Obsessive Compulsive Disorder during COVID-19 – two- and six-month follow-ups.

OCD during COVID-19

Lior Carmi, PhD¹,²,³, Oded Ben-Arush, PhD², Leah Fostick, PhD⁴, Hagit Cohen, PhD⁵, and Zohar Joseph, MD¹,²

1. The Post-Trauma Center, Chaim Sheba Sheba Medical Center, Israel
2. The Israeli Center for OCD, Modiin, Israel
3. The Data Science Institution, The interdisciplinary center, Herzliya, Israel.
4. Department of Communication Disorders, Ariel University, Israel
5. Anxiety and Stress Research Unit, Beer-Sheva Mental Health Center, Faculty of Health Sciences, Division of Psychiatry, Ben-Gurion University of the Negev, Israel

Corresponding author: Prof. Joseph Zohar, Chaim Sheba Medical Center, 2 Sheba road St. Phone number: +97235357805, Email: Joseph.Zohar@sheba.health.gov.il

© The Author(s) 2021. Published by Oxford University Press on behalf of CINP. This is an Open Access article distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/4.0/), which permits unrestricted reuse, distribution, and reproduction in any medium, provided the original work is properly cited.
Abstract

Background: Psychiatric patients are perceived to be especially vulnerable during a pandemic as it increases stress and uncertainty. Several current publications have considered Obsessive-Compulsive Disorder (OCD) patients to be particularly vulnerable during the Coronavirus Disease 2019 (COVID-19), and clinicians were advised to adjust treatments accordingly. The purpose of this study was to evaluate the two- and six-month impacts of COVID-19 on the symptom severity of OCD patients.

Methods: A cohort of OCD patients, actively treated with Exposure and Response Prevention [ERP] combined with pharmacological treatment, was evaluated as part of their regular psychiatric assessment twice: 113 patients were evaluated at their two-month follow-up, and 90 patients (from that cohort), were evaluated at their six-month follow up.

Results: Eighty-four percent of the patients at the two-month follow-up and 96% of the patients at the six-month follow-up did not show OC symptom deterioration. The results were also replicated in the OCD subgroup that included contamination (washers) and patients with illness obsessions who were believed to be particularly vulnerable, considering their obsessional content.

Conclusion: OCD patients (including those with obsessions related to contamination and health) who are under an active ERP and pharmacological treatment, did not experience exacerbated symptoms during COVID-19 at their two- and six-month follow-ups.

Keywords: OCD; CBT; COVID-19.
Significance Statement: This is a six-months follow-up study of OCD patients during COVID-19. The results indicated a clinical stability among most of the patients, including those with contamination and illness obsessions. Clinical implications are discussed.
Introduction

In March 2019, Coronavirus Disease 2019 (COVID-19) was officially recognized as a worldwide pandemic. Accordingly, lockdown and safety measures, including social distancing and strict hygiene regulations, were taken by many countries. The dramatic increase in health-related stress and economic issues, changes in daily routines and reduced availability of mental health services has led to increasing concern regarding the psychological effects of the lockdown (Ghebreyesus, 2020; Rubin and Wessely, 2020). Accordingly, the vulnerability of psychiatric patients during the COVID-19 outbreak has been addressed in scientific publications (Wang et al., 2020).

Several publications have considered Obsessive-Compulsive Disorder (OCD) patients to be particularly vulnerable during COVID-19 and expected that they will require special care and altered treatment (Fineberg et al., 2020). The assumption was that since OCD patients are characterized by the feeling of uncertainty (Coles et al., 2005; Hellriegel et al., 2017) and the need to avert danger, COVID-19 would enhance their obsessions and compulsions and consequently result in a higher risk of deterioration among these patients (Banerjee, 2020; Kumar and Somani, 2020). This would be specifically true for those patients with contamination (washer) and illness obsessions as their obsessional content is related to virus infection (Fineberg et al., 2020).

