

3.3 Who is not suitable for OCD-NET

We recommend that the patient is assessed and managed according to local clinical guidelines if there are indications that OCD-NET may not be a suitable treatment option. In some cases, treatment can be delayed if an issue is expected to be resolved in a timely manner, for example if a patient will have sufficient time to work on the treatment in a few weeks time. Indications that an individual is not suitable for OCD-NET include:

- Moderate to high suicidal ideations where written contact with a therapist 1-3 times per week is not enough to safely monitor and address risk.
- Expresses low motivation, has attention deficits, or marked lethargy.
- Does not have sufficient time (about 45min/day) to work on treatment.

- Psychosis, bipolar disorder, untreated substance use disorder, or other severe clinical condition that might interfere with treatment.
- Severe depression (e.g., MADRS 35).
- Another ongoing psychological treatment.

3.4 Presenting OCD-NET as an option to the patient

It is important to stress that previous trials of OCD-NET have been conducted on patients that have actively requested internet-based treatment when giving this option. Thus, forcing someone to undertake a treatment they do not agree with is unhelpful at the very least and can also be harmful.

With that in mind, we believe there are two particularly strong arguments for the use of OCD-NET rather than face-to-face therapy: patients can access the treatment content and therapist therapist support whenever they want to, and treatment can start right away rather than after a waiting time.

We have also found that many patients like to contribute to research and the development of new treatments. For example, most patients will see the benefit of evaluating remote treatment options.

Other suggestions:

- Write your first message on the first day of treatment to welcome the patient and notify them of ways to contact you with questions
- Provide encouragement throughout treatment to motivate the patient and establish a therapeutic working alliance

3.5 Modules in OCD-NET

There are 10 modules in OCD-NET, which patients are expected to complete in 12 weeks. Each module consists of texts and uses well established evidence based interventions for OCD, with exposure and response prevention (ERP) being the core intervention. To progress to the next module participants have to complete homework assignments (such as reading text material, answering a quiz at the end of each module, completing worksheets, or report about ERP exercises) which are viewed by their therapist. A patient is ready for the next module once they have demonstrated the key knowledge and skills through homework, worksheets and/or messages to the therapist.

Treatment module	**Content**	**Key knowledge and skills**
1. Introduction to the treatment	Introduction to CBT Information about OCD	Identifying obsessions and compulsions
2. A CBT model of OCD	Psychological model of OCD with patient examples	Understanding the role of compulsions in maintaining OCD
3. Thinking mistakes in OCD	Common cognitive biases and unhelpful interpretations of thoughts in OCD	Understanding how interpretations can exacerbate anxiety
4. Introduction to ERP	Goal setting Planning ERP exercises	Understanding the rationale for ERP Setting specific, measurable goals for treatment
5. More about ERP	Best practices in ERP	Understanding why it is important to repeat ERP exercises Gradually increasing the difficulty of ERP exercises

Treatment module	Content	Key knowledge and skills
6. Imaginal exposure	Instructions to get started with imaginal exposures	Understanding when imaginal exposure is a useful ERP strategy
7. Re-exposure	Undoing habitual compulsions	Applying re-exposure techniques in ERP exercises
8. Difficulties during treatment	Common problems in ERP Motivation traps	Problem-solving skills for common problems in ERP
9. Long term goals and values	Increasing valued behaviours Aligning ERP exercises with long term values	Adding valued behaviours to weekly plan
10. Summary and wrap up	Maintaining progress Relapse prevention	Understanding that improvements can occur after treatment if ERP is practiced continuously

We view modules 1, 2, 4, and 5 as the core modules in OCD-NET. Modules 1 and 2 consist of two essential features: the patient needs to report at least some intrusions/compulsions in the OCD diary, and the patient needs to understand the CBT model of OCD. These two features are the building blocks for the subsequent ERP exercises in module 4 and 5. We usually recommend patients to do modules 1-5 in a relatively quick pace in order to get to the active treatment as soon as possible. It is not crucial to have a detailed plan for each ERP exercise before starting; you should encourage patients to get started and fine-tune ERP exercises as they go along.

You can consider modules 3 and 6 as optional for the patient. We advise all our patients to read the text in module 3 (thinking mistakes), but if the patient does not feel that this cognitive intervention is relevant for them, we proceed directly to module 4 (ERP). Module 6 (imaginal exposure) may be beneficial for some patients but our experience is that many patients skip this intervention. Although the text is written from a habituation lens, we often tell our patients that imaginal exposure may be a tool to learn that having a thought or image is not the same as acting that way, and to tolerate uncertainty.

The number of completed modules is not an essential predictor of treatment outcomes in OCD-NET. We have two goals only: get the patient to module 5 and get the patient to do a lot of ERP exercises. Thus it is not essential that the patient progress through all modules as long as he/she does ERP and reports this frequently to the therapist. Patients will gain access to all modules at the end of treatment, and will be able to log onto the platform for one year after completing the OCD-NET treatment. Thus, the role of the therapist is to encourage the patient to do ERP exercises and help them to design and evaluate ERP exercises effectively.

Modules 6-9 can be opened in any order to fit the needs of each patient. For example, a patient might not have any use of imaginal exposure but finds that they have a hard time refraining from habitual compulsions. In that case, you may open up module 7 (re-exposure) instead of module 6 (imaginal exposure). Other patients may struggle with ERP exercises and will find module 8 (difficulties during the treatment) useful. Use your clinical judgement and discuss with your supervisor.

