**Intensive Cognitive Behavioural Therapy for Obsessive Compulsive Disorder:
Perspectives of Service Users**

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Abstract

Background: The National Institute for Health and Care Excellence (NICE) recommend an intensive version of treatment for service users who have not responded to ≥ 2 treatments for Obsessive Compulsive Disorder (OCD). The views of service users for whom this format of treatment is recommended are unknown.

Method: Thirty semi-structured telephone interviews were conducted with participants with OCD. All participants had previously undertaken ≥ 2 unsuccessful courses of CBT. Interviews were analysed using reflexive thematic analysis.

Results: Participants reported that an intensive format may provide the time required to tackle important aspects of therapy that were not achieved or tackled during weekly CBT (e.g. in-session ERP). Individual preference is seen to play an important role and consequently an intensive format will not be well-suited to all who have experienced previous CBT failure. Four themes were identified: 1) Continuity and momentum, 2) Hmm, yes, but...: reservations about intensive CBT, 3) The fortune is in the follow-up, and 4) Understanding individual preference.

Conclusion: Findings support the NICE recommendation. Participants with OCD who had experienced multiple CBT failures perceived intensive CBT to be broadly acceptable with potential therapeutic advantages. Reservations related to the possibility of relapse after therapy were expressed. Clinical implications and future research directions are discussed.

Key words: Obsessive Compulsive Disorder, OCD, Intensive Cognitive Behavioural Therapy, iCBT, CBT, Treatment failure, NICE guidelines

Introduction

Cognitive Behavioural Therapy (CBT) that includes Exposure and Response Prevention (ERP) is recognised as the first line and most effective psychological treatment for Obsessive Compulsive Disorder (OCD) (NICE, 2005, 2018; Öst et al., 2015). However, approximately only half of those who receive CBT experience full remission from this treatment (Farris et al., 2013; Rasmussen & Eisen, 1997). Partial treatment response results in high rates of relapse (Eisen et al., 2013; Pallanti et al., 2002) continued service user distress and disability (Hollander et al., 1997), re-referral, and utilisation of services. The costs associated with this are high both for the individual affected and economically (Dobson & Beshai, 2013).

Research has traditionally examined treatment non-response from the perspective of the therapist, where patient factors such as poor engagement with ERP/ Behavioural Experiments (BE), noncompliance with homework and comorbidity are frequently identified (Sanderson & Bruce, 2007). However, more recently attempts have been made to investigate treatment non-response from the perspective of service users. Millar and colleagues (2020) employed qualitative methods with the aim of understanding the experience of non-response to traditional CBT for OCD through the eyes of the patient. This study's findings are consistent with those cited by therapists above, but differences were apparent in terms of the context in which these factors are perceived to occur and who they are attributed to. Service users perceived their non-response to CBT to be associated with difficulties in being able to fully engage with ERP. Reasons for this were described as interrelated and included: ineffective therapeutic alliance, insufficient treatment rationale, absence of therapist assisted/modelled ERP and insufficient time within the session. Thus, from the patient's perspective, treatment failure was largely attributed to the therapist.

One potential solution to the therapeutic interaction difficulties described by participants (Millar et al., 2020) may be to examine the format in which therapy is delivered.

CBT for OCD is typically delivered on an outpatient basis in which the service user attends one office-based session per week, for approximately 45-60 minutes, over a period of 10-20 weeks (Beck & Beck, 1995). However, for service users with OCD who have not responded to ≥ 2 adequate treatments, NICE (2005, 2018) stepped care guidance recommends an intensive version of treatment. This recommendation is in line with research suggesting that an intensive treatment should be considered for those with ‘treatment refractory’ OCD (Storch et al., 2003). The design of an intensive treatment (i.e. several hours of therapy delivered each session, with more than one session per week) may facilitate the time required for factors related to therapeutic interaction to be picked up on in therapy and subsequently addressed. Several other reasons have been identified as to why an intensive format should be considered for OCD. For instance, clinical improvement in a short time may be crucial for individuals whose job or relationship is at risk and may also provide a solution when geographical distance from treatment centres is an issue (Oldfield et al., 2011). Therapeutic advantages such as providing a focused period of time in which the individual can concentrate on their recovery with minimal distractions from job responsibilities or childcare are noted (Shikatani et al., 2016). The intensive format may also help with continuity of treatment, enabling both the patient and therapist to keep therapeutic work fresh in mind. It may be particularly useful for overcoming avoidance and difficulties associated with depression, with less time required to build momentum (Ehlers et al., 2010) and thus more time to focus on exposure-based tasks.

To date, only one study has qualitatively examined service users’ views on an intensive outpatient version of CBT (Bevan et al., 2010). This study focused on the perceived acceptability of intensive CBT in comparison to weekly CBT in patients with OCD. This study provides some evidence for the acceptability of intensive CBT. Participants who undertook intensive CBT chose to do so and at the completion of therapy all participants expressed a definite preference for intensive CBT. Nonetheless, Bevan and colleagues (2010) recruited a range of participants some of whom were presenting for CBT for the first time. Only three of

the intensive participants and two of the weekly participants had an experience of previous CBT. Thus, the views of service users for whom the NICE recommendation is in place, are yet to be investigated. This is important, as the views of those who have experienced multiple CBT failures may be different to those undertaking an intensive treatment as their first experience of CBT for OCD. The aim of the current study was to gain an in-depth understanding from those who have experienced multiple treatment failures on the prospect towards or experience of CBT delivered in an intensive format.

Method

Design

Qualitative methodology was chosen as the most suitable approach for exploring service users' experience of and perspectives on intensive CBT.

Participants and Recruitment

Participants were eligible to participate if they were ≥ 18 years, met diagnostic criteria for OCD (as specified by the Diagnostic and Statistical Manual of Mental Disorders 5th ed. (DSM-5) (APA, 2013), identified OCD as their main problem, and reported having had ≥ 2 courses of CBT from which they had an incomplete response. Purposive and snowball sampling techniques were used to recruit participants (Robinson, 2014). Participants were recruited via social media adverts, websites of UK OCD charities, and from attendance at OCD service users' national conferences. All participants who were screened as eligible to take part completed the study.

Measures

Structured Clinical Interview for DSM-5 Disorders (SCID-5) (First et al., 2015).

To confirm OCD diagnosis, participants were administered the OCD relevant section of the SCID-5: a clinician administered diagnostic interview that is used to determine DSM-5 disorders, reported to have acceptable reliability and validity (First et al., 2015).

Obsessive Compulsive Inventory (OCI) (Foa et al., 1998).

This 42-item self-report measure assesses severity of OCD symptoms. Items are rated on two five-point (0–4) Likert scales which measure the distress and frequency of each symptom. A total score of 42 or more is indicative of OCD. The OCI has been found to have good reliability and convergent validity (Foa et al., 1998). As is standard, only the total index of distress was used (Cronbach's $\alpha = .94$).

