Slide 1

ROGERS
Behavioral Health

Future directions in treating OCD:
A research update

Martin E. Franklin, PhD, and Rachel Schwartz, PhD

August 12, 2025

Slide 2

Quick overview of logistics

- Our program starts with a 70- to 75-minute didactic presentation.
- Following the presentation, there will be a dedicated time to answer your questions.
  - During the program, please use the Q&A feature, located in the toolbar at the bottom of your screen, to send your question to the moderator.
  - The moderator will review all questions submitted and select the most appropriate ones to ask during the Q&A portion of the program.

Slide 3

Disclosures

Martin E. Franklin, PhD, and Rachel Schwartz, PhD, have declared that they do not, nor do their family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation.

The presenters have declared that they do not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships. Further, Rogers Behavioral Health does not accept commercial support for its CE programs.

Slide 4

Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Identify at least one benefit and one limitation of using telehealth for ERP in higher levels of pediatric OCD care.
2. Summarize the difference between "non-fear-based" and fear-based OCD and the rationale for the need to modify standard ERP for non-fear-based presentations.
3. Describe at least three evidence-informed modifications to ERP that could enhance treatment for disgust and "Not Just Right" symptoms in OCD.

What will be covered in this webinar

- Pediatric OCD: Recent Empirical Findings
- Modifying Exposure Plus Response Prevention for Non-Fear-Based Forms of OCD
- Implications of These Research Findings for Clinical Practice

Please note:
Our focus for the content of this program is on the healthcare professional who is practicing in a clinical setting.

5

Presenter subjectivities

Martin E. Franklin, PhD

Professional identities
- Executive Director/OCD Service Line Leader & Associate Prof Emeritus, Univ of Pennsylvania SOM
- Licensed Clinical Psychologist
- PhD in clinical psychology, University of Rhode Island

Personal identities
- He/him/his

Rachel Schwartz, PhD

Professional identities
- Associate Research Psychologist
- Licensed Clinical Psychologist
- PhD in clinical psychology, University of Pennsylvania

Personal identities
- She/her/hers

We acknowledge that our experience, intersectionality, privilege – and lack thereof – informs what we each bring to our research, clinical practice, and teaching

6

Pediatric OCD: Recent Empirical Findings

7

8

Slide 9

Multimodal Treatment for Pediatric OCD Delivered via Telehealth vs. In Person: Predictors, Moderators, and Medication Effects

Franklin, M., Engelmann, J., Schwartz, R., Zickgraf, H., Eken, S. (Rogers Behavioral Health); Freeman J. (Brown University); Himle M. (University of Utah)

Symposium:
Saturday, November 16, 2024

opening our doors

Inspiring Community Engagement, Advocacy, & Innovation to Advance CBT

58th Annual Convention
November 14–17, 2024 | *Philadelphia*

ABCT

9

Slide 10

(S)SRIs for OCD: Summary

- + Consistently superior to PBO in several multi-site RCTs
- + Maintenance of gains with continued treatment
- + Readily available
- - Residual impairment is the norm
- - Some non-responders and dose-limiting side effects
- - Relapse upon SRI discontinuation
- - FDA "Black Box" warning

10

Slide 11

CBT for OCD: Summary

Positives

- CBT is efficacious relative to various control conditions
- Robust symptom reduction
- Compatible with SSRIs
- COMB > CBT & SSRIs alone, but not always (Foa et al., 2005; POTS I, 2004)
- Follow-up assessments attest to the durability of TX gains (e.g., Storch et al., 2007; Foa et al., 2013)

Negatives

- Treatment refusal is an issue
- High quality CBT is difficult to find in most community settings
- TX response is neither universal nor complete: Partial and non-responders (20% – 30%, e.g., Torp et al., 2015)
- **Barriers that limit access to care: Might telehealth help bridge these gaps?**

11

Slide 12

Telehealth in Psychology/Psychiatry: An Alternative/Equivalent Platform?

- A potential avenue for care when access to care is limited by distance/travel, time/expense, & therapist availability
- For whom does it work?
- For whom does it NOT work?
- Some interest in these topics for a decade, but then the pandemic hit…

12

Participants

- 643 patients received telehealth after June 2020
  (67% female; 69% Caucasian, 20% did not disclose race/ethnicity)

- 643 controls matched on age & location received in-person care
  (55% female, 80% Caucasian, 9% did not disclose race/ethnicity)

- *Total sample size = 1,286 youth w/ OCD!!!*

- Mean age for both groups = 14.1, range 7 – 17 inclusive

13

Measures & Criteria

- **CY-BOCS** (Scahill et al., 1997)
  ✓ Primary outcome measure in clinical trials; range 0 - 40
  ✓ Self-report comparable to clinician-rated (Conelea et al., 2012)

- **CY-BOCS Criteria** (from Farhat et al., 2022)
  ✓ Responder Criteria: $\geq$ 35% CY-BOCS reduction
  ✓ Remission: Post-TX CY-BOCS $\leq$ 12

- **PQ-LES-Q** (Endicott et al., 2006)
  ✓ 14 item scale
  ✓ Scores range from 14 to 70 and are expressed as % (0 – 100)

14

Levels of care

Partial hospitalization (PHP):

- 6 hours of programming per day
- Typical stay of 4 – 6 weeks
- 3 hours of individual CBT blocks
- Also group, education, & "Parent University"

Intensive outpatient (IOP):

- 3 hours of programming per day
- Typical stay of 2 – 4 weeks
- Includes group & education

