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Development of a protocol for videoconferencing-based exposure and response prevention treatment of obsessive-compulsive disorder during the Covid-19 pandemic

REPLIES TO REVIEWERS

We would like to thank the reviewers for their comments and suggestions. Major revisions have been made to the manuscript to incorporate all the suggestions. References have been added and re-ordered. Tables have been re-ordered. All changes made have been highlighted in red font.

Reviewer #1:

Specific Comments to Authors

1. Title. The title does capture the main theme of the article: i.e., protocol development for a video-conferencing based treatment model for OCD.

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2 Abstract. The abstract is succinct and relevant to the topic.

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3 Key words. Do the key words reflect the focus of the manuscript? Yes. I, however, suggest adding tele-medicine to the key words.

REPLY

"Telemedicine" has been added to the keywords.

Key words – Videoconferencing; Exposure-response-prevention; Obsessive-compulsive disorder; Telemedicine; COVID-19

4 Background. Does the manuscript adequately describe the background, present status and significance of the study? Yes, A good introduction in to what is currently available and the need to improve the services, especially in a rural backdrop. The authors have also described the difficulties faced during the COVID-19 crisis as another reason to justify developing a robust video-based therapy protocol.

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5 Methods. Does the manuscript describe methods (e.g., experiments, data analysis, surveys, and clinical trials, etc.) in adequate detail? Yes.

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6 Results. Are the research objectives achieved by the experiments used in this study? What are the contributions that the study has made for research progress in this field? This study will strengthen the current knowledge-base in the field of tele-medicine.

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7 Discussion. Does the manuscript interpret the findings adequately and appropriately, highlighting the key points concisely, clearly and logically? Are the findings and their applicability/relevance to the literature stated in a clear and definite manner? Is the discussion accurate and does it discuss the paper's scientific significance and/or relevance to clinical practice sufficiently? Yes.

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8 Illustrations and tables. Are the figures, diagrams and tables sufficient, good quality and appropriately illustrative of the paper contents? Do figures require labelling with arrows, asterisks etc., better legends? The six tables are self-explanatory and compliment the text well.

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9 Biostatistics. Does the manuscript meet the requirements of biostatistics? Yes

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10 Units. Does the manuscript meet the requirements of use of SI units? NA

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11 References. Does the manuscript cite appropriately the latest, important and authoritative references in the introduction and discussion sections? Does the author self-cite, omit, incorrectly cite and/or over-cite references? References are appropriately cited.

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12 Quality of manuscript organization and presentation. Is the manuscript well, concisely and coherently organized and presented? Is the style, language and grammar accurate and appropriate? Minor language adjustments needed. For example: Page 10 'Finally, the hierarchies were not inflexible and were changed according to the patient's needs' change patient's to patients'.

REPLY

This sentence has been changed (Materials and Methods - *Modifications in technique required for conducting videoconferencing-based ERP*).

Finally, the hierarchies were continuously upgraded during treatment on the basis of new information provided by patients or caregivers.

13 Research methods and reporting. Authors should have prepared their manuscripts according to manuscript type and the appropriate categories, as follows: (1) CARE Checklist (2013) - Case report; (2) CONSORT 2010 Statement - Clinical Trials study, Prospective study, Randomized Controlled trial, Randomized Clinical trial; (3) PRISMA 2009 Checklist - Evidence-Based Medicine, Systematic review,

Meta-Analysis; (4) STROBE Statement - Case Control study, Observational study, Retrospective Cohort study; and (5) The ARRIVE Guidelines - Basic study. Did the author prepare the manuscript according to the appropriate research methods and reporting? STROBE statement attached.

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14 Ethics statements. For all manuscripts involving human studies and/or animal experiments, author(s) must submit the related formal ethics documents that were reviewed and approved by their local ethical review committee. Did the manuscript meet the requirements of ethics? Noted. No concerns

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Reviewer #2:

Specific Comments to Authors

However, there are some issues need to be clearly illustrated.

(1) In my opinion, this is research of an intervention. And it also can be seen by author's description "In result part, authors say that a large proportion of the eligible patients (79%) underwent (n=12) or are currently undergoing ERP (n=22). "Therefore, authors need to provide oral or written consent from patients or their family guidance in ethical considerations part.

REPLY

Information regarding consent from patients has been added in the revised version (Materials and methods section- *Ethical considerations*).