Patient Health Questionnaire (PHQ-9) (Kroenke et al., 2001).

The PHQ-9 is a nine item self-report measure of depressive symptom severity. Each diagnostic criteria for depression is scored from '0' (not at all) to '3' (nearly every day). Total scores range from 0-27; with recommended cuts-offs as follows: 0-4 none or minimal; 5-9 mild; 10-14 moderate; 15-19 moderately severe; 20-27 severe depressive symptoms. The PHQ-9 has been found to be a reliable and valid measure of depression severity, internal consistency $\alpha = .89$ (Kroenke et al., 2001). In the current study, internal consistency was $\alpha = .96$.

General Anxiety Disorder Assessment (GAD-7) (Kroenke et al., 2007).

The GAD-7 is a seven item self-report measure of generalised anxiety symptom severity. The scale ranges from '0' (not at all) to '3' (nearly every day). Total scores range from 0-21 and recommended cut-offs are as follows: 0-4 minimal; 5-9 mild; 10-14 moderate; 15-21 severe. The GAD-7 has been found to have excellent internal consistency ($\alpha = .92$), good

reliability, as well as criterion, construct, factorial, and procedural validity (Kroenke et al., 2007). Internal consistency in the current study was $\alpha = .92$.

Work and Social Adjustment Scale (WSAS) (Mundt et al., 2002).

This five item self-report measure examines an individual's level of impairment in functioning. The scale ranges from '0' (not at all) to '3' (nearly every day). The scale has good reliability and validity, with internal consistency ranging from $\alpha = .70$ to $\alpha = .94$. It has been found to be sensitive to patient differences in disorder severity and treatment related change (Mundt et al., 2002). In the current study, internal consistency was $\alpha = .91$.

OCD-Self Efficacy Scale (OCD-SES)

The OCD Self Efficacy Scale (OCD-SES) is a 14 item self-report questionnaire adapted from the Hoarding Self Efficacy Questionnaire (Lambe & Salkovskis, 2015), which had reasonable internal consistency ($\alpha = .67$) and was developed in line with Bandura's (2006) guidelines for developing self-efficacy measures. The OCD-SES contains 11 items that explore individual's beliefs in their perceived current capacity and ability to exert control over their OCD and three items regarding their mid to long term confidence. Items represent tasks required for an individual to overcome OCD (e.g. 'resist the urge to respond to my OCD'). For each statement participants are asked to rate how confident they are on a scale from '0' (no confidence) to '100' (completely confident). In the current study only the 11 items pertaining to participants current perceived efficacy were used. The internal consistency was excellent ($\alpha = .94$).

Qualitative Interviews¹

A semi-structured interview was developed by two clinical psychologists (JM & PM) who work at a national centre of excellence for the treatment of OCD, in collaboration with an

¹ The semi-structured interview schedule is available from the corresponding author on request.

individual with personal experience of both weekly and intensive CBT for OCD. Questions started by asking participants to talk about previous experiences of CBT and to describe the delivery of therapy they had previously undertaken. Participants were asked about what aspects they found most helpful or potentially unhelpful. Participants were then provided with a definition of intensive CBT. Intensive CBT was defined as 12-20 hours of CBT delivered on two or three days each week over a three-week period, with three booster sessions offered once a month post therapy. Participants who had not experienced intensive CBT were asked about their views on the prospect of receiving CBT in this format. For participants who had an experience of intensive CBT, they were asked about their experience of this treatment. The semi-structured interview was piloted with a person with personal experience of OCD who had not experienced intensive CBT. In response to the pilot interview additional optional prompts were added. During the interview the researcher encouraged participants to elaborate on their answers, provided prompts and sought clarification where necessary. Participants were invited to ask questions throughout the interview and on its conclusion.

Procedure

Ethical approval was granted by the University of Bath Research Ethics Committee (17-304). Participants who expressed an interest in participating were contacted by phone to discuss the study and their eligibility. If inclusion criteria were met, participants were emailed a link that directed them to an online questionnaire portal. Participants were asked to read an information sheet and informed consent was obtained via an online consent form. Participants were then asked to complete the series of questionnaires. A time for the interview was then scheduled. Individual interviews were conducted by telephone and lasted approximately 60 minutes (range 24 - 100 minutes). Interviews were recorded using a digital voice recorder and were transcribed verbatim, with identifying information removed and pseudonyms inserted. If

participants requested further support, they were signposted to appropriate resources. On completion participants received a £5 electronic voucher in appreciation for their time.

Data analytic strategy and approach

The data set comprised 30 completed questionnaire batteries and 30 transcribed interviews. Descriptive statistics were used to summarise clinical characteristics of the sample and reports of previous CBT. Transcripts were analysed using reflexive thematic analysis (RTA), as described by Braun and Clarke (2006; 2013). RTA is well suited to exploring individual's experiences and how they make sense of them and was chosen to enable patterns and themes to be derived from the data. The six-phase process was followed (Braun & Clarke, 2006; 2013). The first author familiarised themselves with the data via reading of transcripts thoroughly. Transcripts were then systematically coded. The data were approached from a critical realist perspective, which assumes that the data represent a valid report of the participant's reality, explained by the way in which the participant talks about their experiences and the meaning this has for them. The analysis was primarily conducted by the first author, a clinical psychologist experienced in the treatment of OCD. An inductive approach was utilised, meaning that the data was the starting point for analysis rather than applying pre-existing theories to the data. However, the author's clinical and academic knowledge is likely to have influenced the analysis and therefore to some extent a deductive approach is incorporated. Codes were arranged utilising a thematic map to identify initial candidate themes. Another researcher also coded a proportion of the transcripts ($n = 15$) and identified potential themes. The first author and the second reviewer met to discuss the codes, candidate themes, associated interpretations and the thematic map. From this discussion and subsequent discussions with co-authors, the overarching and subthemes were refined and finalised.

Results

Participants

To contextualise the sample, a demographic summary of participants' characteristics, treatment history and symptom severity is presented in Table 1. The trajectory of participants' age of OCD onset and the significant delay in receiving treatment for OCD is consistent with the literature (Fineberg et al., 2019). One third of the sample had experienced an intensive format of CBT. Symptom severity measures indicated that participants on average were experiencing moderate to severe OCD, mild to moderate depression, mild symptoms of generalised anxiety and significant functional impairment. However, as measured by the self-efficacy scale, participants expressed a moderately high level of confidence that they would be able to overcome their OCD.

Table 1.