15

CY-BOCS & PQ-LES-Q Continuous Data

	In-Person (n = 643)			Telehealth (n = 643)		
	PHP (n = 409)			PHP (n = 409)		
	Admission M (SD)	Discharge M (SD)	Effect (d)	Admission M (SD)	Discharge M (SD)	Effect (d)
CYBOCS	25.0 (5.3)	15.5 (7.5)	1.5	25.2 (5.3)	16.7 (7.0)	1.4
PQ-LES-Q	44.7 (9.1)	51.6 (9.9)	0.7	45.1 (9.2)	51.3 (9.0)	0.7
	IOP (n = 234)			IOP (n = 234)		
CYBOCS	22.6 (4.7)	14.8 (7.3)	1.3	21.7 (4.0)	16.5 (6.2)	1.0
PQ-LES-Q	48.2 (8.5)	52.5 (9.4)	0.5	48.3 (7.9)	51.7 (8.9)	0.4

16

4

Summary of Regression Analyses/Predictors

- Four variables predicted CY-BOCS scores at discharge:
  - Telehealth, age, diagnosis count, length of stay
- Age and diagnosis count also predicted PQ-LES-Q, both negatively
- **On average, Telelhealth patients discharged with CY-BOCS scores 1.25 points higher than IP patients**
- **$\leq$ 3 point Y-BOCS difference not considered clinically meaningful** (e.g., Foa et al., 2022)

17

Moderators

- Setting, age, diagnosis count, race (White/non-White), ethnicity (Hispanic/non-Hispanic), and sex all assessed
- None moderated either CY-BOCS at discharge or PQ-LES-Q at discharge
  - ▶ Except for a trending ($p < 0.1$) effect suggesting that telehealth may have been more beneficial for girls than for boys ◀

18

Clinical Implications

- Telehealth offers a feasible and efficacious alternative to in-person
- Telehealth predicts slightly higher discharge CY-BOCS
  - Especially at IOP
  - More work is needed to consider additional variables
- Treatment response was robust across variables
- Large-scale test and robust response to telehealth supports its continued use
- Telehealth offers a viable choice when travel/distance and paucity of local expertise limits access to this EST

19

SRI Dose-Response Effects

- Despite the Black Box Warning for youth, SRIs appear to be safe and effective for OCD for use across the developmental spectrum
- Clinical practice guidelines recommend combining SRIs with cognitive behavioral therapy (CBT) that focuses on exposure and response prevention (ERP)
- SRI dosing for OCD has been studied in randomized controlled trials but not in naturalistic settings

20

Clinical Trials of SRIs for Pediatric OCD

Figure 2. Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) Scores During 12 Weeks of Acute Treatment
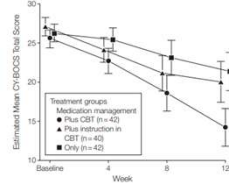
Points are group-specific estimated mean CY-BOCS scores at each time point. Point estimates were derived from the fitted linear mixed models, averaged over site, sex, age (<12 vs ≥12 years), and baseline severity (Clinical Global Impression Severity scale, <5 vs ≥5). Error bars are point-wise 95% CIs.

- "Optimal" doses of SRIs for treating pediatric OCD were initially determined by expert consensus based on clinical trial results.
- The POTS II study, a randomized controlled trial published in 2011, formally tested whether augmentation of these optimal doses of SRIs with CBT (both long and short forms) resulted in OCD symptom improvement compared to SRI alone

(Franklin et al., 2011)

21

Optimal SRI Doses for Pediatric OCD

Table 3: SRI dosing

Drug	Usual Starting dose	~ Mean Dose*	Upper Dose	Incremental Dose
Citalopram**	20	40	60	20
Clomipramine	50	150	250	50
Escitalopram**	10	20	30	10
Fluoxetine	20	40	60	20
Fluvoxamine	50	175	250	50
Paroxetine	20	30	50	10
Paroxetine-CR	20	30	50	10
Sertraline	50	125	200	50
Venlafaxine**	25	100	225	25
Venlafaxine XR**	37.5	112.5	225	37.5

*Mean dose derived from registration trials, expert recommendation and the applicant's clinical experience
**Not included in Expert Consensus Guidelines

(Freeman, et al., 2009)

22

Retrospective Study of Rogers Patients

- Explore the effectiveness of optimizing SRI doses in patients being treated for pediatric OCD.
- Optimal doses were defined as they were for the POTS II study.
- We hypothesized that all patients would show significant symptom improvement with intensive CBT for OCD, and those taking an optimal SRI dose would show more improvement.
- Retrospective analysis of patient data was approved by the Rogers Behavioral Health Institutional Review Board.
- Results presented today are preliminary. About 1/2 of the full sample still needs to be analyzed.

23

Eligibility Criteria

- First stay at Rogers Behavioral Health, admitting to an OCD program at the PHP or IOP level of care between 1/1/2017 and 12/31/2023.
- Age 7-17 at admission
- Primary diagnosis of OCD in Cerner
- Admission and discharge scores available on the CY-BOCS

24

Methods

- Database query identified eligible patients. A stay was defined as contiguous treatment (readmission ≤ 14 days between encounters) at the PHP/IOP level of care.
- Psychiatrist reviewer determined cases that should be excluded (e.g., medication dose was still being titrated at discharge, step-up to residential, illness or other factors that prevented medication from being taken as prescribed).
- Research assistants extracted medication names and doses at admission and discharge from the electronic health record.
- Computer algorithm scored medication names and doses to determine optimization status at admission and discharge.
- Regression analysis examined CY-BOCS and PQ-LES-Q scores at discharge as a function of medication status group, controlling for score at admission and age.