Ethical considerations

This observational study was a part of a larger study on home-based TMH services for all patients[37]. The protocol was approved by the institute's ethics committee. Due to the restrictions imposed by the pandemic, verbal informed consent over the phone was allowed. As explained above, data regarding outcomes were obtained only from patients who had verbally consented to undertake ERP and had actively engaged in the process of treatment. However, patients were not contacted or assessed separately to determine these outcomes. Rather, all data regarding outcomes were extracted from routine medical and treatment records. Patient identities have not been revealed. Therefore, written informed consent from patients was not obtained for information about treatment outcomes. All the methods followed the guidelines of the Declaration of Helsinki for medical research involving human subjects.

(2) In participants part, what is the meaning for the sentences "During subsequent follow-up, the diagnosis was revised in one patient ". It means the patients became worse, or became better. It is not clear from current description.

REPLY

The explanation for revision of diagnosis is provided (Results – *Participants*)

During subsequent follow-up, one patient whose diagnosis was changed from OCD to personality disorder was excluded

(3) The logic thread of the manuscript is clear. Here's what I learned that the manuscript can be organized by introduction, method (participants, materials, data procedure, data analysis), results, discussion, conclude.

REPLY

The manuscript has been arranged as introduction, method, results, discussion, conclusion. Under methods, 'setting' includes participants, 'Videoconferencing-based ERP for OCD' includes materials and data procedure, 'Statistical analysis' includes data analysis.

(4) The article need provide more evidence for the efficacy of the VC-ERP, especially for the quantitative evidence and qualitative evidence.

REPLY

The section on - *The efficacy, advantages, and disadvantages of videoconferencing-based ERP for OCD* (Discussion) – has been reorganized. The existing evidence on VC-ERP treatment of OCD from all available sources has been included.

The efficacy, advantages, and disadvantages of videoconferencing-based ERP for OCD

Several reviews[6-10] and meta-analyses[11, 13] of TMH-based treatments for OCD have found that VC-based treatment is useful, but they have only included a few trials of VC-ERP for OCD. Similarly, meta-analyses[25, 45, 46] and reviews[17, 47-50] that have found VC-based treatments to be effective for psychiatric disorders have included a limited number of VC-ERP studies of OCD. This is not surprising because there are only three randomized-controlled trials (RCTs) of VC-ERP in OCD[51-53]. A fourth RCT of VC treatment for anxiety and mood disorders included four patients with OCD[54]. These RCTs have shown that VC-ERP is more efficacious than neutral or active control treatments and equal in efficacy to in-person ERP. Treatment gains are maintained for several months and VC-ERP had a more positive impact on the treatment alliance and patient engagement. Open trials have similarly shown that VC-ERP is an effective, feasible, acceptable, and cost-saving treatment, which can be used to supplement in-person ERP[27, 55-58]. However, the RCTs have small sample sizes and are of brief duration. Therefore, without properly conducted RCTs with non-inferiority or equivalence designs, the current evidence in favour of VC-ERP for OCD cannot be considered adequate[59].

Like other TMH-based treatments, VC-ERP has several advantages compared to in-person ERP[7, 13, 17, 50, 52]. It leads to wider dissemination of ERP and greater patient

access to evidence-based ERP. Home-based ERP allows greater flexibility, greater involvement of family members in ERP, and more opportunities to address the negative attitudes or accommodations by the family. It can be cost-effective because it reduces travel costs and absence from work. Since patients receive treatment at home, the stigma associated with seeking psychiatric treatment is lessened. However, VC-ERP has its challenges. It is heavily dependent on external factors such as technological infrastructure, internet penetration and affordability, network connectivity, and the user's familiarity with technology. Patient and family motivation might be poor, forging effective treatment alliances may be difficult, and supervision and monitoring may not be optimal[50, 52, 56].

(5) In discussion part, there is no evidence for the comparison between Videoconferencing-based ERP for OCD versus internet-based CBT in this manuscript, why comparing the efficacy of treatment between two methods.

The section on - *Videoconferencing-based ERP for OCD versus internet-based CBT* Discussion) – has been re-written. It provides a more detailed comparison between internet-based CBT and VC-ERP. These two methods have been compared because these are the two of the commonest methods of TMH-based treatment of OCD.