Participant characteristics, treatment history and symptom severity

Participant Characteristics		
Demographics		<i>N (%)</i>
Gender	Male	8 (26.7)
	Female	22 (73.3)
Ethnicity	Asian & Black African	2 (6.6)
	White	28 (93.3)
Education	GCSE or equivalent	3 (10)
	A level or equivalent	3 (10)
	Diploma	1 (3.3)
	Undergraduate degree	13 (43.3)
	Postgraduate degree	10 (33.3)
Employment	Unemployed (available for work)	1 (3.3)
	Sickness Benefits	6 (20)
	Student	1 (3.3)
	Employed part time	5 (16.6)
	Employed Full time	12 (40)
	Other (carer, retired)	5 (16.7)
		<i>M (SD)</i>
Current Age		39.47 (11.81)
Symptom Severity	OCI	52.67 (37.58)
	PHQ-9	9.23 (9.15)
	GAD-7	8.93 (6.15)
	WSAS	17.43 (11.81)
	OCD-SES	79.70 (21.10)
History of OCD & treatment		<i>M (SD) years</i>
Duration of OCD		26.8 (12.19)
Age of onset		12.67 (7.57)
Age significantly interfered with life		16.6 (7.79)
Age found out that problem was OCD		20.56 (8.88)
Age first diagnosed with OCD		28.63 (11.40)
Age first sought help		26.3 (11.74)
Age first offered treatment for OCD		29.37 (12.02)
		<i>Mdn (Range)</i>
Number of past sets of therapy		3 (2-10)
Number of past sets of CBT		3 (3-8)
Experience of treatment formats		<i>N (%)</i>
Experience of weekly CBT only		20 (66.6)
Experience of Intensive CBT		10 (33.3)

GAD -7 = Generalised Anxiety Disorder; *M* = Mean; *N* = Number of participants; OCD-Self Efficacy Scale = OCD-SES; OCI = Obsessive Compulsive Inventory (Distress); PHQ-9 = Patient Health Questionnaire; *SD* = Standard deviation; WSAS = Work and Social Adjustment Scale.

Qualitative Analysis

The analysis of participants' experiences and views on intensive CBT identified four overarching themes: 1) *Continuity and Momentum*, 2) *Hmm, yes, but...: reservations about intensive CBT*, 3) *The fortune is in the follow-up* and 4) *Understanding individual preference*. These are shown with sub-themes and headings in Appendix 1.

Overarching Theme 1: Continuity and Momentum

This theme captured participants' narratives on the aspects of the therapeutic process that are perceived to be influenced by the continuity and momentum that result from an intensive format. It focused on participants' perceptions of how longer sessions could be used and described gains that were perceived to be likely as a result. This theme comprised four subthemes; 1) *Therapeutic flow and engagement*, 2) *"The therapy that gave me wings": In-session ERP*, 3) *Big, fast, gains*, and 4) *Clearing the decks for success*.

Subtheme 1.1: Therapeutic flow and engagement.

The concept of intensive CBT facilitating greater continuity within treatment, featured strongly for all participants. Participants contrasted this idea with experiences of weekly treatment, where shorter session durations had, at times, been perceived as an interruption.

You might've been in a moment [...] where you felt like you really wanted to carry on talking about it some more, because you felt like there were things you needed to explore, because of the fact that it's an hour you haven't been able to do that as much as you wanted to. Or as much as what your therapist might have thought would be useful (Karina, x 3 weekly).

For some participants, the passage of time in-between sessions was construed to have an undesirable diluting effect on their ability to recall important elements of previous sessions.

As hard as you try, when you come back to it a week later, it's very difficult to then get yourself back into that frame of mind, where you think, you know, about this particular obsession, or difficult to remember what you sort of said about it (Leticia, x 3 weekly).

Participants also suggested that longer sessions would be advantageous for the purpose of allowing enough time for making sense of their intrusive thoughts/ images. This was discussed by some participants as being a fundamental but challenging part of therapy, better facilitated by a single longer session.

The therapist needs time to be able to question where that thought is coming from, "what does that mean?", "So what would that mean if it was dirty?" That took about three hours to get down to realising what was driving my thoughts and if that had been broken up into three weeks, I'm fairly certain I wouldn't have got that conclusion about myself, because I would have broken that train of thought. You lose that focus of that moment on drilling down on something (Harper, x 3 weekly, x 2 intensive).

Furthermore, homework tasks were constructed as important to therapeutic progress and participants' narratives evidenced their desire to undertake such tasks. However, participants contrasted this theoretical benefit with the difficulties of utilising the time in-between sessions as intended.

On one hand it's really good to have it weekly, because you keep on top of it [...] have the time [to] practice [...]. At the end of a session, I'd be like "yep, I'm going to tackle that", but then often what I'd find is that in-between sessions I'd sort of forget about it [...] get distracted by other things (Sophia, x 3 weekly).

Participants who had not undertaken intensive CBT perceived the intensive format to have the potential to provide a scaffolding that would facilitate the tackling of tasks that were

difficult to undertake alone. Participants promoted the idea that longer sessions would facilitate increased engagement.

Doing it all in one block would just be very helpful [...] I think when it's week by week, you kind of go away and sort of, you might not always, put into practice what you've learnt[...] and it would make you more inclined to actually do it as well, if you've got to go back week after week and you're sort of ruminating about it, you might not go back the next week, so I think that that would be very, very, very effective for someone like me (Allie, x 3 weekly).

Participants who had undertaken intensive CBT described engaging with aspects of therapy in session that they had been previously avoiding.

It [ERP] was actually there and then and there was no, like, building up to it; there was no escaping it, you know it was like, you're there, you're doing it. Because, before I was having the sessions then going away and being in my own head for a week, just basically arguing with myself, but with this [intensive] I was actually doing the hard stuff (Keryn, x 3 weekly, 1 intensive).

Participants who had not experienced intensive CBT proposed that greater continuity in treatment would result in the building of momentum, focus and potentially facilitate better outcomes.

It may be that by having it constant, today and tomorrow and tomorrow, won't give the emotional brain [a] chance to slacken off and go back down into a lull period, then psych back up. For the exposure to be happening, you wouldn't have a chance to be, "oh that's over with, I've got a whole week now to think about it". Whereas if it was going to be tomorrow, maybe that level of exposure would have had a different outcome (Gary, x 3 weekly).

The notion of successful momentum building was reported by participants with experience of intensive CBT, mirroring the expectations of those who had not experienced it.

I think the intensive is really important because you need that momentum, I really feel you need that momentum to really make strides (Max x 2 weekly, 1 intensive).

In summary, both participants with and without an experience of intensive CBT described intensive CBT to facilitate greater engagement because of the continuity and momentum of an intensive approach.

Subtheme 1.2: “The therapy that gave me wings”: In-session ERP.