25

Medication Status Groups

- **Stayed None:** Patients who were not taking an SRI at both admission and discharge. *N* = 108
- **Stayed Suboptimized:** Patients who were taking a sub-optimal dose of an SRI at both admission and discharge. *N* = 166
- **Became Optimized:** Patients who were taking a sub-optimal dose of an SRI at admission and an optimal dose of an SRI at discharge. *N* = 141
- **Stayed Optimized:** Patients who were taking an optimal dose of an SRI at both admission and discharge. *N* = 158

Total sample size: 573

26

Sample Characteristics

- **Sex:** 325 female, 244 male, 4 not reported
- **Race:** 417 white, 66 non-white, 90 not reported
- **Ethnicity:** 448 not Hispanic/Latino, 47 Hispanic/Latino, 78 not reported
- **Age:** Mean = 13.7 years, SD = 2.34 years, Range 7-17
- **Level of Care at Admission:** 116 IOP, 457 PHP
- **Maximum Level of Care During Stay:** 91 IOP, 482 PHP
- **Number of Encounters in Stay:** Mean = 1.6, SD = 0.6, Range = 1-4
- **Length of Stay** *(combined for multiple encounters)***:** Mean = 60 days, SD = 28 days, Range = 9-252 days

27

Results: OCD Symptoms
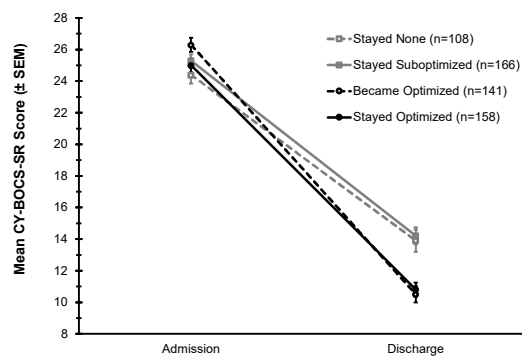
Medication Group Effect: $F_{(3, 567)}$ = 18.73, *p* < .001

28

Results: Quality of Life

Mean PQ-LES-Q Score (± SEM)

- Stayed None (n=97)
- Stayed Suboptimized (n=151)
- Became Optimized (n=137)
- Stayed Optimized (n=155)

Admission — Discharge
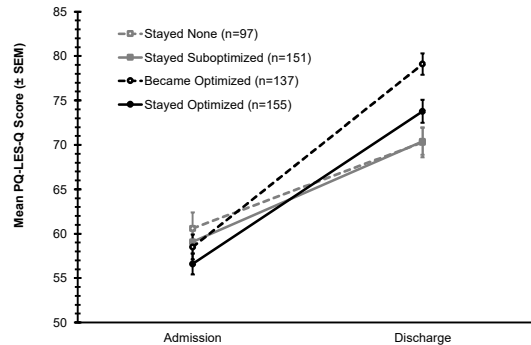
Medication Group Effect: $F(3, 534) = 14.63$, $p < .001$

29

Study Strengths and Limitations

Strengths

- Naturalistic setting
- Large sample size
- Standardized CBT protocol
- Medical review of cases to include/exclude
- Medication information extraction and scoring was manualized, multiple raters verified accuracy

Limitations

- Not a randomized trial
- Medication adherence during study and medication history prior to study not systematically tracked
- Results may not generalize to traditional outpatient settings

30

Implications

- Strong CBT effect across all medication groups underscores the importance of CBT with ERP for treating pediatric OCD.
- Patients on optimal doses of an SRI, either coming into treatment or reached during treatment, had greater OCD symptom reduction.
- Discharge quality of life was higher for patients on an optimal dose of an SRI, especially those who reached an optimal SRI dose during treatment.
- Clinical trial results were replicated in a naturalistic setting.

31

Future Directions

- Finish scoring the medication data.
- Control for comorbid diagnoses and other potential predictors/moderators of treatment efficacy.
- Account for additional, non-SRI medications (e.g., augmentation).
- Examine whether effects differ for each individual SRI.
- Conduct similar studies with child/adolescent residential patients and with adult patients at PHP/IOP/residential.

32

Acknowledgments

- **Medical review and expertise:** Dr. Matt Boyer
- **Medication scoring:** Holly Pelnar, My Le Tran, Kenny Richards, Victoria Hummel
- **Investigative Team:** Marty Franklin, Jeff Engelmann, Rachel Schwartz, Matt Boyer, Stephan Siwiec

33

Modifying Exposure Plus Response Prevention for Non-Fear-Based Forms of OCD

34

When there's nothing to fear…

- OCD was classified as an anxiety disorder until DSM-5
- Fear/anxiety often present, but…
  1) Absent in 49-58% cases
  2) Often not the only emotion driving symptoms

(Bragdon & Coles 2017; Foa et al., 1999)

35

"Not Just Right" (Incompleteness)

- Perform rituals to achieve a "just right" feeling or inner completeness

36

"Not Just Right" (Incompleteness)

Example:
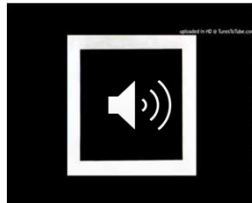
Universally experienced, but in OCD:
- More disturbing
- Difficult to suppress
- Prompt more ritualizing

(Fornes-Romero et al., 2017; Coles et al., 2005)

37

"Not Just Right" (Incompleteness)