This rationale is mainly rooted in the link between stress and the exacerbation of psychiatric symptomatology (Williams et al., 1981; Brown and Harris, 2012). The general assumption is that psychiatric patients, who are already less functional during normal routines, are expected to function even less under stressful circumstances. However, the findings from studies conducted during earlier times of external and global stressors (e.g., wars) found no symptomatic exacerbation at times when real, external threats to physical
health were present (Schlossberg, 1992) (Sasson et al., 1999); therefore, they do not support this view. Indeed, several COVID-19 studies have also found limited exacerbation of OC symptoms in OCD patients (Sharma et al., 2020) (Benatti et al., 2020; Nissen et al., 2020), but all are limited to the initial impact of the pandemic and suffer from methodological shortcomings. Hence, although the course of the current pandemic (COVID-19) is not yet fully understood, its initial (two-month) and six-month impacts on OCD symptomology can now be assessed.

**Methods**

The study was IRB approved by the IRB committee of Chaim Sheba Medical Center.

**Participants**

All OCD patients from the Israeli Center for OCD who arrived to clinical assessments during April-May 2020 and during September 2020 were evaluated in the study. The participants were diagnosed with OCD by a psychiatrist or psychologist and were under ongoing treatment using Cognitive Behavioural Treatment (CBT) and Exposure and Response Prevention (ERP) in the Israeli Center for OCD clinic (see below). The inclusion criteria were as follows: A. Primary diagnosis of OCD, B. Being treated for OCD for at least four months before the beginning of the COVID-19 crisis and still in ongoing treatment or maintenance with the same clinicians (LC, OBA, and JZ), and C. Stable medication dosages for at least two months (please see table 1 for the demographic characteristics). The patients were clinically evaluated in person (physically or via Zoom) as part of their treatment routine, and the evaluations were conducted by the same treating psychiatrist or psychologists. In order to achieve coherency in the rating, the interviews were conducted with two clinicians in the room (LC and JZ or OBA and JZ) and final score was achieved in agreement.
The participants are treated at the Israeli Center for OCD. The treatment includes cognitive and behavioural treatment along with intensive Exposure and Response Prevention (ERP) treatment (a few times a week) and family intervention. Patients are also enrolled in a WhatsApp group with their psychologist and ERP trainers and are monitored daily on their progress (i.e., close monitoring takes place even after the patients leave the clinic). All patients are prescribed medium to high dosages of Serotonin Reuptake Inhibitors (SRIs); and in some cases, there is an augmentation of small dosages (usually 2.5 mg) of the D2 antagonist aripiprazole (Table 1).

Clinical assessments

The following Global Clinical Impression – Improvement (CGI-I) questionnaires were given.

1. To what extent does Covid-19 influence your therapeutic course?
   a. Very much improved
   b. Much improved
   c. Minimally improved
   d. No influence
   e. Minimally worse
   f. Much worse
   g. Very much worse

2. What is your level of compliance with the health regulations (e.g., wearing a mask, practicing social distancing, washing hands, keeping the quarantine, etc.) compared to your family/friends/relatives?
   a. Much more relaxed
   b. More relaxed
c. A little more relaxed
d. Same as my surroundings
e. A little more strict
f. More strict
g. Much more strict

3. Does the Corona ‘affect’ your obsession content or compulsions?

a. Not at all
b. Not
c. Probably not
d. Not sure
e. Probably yes
f. Yes
g. Definitely yes

Statistical Analysis

The data analysis was performed using the IBM SPSS 25 software. The clinical evaluation questions for OCD were analyzed using a chi-squared test. The difference between the OCD subgroups in the three questions was analyzed using a chi-squared test for independence, with the groups (Other (i.e., non-contamination and non-illness obsessions as one group and Contamination and Illness domains in the second group) as independent variables and the questions (all three of them) and responses as dependent variables. In each question all 7 answers were analysed and the required p-value for significance was corrected (Pc) for the
relevant number of comparisons. A t-test was employed to evaluate the mean differences between groups.