This subtheme captured participants’ views on intensive CBT encompassing longer sessions and this facilitating time for in-session ERP to be undertaken. Participants who had not undertaken intensive CBT speculated that a consequence of longer sessions would be the inclusion of in-session ERP and/ or BE. Participants reported that this would be desirable for two key reasons; firstly, it would provide the opportunity for the therapist to model the theory of what they were asking patients to do.

You’re talking about it all in the office and you’re like, “Yeah I can do this.” Then as soon as you leave the office, you’ve got to do it for real [...] if you’ve got more time, then maybe they [therapist] could actually do it with you in the office. Just start it off, kind of reinforce what you actually need to do (Ethan, x 3 weekly).

Secondly, participants described that an intensive format would allow for experiential learning to occur in sessions. Participants described that longer session times would enable them to try out how the therapy worked whilst in a supported environment. This was perceived to foster the likelihood of ERP continuing outside of the session.

So instead of saying, “here’s what we want you to do this week”, you could actually perhaps put it into practice during the session, so you know it works. Then you’ve already kind of got experience of it and probably more likely to try it out on your own (Jeremy, x 3 weekly).

Participants with experience of intensive CBT described therapy sessions where the time had been used to focus on undertaking ERP in environments specific to their OCD. Participants described the therapist involvement as important and valuable.

The therapy that gave me my wings was intensive. The exposures were clinically supported; so, I went out in situ in hospitals, and touching sinks and public phone boxes, and buying things from people with cuts on their hands; all with a clinician (Janice, x 2 weekly, x 1 intensive).

A prominent thread from those who had undertaken intensive CBT was the importance of sessions being long enough to allow the therapist to complete the ERP session with the patient. The extended session time was constructed as a facilitator of enabling the patient to feel secure enough to take the leap-of-faith required. This belief was underpinned by participants’ experiences of what they had previously lost as a direct consequence of their OCD (e.g. losing one’s home, savings etc.).

The number one thing is having the right support and having the right support in therapy. I think that is a big thing for me and I’d imagine for a lot of people, cause the reason you can’t do the exposure on your own is cause you feel you can’t do the exposing. It is to know that the person with you isn’t going to leave you, until you’re okay. That was key for me (Harper, x 3 weekly, x 2 intensive).

Participants with experience of intensive CBT also described the importance of the ‘extremes’ to which ERP/ BE needed to be taken to be effective (i.e. anti-obsessional tasks). The longer session was again construed as a facilitator of this.

What made the difference I think, was that it was anti-obsessional; so, doing things that nobody would do on the normal spectrum of things [...] It was putting your hand into the toilet water and then not washing and touching things in the flat, including things that you couldn't wash, including inside the fridge and all the kitchen utensils (Sharon, x2 weekly, x 1 intensive).

Overall a key benefit of the intensive approach was perceived to be the longer session time which was viewed as key for facilitating in-session therapist assisted and supported ERP. The in-session ERP was perceived as important for learning how OCD works and for instilling participants' confidence in tackling their OCD.

Subtheme 1.3: Big, fast, gains.

Participants with experience of intensive CBT described the rapid pace at which gains had occurred. This included taking action against OCD that was perceived to occur more quickly than expected, or in comparison to their experiences of weekly CBT.

Yeah, the two intensive days, they were like ten till four, ten till three, I can't remember the exact times, but that really kicked me into action to do that. Doing stuff that I thought would have been way down the track (Amber, x 2 weekly, x 1 intensive).

The concept of increased self-confidence as a consequence of fast gains, also featured strongly for these participants. Participants reported that as they started to tackle their OCD successfully in session, their confidence in their ability to continue to make progress increased.

I think you really need to do the intensive, go out and do the stuff you don't want to do, or whatever it is. I think that gets the ball rolling and it builds confidence quickly [...] I think it does start to have an immediate impact in a very short and quick time (Harper, x 3 weekly, x 2 intensive).

Participants spoke about the impetus for choosing to change, describing the significant discoveries that had occurred during an intensive session with the realisation of what worked and how they could maintain their gains.

All the agonising, and the intensive fear, was all before it, like months and months before it, and the night before it. Then we did it [intensive] [...]. So that was big. You could see the graphs; handwashing plummeted, and the showering plummeted, from that day after the intensive. The next few days, I thought, "Well, if this is what it takes to keep this OCD away, then I'll do it every day" (Sharon, x2 weekly, x 1 intensive).

Overall, the gains reported related to taking action in therapy quickly, which resulted in increased confidence and continuing to use ERP after treatment to maintain gains.

Subtheme 1.4: Clearing the decks for success

This subtheme captures participants' narratives around what they perceive is required to successfully participate in intensive CBT. Participants described a high level of preparation and commitment and the attitude deemed necessary to maximise potential benefits. Participant narratives described the commitment as one that not only affected the individual undertaking the CBT, but was something requiring consensus and priority within the family unit.

As a family, we'd had to block out time for my recovery. Just like if someone was going for an intensive driving course; you change your world because you're going to go for two weeks, learn to drive. Or the child that goes for intensive swimming lessons two

times a day for three weeks, and then they can swim. It was a family decision to make sure that child gets [...] It was exactly the same in this house, it was a family decision that we were going to change our world to allow for intensive treatment of OCD. Everything was set up for my recovery; even down to what dinners we ate. The only thing I had to do was my homework, we cleared the decks for my recovery. There was a commitment that came over and above what it was for the weekly (Janice, x 2 weekly, x 1 intensive).

Participants were keen to highlight that in order to undertake intensive CBT it was necessary to plan ahead to ensure sufficient time is scheduled for the treatment.

You've got to want to do it [undertake CBT] and actually, you've got to carve out the time to do it [intensive CBT] (Tina, x 5 weekly, x 2 intensive).

Participants reported that in order to maximise gains, it was important to focus on and engage with therapy as fully as possible as soon as it had commenced.

I found the intensive really good because it was like jump starting everything, it was just going all in, right from the start and it was just kind of push, push, push until the end (Keryn, x 3 weekly, x 1 intensive).

Participants noted the importance of integrating ERP into their life in-between the intensive treatment sessions, again with the aim of maximising gains.

The therapy is several hours twice a week [...] and then the rest of time you're doing stuff [...] and you get out what you put in. So, if you can treat it like a full-time job, the better for you (Max, x 3 weekly, x 1 intensive).

Some participant's narratives alluded to intensive treatment being viewed as a last resort, requiring maximum dedication. Participants prefaced that getting to the point of being offered intensive treatment had been a long and difficult process.

It needs to become the new way of life and the only way you can do that is by focusing on it. [...] obviously you must carry on with normal life, but I have to be the focus for a period of time (Harper, x 3 weekly, x 2 intensive).

Overall, the narratives of participants with experience of intensive CBT, was one of being motivated and ready to engage, and consequently directing their focus and resources to maximising the outcome of treatment.