3.6 Closing remarks

We hope that you have found this therapist guide useful. Our goal has been to present a few ideas about how to deliver OCD-NET effectively. These are just the first building blocks and you will likely find that adaptations are needed to your particular patients and your own style as a therapist.

We strive to continuously update and improve this material and would appreciate any feedback. You can reach us at ocdnet.support@webcbt.se or talk to us in person at a training session.

Chapter 4

BDD-NET therapist manual

4.1 What is BDD-NET?

BDD-NET is a therapist-guided internet-delivered cognitive behaviour therapy that consists of eight interactive modules and focuses on exposure with response prevention (ERP). This means that patients do most of the active treatment work away from their computer or mobile device, for example when they are performing ERP exercises.

4.1.1 Differences between BDD-NET and other psychological treatments for BDD

BDD-NET is based on two existing treatment manuals for body dysmorphic disorder (BDD) (Veale and Neziroglu, 2010; Wilhelm et al., 2013) and includes cognitive as well as behavioural techniques. Exposure and response prevention (ERP) techniques are emphasised in BDD-NET because they provide concrete exercises for patients to complete. Results from the two clinical trials of BDD-NET (Enander et al., 2014, 2016) suggest that ERP is an effective strategy in this guided self-help treatment. Within the ERP exercises, we suggest that therapists maximise inhibitory learning (Craske et al., 2014) by focusing on the new insights that patients get from ERP, rather than habituation.

ERP and other techniques in BDD-NET are most effective in patients with at least moderate insight into their BDD who are ready to try new behaviours. For patients with delusional BDD or those that express low commitment to change, other treatment options should be considered (see chapter 14 in Veale and Neziroglu (2010) for a discussion of these issues).

4.2 Who is suitable for BDD-NET

BDD-NET is developed to treat adults with BDD. Patients may have comorbid conditions, for example other anxiety disorders, depression, or obsessive compulsive disorder. Patients may also take antidepressant medication during the course of treatment. We recommend that patients do not change the dose during the course of treatment. BDD-NET may also be delivered to patients with any level of BDD symptom severity. The intended use of BDD-NET is within a stepped-care model where patients are offered low-intensity treatments as a first step, see the NICE-guidelines. BDD-NET is text-based and requires sufficient reading skills and understanding of English.

4.3 Who is not suitable for BDD-NET

We recommend that the patient is assessed and managed according to local clinical guidelines if there are indications that BDD-NET may not be a suitable treatment option. In some cases, treatment can be delayed if an issue is expected to be resolved in a timely manner, for example if a patient will have sufficient time to work on the treatment in a few weeks time. Indications that an individual is not suitable for BDD-NET include:

- Moderate to high suicidal ideations where written contact with a therapist 1-3 times per week is not enough to safely monitor and address risk.
- Expresses low motivation, has attention deficits, or marked lethargy.
- Does not have sufficient time (about 45min/day) to work on treatment.
- Psychosis, bipolar disorder, untreated substance use disorder, or other severe clinical condition that might interfere with treatment.
- Severe depression (e.g., MADRS 35).
- Another ongoing psychological treatment.

4.4 Presenting BDD-NET as an option to the patient

It is important to stress that previous trials of BDD-NET have been conducted on patients that have actively requested internet-based treatment when giving this option. Thus, forcing someone to undertake a treatment they do not agree with is unhelpful at the very least and can also be harmful. Below are aspects that therapists might want to consider before patients start BDD-NET.

4.4.1 Assessing insight

Participating in internet-based treatments such as BDD-NET is voluntary, and therapists need to make sure that patients are willing to challenge their BDD in treatment. Lack of insight is common in BDD and BDD-NET is designed to work for patients that express varying degrees of insight. It is our experience that patients need to at least be willing to try out alternative behaviours during the course of treatment, even if they might still be convinced that their appearance concerns are justified at the start of treatment.

4.4.2 Managing expectations

Some patients may have expectations to be completely free from anxiety after BDD-NET, and that all that is required of them is to read and understand what is written in the treatment modules. Such expectations are discussed in module 4 (goal setting) but therapists are advised to assess whether patients are willing to challenge their BDD through exposure with response prevention and try out alternative behaviours before starting BDD-NET. If someone completely refuses to try new behaviours they are unlikely to actively participate in BDD-NET and benefit from the treatment.

4.4.3 A good start in BDD-NET

Many patients with BDD find BDD-NET an interesting treatment option, particularly those who avoid many activities due to their appearance concerns. The strongest arguments in favour of ICBT treatments

like BDD-NET, from a patient perspective, is that the treatment content and the therapist are accessible throughout the week, and that the treatment starts promptly after evaluation rather than after a time in waiting list.

To give patients a positive first impression of the treatment, we suggest that therapists write their first message on the first day of treatment to welcome the patient and introduce treatment content. Provide encouragement throughout treatment to motivate the patient and establish a therapeutic working alliance. Patients sometimes struggle with crucial treatment components such as the BDD diary exposure with response prevention (ERP), and therapists should provide extra support at those points, if needed.

4.5 Modules in BDD-NET

Below is an overview of the eight treatment modules. We recommend that therapists look at them from a patient's point of view before starting the first treatment. A patient is ready for the next module once they have demonstrated the key knowledge and skills through homework, worksheets and/or messages to the therapist.