Videoconferencing-based ERP for OCD versus internet-based CBT

Currently, there seems to be a greater emphasis on delivering online or internet-based ERP or CBT for OCD particularly in high-income countries[9]. The two types of treatment have their advantages and disadvantages. Internet-based CBT has a broader evidence base and the number of trials including RCTs is much more than those of VC-ERP[10, 11-14]. Its efficacy is comparable to in-person CBT. Internet-based CBT is particularly useful as an initial option for mild or moderate OCD. Moreover, it is more readily accessible and offers a wider choice of techniques and varying levels of clinician assistance. The treatment is efficacious and cost-effective even with low levels of clinician support[15]. Moreover, greater levels of clinician support can help minimize dropouts, and treatment gains are usually enduring.

Despite these advantages, there is no difference in efficacy between VC-ERP and internet-based treatments[13]. Indeed, some of the evidence seems to indicate that VC-ERP may be more efficacious than internet-based treatments[45, 60]. Moreover, VC-ERP resembles the "gold-standard" in-person ERP more closely than internet-based ERP[13, 16, 17, 45, 46]. Since VC-ERP is conducted at home, it has the advantage of greater convenience, more chances of the behavioural gains generalizing to natural settings, increased involvement of the family, and a better insight into the patient's home environment[6, 16, 17, 45, 50]. Some reviews also suggest that VC-ERP is more suitable for those with severe OCD[8, 9] and patients from remote locations[16, 45-47, 50], whereas internet-based treatments are more useful in milder OCD and for people with better access to the internet[8-10]. Lastly, the main advantage of VC-ERP seems to be the greater therapeutic contact it provides particularly in comparison to internet-based treatments with minimal therapist contact. There is considerable evidence to indicate that higher levels of therapeutic contact are associated with greater efficacy of TMH-based treatments for OCD[7, 9, 14, 61, 62].

The choice of VC-ERP in this study was influenced by these considerations along with the prior experience of in-person ERP in the department, the availability of a home-based platform for VC-ERP, and the unavailability of internet-based treatments.

Reviewer #3:

Specific Comments to Authors

This study extensively covered the development and implementation of a videoconferencing-based exposure and response prevention (VC-ERP) therapy for obsessive-compulsive disorder during the Covid-19 pandemic, which also helps promote options of increasing the accessibility of mental health service in resource-limited settings. The study was a non-randomized, non-controlled descriptive study, and the small sample size and significant heterogeneity among participants - both in

primary OCD and in OCD secondary to other psychiatric disorders - compromised the scientific validity of the findings.

REPLY

We agree with the observations of the reviewer. We have acknowledged these limitations of the current study (Discussion - *Findings of the present study and its limitations*).

Findings of the present study and its limitations

Being a preliminary report, this study had several obvious limitations. It was largely a descriptive account of the development and implementation of VC-ERP for OCD from a relatively under-resourced setting. The number of patients who had completed the treatment was very small and all data related to the efficacy of VC-ERP are therefore prone to a high risk of bias. This risk is increased further because patients were not randomized to VC-ERP treatment and there was no control group. A selection bias toward better-motivated patients is also possible. Since this was a naturalistic observational study, it was not possible to control for confounding factors such as the effect of pharmacological treatment or comorbid conditions.

However, these observations apply only to the part about the efficacy of the VC-ERP treatment. This was not the principal focus of this study. Rather, this study primarily aimed to describe the development of a VC-ERP protocol for the treatment of OCD during the pandemic, examine its operational viability, and the feasibility of conducting such treatment. Therefore, the efficacy of VC-ERP was only a small part of the findings of this study. In the revised manuscript, the results section of the Abstract, the relevant sections of the Materials and Method (*Outcomes of videoconferencing-based ERP*), the Results (*Videoconferencing-based ERP for OCD: feasibility, acceptability, and efficacy*), the Discussion (*Findings of the present study and its limitations*), and the Conclusion section have been re-written to emphasize the fact that development and feasibility of the VC-ERP treatment were the primary concerns of the study and efficacy of VC-ERP was a relatively small part of the findings.

Reviewer #4:

Specific Comments to Authors

For this study, I propose the following suggestions:

1. As the author said, not everyone participated in the study. For the treatment of obsessive-compulsive disorder itself, the patient's compliance also plays a decisive role. The patients who completed VC-ERP were those with good compliance, and the results obtained in this way seem to be biased, so it is recommended to explain in the limitation section.