Overarching Theme 2: Hmm, yes, but...: reservations about intensive CBT

This theme captured participants' narratives around reservations they held regarding an intensive format. Participants described aspects of the intensive process they perceived would make it difficult or potentially unsuitable. Participants also described factors relevant to the intensive process they perceived would need to be addressed. Three subthemes were identified 1) *Too intense*, 2) *"Can I trust you?": The importance of therapeutic alliance* and 3) *Slap bang, crash and burn: Relapse after intensive CBT*.

Subtheme 2.1: Too intense.

Participants discussed that an intensive approach may not be appropriate for everyone. Participants fell into one of two groups; first, those who identified that for 'others' intensive CBT may be too intensive, suggesting it may be emotionally overwhelming or exhausting. However, these participants did not anticipate, or had not experienced this to be the case for themselves.

Well, I guess it might be emotionally quite exhausting on somebody, so that might be problematic. It might be addressing, sort of, lots of different issues all at once, [it] might be a bit overloading. But for me, I would quite like that. I think I would like to get it all out the way (Semone, x 3 weekly).

The second group personally identified with the idea of intensive treatment being too difficult to undertake. Three main reasons were identified. Firstly, participants expressed the idea that undertaking intensive CBT would be *emotionally taxing or overwhelming* due to the extended time that they would need to endure anxiety within the treatment session.

I have a pretty low threshold for the anxiety I could take [...] thinking about what I could handle at the moment (Alicia, x 8 weekly).

I think to do CBT and or exposure response for two or three hours at a time would be exhausting (Leticia, x 3 weekly)

Secondly, some participants identified that having the *diagnosis of OCD* itself or additional *comorbidities*, would preclude them from intensive CBT. These participants held the belief that because of their difficulties their capacity to meaningfully engage in therapy for an extended period was reduced. These participants expressed the belief that a slower pace of therapy was important in the treatment of OCD.

I think for anybody who has dealt with mental health issues to go in for two or three hours, would be extremely taxing, but for someone with OCD [...] I think your mind can only handle so much at one period. I think with OCD you actually have to go slow [...] You can't cram that much into one session because it's ineffective after an hour or so (Joy, x 3 weekly).

Participants also discussed the broader impact, disability and damage that had occurred in their life because of their OCD and related comorbidities. This was perceived by some participants as indicative of therapy requiring a longer passage of time.

I needed that time to go away and process it [...] I had so much work to do and it took time to chip away at a lot of the things [...] A lot of the collateral damage, I suppose, and a lot of the stuff to do with my depression and my self-esteem too (Beth, x 5 weekly).

Thirdly, participants identified CBT as comprising a *large amount of content*. Participants anticipated that they would need a longer period of time to process this and cope with the demands of therapy.

It would've probably pushed me over the edge a bit. I think there's so much content to kind of get your head around and then to apply to yourself, that I think for me personally there needed to be that breathing space in between of a week to integrate (Polly, x 4 weekly).

Overall participants who had not experienced intensive treatment were divided in their views. Some participants viewed intensive treatment as difficult due to the likely emotional impact, their OCD and associated comorbidities and quantity of CBT content. However, while other participants acknowledge these possibilities, most believed these restrictions would not apply to themselves.

Subtheme 2.2: “Can I trust you?” : The importance of therapeutic alliance.

Here, participants emphasised that whilst the therapeutic relationship is essential for the success of therapy regardless of delivery format, it is particularly crucial for intensive CBT. This notion was underpinned by the level of trust participants conveyed is required to undertake intensive CBT.

It's very dependent on your therapist, who you've got as a therapist [...] I think that therapeutic relationship is really important, I'd be thinking "can I trust you?" [...] it's got to be somebody you get on with, you trust, and you respond to, and [...] they understand the problem (Genevieve, x 2 weekly, x 1 intensive).

The amount of time participants perceived it would take to build the trust required to participate in intensive CBT varied, ranging from a short to an extended period. Some participants described establishing trust, rapport and an effective therapeutic alliance with their therapist very quickly.

I was really, sort of, blown away, in a way, by her belief in me and I think that was something that I'll always remember, her, her just belief right from the start (Janice, x 2 weekly, x 1 intensive).

The relationship between you and your therapist is really important, like with the various different episodes of CBT that I've had, I've always found that I've been able to build up a really good rapport with my therapist at the start, because they've always been really skilled [...] known the subject matter really well [...] warm and empathetic (Kasia, x 4 weekly).

Other participants described requiring a greater amount of time to build trust in both the therapist and the therapy being delivering.

I would say probably 80% of the total change happened on those two [intensive] days. However, I would not have been able to get to them without the trust-building with the therapist as a person, and the building trust, very slowly, in the method, and the theory. A lot of that was done in the traditional office-based sessions for one hour, and a bit of thinking time in between. My main concern at the time would have been that I couldn't

trust the person enough [...]. There was a lot of pushing, in a positive way, from my therapist (Sharon, x 2 weekly, x 1 intensive).

Within this subtheme it was unanimous that the therapeutic relationship is essential. Variation only occurred with regards to the length of time anticipated to establish this.

Subtheme 2.3: Slap bang, crash and burn: Relapse after intensive CBT.

Participants who had not experienced intensive CBT reflected on the possibility of relapse occurring more quickly after intensive CBT. Participants expressed concern that as therapy would occur over a shorter period, there may not be sufficient time for everyday life to occur and for obstacles to be addressed within therapy.

Knowing what I know now, for me personally, I think intensive would have worked really, really well, but then I wonder if I would have relapsed quicker because I had no time to do those things on my own (Gavin, x 3 weekly).

Some participants described with an element of certainty that if intensive CBT was delivered and then ceased without follow-up, then relapse was likely.

If you just did the intensive weeks and then it stopped, you're then left completely alone to do any of the homework that you need to do. I think you definitely, without a doubt, [would] relapse. I think if it was slap bang, here's two weeks, and then go away and get on with it yourself, I don't think it would work (Cooper, x 3 weekly).

I've done some intensive treatment in [location] where I meet with somebody every day during the week [...] I've done that a couple of times and it has shifted things, but I've never been able to keep it going for very long (Natalie, x 4 weekly, x 2 intensive).

Some participants perceived they had 'further to fall', with gains made in intensive CBT. This was suggested to be caused by therapy coming to an end and there being no provision of follow-

up on completion.

You can make progress fast, but, [...] once the stabilisers are off, and you're on your own, you can crash and burn and fall back, and when you fall back, I think you fall further than you expect (Hunter, x 2 weekly, x 1 intensive).

Overall participants described concerns anticipating relapse or having experienced relapse. This was attributed to the lack of provision in follow-up after the formal part of intensive CBT had concluded.

Overarching Theme 3: The Fortune is in the follow-up.