Treatment module	**Content**	**Key knowledge and skills**
1. Introduction to BDD and the treatment	An introduction to BDD Introduction to the treatment content	Identifying safety and avoidance behaviours
2. A CBT model of BDD	Psychological explanation of the link between thoughts, emotions, and behaviours	Understanding how safety and avoidance behaviours maintain BDD
3. Interpretation traps	Common cognitive biases in BDD	Understanding how interpretations can exacerbate anxiety
4. Introduction to ERP	Goal setting and planning of exposure with response prevention	Understanding the rationale for ERP Formulating specific and measurable goals for treatment Planning a first ERP exercise
5. More about ERP	Doing and evaluating ERP exercises	Doing ERP Understanding the importance of repeated ERP exercises
6. Values and Goals	Identifying and acting in accordance with personal values	Adding valued behaviours to weekly plan Understanding the difference between values and goals
7. Difficulties during treatment	Strategies to deal with common difficulties and setbacks	Problem-solving skills around common difficulties in ERP
8. Summary and Relapse Prevention	Treatment summary, evaluation of treatment, and designing a relapse prevention plan	Understanding that improvements can happen after treatment Understanding the role of continuous ERP in maintaining progress

The emphasis is on doing exposure with response prevention (ERP), which we view as the main component of BDD-NET. We suggest that therapists encourage patients to progress through the first three modules as fast as possible (preferably in two weeks or less), check that they have understood the rationale for ERP, and then start doing ERP. Once patients are doing regular ERP-exercises, therapists can open up modules 6-7 for them to complete while continuing to do daily ERP. Module 8 can then be opened up with one to two weeks left in treatment.

4.6 Closing remarks

The strategies outlined here should be viewed as the first building blocks in becoming an effective ICBT therapist using BDD-NET. As in regular clinical practice, we recommend continuous supervision and that therapists discuss difficult cases with colleagues.

We strive to continuously update and improve this material and would appreciate any feedback. You can reach us at ocdnet.support@webcbt.se or talk to us in person at a training session.

Chapter 5

Being an effective ICBT therapist

Being a therapist in internet-based CBT (ICBT) differs in several ways from regular face-to-face treatment. The first difference is the mode of communication: asynchronous text messages rather than live face-to-face talking. The second is that therapists are more closely integrated in the treatment content, and will rely more heavily on the written material. Third, there is less therapist oversight during active ERP exercises. We will discuss these implications, and give examples on effective messages in different scenarios, below.

5.1 Support messages

Therapists should write to patients on their first day in treatment, introduce themselves (if they have not been in contact before) and present the treatment. For example, therapists can give instructions for how to navigate the platform, how much time the patient should spend on the first module, and how to contact mental health services in case of an emergency.

Click to read an example of the first message sent to a patient

Welcome to the treatment!

My name is Oskar and I will be your therapist during the 12 weeks that you are in treatment. You can write messages to me whenever you have questions or want to discuss the treatment content. I check the platform every day and will respond as quickly as I can.

The treatment is structured as modules, and each module contains homework exercises as well as worksheets. Once you have read a module and completed the homework, it is sent to me and I will give you feedback. As you can see, module 1 is already opened and I look forward to your comments!

Again, don't hesitate to contact me if you have any questions.

Best, Oskar

We recommend that therapists check and respond to messages at least once per day. Patients in the studies on BDD-NET and OCD-NET have all received responses within 24 hours on weekdays. We believe that the frequent feedback from a therapist is important to keep patients engaged in the therapy throughout treatment.

The most common questions that patients pose in ICBT relate to understanding and applying the treatment material, clarifying the therapeutic process, and addressing technical challenges (Soucy et al., 2019).

5.1.1 Keep your messages short

Messages should be concise and to the point but still using a personal touch. The main aim is to provide encouragement and reinforce key behaviours in the treatment, such as registrations in the OCD/BDD diary and performing ERP exercises.

There are some exceptions to this rule. Therapists are advised to write longer messages when needed: to highlight examples in the diary that are informative and relate these to the CBT model of OCD/BDD, or to provide encouragement by linking ERP exercises to a patient's long-term goals and values.

5.1.2 Write often

Frequent communication is particularly useful at the start of treatment and when patients are in the startup phase of ERP. In many ways, ICBT may be an even more intensive treatment than traditional face-to-face CBT for patients. Our standard procedure is to contact patients at least twice weekly, but more often when needed. For example, therapists may confirm an exposure exercise in the morning and check in during the afternoon for a follow-up.

There are exceptions to the rule of frequent messages: some patients will prefer to do ERP exercises on their own and will not have many questions. This is perfectly fine; some patients benefit greatly from the ICBT treatment without the therapist support.

Click to read an example of a short message that is highly encouraged in OCD-NET and BDD-NET

Hi! I'm just checking in to follow-up how your exposure exercises have gone so far. Please let me know, I look forward to hearing from you. I will be checking in later today!

5.1.3 What to include in support messages

We recommend that therapists begin by summarising the content in the patient's message and validate concerns and/or struggles they may have mentioned. Therapists should then address and provide feedback on specific treatment activities (completing content on the platform or practicing skills from treatment in their daily life), with an emphasis on positive reinforcement and encouragement. An effective ending typically includes a suggestion of next steps, encouragement to continue with planned exercises, a question, or a call to action.