REPLY

This has been done (Discussion - *Findings of the present study and its* limitations).

Findings of the present study and its limitations

Being a preliminary report, this study had several obvious limitations. It was largely a descriptive account of the development and implementation of VC-ERP for OCD from a relatively under-resourced setting. The number of patients who had completed the treatment was very small and all data related to the efficacy of VC-ERP are therefore prone to a high risk of bias. This risk is increased further because patients were not randomized to VC-ERP treatment and there was no control group. A selection bias toward better-motivated patients is also possible. Since this was a naturalistic observational study, it was not possible to control for confounding factors such as the effect of pharmacological treatment or comorbid conditions.

2. The authors should add whether the methods followed the Declaration of Helsinki.

REPLY

This has been done. The ethical considerations followed during the conduct of this study have been re-written (Materials and methods section- *Ethical considerations*). The statement made above has been modified and clarified. The informed consent

statement has also been changed accordingly. Details of informed consent have been added to the title page.

Ethical considerations

This observational study was a part of a larger study on home-based TMH services for all patients[37]. The protocol was approved by the institute's ethics committee. Due to the restrictions imposed by the pandemic, verbal informed consent over the phone was allowed. As explained above, data regarding outcomes were obtained only from patients who had verbally consented to undertake ERP and had actively engaged in the process of treatment. However, patients were not contacted or assessed separately to determine these outcomes. Rather, all data regarding outcomes were extracted from routine medical and treatment records. Patient identities have not been revealed. Therefore, written informed consent from patients was not obtained for information about treatment outcomes. All the methods followed the guidelines of the Declaration of Helsinki for medical research involving human subjects.

3. The authors used the Student's t-test. Are the data normally distributed?

REPLY

The Wilcoxon Signed Rank test was used instead of Student's t- test in view small sample size and possible non-normal distribution.

(Materials and Methods)

Statistical analysis

Frequencies, means, and standard deviations were used to characterize the sample. Loss to follow-up during any time was considered a dropout. Pre- and post-treatment comparisons were carried out using the Wilcoxon Signed Rank test.

4. Many patients complicated with other mental disorders and used related psychotropic drugs. How to evaluate drug confounding factors?

REPLY

Since this was a naturalistic observational study and only 11 patients who completed ERP treatment were considered, it was not possible to control for these confounders. This has been mentioned as a limitation of this study (Discussion - *Findings of the present study and its* limitations - see above). However, all patients were receiving medications and the results suggested that comorbid conditions did not affect the efficacy of ERP.

5. Table 5: Only 11 patients finally completed VC-ERP, with multiple confounding factors (df=20). The statistical results were not convinced.

REPLY

We have acknowledged this as a limitation (Discussion - *Findings of the present study and its limitations* - see above). However, the principal focus of this study was development of a VC-ERP protocol for the treatment of OCD, examining its operational viability, and the feasibility of conducting such treatment. The efficacy of VC-ERP was only a small part of the findings of this study. In the revised manuscript, the results section of the Abstract, the relevant sections of the Materials and Method (*Outcomes of videoconferencing-based ERP*), the Results (*Videoconferencing-based ERP for OCD: feasibility, acceptability, and efficacy*), the Discussion (*Findings of the present study and its limitations*), and the Conclusion section have been re-written to emphasize the fact that development and feasibility of the VC-ERP treatment were the primary concerns of the study and efficacy of VC-ERP was a relatively small part of the findings.

Reviewer #5:

Specific Comments to Authors

1 Title: The title reflects the main subject of the manuscript.

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2 Abstract: It summarizes the work in this study.

(a) However, some words should be described instead of using unclear meaning such as "minimum standards of care", "effective".

REPLY

These words have been replaced.

Abstract (Methods) **-** After a systematic evaluation of the available treatment options, an initial protocol for delivering VC-ERP was developed.

Abstract (Results) - The VC-ERP treatment was found to be efficacious in the 11 patients who had completed the treatment. Significant reductions in symptoms and maintenance of treatment gains on follow-up were observed.

Abstract (Conclusions) **-** This study provides preliminary evidence for the feasibility and usefulness of VC-ERP in the treatment of OCD.

Core tip – last line the word effective has been replaced by "efficacious" – "The results, though preliminary showed that VC-ERP was an efficacious and feasible mode of treatment and may be a useful option for OCD even in low-resource settings."