This theme captured participants' narratives around the importance of follow-up after completion of therapy and featured strongly within the sample. All participants discussed issues related to follow-up, regardless of whether they had undertaken intensive CBT. There was a unified construction of follow-up as an essential and highly desirable component of therapy that was rarely available or offered to participants. No subthemes were identified here, but six headings that discern different aspects of the theme are denoted in bold italics.

Participants' narratives reinforced the idea that gains made in intensive therapy were likely to only be maintained with ***appropriate follow-up***.

I think after that initial three or four weeks of intensive you probably need to stay in touch with your therapist for at least six months. I don't think this is something that you're going to get rid of in a month without continued support (Gary, x 3 weekly).

Some participants highlighted the perceived usefulness of follow-up in the form of ***booster sessions***. Participants described how these sessions could be used to address obstacles that had arisen since the completion of therapy and thus resolve any issues to ensure the participant is kept on track.

With those booster sessions, say something happened today, I can write that down and I can come in [...] unpack it with therapist and they might say, “Go away now and do lick that bin and roll around in it”, and that might actually help you for the next time that something happens around a bin. Whereas if you haven’t got that check in, and something happens that you don’t cope with, you’re just left feeling like a failure and that’s when things can all start to go wrong (Harper, x 3 weekly, x 2 intensive).

Participants highlighted the idea that sufficient follow-up did not need to be time consuming, suggesting it was more the act of reinforcing what had been learned and achieved.

Some sort of follow-up for people who have [been] discharged from services, just to see how they’re doing to kind of really reinforce the CBT model would be quite helpful and I don’t think it [has to be] that time consuming (Ethan, x 3 weekly).

Participants suggested the use of communication/ messaging **technology** as a viable alternative to face-to-face follow-up, reiterating the idea that follow-up could be relatively minimal.

Some form of checking in with your therapist, whether that be through a phone call or Skype or through an app [...] It doesn’t have to be huge long sessions, but I think you do need to check-in with them (Gavin, x 3 weekly).

There was a strong narrative around the possibility of other **allied health professionals** who are “CBT literate” potentially providing follow-up. Participants were keen to demonstrate their awareness of the higher costs of psychologists and OCD specialists and to think laterally about other ways in which continuity in care could be provided. *In terms of having somebody CBT-literate support me; it wouldn’t necessarily need to be the same therapist as long as they know OCD, it could be someone in training, or another background (Leticia, x 3 weekly).*

Emphasis was placed on the ideal form of follow-up being *flexible and responsive to needs*, seeing decreased frequency when patients were doing well.

I think a year would be good, a year from when the intensive treatment ends [...] Being able to check in, having somebody flexible, who might say, “You are doing reasonably well; let’s not meet for a month”, or, “You’re really struggling; let’s meet on a weekly basis”. Not having it open-ended, because that means you can end up procrastinating, but not having that, “OK, the money has run out” limit either (Sophia, x 3 weekly).

Frequently discussed was the premise of the patient’s file being “kept open” by the treating service after the patient had been formally discharged. This idea was premised as a potential way of supporting ongoing follow-up where needed, and preventing difficulties encountered with re-referral.

Stuff just does come up and to be able to know you’ve got somewhere to go, where you’re not going to have to re-explain your history, where somebody gets the problem (Harper, x 3 weekly, x 2 intensive).

I was amazed when I heard about that [NHS] trust [that keeps patient files open after discharge], and the person who told me about it said it made a lot of difference to them (Joy, x 3 weekly).

Participants constructed arguments around the disparity in provision of follow-up for physical health in comparison to mental health problems. Physical health problems were constructed as socially acceptable with the individual suffering perceived not to be at fault and thus the process of recovery unquestionably requiring follow-up. However, for mental health problems a different set of rules were perceived to apply. The onus was perceived to be on the individual to be completely well at the designated end of the treatment with no follow-up

necessary. Participants also alluded to the economic costs involved in not providing appropriate follow-up.

I know they say the NHS is completely overflowing [...], but I just don't get why it's completely standard you know, for physical health problems, you just wouldn't see it [the absence of follow-up] with a physical health problem. You'd get your treatment [...] then the specialist would say "now come back and see me in a month" or two months and if you're doing fine you might come back in a year. But no, not if it's for mental health, you gotta fight [...], surely follow-up would save [NHS] a fortune in the end (Cooper, x 3 weekly).

Overall, participants described a range of different models of follow-up in terms of duration, provision and mode of delivery, with the bottom line being a consensus that follow-up should be a routine part of care.

Overarching Theme 4: Understanding Individual Preference.

This theme captured factors specific to the individual that participants perceived as important in influencing their preference for treatment format. Three subthemes were identified, these include; 1) *Failing made me ready*, 2) *Patient choice, circumstance and severity* and, 3) *The best of both worlds*.

Subtheme 4.1: Failing made me ready.

Some participants described previous experiences of undertaking weekly treatment as influencing their preference for an intensive version of treatment.

I trusted, obviously, what she was saying even though it felt frightening. And I had the advantage of having CBT a few times before so at least I'd had that foundation (Amber, x 2 weekly, x 1 intensive).

Similarly, participants reported that due to a series of previous unsuccessful courses of weekly CBT, they were keen to undertake a different format of therapy.

Because I've gone down these routes of therapy that's been spread out over all these weeks and it's not worked, then I'm thinking there needs to be an alternative (Nadia, x 8 weekly).

Some participants equated an intensive version of CBT with its provision by a specialist therapist. This suggested that participants perceived intensive CBT to be a specialist treatment and some attributed aspects of their previous CBT as unsuccessful due to a deficit in a previous therapist's skills.

In a nutshell, a highly trained OCD professional with an intensive course of therapy rather than a therapist that isn't an OCD specialist over a period of weeks, because that hasn't worked. The idea and the concept of CBT is right, and I think it works. It's what we need. It just needs to be much more intensive (Jeremy, x 3 weekly).

Overall participants' experience of previous CBT was perceived as an important factor in influencing their preference for intensive CBT. It was constructed as a part of the potential for further CBT to be successful as it would be undertaken in a different format.

Subtheme 4.2: Patient choice, circumstance and severity.

This subtheme captured participants' preferences for treatment based on three criteria. The first relates to service user choice. Several participants suggested that people should be provided with information on different treatment options and be able to contribute to discussions around which might suit them best.

It's giving people choice, but also giving people information about what other people's experiences have been (Sharon, x 2 weekly, x 1 intensive).

Secondly, participants discussed practical and logistical factors likely to be important when determining if an intensive format is preferable.

I think it's going to depend on the person and what they've got going on in their lives [...] whether it's easier for them to take three weeks off work and just get it done (Penny, x 6 weekly).

The only thing about weekly was it was easy to fit around the rest of my life. Actually, finding the time when people are working, might be difficult. Or if they had childcare duties or things like that (Semone, x 3 weekly).