What to include in support messages
Summarise the main points or questions of the patient's message
Validate concerns and/or struggles mentioned
Provide positive feedback and encouragement on engagement with the treatment and practice of treatment skills
End with a call to action, suggestion of next steps, or a question

Click to read a typical answer to the first module in OCD-NET

Thank you for completing the first module. You have answered all the questions correctly and given an accurate description of OCD. Well done!

Your most important task for the coming week is to fill in the OCD diary each day. This is the foundation of the active treatment phase that will begin later. Filling out the OCD diary can sometimes provoke anxiety, but please remember that it is a necessary first step on your way to lasting changes in your life.

I have unlocked module 2 for you now. I look forward to working together during the coming weeks!

Click to read a typical answer to the first module in BDD-NET

Great answers to the questions in module 1! You write that you recognise your own experience in the examples given, which is a sign that this treatment is a good fit for you. In the first modules, we provide information about BDD that might be obvious for someone who has first-hand experience of the condition. Still, it is useful to know about the perspective we will have in this treatment. You will learn more about the psychological model of BDD in the next module.

Again, good job on module 1! I have opened up the next module and look forward to hearing back from you soon.

5.2 Promoting hands-on ERP exercises

The most important task as an ICBT therapist is to reinforce approach behaviours and active engagement with the treatment content. It's preferable that patients learn key concepts and techniques through practice; a completed exposure is better than waiting for the perfect exposure.

Therapists should be cautious about providing too much information and detailed feedback at the expense of actionable advice that patients can put into practice. For example, a lack of clarity in an ERP exercise or choosing the wrong ERP exercise could result in the patient getting stuck and asking questions. A therapist could then address both the uncertainties and promote behaviour change through ERP by suggesting a variation of the ERP exercise or suggesting a new one. This is likely to be a more effective strategy compared to just addressing the questions one by one without linking them to ERP exercises or behaviour change. Wrinkles can be ironed out along the way. We have provided examples on therapist answers to common clinical issues in the sections that follow.

5.3 Reinforcing progress

Therapists are advised to provide lots of encouragement when patients complete core activities in ICBT such as the OCD/BDD diary and performing ERP exercises. It is helpful to clarify how these activities contribute to the patient's long-term goals, to repeat main takeaways from the modules, and to communicate in a personal tone in order to avoid rigid responses. For example, we often give personal examples of intrusive thoughts (preferably bizarre ones) in order to normalise that having unwanted thoughts is not dangerous.

Click to read an example of a therapist response that reinforces progress in module 3

Hi! It's great to see that you work through the material so quickly and are eager to get started with exercises!

You have done a thorough job on this module about interpretations. It's clear to me that you have embraced the CBT-perspective on thoughts: it is not the thoughts themselves but how we **interpret** *those thoughts that matters. The problems occur when we respond with compulsions and other behaviours in response to the intrusive thoughts, which reinforces the thoughts.*

In this treatment, we will not try to change the thoughts themselves, for example by trying to disprove them. Obsessive thoughts resist logic and will not disappear just by arguing with yourself. Rather, the goal is for you to gain new experiences by responding differently to the obsessive thoughts.

Great work on module 3, I have granted access to module 4. Good luck and please reach out if you have any questions!

Click to read an example of a therapist encouraging a patient to accept their obsessive thoughts

Hi X! Trying to avoid or fight your obsessional thoughts usually backfires. These strategies intensify the obsessions and keep you convinced that these thoughts are more harmful, dangerous, and important than they really are. You become stuck in a vicious cycle.

My suggestion is that you try to accept your obsessive thoughts. Strive to accept the thought "what if I flirted with that person?" and accept the possibility that you might have flirted. Don't try to debate or argue with

your obsessive thoughts. By accepting the thought, you might conclude that "yes, I might have flirted with several people, I have to accept that possibility."

This is not an easy thing to do, and our automatic response is usually to argue with our thoughts. But if you constantly try to argue or debate with your obsessive thoughts–or in any other way try to make them go away–they will find a way back sooner or later. Try to let your obsessive thoughts exist along every other thought and accept that they occur from time to time. What do you think?

5.4 Common clinical issues

This list is based on our clinical experience of developing and working with ICBT for OCD and BDD. We will update the list when we become aware of other common issues, so please discuss difficult cases with your colleagues and in supervision. If you want to make us aware of a common clinical issue not listed below, send an email to ocdnet.support@webcbt.se.

5.4.1 Patients who ask many questions

Asking questions to get reassurance is a common strategy for anxiety reduction in both BDD and OCD. Therapists should therefore expect more frequent questions from patients when anxiety levels are likely to be high: in the beginning of treatment (when they learn more about their OCD/BDD), and when they are about to start ERP exercises. For example, it is common for patients to ask whether their OCD/BDD beliefs are realistic or not, and whether a particular ERP exercise is safe to do. When this is the case, we recommend that therapists validate the anxiety patients feel when they challenge their OCD/BDD, but that they refrain from providing reassurance.

Click to read a therapist response when a patient asks if just talking about the obsessions means that the feared outcome is likely to happen

Hi! First of all, excellent work on filling out the OCD diary. This is a cornerstone in treatment and gives you important information for when you plan and do exposure exercises. Keep it up!