(b) Be careful of mentioning the result out of this study, for example, "...similar to inpatient ERP in the short term but better in the long term". Hybrid care...yielded better results.

REPLY

The sentences - "The efficacy and feasibility outcomes with VC-ERP were similar to inpatient ERP in the short term but better in the long term. Hybrid care combining VC-ERP with in-person ERP yielded better results." – have been omitted from the Abstract and from the relevant section of the Results (*Videoconferencing-based ERP for OCD: effectiveness, feasibility, and acceptability*).

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3 Key words: The key words reflect the focus of the manuscript and "covid-19 pandemic" can be added 4

REPLY

Key words have been modified and include COVID-19.

Key words – Videoconferencing; Exposure-response-prevention; Obsessive-compulsive disorder; Telemedicine; COVID-19

4. Background: VC-ERP or TMH-based ERP or CBT in other countries should be elaborated.

REPLY

This has been done. (Introduction, last paragraph)

A major lacuna in the existing literature on TMH-based psychotherapy for OCD is that most of the studies have been conducted in Western countries[13, 14]. This applies to studies of internet-based CBT, VC-ERP, and other online interventions. Only a few studies of these interventions from Japan[26, 27], Korea[28], and the Middle East[29] could be identified. In general, research on the efficacy of TMH in the treatment of psychiatric disorders from developing countries is limited and reviews of the subject have not included trials on TMH-based treatment of OCD[30-32]. Apart from the lack of evidence, cultural acceptability of TMH-based treatments, their efficacy, and engagement with these treatments are also quite different in these countries. The situation in India is similar. Though VC-based TMH services were used in India before the pandemic and there was an upsurge in these services during it, there are large gaps in the delivery of these services[33, 34]. Controlled trials on TMH-based psychotherapy of OCD are not available. Therefore, a new beginning had to be made. This study describes the formulation and implementation of VC-ERP treatment for OCD during the pandemic and its current status in terms of feasibility and usefulness.

5 Methods:

5.1-The reasons and details of using different platforms (Zoom, WhatsApp, messaging, phone call, email)

REPLY

The reason for using different platforms and other details have been included. (Materials and methods - *Videoconferencing-based ERP for OCD*)

The use of multiple digital modes of patient-clinician communication was consonant with the hybrid model of care, which had been particularly recommended during the pandemic[38]. This improves the flexibility and versatility of TMH-based care and maintains its continuity by switching between different modes when one of them fails.

5.2- Expertise or experiences of treating OCD patients from group leaders?

REPLY

The department including the group leaders had extensive experience of conducting in-person ERP.

This has been clarified and referenced in the Materials and methods section (*Setting*)

"Patients with OCD attending the unit were already being treated with in-person ERP mostly on an inpatient basis. Inpatient ERP was associated with good short-term outcomes, but the long-term outcomes were unclear because of the high dropout rate after discharge[35]." The department had also been running a home-based TMH service on a smaller scale since September 2018. This service was used for VC-based follow-up of patients who had completed in-person ERP. Following the shutdown of the outpatient clinics in March 2020, the home-based TMH service was upgraded and scaled up to cater to all outpatients. The features of this service have been described elsewhere[37]. This expanded platform allowed the delivery of VC-ERP based on the treatment protocol for in-person ERP.

This has been re-emphasized in the Discussion (*Videoconferencing-based ERP for OCD versus internet-based CBT*)

The choice of VC-ERP in this study was influenced by these considerations along with the prior experience of in-person ERP in the department, the availability of a home-based platform for VC-ERP, and the unavailability of internet-based treatments.

5.3- Again, please clarify minimum standards of care.

REPLY

The phrase "minimum standards of care" has been removed. It has been replaced with -

Standardized guidelines for VC-ERP were prepared and it was ensured that clinicians adhered to these standards of care.

(Materials and methods - *Videoconferencing-based ERP for OCD*)

5.4- Is YBOCS used for screening? Which version of YBOCS do the authors used in this study, interviewer-rated or self-rated?

REPLY

The clinician-administered version of the YBOCS was used. The YBOCS checklist of common obsessions and compulsions was used for screening and the scale was used to rate severity of OC symptoms. This has been clarified in the Materials and methods section - *Modifications in technique required for conducting videoconferencing-based ERP*.