- Perform rituals to achieve a feeling of "just right" or inner completeness

- Up to 74% experience clinical levels; sole presentation in 18%-35%

- Associated with worse OCD severity, comorbidity, functioning, quality of life, disability

(Belloch et al., 2016; Ecker & Gönner 2008; Sibrava et al., 2016; Stewart et al., 2017)

38

Disgust

- OCD: more sensitive and prone to disgust than other anxiety disorders/non-anxious controls

- Rituals performed to eliminate revulsion/disgust vs. to prevent feared outcomes ("just icky," "gross")

- Primary or sole emotional driver of OCD symptoms in 19-23% of cases

(Bhikram et al., 2017; Andersson et al., 2015; Bragdon & Coles, 2017)

39

Washing hands…

"If I don't I'll get sick."
Fear/Anxiety

"I just have to until it feels right."
Not Just Right

"If I don't I'll feel gross."
Disgust

Non-Fear-Based (NFB) OCD

40

10

Slide 41

ERP was designed for *fear/anxiety*…

- Emphasis on testing & disconfirming "feared outcomes"

- Not Just Right & Disgust habituate more slowly and less overall than anxiety/fear

- Existing ERP manuals don't provide explicit instructions for Non-Fear-Based forms of OCD

(Milgram et al., 2022; McKay 2006; Mithcell et al., 2024; Olatunji et al., 2009)

41

Slide 42

Worse treatment outcomes: *Not Just Right*

Uncontrolled meta-analysis:

Author(s), Year	Hedges' g [95% CI]
Abramowitz et al., 2013	0.39 [-0.09, 0.87]
Chase et al., 2015	0.64 [0.45, 0.82]
Coles & Ravid, 2016	1.21 [0.62, 1.80]
Dowling et al., 2016	0.32 [0.04, 0.61]
Enander et al., 2012	0.61 [0.30, 0.92]
Fitch, 2016	1.03 [0.11, 1.95]
Gönner et al., 2016	0.76 [0.55, 0.98]
Mahoney et al., 2014	0.66 [0.25, 1.08]
Wilson et al., 2014	0.60 [0.23, 0.97]
Wootton et al., 2013 (bCBT)	0.35 [-0.13, 0.84]
Wootton et al., 2013 (iCBT)	0.65 [0.03, 1.27]
Wootton et al., 2014 (Trial 1)	0.62 [-0.16, 1.39]
Wootton et al., 2014 (Trial 2)	0.12 [-0.26, 0.49]
RE Model	0.57 [0.44, 0.71]

Pre-Post INC (Within-Groups) Hedges' g

Worsen ← → Improve

(Schwartz 2018)

42

Slide 43

Worse treatment outcomes: *Not Just Right*

Controlled meta-analysis:

Author(s), Year	Hedges' g [95% CI]	Control
Fitch, 2016	0.01 [-0.88, 0.90]	PMR
Mahoney et al., 2014	0.55 [0.05, 1.05]	TAU
Wootton et al., 2013	0.47 [-0.13, 1.07]	WL
RE Model	0.44 [0.08, 0.79]	

Controlled (Between-Groups) Hedges' g

← *Control advantage*   *Treatment advantage* →

(Schwartz 2018)

43

Slide 44
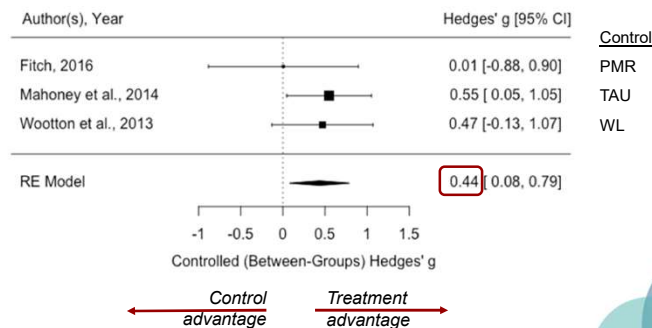
Worse treatment outcomes: *Disgust*

- Among 101 adults with OCD, primary disgust predicted worse outcomes in internet-based CBT (Andersson et al., 2015)

- Meta-analysis of 8 studies (1 OCD) examining exposure-based treatments for anxiety-related disorders broadly: (Pascal et al., 2020)

	Effect size (*g*)
Anxiety	0.79 *(large)*
Disgust	0.36 *(small)*

44

Worse treatment outcomes: *Youth*

Available online at www.sciencedirect.com
ScienceDirect
Behavior Therapy 52 (2021) 53–63

Behavior Therapy
www.elsevier.com/locate/bt

Incompleteness and Disgust Predict Treatment Outcome in
Pediatric Obsessive-Compulsive Disorder

Matti Cervin
Lund University and Skåne Child and Adolescent Psychiatry

Sean Perrin
Lund University

Among 111 youth with OCD,
higher levels of Disgust and Not Just Right at baseline
predicted a worse response in a real-world setting

45

Tailoring ERP could help

Disgust

- Authors of 2020 meta-analysis speculate that disgust may improve less than anxiety because the treatments examined were not tailored to disgust

Not Just Right (NJR)

- Tailored treatments produced significantly larger NJR improvement in Schwartz (2018) meta-analysis:

	Effect size (g)
Tailored (n = 2)	**1.03 - 1.12** *(large)*
Not tailored (n = 9)	**0.12 - 0.76** *(small-medium)*

p = .02

(Schwartz 2018; Pascal et al., 2020)

46

Still unclear:

- What tailoring ERP entails: no standardized protocols or guidelines for Non-Fear-Based OCD

- Which individual tailoring strategies are helpful, and which are not?