You write that thinking about the obsessions makes them stronger and it feels like you will go crazy from the anxiety. You are not alone in this, and I understand that having more obsessions than usual is very stressful when you are doing a lot of behaviours to avoid having them.

Sometimes this can occur when we try to suppress the thoughts, or force them out of our mind by trying to focus on something else. However, this strategy often backfires and makes the obsessions even stronger in the long-term, since you are constantly reminded of what you are trying to avoid, and you act as if the obsessions are dangerous. Do you recognise this scenario?

We propose a different perspective in this treatment: that we treat the obsessional thoughts as any other thought, and that we, rather than trying to control or suppress our thoughts, accept that our brain sometimes produces unpleasant thoughts that are nonetheless harmless. You will read more about this in modules 2 and 3. I have opened up module 2 now and look forward to hearing what you think!

Click to read an example of a therapist writing about his own bizarre thoughts

Hi X! It's impossible to **not** *think certain thoughts. It is likely that you will always have intrusive sexual thoughts about people close to you. It's part of being human and I want to remind you to accept that you have those thoughts from time to time. As soon as you try to argue with your thoughts or try to analyse them you will be trapped and the thoughts will be disturbing.*

Every morning when I walk my daughter to school, I get an intrusive thought that I might throw her off a bridge. I can't avoid thinking these thoughts, and I know that if I start to argue with them or try to make them go away, they will return and become more disturbing. So instead I accept them and let them exist among my other, more neutral or positive, thoughts. This is what I want you to try from now on!

You have done a great job on the exposures these past days and I think that the content in module 9 will be helpful for you.

Other times, there is genuine confusion about the point of a particular ERP exercise or the content in a module (most common in the modules about interpretations). When this is the case, make sure that the patient has learned key skills and takeaways needed for ERP: understanding the CBT model and the role of safety behaviours/compulsions in maintaining the disorder, the rationale for ERP, having specific and measurable goals, and having a plan for ERP exercises. Once these foundations are in place, therapists should encourage patients to get started with ERP and adapt exercises as they go along.

Click to view an example of a therapist explaining the rationale for imaginal exposure

Imaginal exposures are a bit special, the point is not for you to **not** *have an emotional reaction to the thoughts. These aggressive thoughts are unpleasant for anyone, and it is likely that you will always experience the thought as repugnant. Rather, the point is for you to practice to let the thought exist without acting on it. By working on imaginal exposures, you accept that you will have unpleasant thoughts from time to time and that you don't need to act on them. The point, then, is that the thought is unpleasant but you can let it exist anyway. We are not able to control our thoughts and trying to do so usually backfires. Imaginal exposure presents another way to relate to your unpleasant thoughts.*

5.4.2 Patients who struggle with ERP exercises

Behaviour change is difficult, and when patients start to challenge their OCD/BDD with ERP they are likely to experience the exercises as difficult at some point. In fact, a patient that never has any difficulties in ERP is likely not doing exercises that are challenging enough!

There are entire modules dedicated to common difficulties during treatment, and therapists can refer to the text in those modules for suggestions on how to respond when patients experience difficulties. We recommend that therapists open up the module on common difficulties if the patient's concern is addressed in the module, even though the patient has just reached module 5.

Click to read an example of a therapist response when a patient has expressed worry about doing the right ERP exercises

Hi, excellent work so far! Having thoughts about not doing the right ERP exercises is something that most patients experience at one point or another. This is to be expected and something that your brain does when you perform ERP. You can view them as one type of obsessive thoughts that we deal with in the same way we deal with all obsessive thoughts: we let them exist and leave them alone.

(Gives a few suggestions of ERP exercises–previously listed in the exposure hierarchy–to be performed the same day.) Perhaps you could do one of these exercises today? I look forward to hearing about how it went!

Click to read an example therapist response when a patient feels like an exposure exercise is too difficult

Hi, thank you for reaching out! You are now in the active phase of treatment where most of the progress happens, and by doing exposure exercises you are giving yourself the best possible chances of getting better. Keep it up!

You mentioned that you had to stop the exposure earlier than planned because the anxiety was stronger than you had anticipated. This is part of the trial and error phase when you are just getting started with exposure exercises. There's lots of valuable information here: you have learned more about the triggers of your most distressing obsessions and you know which compulsions are the hardest to resist.

Let's think about the next steps. An idea that comes to mind right away is that, next time, you can apply the re-exposure technique if you find it difficult to resist the compulsions in the moment. Another option would be to do an easier exposure next time and try to resist your compulsions for a longer time. What are your thoughts, do you have a strategy for your next exposure? I look forward to hearing from you and will be here to help you throughout treatment!

5.4.3 Low engagement

The best way to deal with low engagement is to prevent it from happening to begin with. Strategies to prevent low engagement include:

1. Writing frequently (especially in the beginning of treatment in order to keep up momentum)
2. Focusing on encouragement in written messages
3. Promptly calling patients that do not respond to messages
4. Providing support and help to patients that struggle with ERP exercises

If a patient becomes less active on the treatment platform, it does not necessarily mean that they have stopped working with the treatment or have given up on the treatment. Some inactive patients are doing a lot of treatment work in their daily life but do not report this spontaneously to their therapist.