The clinician-administered version of the Yale-Brown Obsessive Compulsive Scale (YBOCS) was used to screen for different obsessions/compulsions as well as to rate the severity of obsessive-compulsive symptoms. The YBOCS is the most commonly used instrument for these purposes because of its reliable psychometric properties[1, 4, 13].

5.5 -The five-step approach should be referred in more detail in table 1

REPLY

A detailed explanation of the five-step ERP has been added as a footnote to Table 1.

5.6 -Inclusion and exclusion criteria if the participants.

REPLY

The process of examining feasibility and efficacy outcomes has been explained in greater details in the Materials and methods section (*Outcomes of videoconferencing-based ERP*). This revised section now includes information about outcomes, patients included and excluded, and the process of obtaining information regarding outcomes.

Outcomes of videoconferencing-based ERP

The main focus of this study was on the feasibility outcomes including operational viability, service utilization, service engagement, need for additional services, frequency of adverse events, and treatment satisfaction and treatment preferences among patients, caregivers and clinicians. The information about treatment engagement and the dropout rate was obtained from the medical records of patients who were offered ERP and either consented or refused the treatment. For all other outcomes, only patients who agreed to undertake ERP and those who completed or were actively engaged in the treatment were included. Patients were not interviewed separately for this part. Rather, information was obtained from their treatment records. Therefore, any patient with incomplete treatment records was excluded. For the efficacy outcomes, only 11 patients who had completed ERP were considered. Pre- and post-treatment YBOCS scores were extracted from their records to determine efficacy of VC-ERP treatment. Information about maintenance of gains post-treatment over 13 months was also extracted from the treatment records.

5.7- According to the using of t-test with small sample size. Does your data normally distributed? If not, considering non parametric test.

REPLY

A non-parametric test, the Wilcoxon Signed Rank test was used instead of Student's t- test in view small sample size and possible non-normal distribution.

(Materials and Methods)

Statistical analysis

Frequencies, means, and standard deviations were used to characterize the sample. Loss to follow-up during any time was considered a dropout. Pre- and post-treatment comparisons were carried out using the Wilcoxon Signed Rank test.

6 Results:

6.1-Many confounders might affect the result, such as pharmacological treatment and comorbidities. How the authors control these effects?

REPLY

Since this was a naturalistic observational study and only 11 patients who completed ERP treatment were considered, it was not possible to control for these confounders. This has been mentioned as a limitation of this study (Discussion - *Findings of the present study and its limitations*). However, all patients were receiving medications and the results suggested that comorbid conditions did not affect the efficacy of ERP.

Findings of the present study and its limitations

Being a preliminary report, this study had several obvious limitations. It was largely a descriptive account of the development and implementation of VC-ERP for OCD from a relatively under-resourced setting. The number of patients who had completed the treatment was very small and all data related to the efficacy of VC-ERP are therefore prone to a high risk of bias. This risk is increased further because patients were not randomized to VC-ERP treatment and there was no control group. A selection bias toward better-motivated patients is also possible. Since this was a naturalistic observational study, it was not possible to control for confounding factors such as the effect of pharmacological treatment or comorbid conditions.

6.2- How about the criteria for using hybrid treatment? How to differentiate the effect of onsite treatment from online one?

REPLY

Hybrid-care involved conducting initial ERP on in-person basis for every step of the hierarchy. Subsequent sessions were conducted through VC. This was more often employed when patients had difficulty in understanding and completing the VC sessions, or if they were poorly motivated for exclusive VC treatment. In-person sessions were also held if the patients/caregivers wanted additional in-person sessions. There were no differences between the procedures followed for VC or in-person ERP sessions. These details are included in Table-1 (Hybrid care) and Table-4 (Using hybrid modes of treatment).

7 Discussion:

7.1-What are the difference between VC-ERP and internet-based CBT?

7.2- It seems like the authors focus on the benefit of VC-ERP. Could it be added more information about the developmental process of the protocol for it? (As stated in the title)

REPLY

A more detailed discussion on the benefits of internet-based CBT compared to VC-ERP treatment has been included in the revision. (Discussion - *The efficacy, advantages, and disadvantages of videoconferencing-based ERP for OCD; Videoconferencing-based ERP for OCD versus internet-based CBT*)

The following lines have been added about internet-based CBT-

Currently, there seems to be a greater emphasis on delivering online or internet-based ERP or CBT for OCD particularly in high-income countries [9]. The two types of treatment have their own advantages and disadvantages. Internet-based CBT has a broader evidence base and the number of trials including RCTs is much more than those of VC-ERP [10, 12-14]. Its efficacy is comparable to in-person CBT. Internet-based CBT is particularly useful as an initial option for mild or moderate OCD. Moreover, it is more readily accessible and offers a wider choice of techniques and varying levels of clinician assistance. The treatment is efficacious and cost-effective even with

low levels of clinician support. However, greater levels of clinician support can help minimize dropouts and treatment gains are usually enduring.