- How aligned are academics and clinicians when it comes to treating this population?

47

Survey Study: Clinician Perspectives on Treating Non-Fear-Based OCD

48

Overview

- 97 mental health providers completed an online survey assessing perspectives on using ERP to treat Non-Fear-Based OCD

- Recruited from professional listservs & online forums

- Eligible if mental health clinician (of any kind, in any setting) with ERP experience

49

Aims

- What tailoring methods are clinicians using for Non-Fear-Based OCD?
- Are clinicians using strategies grounded in empirical literature?
- Identify novel strategies that aren't yet being studied
- How well do these methods work?

→ Inform the development & evaluation of the first treatment protocol for Non-Fear-Based OCD

50

Survey

- Defined ERP, Not Just Right, & Disgust OCD with example vignettes
- List of tailoring strategies, derived from literature review and our clinical experiences:

"Which of the following modifications to standard treatment have you used when conducting ERP with [Not Just Right / Disgust] OCD symptoms, if any?" (Yes / No)

If Yes: "How **helpful** was this strategy for [adult/youth] clients?"
1 = Not Helpful at all   to   4 = Very Helpful

- Space to describe other tailoring strategies not listed

51

Participating clinicians (N = 97)

Demographics:

	n(%) or M(SD)
Age	36.7 (9.9)
Race & Ethnicity	
White	89 (91.8%)
Asian	3 (3.1%)
Black	2 (2.1%)
Multiple/mixed race	2 (2.1%)
Pacific Islander or Native Hawaiian	1 (1.0%)
Hispanic	4 (4.2%)
Gender	
Woman	81 (83.5%)
Man	12 (12.4%)
Non-conforming or other	4 (4.2%)

52

13

Participating clinicians (N = 97)

Professional Characteristics:

Profession	n(%)
Social worker/therapist/mental health counselor	58 (59.8%)
Clinical psychologist	23 (23.7%)
Medical student	7 (7.2%)
Psychology student/trainee	5 (5.2%)
Behavioral specialist/technician	4 (4.1%)
Highest Degree	
Masters	62 (63.9%)
Doctorate	24 (24.7%)
Bachelors	11 (11.3%)
Theoretical Orientation	
Cognitive-behavioral (CBT)	69 (71.1%)
Third-wave (e.g., ACT, DBT)	23 (23.7%)
Integrative/Holistic	2 (2.1%)
Combined CBT and third-wave	2 (2.1%)
Humanistic/Experiential	1 (1.0%)
Licensed to Practice Therapy	78 (80.4%)

53

Participating clinicians (N = 97)

Professional Characteristics:

Primary Clinical Setting	n(%) or M(SD)
Private practice	29 (29.9%)
Psychiatric hospital	23 (23.7%)
Other hospital setting	12 (12.4%)
Academic medical center	8 (8.2%)
Community mental health center	7 (7.2%)
Veterans Affairs	2 (2.1%)
Other	16 (16.5%)
Clinical Intensity	
Outpatient	51 (52.6%)
IOP or PHP	33 (34.0%)
Inpatient or residential	13 (13.4%)
Patient Population(s) *(could select multiple)*	
Adults	84 (86.6%)
Adolescents (ages 12-17)	57 (58.8%)
Children (up to age 12)	36 (37.1%)
Hours/week conducting therapy	22.6 (13.0)

54

Participating clinicians (N = 97)

ERP Experience:
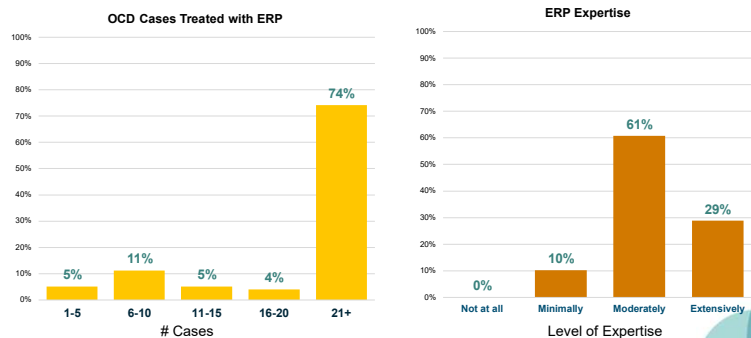
55

Participating clinicians (N = 97)

Non-Fear-Based OCD Experience:

56

14
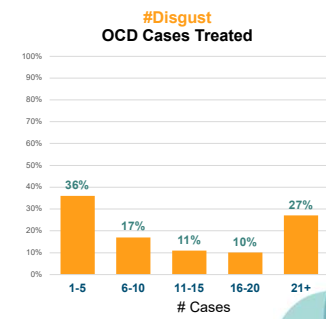
How effective is ERP "generally speaking" for...
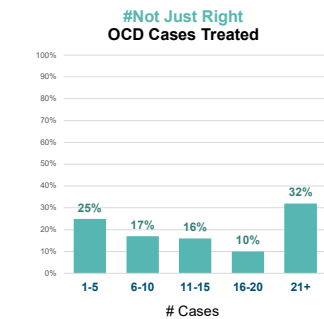

Very effective 4
Somewhat effective 3
Not effective at all 2
More harmful than helpful 1