Results

At the two-month follow-up, a total of 113 OCD patients were evaluated (Table 1). Sixty-five of them (58%) were in an active phase of the treatment (ERP 2-3 times a week and active family consultation) while 48 were in a maintenance phase (clinical monitoring every 1 to 6 months) (42%).

At the six-month follow-up, from the initial cohort of 113 patients, 11 patients finished their active phase of treatment and were not available during the data collection time, and 12 patients stopped treatment (7 due to financial issues and the other 5 patients due to other reasons – none related COVID-19 issues). Thus, the final analysis was conducted on 90 patients (54 in an active phase and 36 in a maintenance phase).

Please insert table 1 here

Two-month follow-up.

Clinician assessment – (CGI-I)

The number of patients who reported no influence of their therapeutic course (CGI-I) following the COVID-19 lockdown was significantly higher (n = 76/113) than the other answers (very much improved (n = 2/113), much improved (n = 10/113), minimally improved (n = 11/113), minimally worse (n = 11/113), much worse (2/113), and very much worse (n = 1/113)) [χ²(6)=266, p<0.001]. Interestingly, the same significant pattern was shown even in those patients suffering primarily from the contamination and illness
obsessions (n = 46) with no statistically significant difference between the subgroups [χ²(6) = 2.16, p = 0.91]. The percentage of each answer for each group is presented in figure 1.

Figure 1. CGI-I scores of OCD patients’ therapeutic course at 2 months following the Covid-19 lockdown. A presentation of the general domains of OCD patients without contamination and illness obsessions (dots), OCD patients with primary contamination and illness obsessions (solid black), and all OCD patients (squares).

**p<0.001

Compliance with health regulations

Regarding the extent to which OCD patients are compliant with the health regulations, 110 (out of 113) patients reported their actions to be more relaxed or the same as their family and friends compared to only three patients reporting slightly stricter compliance [χ²(6) = 252, p < 0.001]. Here, again, a similar pattern was found for those patients with contamination and illness obsessions (Figure 2) with no statistically significant difference between the subgroups [χ²(6) = 2.16, p=0.91]
Figure 2. The degree of OCD patients’ compliance with health regulations at 2 months compared to their surroundings following the Covid-19 lockdown. A presentation of the general domains of OCD patients without contamination and hypochondriasis (dots), OCD patients with primary contamination and illness obsessions (solid black), and all OCD patients (squares). **p<0.001

COVID-19 as an obsession

The number of OCD patients who reported that COVID-19 did not affect their OCD was significantly higher (not at all (n = 102/113) and not (n = 4/113)) than other answers (probably not (n = 3/113) and probably yes (n = 4/113)) [χ²(3) = 256.74, p < 0.001]. Here, again, the same significant pattern was identical, even in those OCD patients suffering primarily from contamination and illness obsessions (n = 46) with no statistically significant difference between the subgroups [χ²(3) = 7.85, p > 0.01], taking into account the multiple comparison correction. The percentage of each answer for each group is presented in Figure 3.

Figure 3. The extent to which COVID-19 became an obsession at 2 months A comparison between general domains of OCD patients without contamination and illness obsessions (dots), OCD patients with primary contamination and illness obsessions (solid black), and all OCD patients (squares). **p<0.001

In addition, the demographic characteristics and treatment phase did not reach statistical significance in any of the questions (Table 2).
Six-month follow-up

Clinician assessment – (CGI-I)

At six months, the number of patients who reported no influence of COVID-19 lockdown on their therapeutic course (CGI-I) was significantly higher (No change; n = 65/90; 72.2%) compared to the other answers (very much improved (n = 12/90; 13.3%), much improved (n = 5/90; 5.5%), minimally improved (n = 4/90; 4.5%), minimally worse (n = 1/90; 1.1%), much worse (2/90; 2.2%), and very much worse (n = 1/90; 1.1%)) [$\chi^2(6)=286$, $p<0.001$]. Furthermore, the same significant pattern was shown even in those patients suffering primarily from the contamination and illness obsessions (n = 36) with no statistically significant difference between the subgroups [$\chi^2(6) = 1.92$, $p = 0.84$].