5.4.4 Lack of time to work on the treatment

One common reason for low engagement is that the patient struggles to find the time to work on ICBT. We recommend that therapists encourage any small steps the patient takes and that they prioritise ERP exercises away from the computer over reading additional modules.

If a patient is completely unable to work on the treatment right now, ask him/her if it possible to delay the start of treatment. The absolute majority of patients responding to OCD-NET and BDD-NET experience this gain within the first 5 weeks after starting treatment. Thus, even if the patient is delayed and start the treatment at week 5, it is still possible to achieve a significant improvement given that the patient works with the treatment intensively during the remaining weeks.

Click to read a therapist response when a patient writes that they might not have time to work on the treatment

Hi, thank you for reaching out. It sounds like you have a hectic schedule right now and I understand that it might be difficult to find time for the treatment with everything that is going on.

Our recommendations regarding the pace to complete modules is what we have learned works for most people, but it is not a one-size-fits-all. You can complete the treatment at a pace that suits you!

The treatment lasts for 12 weeks, and after that you will no longer be able to write to me via the platform. Even if you don't complete all the modules during this time, you can still learn about the key insights from modules 1 and 2, and try a few exposure exercises in modules 4 and 5. This will give you a good start when continuing to work towards your long-term goals. Keep in mind that the treatment materials will be available for one year after the active treatment phase, giving you plenty of time to implement the strategies in your life.

How does that sound? Can you commit to reading the core modules and trying a few exposure exercises during the treatment period? Perhaps you can schedule time to read the next module in the week to come?

5.4.5 Skepticism about ICBT

Some patients may be skeptical about ICBT in general or in their ability to complete a remote treatment without face-to-face support from a therapist. We recommend that therapists validate and acknowledge that these concerns are common early in treatment and, importantly, help skeptical patients experience *early wins* by starting with swift and easy ERP exercises.

Click to read an example response to a patient that is ambivalent towards CBT

Hi X! I notice that you are ambivalent about doing this treatment and that you have some doubts whether CBT will really help you. First of all, I really appreciate that you are honest about this!

It is completely normal to be ambivalent early in the treatment. Most people feel that their rituals are excessive and out of control, but still worry that a disaster might happen if they stop doing them. Others might be afraid that they will be asked to do absurd things in treatment that is completely against their idea of normal behaviours. Another reason for being ambivalent is not feeling like you have enough time to devote to treatment. If one or more of these apply to you, know that others who have ended up benefitting greatly from the treatment have also been ambivalent.

Overcoming OCD/BDD is challenging, and you will have to face your fears and reduce (or stop) your rituals at some point. But it's worth it. The anxiety and fear provoked by the treatment are temporary side effects, and they don't have any long-lasting harmful consequences. If you engage with this treatment, you have a good chance of reclaiming control and freedom in your life.

My role as your therapist is to support you throughout treatment, and I want to stress that **you** *are the one in the driver's seat. You decide which goals are important to reach, and you will do the work to get better. I therefore ask that you give this treatment a chance and do your best to follow the instructions, because then you will be giving yourself the best possible chances of getting over your OCD/BDD.*

It is important to stress that OCD-NET and BDD-NET have never been designed as full alternatives to face-to-face CBT but should instead be seen as a complementary approach. Patients who are skeptical about ICBT from the beginning will probably not benefit from this treatment modality. Alternative formats and treatments are probably a more feasible option in these cases.

5.4.6 Perceived external pressure

Some patients are pressured to come for an assessment, typically by a close relative or, in the case of BDD, sometimes by a cosmetic surgeon. Patients that are under external pressure to undergo treatment should not be selected for ICBT treatments such as OCD-NET or BDD-NET, since these treatments require self-guided exposure exercises to be effective.

5.4.7 Deterioration in symptom measures

A deterioration in symptom measures can sometimes occur when patients start doing ERP exercises and is usually not an issue if symptoms are reduced in the following weeks.

If symptom levels remain high despite frequent ERP exercises, share this information with the patient and discuss what might explain this pattern. We list some common explanations below.

Reason for increased symptoms	Proposed solution
Subtle avoidance or safety behaviours during ERP	Help the patient identify and remove these by probing mental safety behaviours: *What goes through your mind as you do ERP, are you trying to manage your anxiety in any way?*
Lack of habituation despite proper ERP	Suggest longer ERP exercises or variations of the same ERP exercise Ask for other signs of improvement: *What have you learned from staying in the situation? Have you been able to continue doing valuable things despite having anxiety?*

5.5 Ending treatment prematurely

5.5.1 Due to inactivity

We recommend that patients who have been inactive for **20 days** end treatment. However, the treatment platform will create a flag after 7 days of inactivity to alert therapists. Before ending treatment, there are several steps that therapists can take to avoid long periods of inactivity.

When the inactivity flag appears:

- Ensure that SMS reminders are working properly: Do you still have the correct number? Are the text messages being sent?
- Check previous messages: Has the patient indicated in a previous message that they will be away? Do they have a plan for how to work on treatment while being away from a computer?
- Write a message on the platform where you encourage the patient to log onto the platform and report their progress in treatment.
- Wait 4 days.

4 days after inactivity flag:

- Make a telephone call to the patient. If no response, write a text message with information about when you will call. Then try at the indicated time.
- Send a letter to the patient with instructions to log onto the platform. Provide information that treatment will end prematurely if the patient is inactive for 20 days.