Thirdly, some participants constructed their preference based on the severity of their OCD. These participants perceived that due to their OCD being very severe the only format of treatment likely to help was intensive.

I think once it's really got severe, like mine is, [...] you need the intensive stuff because if you just do an hour and then go away, it's not actually going to make any inroad into it (Natalie, 4 weekly, x 2 intensive).

Some participants described how the longstanding nature of their OCD meant their symptoms had become entrenched. Thus, intensive CBT was the only format likely to prove helpful.

Like a lot of us, I've had OCD for the best part of 30 odd years and to get out of that behaviour and that way of thinking that's so ingrained in you, you do need a big hit of therapy all in one go. I think the more condensed and full-on the better (Nadia, x 8 weekly).

Other participants positioned intensive CBT as the most viable option due to the level of disability they were experiencing as a result of their OCD, for instance inability to work.

Now that I can't work, I can almost devote, if you like, every moment of every day to working on my OCD. I'm beginning to realise that this is something that has to be worked on 24/7 to get anywhere (Jeremy, x 3 weekly).

Several participants expressed concern regarding resource limitations with regards to accessing intensive CBT on an outpatient basis. Participants suggested that intensive CBT should be more easily accessible and not only obtainable on an inpatient basis.

To get in-patient, which I would say is the closest thing to intensive that is more widely available, you have to surrender completely. Lose your job [...] leave family behind, young children [...]. It's a massive thing. [...] Even when we were living in a hotel driving around at night wondering what hotel to check in to that isn't contaminated. I still couldn't bring myself to do that. But, it [intensive] shouldn't be a type of care that's limited only to people who are doing that [inpatient admission]. That same level of care should be available to people who are able to carry on a little in their day to day life (Harper, x 3 weekly, x 2 intensive).

Overall, participants described a range of factors that they perceived as relevant to their preference for format of treatment. Underlying these preferences was the concept that patients should be able to express their preference and that intensive CBT is a desired outpatient care option.

Subtheme 4.3: The best of both worlds.

Participants frequently constructed an ideal format of therapy, consisting of a combination of intensive and weekly sessions.

I wouldn't want one or the other because I think the intensive got you up to speed, rather than the information being drip fed over the weeks, and then the weekly you link it all together (Amber, x 2 weekly, x 1 intensive).

However, participants varied in their views on the order or the combination of treatment format they would desire. Some participants expressed a preference for beginning treatment with intensive sessions, others suggested a mixed approach.

An intensive burst, but then with continuing support with less intensity would probably be the best [...] for maybe eight weeks, an hour a week and then just checking in (Jeremy, x 3 weekly).

An ideal scenario I would say, a couple of weeks where you had weekly, then maybe at least two or three [intensive sessions] a week, for a couple of weeks, and then go back to weekly for at least two or three months. Then go [to] catch up sessions (Genevieve, x 2 weekly, x 1 intensive).

In my last CBT, I had twenty weeks straight [...] some longer sessions would have been helpful. A couple of those being 1.5 to 2 hours long, spacing the later sessions out (Sophia, x 3 weekly).

There was clear agreement across the sample that treatment should not finish abruptly. Phasing out of sessions was a strong preference and perceived to allow incorporation of gains made into daily life and management of future obstacles.

A really good combination [...] we started seeing each other weekly and then she was away [...] so it went down to two weekly, and we thought, "shall we keep it like this?" Then it went down to monthly, then to six weekly [...] this meant that I saw [therapist] for just shy of a year right. Which meant that it gave me so much more time to go out, to

do the homework, to live my life, but to still know that I had that psychological safety net of [therapist] (Penny, x 6 weekly).

Overall, there was not a consensus on the preference of how an intensive treatment should be delivered. However, a proportion of participants recognised the benefits of both formats and suggested different hybrids of the treatment as preferable.

Discussion

The main purpose of this study was to provide an in-depth examination of how people view and experience intensive CBT. This was done from the perspective of OCD participants who had experienced multiple CBT failures. The results brought forward key factors that participants perceived would be accommodated by an intensive format that had been missing or not covered sufficiently in their previous experiences of weekly CBT. These factors fell under four overarching themes. They encompassed perceptions on the process and utilisation of intensive sessions, along with the gains both anticipated and actualised, and the mind set required to undertake intensive CBT (Theme 1: *Continuity and momentum*). While advantages to the intensive format were identified, there were caveats. Reservations identified as relevant to an intensive approach (Theme 2: *Hmm, yes, but...reservations about intensive CBT*), as well as the perceived follow-up required (Theme 3: *The fortune is in the follow-up*), and factors specific to the individual that influence format preference (Theme 4: *Understanding individual preference*) were all key. Most themes were shared by participants with or without an experience of intensive CBT, the only exception being the subtheme of ‘Big, fast gains’ which was specific to those with a lived experience of intensive CBT.

The first overarching theme, focused on continuity and momentum, and was consistent with many issues identified from the perspective of the patient with regards to treatment failure (Millar et al., 2020). Participants brought forward aspects that they were dissatisfied with from

their weekly format treatment (e.g. lack of time for in-session ERP), describing the intensive format as a possible solution for the identified difficulties. Participants identified having longer sessions as a potential benefit in maximizing the therapy continuity and momentum seen as lost between weekly sessions. They also viewed the intensive format as a solution to the previous experience of inadequate therapist assisted ERP and the likelihood of increased progress. For many patients, undertaking ERP is a daunting prospect and even more so on one's own (Kozak & Coles, 2005). The opportunity to utilise longer sessions to try out both 'therapist directed' and then 'self-directed' ERP (Tolin & Hannan, 2005) makes practical sense, and is supported by outcome research as superior (Tolin et al., 2007).

Some participants perceived their OCD diagnosis and associated comorbidities to preclude them from an intensive approach. OCD is found to have high rates of comorbidities, particularly with depression (Abramowitz, 2004). In an intensive version of Cognitive Therapy for Post-Traumatic Stress Disorder, Ehlers and colleagues (2010) found that the intensive format led to greater reductions in comorbid depressive symptoms, which were maintained throughout the follow-up period. It is possible that an intensive version of CBT for OCD could bring secondary benefits for participants with comorbid depression, further enquiry is required. Nonetheless, this has not been tested in the OCD field, and patient perceptions relating to the suitability of intensive CBT for more complex cases may need to be overcome.