M = 3.43 (NJR)
M = 3.38 (Disgust)

error bars = SD
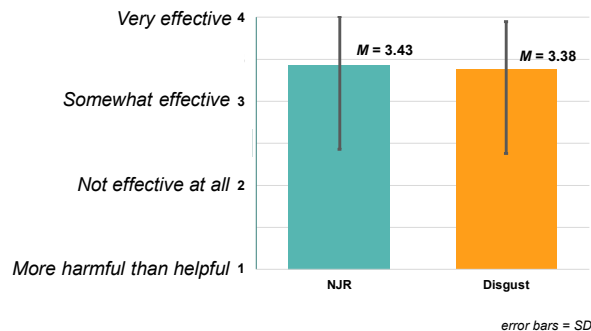
57

Least used/helpful strategies

Endorsement (Not Just Right / Disgust)

- Forgoing exposure altogether   8% / 3%
- Forgoing response prevention altogether   3% / 2%

58

Least used/helpful strategies

	Helpfulness (Adult/Youth)	
	Not Just Right	Disgust
Forgoing exposure altogether	2.62/2.67*	3.0*/n/a
Forgoing response prevention altogether	3.0*/1.50*	3.0*/2.0*

*Based on n ≤ 3

1/Not helpful at all   2/Only a little helpful   3/Fairly helpful   4/Very helpful

59

Tailoring ERP

Do principles of fear extinction apply?

1) Not Just Right & Disgust habituate less & more slowly
→ **Modify timescale/dose**

Endorsement (Not Just Right / Disgust)

- Extend exposure sessions   38% / 26%
- Extend treatment overall   43% / 38%

60

15

Slide 61

Tailoring ERP

Do principles of fear extinction apply?

1) Not Just Right & Disgust habituate less & more slowly

→ **Modify timescale/dose**

	Helpfulness (Adult/Youth)		
	Not Just Right	Disgust	Expertise
Extend exposure sessions	3.41/3.12	**3.50**/3.38	+
Extend treatment overall	3.21/3.28	3.19/3.25	++

1/Not helpful at all   2/Only a little helpful   3/Fairly helpful   4/Very helpful

61

Slide 62

Tailoring ERP

Do principles of fear extinction apply?

1) Not Just Right & Disgust habituate less & more slowly

→ **Enhance tolerability**

Endorsement (Not Just Right / Disgust)

- Gradually phase out rituals — **77%** / **69%**
- Use distraction during exposure — 33% / 28%
  (e.g., see if able to tell a story while distressed)
- Add relaxation to exposure — 22% / 22%

62

Slide 63

Tailoring ERP

Do principles of fear extinction apply?

1) Not Just Right & Disgust habituate less & more slowly

→ **Enhance tolerability**

	Helpfulness (Adult/Youth)		
	Not Just Right	Disgust	Expertise
Gradually phase out rituals	3.26/3.21	3.28/3.32	
Use distraction during exposure (e.g., see if able to tell a story while distressed)	3.04/3.10	3.22/3.18	-
Add relaxation to exposure	3.18/3.27	3.11/3.00	- -

1/Not helpful at all   2/Only a little helpful   3/Fairly helpful   4/Very helpful

63

Slide 64

Tailoring ERP

Do principles of fear extinction apply?

1) Not Just Right & Disgust habituate less & more slowly

→ **Frameworks that don't rely on habituation**

Acceptance & Commitment Therapy (ACT)	Inhibitory Learning
Learn to accept – and function while in a state of – distress, rather than working towards eliminating distress.	Goal of exposure is to form new associations that compete with (inhibit) the original association – not to "break" the original association via habituation.

64

Slide 65

Tailoring ERP

Do principles of fear extinction apply?

1) Not Just Right & Disgust habituate less & more slowly
→ **Frameworks that don't rely on habituation**

Endorsement (Not Just Right / Disgust)

- De-emphasize within-session habituation — 55% / 44%
- Emphasize tolerating discomfort — **94%** / **94%**
- ACT/mindfulness techniques — 79% / 72%
- Other inhibitory learning strategies (beyond those listed) — 30% / 14%

65

Slide 66

Tailoring ERP

Do principles of fear extinction apply?

1) Not Just Right & Disgust habituate less & more slowly
→ **Frameworks that don't rely on habituation**

	Helpfulness (Adult/Youth)		
	Not Just Right	Disgust	Expertise
De-emphasize within-session habituation	3.17/3.08	3.19/3.04	+
Emphasize tolerating discomfort	3.48/3.46	3.39/3.36	++
ACT/mindfulness techniques	**3.53**/3.12	**3.55**/3.29	
Other inhibitory learning strategies (beyond those listed)	**3.55**/3.25	3.23/3.00	+

1/Not helpful at all   2/Only a little helpful   3/Fairly helpful   4/Very helpful

66

Slide 67

Tailoring ERP

Do principles of fear extinction apply?

2) Disgust is learned via evaluative conditioning
→ **Add positively valenced stimuli to change attitudes**

- Counterconditioning
- US Reevaluation
- Imagery rescripting

67

Slide 68

Tailoring ERP

Do principles of fear extinction apply?

2) Disgust is learned via evaluative conditioning
→ **Add positively valenced stimuli to change attitudes**

- **Counterconditioning**
- US Reevaluation
- Imagery rescripting

(Ludvik et al., 2015; Engelhard et al., 2014)

68

17

Slide 69

Tailoring ERP

Do principles of fear extinction apply?

2) Disgust is learned via <u>evaluative</u> conditioning

→ **Add positively valenced stimuli to change attitudes**

- Counterconditioning
- **US Reevaluation**
- Imagery rescripting

(or new info, relaxation…)

(Ludvik et al., 2015; Engelhard et al., 2014)

69

Slide 70

Tailoring ERP

Do principles of fear extinction apply?