Compliance with health regulations

The vast majority of the patients reported at 6 months that their level of compliance with health regulation was slightly more relaxed or the same as their family and friends (n= 87/90; 96.6%) compared to only six patients reporting slightly stricter compliance (n= 3/90; 3.4%) [$\chi^2(6) = 261$, $p < 0.001$]. Here, again, patients with the contamination and illness obsessions did not differ from the general findings with no statistically significant difference between the subgroups [$\chi^2(6) = 2.22$, $p=0.93$])
COVID-19 as an Obsession

At six months, the number of OCD patients that reported that COVID-19 did not affect their OCD was significantly higher (not at all (n = 75/90; 83.3%) and no (n = 8/90; 8.8%)) than other answers (probably not (n = 3/90; 3.3%), probably yes (n = 2/90; 2.2%), and yes (n=2/90; 2.2%)) [χ^2 (3) = 242, p < 0.001]. Here, again, the same significant pattern was identical even in those OCD patients suffering primarily from contamination and illness obsessions (n = 36) with no statistically significant difference between the subgroups [χ^2 (3) = 5.67, p > 0.01], taking into account the multiple comparison correction.

No statistically significant difference was found for each of the questions between the two- and six-month follow-ups or any of the demographic characteristics.

Discussion

The present study is, to the best of our knowledge, the first to include longitudinal follow-ups on OCD symptoms in OCD patients at two and six months from the first pandemic lockdown. We found that 84% of the patients at the 2-month follow-up and 96% of the patients at the six-month follow-up showed no OCD exacerbation. This finding was not influenced by age, gender, occupational status, or OCRD comorbidities. This pattern was also found in OCD patients who would be intuitively considered to be influenced by the viral pandemic, i.e., those with primarily contamination (washer) and illness obsessions.
Our findings are in line with previous studies conducted at the two-month follow-up under the same methodology (i.e., in-person assessment with a clinician). The first ((Davide et al., 2020), n=30) investigated OCD exacerbation in children and adolescents and reported deterioration in 13% of the patients. The second ((Matsunaga et al., 2020), n=60) reported exacerbation in 10% of the cohort. Other studies examining the initial impact of the Covid-19 pandemic on OCD have found deterioration in some patients, ranging from 6% (Chakraborty and Karmakar, 2020; Sharma et al., 2020) to 36% (Benatti et al., 2020; Nissen et al., 2020) and 54% (Tanir et al., 2020). However, in all of them, patients were evaluated mainly through the telephone or an internet survey (Benatti et al., 2020; Chakraborty and Karmakar, 2020; Nissen et al., 2020; Sharma et al., 2020; Tanir et al., 2020) which exposed the results to a subjective perspective (self-rating vs clinician rating) and to a biased cohort (only those who agreed to conduct the follow-up or answered the online message).

Our results are also in line with prior reports, which found that during external and real threats to physical health, psychiatric patients managed to function well. These findings were found for schizophrenic patients who managed to overcome their internal auditory and visual hallucinations while facing real external threats (during the Gulf War in Israel) and functioned as requested and in an organized manner (Melamed et al., 1996). This was also the case for patients with panic disorder who managed to overcome their suffocation pathology from wearing gas masks and getting into crowded, locked shelters during the Gulf War without developing panic attacks (Sasson et al., 1999). Thus, an optional explanation for our results (and the former results) might be the difference between personal and nonpersonal stressors. This suggests that personal or psychological stress (Cohen et al., 2007) (e.g., loss of a job, divorce, etc.) might be experienced with a sense of responsibility and self-blame compared to events in which external and no personal stressor emerges (e.g., rocket attacks, earthquakes, tsunamis, COVID-19, etc.). Thus, while personal stressors tap the pathology and
exacerbate the symptoms, nonpersonal stress pushes the internal pathology to the back seat and results in adaptive, lifesaving adaptive mechanisms.

