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B4DT compresses evidence-based ERP into four consecutive days - challenging how OCD care can be delivered with intensity, speed, and sustained clinical impact.

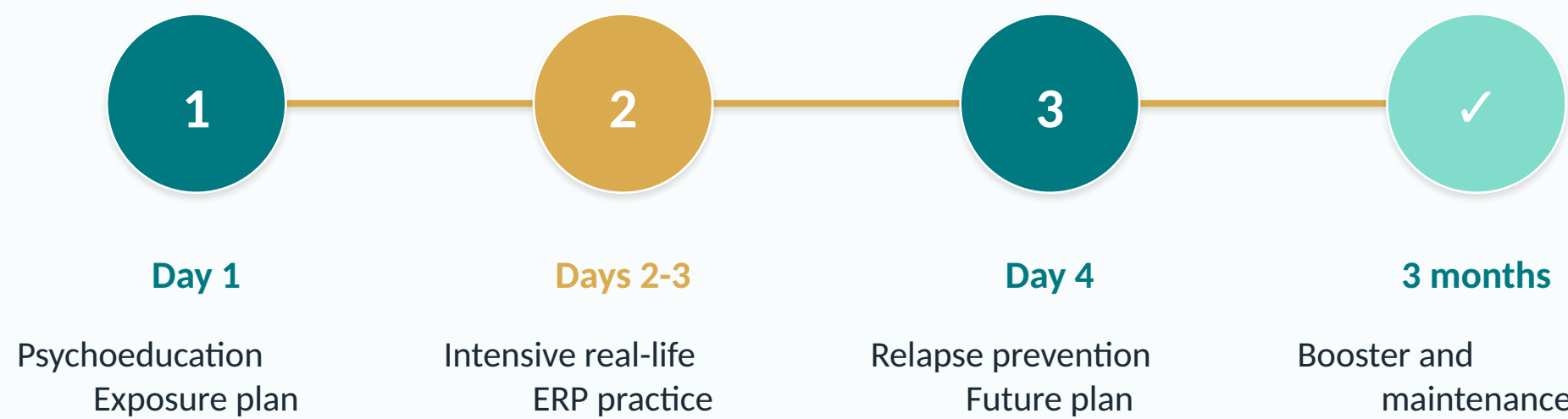
- OCD affects 1-3% of the population and causes major functional impairment.
- CBT with ERP and SSRIs are first-line treatments.
- Standard weekly ERP is effective, but real-world access is limited by waiting lists, therapist availability, cost and treatment duration.
- B4DT is an ultra-concentrated, manualized ERP model developed to accelerate access and therapeutic change.

Aim: Map the evidence on the efficacy and effectiveness of B4DT across populations and clinical settings.

- Assess remission, recovery, relapse and long-term outcomes.
- Evaluate patient satisfaction and acceptability.
- Identify predictors of response and implementation considerations.

- Design: Scoping review.
- Framework: Arksey & O'Malley, refined by JBI; reporting guided by PRISMA-ScR.
- Search period: January 2005 to July 2025.
- Included original quantitative, qualitative and mixed-method studies focused on B4DT for OCD.
- Excluded grey literature, reviews, abstracts, letters and non-English sources.

Four consecutive days of therapist-assisted ERP in a group-based, individually tailored model.



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graph LR
    A[184 identified] --> B[171 screened]
    B --> C[70 full-text]
    C --> D[15 quality]
    D --> E[12 included]
    F[Twelve studies met final inclusion criteria after screening and quality appraisal.]
  
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Stage	Count
Identified	184
Screened	171
Full-text	70
Quality	15
Included	12

Twelve studies met final inclusion criteria after screening and quality appraisal.

75%
Norway
9/12 studies

25%
International
USA, Iceland,
Germany

3
RCTs
controlled
evidence

33-165
Sample size
range per study

Designs included pre-post studies, naturalistic longitudinal effectiveness studies, RCTs and one case series.

The infographic consists of six light blue rounded rectangular boxes arranged in a 2x3 grid. Each box contains a large percentage value, a bolded label, and a descriptive subtitle. The colors of the percentage values are: blue, orange, green, orange, blue, and orange.

Value	Label	Description
83.1%	response	12-month adult follow-up
67.7%	recovery	12-month adult follow-up
0%	dropout	after treatment started
~72%	recovered	4-year outcome
94.9%	response	Iceland post-treatment
~95%	response	US post-treatment

Across studies, B4DT showed large reductions in OCD severity, high remission/response, strong satisfaction and low attrition.

- 1 Efficacy and satisfaction
- 2 Long-term maintenance
- 3 Controlled trial evidence
- 4 Routine implementation
- 5 Predictors of response
- 6 Comorbid and functional outcomes

- JBI Critical Appraisal Tool used for quality assessment.
- 15 studies assessed; 3 excluded due to quality scores below threshold.
- Final 12 studies were high quality.
- Revised Newcastle-Ottawa Scale suggested mostly low to moderate risk of bias.

B4DT changes the treatment architecture, not only the timetable:

- massed ERP across consecutive days;
- high therapist availability;
- real-world exposure practice;
- group motivation with individualized targets;
- active relapse-prevention planning.

- Potential to reduce OCD waiting lists and accelerate access to evidence-based ERP.
- Requires therapist training, fidelity monitoring and protected intensive treatment blocks.
- Measurement-based care should include Y-BOCS/CY-BOCS, functioning and follow-up outcomes.
- Cultural adaptation is essential before broad implementation.

- Evidence base remains young and geographically concentrated.
- Many studies were naturalistic or pre-post designs.
- Heterogeneity limits direct comparison.
- Limited cost-effectiveness and long-term implementation data.

- Multicentre international replication.
- Direct comparison with standard weekly ERP.
- Health-economic evaluation.
- Training, fidelity and adherence-enhancement models.

B4DT demonstrates strong promise as an intensive, acceptable and scalable ERP model for OCD, with high response and remission rates, durable long-term outcomes, and meaningful improvements beyond core OCD symptoms.

Future implementation should be guided by therapist training, fidelity, cultural adaptation, patient selection and measurement-based follow-up.

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