2) Disgust is learned via <u>evaluative</u> conditioning

→ **Add positively valenced stimuli to change attitudes**

- Counterconditioning
- US Reevaluation
- **Imagery rescripting** — *Guided process of altering disgusting images (mental or physical) into neutral or positive ones*

(Fink-Lamotte et al., 2018; Fink-Lamotte et al., 2022)
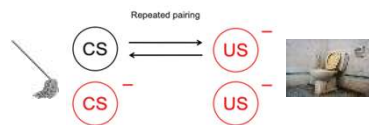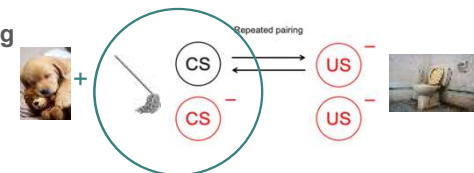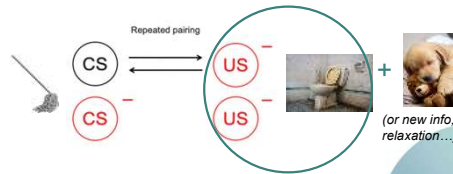
70

Slide 71

Tailoring ERP

Do principles of fear extinction apply?

2) Disgust is learned via <u>evaluative</u> conditioning

→ **Add positively valenced stimuli to change attitudes**

	Endorsement
Counterconditioning	8%
US Reevaluation	23%
Imagery rescripting	19%

71

Slide 72

Tailoring ERP

Do principles of fear extinction apply?

2) Disgust is learned via <u>evaluative</u> conditioning

→ **Add positively valenced stimuli to change attitudes**

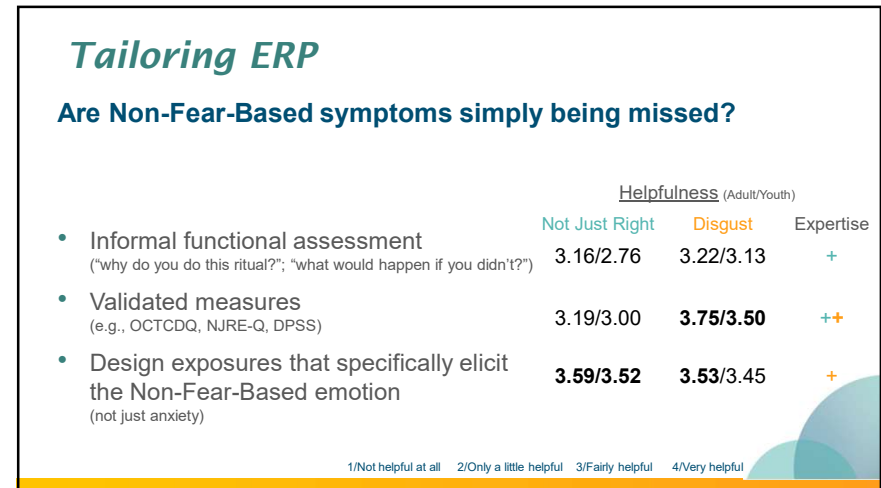|	Helpfulness		
	Adult	Youth	Expertise
Counterconditioning	3.00*	2.80*	
US Reevaluation	2.78	3.00	
Imagery rescripting	3.33	**3.73**	-

*Based on n $\leq$ 7

1/Not helpful at all   2/Only a little helpful   3/Fairly helpful   4/Very helpful

72

18

Slide 73

Tailoring ERP

Are Non-Fear-Based symptoms simply being missed?

Endorsement (Not Just Right / Disgust)

- Informal functional assessment
  ("Why do you do this ritual?"; "What would happen if you didn't?")
  98% / **97%**

- Validated measures
  (e.g., OCTCDQ, NJRE-Q, DPSS)
  37% / 21%

- Design exposures that specifically elicit
  the Non-Fear-Based emotion
  (not just anxiety)
  95% / **92%**

73

Slide 74

Tailoring ERP

Are Non-Fear-Based symptoms simply being missed?

	Helpfulness (Adult/Youth)		
	Not Just Right	Disgust	Expertise
Informal functional assessment ("why do you do this ritual?"; "what would happen if you didn't?")	3.16/2.76	3.22/3.13	+
Validated measures (e.g., OCTCDQ, NJRE-Q, DPSS)	3.19/3.00	**3.75/3.50**	++
Design exposures that specifically elicit the Non-Fear-Based emotion (not just anxiety)	**3.59/3.52**	**3.53**/3.45	+

1/Not helpful at all   2/Only a little helpful   3/Fairly helpful   4/Very helpful

74

Slide 75

Tailoring ERP

Are Non-Fear-Based symptoms simply being missed?

→ Modify vehicles of exposure implementation: **SUDS & Hierarchy**

Endorsement (Not Just Right / Disgust)

- Change 0-100 SUDS to a simpler scale
  (e.g., easy/medium/difficult)
  58% / 47%

- Expand SUDS to include NFB levels
  55% / 58%

- Separate NFB SUDS scale/anchors
  23% / 24%

- Separate hierarchy for NFB exposures
  (vs. one for all)
  35% / 28%

75

Slide 76

Tailoring ERP

Are Non-Fear-Based symptoms simply being missed?