Another explanation might be the ‘pulling together’ effect (Joiner Jr et al., 2006). According to this theory, at times of pan community, (national/global) threats and traumatic events, people tend to “pull together”, i.e., the feeling of cohesiveness and belongingness increases. Accordingly, this cohesiveness acts as a protective mechanism, and personal stressors at these times tend to be secondary or less dominant.

An alternative explanation for our results might be the contribution of the inherent avoidance element of the quarantine (e.g., less driving, not touching public handles, not using public transportation, etc.) that might have contributed to some extent to the stability of the patients. However, as in our clinic, the treatment continued throughout this time and exposure continued, which (with the necessary adjustments) also balanced these ‘legitimate’ avoidance behaviours to some extent.

Several limitations are to be mentioned. The first limitation regards the specificity of the study. Our results are limited only to patients who are currently in treatment (whether in the active or maintenance phase). Furthermore, the patients in this study were treated in a private clinic. Those in the acute phase of the treatment experienced intensive ERP treatment (up to a few times a week) and close interaction and monitoring patients throughout the day (via WhatsApp groups). Those in the maintenance phase experienced less intensive treatment (e.g., meetings every couple of weeks). In addition, the treatment was continued (with minor adaptations) during the lockdown. In addition, many of the patients in the Center for OCD work, and all of them have been prescribed medium to high dosages of an SRI (some with a D2 partial agonist as an augmentation). In this regard, our results are limited only to patients who have already participated in intensive treatment for a few months or have been in the
maintenance phase of this treatment. Notably, the same pattern of results was maintained for the acute and maintenance phases; accordingly, the generalizability of those results is limited only to patients who are in treatment.

The second limitation regards the absence of a ‘gold standard’ measure (i.e., YBOCS) or validated measures for relapse and remission. However, the fact that the evaluations were made by the authors (LC, OBA & JZ) who are very familiar with the patients (all were treated by them for more than half a year) might ‘compensate’ for the absence of these measurements to some extent.

In conclusion, our findings may imply that at least for patients who are under active treatment the ongoing CBT and SRI treatment, should be continued, including exposures (considering the health regulations and requirements). Further studies examining the more chronic effects of COVID-19 and further exploring the different effects of the pandemic on treated and untreated OCD (and other disorders) are warranted.
Funding Statement: This research received no specific grant from any funding agency, commercial or not-for-profit sectors

Acknowledgments

The manuscript was edited by a language editing services. However, the authors are entirely responsible for the scientific content of the paper.

Conflict of interest

None.
References

Banerjee D (2020) The other side of COVID-19: Impact on Obsessive Compulsive Disorder (OCD) and Hoarding. Psychiatry Research.

Benatti B, Albert U, Maina G, Fiorillo A, Celebre L, Girone N, Fineberg N, Bramante S, Rigardetto S, Dell’Osso B (2020) What Happened to Patients With Obsessive Compulsive Disorder During the COVID-19 Pandemic? A Multicentre Report From Tertiary Clinics in Northern Italy. Frontiers in Psychiatry 11:720.

Brown GW, Harris T (2012) Social origins of depression: A study of psychiatric disorder in women: Routledge.

Chakraborty A, Karmakar S (2020) Impact of COVID-19 on Obsessive Compulsive Disorder (OCD). Iranian Journal of Psychiatry 15:256-259.

Cohen S, Janicki-Deverts D, Miller GE (2007) Psychological stress and disease. Jama 298:1685-1687.

Coles ME, Heimberg RG, Frost RO, Steketee G (2005) Not just right experiences and obsessive–compulsive features:: Experimental and self-monitoring perspectives. Behaviour Research and Therapy 43:153-167.