7.3- How can this protocol be generalized for other OCD patients which were not included in this study?

REPLY

The following lines about the generalization of the results of the current study have been added to the revision (Discussion - *Findings of the present study and its limitations*).

Since this was a naturalistic observation study among patients from routine care settings, these results can be generalized to other patients from similar clinical settings. Moreover, since the treatment was conducted in a low-resource setting of a developing country like India, these results could be particularly relevant for countries with similar resource constraints. Although the treatment was mostly conducted during the pandemic, the findings showed that it was feasible to implement the treatment even after the pandemic had subsided.

8 Illustrations and tables: Most of tables are too jam-packed.

REPLY

All tables have been substantially revised to reduce their content and make them more readable.

9 Biostatistics: Does the manuscript meet the requirements of biostatistics? -yes

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10 Units: Does the manuscript meet the requirements of use of SI units? -yes

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11 References: The references of VC-ERP or internet-based CBT for OCD from other countries should be added.

REPLY

This has been done. References 27-34 include studies from Japan, Korea, Middle-Eastern countries, India, and reviews of studies from LAMI countries.

12 Quality of manuscript organization and presentation: Is the manuscript well, concisely and coherently organized and presented? Is the style, language and grammar accurate and appropriate? -yes

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13 Research methods and reporting: The authors mostly complied with STROBE statement.

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14 Ethics statements: Please clarify this statement" Since patients were not contacted or assessed for this study, written informed consent was not required"

REPLY

The ethical considerations followed during the conduct of this study have been re-written. (Materials and methods section- *Ethical considerations*). The statement made above has been modified and clarified. The informed consent statement has also been changed accordingly. Details of informed consent have been added to the title page.

Ethical considerations

This observational study was a part of a larger study on home-based TMH services for all patients[37]. The protocol was approved by the institute's ethics committee. Due to the restrictions imposed by the pandemic, verbal informed consent over the phone was allowed. As explained above, data regarding outcomes were obtained

only from patients who had verbally consented to undertake ERP and had actively engaged in the process of treatment. However, patients were not contacted or assessed separately to determine these outcomes. Rather, all data regarding outcomes were extracted from routine medical and treatment records. Patient identities have not been revealed. Therefore, written informed consent from patients was not obtained for information about treatment outcomes. All the methods followed the guidelines of the Declaration of Helsinki for medical research involving human subjects.

Company editor-in-chief:

Please authors are required to provide standard three-line tables, that is, only the top line, bottom line, and column line are displayed, while other table lines are hidden. The contents of each cell in the table should conform to the editing specifications, and the lines of each row or column of the table should be aligned. Do not use carriage returns or spaces to replace lines or vertical lines and do not segment cell content.

REPLY

As per the guidelines for observational studies, the three-line format has been followed for all tables with one horizontal line under the title, a second under the column headings, and a third below the last row of the table (being above any footnotes). Vertical lines and italics have been omitted. Since the tables are spread over two pages, there is an additional line at the top of the second pages. This will disappear when the tables are displayed in a single page.

Before final acceptance, when revising the manuscript, the author must supplement and improve the highlights of the latest cutting-edge research results, thereby further improving the content of the manuscript. To this end, authors are advised to apply a new tool, the Reference Citation Analysis (RCA). RCA is an artificial intelligence technology-based open multidisciplinary citation analysis database. In it, upon obtaining search results from the keywords entered by the author, "Impact Index Per Article" under "Ranked by" should be selected to find the latest highlight articles, which can then be used to further improve an article under

preparation/peer-review/revision. Please visit our RCA database for more information at: https://www.referencecitationanalysis.com/.

REPLY

We have downloaded 60 of the 64 available references from the RCA website and ranked them according to the "Impact Index Per Article." But we are not sure how this information has to be included in the revised manuscript. If we receive some guidance how to do this, this ranking can be included.