After 20 days of inactivity:

- Check that the assessment dates are correct.
- Write one more message to the patient where you inform that the treatment has ended and ask that they complete assessments.
- Move the patient to "post-assessment" group.

5.5.2 Increased suicidality or self-harm

Patients who express ongoing suicidal thoughts or have ongoing self-harm behaviour should be referred to treatments with more intensive monitoring and are generally not recommended to start ICBT. However, some patients who undergo CBT for OCD and BDD express a short-term increase in suicidal ideation or self-harm behaviour while in treatment.

If this is detected either through patient-therapist messages or in weekly measurements, we recommend that therapists follow local guidelines to assess and manage risk. If a patient requires more intensive monitoring, recurring telephone assessments can be added while continuing with the treatment. In other cases, treatment will need to be ended prematurely in order to manage the increase in suicidality.

5.5.3 Other reasons

A patient may request that they end treatment early for another reason than the two outlined above. Our recommendation is that therapists encourage patients to continue if they express common difficulties (e.g., struggling with the first ERP exercise or is skeptical of OCD-NET/BDD-NET prior to trying ERP for the

first time). Most of these difficulties can be resolved within a week or two with increased therapist support. Seek supervision when necessary.

If a patient asks to end treatment early, call them. Go through the following points in the call:

- What is the reason, are there any misunderstandings about the treatment that you can clarify? Are they concerned about not doing well enough in the treatment? See if you can motivate the patient to at least try a few exposure exercises.

- Does the patient feel that the treatment does not address their main concerns? See if you can understand what type of help the patient wants and assess whether the ongoing treatment is likely to address that or not.

- Is the patient likely to benefit from the treatment if they perform key behaviours (e.g., exposure with response prevention)? If not, it is advisable to end treatment early rather than complete the full duration.

You may come to the conclusion that the treatment is not suitable for the patient (see a list in the OCD-NET and BDD-NET manuals), or that the patient is unlikely to benefit from OCD-NET or BDD-NET. Weekly assessments should then be de-activated on the platform, but keep the post-assessment as is. If no further action is necessary, inform the patient that they will be asked to return to the clinic for a post-assessment after the treatment period is over.

Chapter 6

Technical support

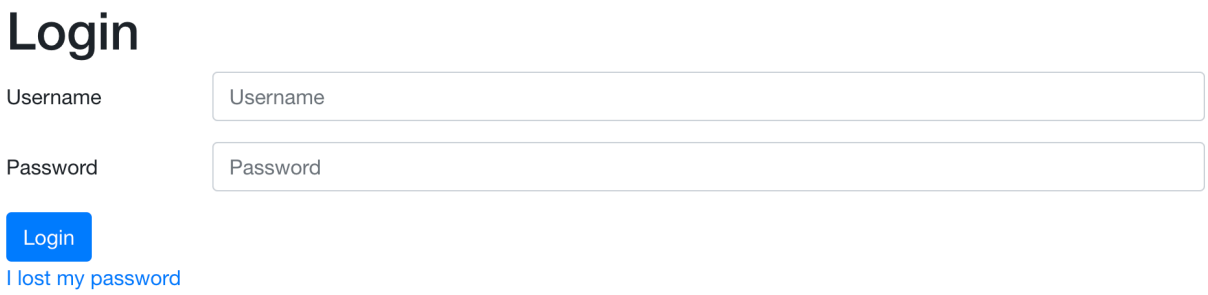
This page contains support for common issues that might arise when using the OCD-NET and BDD-NET treatments.

6.1 Technical support for patients

The platform is designed to be user-friendly for patients with varying technical know-how. They will, however, require technical support from time to time. If patients report technical issues that you cannot address yourself, send an email to ocdnet.support@webcbt.se and ask for assistance.

6.1.1 Forgotten username or password

If a patient has forgotten their password, they can request a new one at the login screen:



If they have forgotten their username, simply look at their *Participant stats* and **Login** is their username.

If a patient is unable to generate a new password on their own, navigate to the patient in question and the *Participant stats* tab. Click the *Change password* button. The site generates a new, secure, password that can be sent to the patient via SMS.

6.1.2 The website does not work

This is usually for one of three reasons: wrong information (URL/username/password), the patient is using an out of date web browser, or there is an issue with cookies on the site.

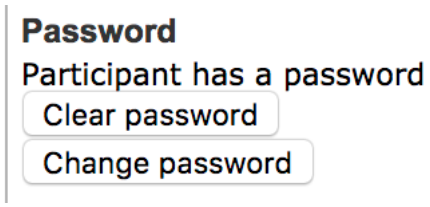


Figure 6.1: Change password button

6.1.2.1 Wrong URL/username/password

Make sure that the patient has correct information for all three. Also make sure that there are no errors in the username!

- URL is https://webcbt.se/ocdnet for OCD and https://webcbt.se/bddnet for BDD
- Username is indicated by "Login" at *Participant stats*
- Their password is hidden to therapists and can be re-generated by patients themselves or by therapists (see above)

6.1.2.2 Recommended web browsers

The treatment is accessible for both desktop web browsers and mobile web browsers (iOS, Android). The platform works best for either **Google Chrome**, **Firefox**, or **Safari**. Internet explorer and Microsoft Edge are not recommended, although newer versions of those browsers usually work just fine.