Davide P, Andrea P, Martina O, Andrea E, Davide D, Mario A (2020) The impact of the COVID-19 pandemic on patients with OCD: effects of contamination symptoms and remission state before the quarantine in a preliminary naturalistic study. Psychiatry Research:113213.

Fineberg N, Van Ameringen M, Drummond L, Hollander E, Stein D, Geller D, Walitza S, Pallanti S, Pellegrini L, Zohar J (2020) How to manage obsessive-compulsive disorder (OCD) under COVID-19: A clinician’s guide from the International College of Obsessive Compulsive Spectrum Disorders (ICOCS) and the Obsessive-Compulsive Research Network (OCRN) of the European College of Neuropsychopharmacology. Comprehensive Psychiatry.

Ghebreyesus TA (2020) Addressing mental health needs: an integral part of COVID-19 response. World Psychiatry 19:129.

Hellriegel J, Barber C, Wikramanayake M, Fineberg NA, Mandy W (2017) Is “not just right experience” (NJRE) in obsessive-compulsive disorder part of an autistic phenotype? CNS spectrums 22:41-50.

Joiner Jr TE, Hollar D, Orden KV (2006) On Buckeyes, Gators, Super Bowl Sunday, and the Miracle on Ice: “Pulling together” is associated with lower suicide rates. Journal of Social and Clinical Psychology 25:179-195.

Kumar A, Somani A (2020) Dealing with Corona virus anxiety and OCD. Asian Journal of Psychiatry:102053.

Matsunaga H, Mukai K, Yamanishi K (2020) The acute impact of the pandemic of COVID-19 on the phenomenological features in the full or partial remitted patients with obsessive–compulsive disorder (OCD). Psychiatry and Clinical Neurosciences.

Melamed Y, Solomon Z, Szor H, Elizur A (1996) The impact of the Gulf War on the mental health of schizophrenic patients. Psychiatry 59:267-273.

Nissen JB, Højgaard D, Thomsen PH (2020) The immediate effect of COVID-19 pandemic on children and adolescents with obsessive compulsive disorder. BMC psychiatry 20:1-10.

Rubin GJ, Wessely S (2020) The psychological effects of quarantining a city. Bmj 368.

Sasson Y, Zohar J, Gross R, Taub M, Fux M (1999) Response to missile attacks on civilian targets in panic disorder. The Journal of clinical psychiatry 60:385-388.

Schlossberg A (1992) Israeli civilians’ reactions to missile attacks. Emergency Psychiatry Today:147-152.

Sharma LP, Balachander S, Thamby A, Bhattacharya M, Kishore C, Shanbhag V, Jaisoorya T, Narayanawamy JC, Arumugham SS, Reddy YJ (2020) Impact of the COVID-19 Pandemic on the Short-term Course of Obsessive-Compulsive Disorder. medRxiv.
Tanir Y, Karayagmurlu A, Kaya İ, Kaynar TB, Türkmen G, Dambasan BN, Meral Y, Coşkun M (2020) Exacerbation of obsessive compulsive disorder symptoms in children and adolescents during COVID-19 pandemic. Psychiatry Research 293:113363.
Wang Q, Xu R, Volkow ND (2020) Increased risk of COVID-19 infection and mortality in people with mental disorders: analysis from electronic health records in the United States. World Psychiatry.
Williams AW, Ware Jr JE, Donald CA (1981) A model of mental health, life events, and social supports applicable to general populations. Journal of Health and social behavior:324-336.