Some participants expressed concern about the intensive format being too intense. Interestingly, most participants expressed concerns that the approach could potentially be too intense for others; however, they did not perceive this as applying to themselves. Bevan et al. (2010) qualitatively examined the experience of participants who had chosen to undertake an intensive version of CBT or had been allocated to undertake weekly CBT. They found that those who had undertaken weekly CBT expressed a similar view regarding intensive CBT potentially being too intense or overwhelming. However, those who had undertaken intensive

CBT did not hold this view, instead perceiving their experience as powerful, motivating, and useful for overcoming avoidance. The importance of establishing an effective therapeutic alliance was emphasised in both the current and Bevan et al. (2010) study. In the current study, longer session time was perceived as being useful for ‘making sense’ of the problem and understanding ‘meaning’ as well as facilitating faster and larger gains. The use of collaborative case formulation early in the treatment of OCD has been found to reduce patient distress and improve therapeutic alliance (Nattrass et al., 2015).

The importance of follow-up sessions for ongoing support and relapse prevention, was raised by all participants. Participants reported that follow-up was consistently not adequately provided in the context of weekly CBT. However, follow-up was emphasised to be of particular importance to intensive CBT. This finding is consistent with the reports of participants who had previously undertaken intensive CBT (Bevan et al., 2010). NICE (2005, 2018) recommend that follow-up be provided for up to 12-months following intensive treatment. However, the extent to which this recommendation is followed in practice is unknown and requires investigation. In general, there is a dearth of literature pertaining to the importance of follow-up sessions.

As a by-product of acknowledging the cost of therapist led follow-up, participants suggested that innovative methods be considered. One suggestion was the use of communication technologies. Although interventions in the form of Computerised CBT (cCBT) are now being trialled for a range of mental health conditions (Andersson et al., 2014; Menon et al., 2017; Tang & Kreindler, 2017), providing follow-up or relapse prevention has not been a focus of this medium. However, this approach has been utilised as a relapse prevention method to maintain smoking abstinence in individuals with Post Traumatic Stress Disorder, with promising preliminary results (Hicks et al., 2017). Utilising a low intensity follow-up intervention would be consistent with a ‘stepped care’ approach. However, it would

reverse the sequencing of such an intervention to come after the high intensity intervention, which would be novel. Qualitative research investigating OCD participants' views on low intensity interventions for OCD found that cCBT with telephone support was viewed by some as an acceptable compromise (Knopp-Hoffer et al., 2016). Thus, investigating such a method for follow-up may be a promising avenue.

An alternative to these more technological approaches could be to extend the 'responsive regulation' model to follow-up (Stiles et al., 2008). This model views patients as active decision makers in their care as opposed to recipients to services. Treatment duration and its end are determined in collaboration when the patient has improved to a 'good enough level' (Barkham et al., 2006). There is evidence to support the cost efficiency and effectiveness of this model (Stiles et al., 2015). Adopting this model to be used as an option for follow-up would allow service users to schedule follow-up appointments to see their therapist when required. The use of patient led appointment scheduling has been successful when trialled in pilot NHS sites and a mental health care system within Australia (Carey, 2011; Carey et al., 2013). The fear that patients would access services indefinitely was not realised.

Overall, participants described a range of factors that they perceived as relevant to their preference of format. Underlying these was the premise that patients should be able to express their preference and that intensive CBT is a desired outpatient care option. Patients' expectancy of a preferred treatment is well documented as a non-specific factor associated with treatment outcome (Arnkoff et al., 2002). Taken together the results of this study suggest that patient preference should be given consideration in clinical settings. However, how widely intensive formats of CBT are available is currently unknown and requires investigation.

Clinical Implications

Three key clinical implications can be derived from this study. The first pertains to ensuring time is spent early on in therapy to explore with the patient their view of their past therapy and to identify with them if there is utility on building on what they have previously learnt. Addressing individuals concerns about therapy and treatment format before commencing treatment may also be of use.

Secondly, participants in this study perceived intensive CBT sessions to serve an important function. It may be the case that what is required is not necessarily a course of intensive treatment, but some extended format sessions with the capacity to make the space for what is therapeutically required. Participants view in-session therapist assisted ERP as an extremely important component of therapy, which is facilitated by longer sessions. Others described additional time being required for formulation and developing a shared understanding of the problem. Providing intensive sessions has implications for services in terms of provision but may be of benefit for patients who have already experienced multiple episodes of standard hourly CBT.

The third clinical implication pertains to the provision of follow-up sessions following therapy completion. The implication is that follow-up sessions may provide the judicious use of ‘approach-supporting behaviours’ (Salkovskis & Millar, 2016) helping patients to commit and engage in therapy knowing that follow-up is available if needed.

Limitations and Future Directions for Research

It is important that the findings from this study are considered within the context of their limitations. The recruitment strategy employed snowballing techniques, thus a random sample of participants with OCD was not recruited. Priority was given to recruiting participants who had multiple experiences of unsuccessful CBT. Nonetheless, appropriate measures were

taken to ensure a clinical population with a confirmed diagnosis of OCD were recruited. The participants on average reported a relatively high degree of self-efficacy relating to their perceived capacity to overcome their OCD. Having confidence in oneself and in treatment are critical factors underlying positive change (Bandura, 1986). It is possible that this factor may have influenced participants' views. Thus, different views of intensive CBT may be held by those who have experienced multiple treatment failures but feel less confident in their ability to change. A different recruitment strategy would be required to investigate this. Ethnic minorities are also underrepresented in this study, this is a limitation that falls under a wider issue within the field of OCD research (Williams et al., 2012a; Williams et al., 2012b).

Conclusion

The findings of this study provide support for the NICE stepped care recommendation (NICE 2005, 2018), by indicating that intensive CBT for OCD is generally an acceptable treatment for individuals with OCD who have experienced multiple CBT failures. Participants reported that an intensive format may accommodate aspects of therapy that were poorly carried out or absent from weekly CBT that are perceived as important for successful CBT (e.g. in-session ERP). At the same time, reservations about the potential speed of intensive CBT make it overwhelming and susceptible to relapse, and the crucial need for follow-up in this context were also expressed. As should be central to all therapy, individual preference plays an important role and as with all treatments, an intensive format will not be well suited to all who have experienced previous CBT failure.

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Appendix 1

Table 2.

Overarching themes, subthemes and headings

Overarching theme	Sub-themes	Headings within sub-themes
1. Continuity and Momentum	1.1 Therapeutic flow and engagement 1.2: “The therapy that gave me wings”: In-session ERP 1.3: Big, Fast, Gains. 1.4: Clearing the decks for success	
2. Hmm, yes, But... reservations about intensive CBT	2.1: Too intense 2.2: Can I trust you? 2.3: Slap bang, crash and burn	<div> Relevant to others Relevant to self Emotionally taxing Comorbidity CBT Content </div>
3. The Fortune is in the follow-up		<ul style="list-style-type: none"> • Appropriate follow-up • Booster Sessions • Technology as follow-up • Flexibility and responsiveness to need • Allied health professionals • Disparity between mental and physical health services
4. Understanding Individual preference	4.1: Failing made me ready 4.2: Patient choice, circumstance and severity 4.3: The best of both worlds	