6.1.2.3 Cookies and cache

Sometimes the browser will save cookies that interfere with access to the treatment platform. This can usually be resolved by clearing cookies and restarting the browser.

- Google Chrome
- Firefox
- Safari desktop
- Safari iOS

6.2 Technical support for therapists

6.2.1 Creating an account

Send an e-mail to us ocdnet.support@webcbt.se containing the following information:

- Username
- Full name
- e-mail
- Phone number (to receive login codes via text messages)

We then create a user and generate a password to be replaced at the first login.

6.2.2 Forgotten password

Admins are able to reset therapist passwords in the *Therapist* tab of the left-hand menu. Click the button called “Must change password” to initiate a password change for that user.

6.3 Other technical issues

Have you spotted an error in the treatment content? Are the questionnaires not displaying correctly? Did you accidentally make some changes that you are not able to revert?

Anything else that is not reviewed in this guide, please let ut know by sending an e-mail to us at ocdnet.support@webcbt.se and we will help you.

We strive to improve the treatment content and the experience for therapists continuously and welcome any feedback!

Chapter 7

References

Bibliography

Andersson, E., Enander, J., Andrén, P., Hedman, E., Ljótsson, B., Hursti, T., Bergström, J., Kaldo, V., Lindefors, N., Andersson, G., and Rück, C. (2012). Internet-based cognitive behaviour therapy for obsessive–compulsive disorder: A randomized controlled trial. *Psychological Medicine*, 42(10):2193–2203.

Andersson, E., Hedman, E., Enander, J., Radu Djurfeldt, D., Ljótsson, B., Cervenka, S., Isung, J., Svanborg, C., Mataix-Cols, D., Kaldo, V., Andersson, G., Lindefors, N., and Rück, C. (2015). D-Cycloserine vs Placebo as Adjunct to Cognitive Behavioral Therapy for Obsessive-Compulsive Disorder and Interaction With Antidepressants: A Randomized Clinical Trial. *JAMA Psychiatry*, 72(7):659.

Andersson, E., Ljótsson, B., Hedman, E., Kaldo, V., Paxling, B., Andersson, G., Lindefors, N., and Rück, C. (2011). Internet-based cognitive behavior therapy for obsessive compulsive disorder: A pilot study. *BMC Psychiatry*, 11(1).

Andersson, E., Steneby, S., Karlsson, K., Ljótsson, B., Hedman, E., Enander, J., Kaldo, V., Andersson, G., Lindefors, N., and Rück, C. (2014). Long-term efficacy of Internet-based cognitive behavior therapy for obsessive–compulsive disorder with or without booster: A randomized controlled trial. *Psychological Medicine*, 44(13):2877–2887.

Craske, M. G., Treanor, M., Conway, C. C., Zbozinek, T., and Vervliet, B. (2014). Maximizing exposure therapy: An inhibitory learning approach. *Behav. Res. Ther.*, 58:10–23.

Enander, J., Andersson, E., Mataix-Cols, D., Lichtenstein, L., Alström, K., Andersson, G., Ljótsson, B., and Rück, C. (2016). Therapist guided internet based cognitive behavioural therapy for body dysmorphic disorder: Single blind randomised controlled trial. *BMJ*, page i241.

Enander, J., Ivanov, V. Z., Andersson, E., Mataix-Cols, D., Ljótsson, B., and Rück, C. (2014). Therapist-guided, Internet-based cognitive-behavioural therapy for body dysmorphic disorder (BDD-NET): A feasibility study. *BMJ Open*, 4(9):e005923.

Foa, E. B., Yadin, E., and Lichner, T. K. (2012). *Exposure and Response (Ritual) Prevention for Obsessive-Compulsive Disorder: Therapist Guide*. Treatments That Work. Oxford University Press, Oxford ; New York, 2nd ed edition.

Patel, S. R., Wheaton, M. G., Andersson, E., Rück, C., Schmidt, A. B., La Lima, C., Galfavy, H., Pascucci, O., Myers, R. W., Dixon, L. B., and Simpson, H. B. (2017). Acceptability, Feasibility and Effectiveness of Internet Based Cognitive Behavioral Therapy for Obsessive Compulsive Disorder in New York. *Behav. Ther.*, pages 1–33.

Rück, C., Lundström, L., Flygare, O., Enander, J., Bottai, M., Mataix-Cols, D., and Andersson, E. (2018). Study protocol for a single-blind, randomised controlled, non-inferiority trial of internet-based versus face-to-face cognitive behaviour therapy for obsessive–compulsive disorder. *BMJ Open*, 8(9):e022254.

Soucy, J. N., Hadjistavropoulos, H. D., Pugh, N. E., Dear, B. F., and Titov, N. (2019). What are Clients Asking Their Therapist During Therapist-Assisted Internet-Delivered Cognitive Behaviour Therapy? A Content Analysis of Client Questions. *Behavioural and Cognitive Psychotherapy*, pages 1–14.

Veale, D. and Neziroglu, F. A. (2010). *Body Dysmorphic Disorder: A Treatment Manual*. Wiley-Blackwell, Chichester, UK. OCLC: 757409960.

Wilhelm, S., Phillips, K. A., and Steketee, G. (2013). *Cognitive-Behavioral Therapy for Body Dysmorphic Disorder: A Treatment Manual*. The Guilford Press, New York.