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.
Table 1. Demographic characteristics of both OCD patient groups.

|                          | OCD Patients 2-month follow-up (N=113) | OCD patients – 6-month follow up (N=90) |
|--------------------------|----------------------------------------|-----------------------------------------|
| Gender (Male/Female (n)) | 56/57                                  | 47/43                                   |
| Age (Range, Mean)        | 8-18, 14.3 ± 3.2                       | 9-18, 14.8, ± 3.2 (n= 17)               |
|                          | 19-73, 33.8 ± 10.5                     | 19-73, 35.6, 33.8 ± 9.6 (n= 73)         |
| Marital Status (n)*      | Single (n=13)                          | Single (n=12)                           |
|                          | Married (n=36)                         | Married (n=34)                          |
| General Employment**     | 68/84 (80%)                            | 51/69 (73%)                             |
| Currently on leave due to pandemic | 45/84 (53%) | 39/69 (56%) |
| OCD domains              |                                        |                                         |
| Harm\Aggressive          | 15 (13%)                               | 12 (13%)                                |
| Sexual\Religious         | 16 (14%)                               | 15 (16%)                                |
| Symmetry\Ordering        | 4 (3%)                                 | 11 (11%)                                |
| Contamination, Illness\Washing | 46 (41%)     | 36 (39%)                                |
| Checking\Repeating       | 29 (26%)                               | 26 (29%)                                |
| OCRD domains             |                                        |                                         |
| Trichotillomania         | 6 (5%)                                 | 5 (5%)                                  |
| Body Dysmorphic Disorder | 2 (2%)                                 | 2 (2%)                                  |
| Skin Picking             | 7 (6%)                                 | 5 (5%)                                  |
| Hoarding                 | 5 (4%)                                 | 4 (4%)                                  |
| Medications              |                                        |                                         |
| Escitalopram 20 mg-40 mg | 27 (24%)                               | 23 (25%)                                |
| Fluoxetine 20 mg-40 mg   | 11 (10%)                               | 8 (9%)                                  |
| Fluoxetine 60 mg-80 mg   | 12 (11%)                               | 7 (8%)                                  |
| Fluvoxamine 200 mg-500 mg| 11 (10%)                               | 9 (10%)                                 |
| Sertraline 150 mg-200 mg | 19 (16%)                               | 16 (18%)                                |
| Sertraline 250-500 mg    | 33 (29%)                               | 27 (30%)                                |
| Aripiprazole augmentation (2.5 mg-5 mg) | 74 (65%) | 63 (70%) |
| Aripiprazole augmentation (7.5 mg-10 mg) | 6 (5%) | 4 (4%) |

*Calculated only for patients above the age of 27 (the average age of marriage in Israel) ** Calculated only for patients above the age of 21
Table 2. The influence of the demographic characteristics of OCD patients at the two-month follow-up.

| AGE          | Marital Status* | OCRD | Currently on leave due to the pandemic** | Gender | Treatment phase |
|--------------|-----------------|------|-----------------------------------------|--------|-----------------|
| Above 40 (N=16) | Below 40 (n=9)  | Married (n=36) | Single (n=1) | NO (n=9) | YES (n=2) | NO (n=4) | YES (n=4) | Male (n=5) | Female (n=5) | Active (n=6) | Maintenance (n=48) |
| Change in CGI-S (Mean) | | | | | | | | | | | |
| 4 | 3.8 | 3.9 | 3.7 | 3.9 | 3.7 | 4 | 3.7 | 3.9 | 3.7 | 3.9 | 3.6 |
| P=0.87 | P=0.91 | P=0.92 | P=0.8 | P=0.95 | P=0.78 |
| Health regulations | | | | | | | | | | | |
| 3.8 | 3.7 | 3.9 | 3.7 | 3.8 | 3.8 | 3.8 | 3.8 | 3.8 | 3.8 | 3.7 |
| P=0.89 | P=0.92 | P=0.93 | P=0.98 | P=0.9 | P=0.83 |
| Obsessional thinking | | | | | | | | | | | |
| 1.2 | 1.2 | 1.1 | 1.3 | 1.2 | 1.2 | 1.2 | 1.3 | 1.2 | 1.1 | 1.3 |
| P=0.91 | P=0.94 | P=0.9 | P=0.89 | P=0.95 | P=0.91 |

* Only above the age of 27 (the average age of marriage in Israel). ** Only above the age of 21.
Figure 1
Figure 2