→ Modify vehicles of exposure implementation: **SUDS & Hierarchy**

	Helpfulness (Adult/Youth)		
	Not Just Right	Disgust	Expertise
Change 0-100 SUDS to simpler scale (e.g., easy/medium/difficult)	3.06/3.40*	3.15/3.43*	
Expand SUDS to include NFB levels	3.34/3.22	3.31/3.45	
Separate NFB SUDS scale/anchors	3.42/3.14	3.29/3.43	– –
Separate hierarchy for NFB exposures (vs. one for all)	3.24/3.32	3.35/3.41	

* Significant with Bonferroni correction

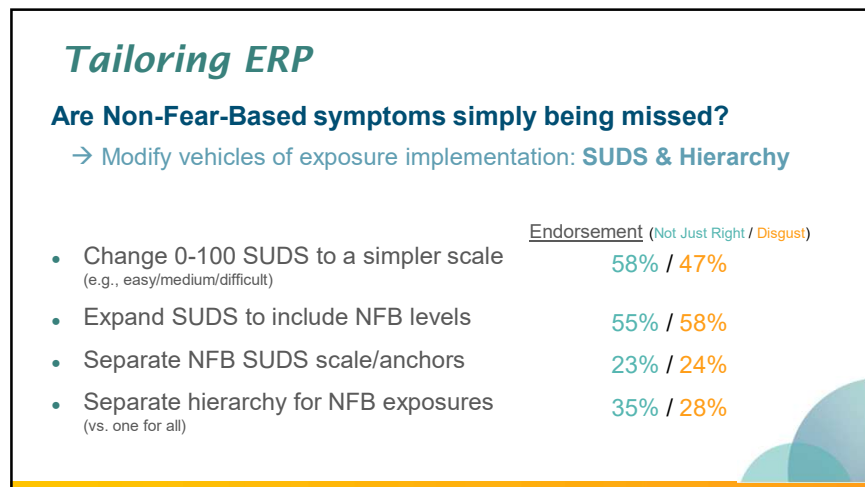1/Not helpful at all   2/Only a little helpful   3/Fairly helpful   4/Very helpful
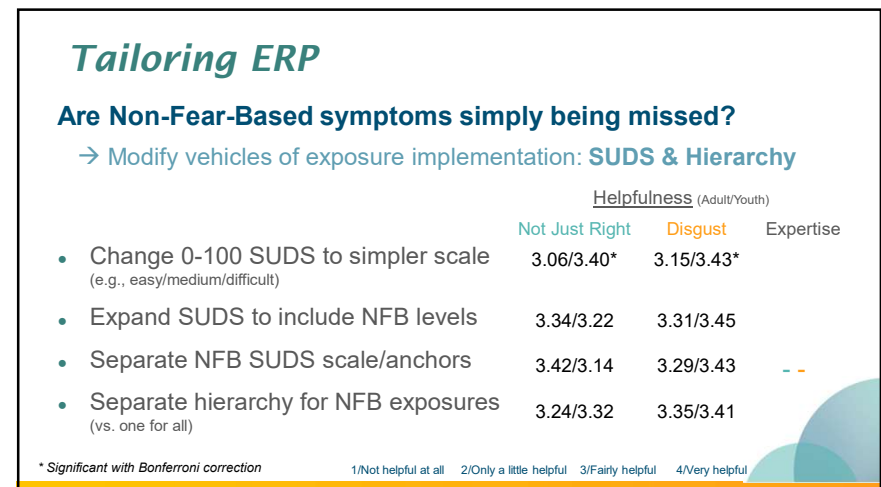
76

Slide 77

Tailoring ERP

Which, if any, cognitive targets are relevant?

- Traditional targets may be less relevant: testing feared outcomes, importance of thoughts…
- Are Not Just Right emotions more "physical" than cognitive?
- Cognitive reappraisal might target the Non-Fear-Based emotion's <u>meaning</u>:

  Not Just Right: unbearable/uncontrollable discomfort → false message from the brain, mismatch between desired perceptual state and reality that is neither inherently good nor bad, tolerable

  Disgust: moral components/guilt, meta-beliefs about disgust, threat level of objects and disgust-related bodily sensations (e.g., nausea)

77

Slide 78

Tailoring ERP

Which, if any, cognitive targets are relevant?

<u>Deemphasize:</u>   Endorsement (Not Just Right / Disgust)

- Testing feared consequences   53% / 39%
- Challenging importance of thoughts   34%
- Imaginal exposure   30%

78

Slide 79

Tailoring ERP

Which, if any, cognitive targets are relevant?

Deemphasize:	Helpfulness (Adult/Youth)		
	Not Just Right	Disgust	Expertise
Testing feared consequences	3.35/3.36	3.19/3.42	++
Challenging importance of thoughts	3.10/3.28		
Imaginal exposure	3.07/3.06		+

1/Not helpful at all   2/Only a little helpful   3/Fairly helpful   4/Very helpful

79

Slide 80

Tailoring ERP

Which, if any, cognitive targets are relevant?

<u>More:</u>   Endorsement (Not Just Right / Disgust)

- Cognitive therapy   **72%** / 58%
- Cognitive strategies when high in disgust <u>sensitivity</u> (distress in response to disgust; vs. behavioral strategies when high in disgust <u>propensity</u> = likelihood of experiencing disgust in a given situation)   44%
- Interoceptive exposure (given visceral component of disgust)   52%

80

20

Tailoring ERP

Which, if any, cognitive targets are relevant?

More:

Helpfulness (Adult/Youth)

	Not Just Right	Disgust	Expertise
Cognitive therapy	3.05/2.83	3.29/3.16	
Cognitive strategies when high in disgust <u>sensitivity</u> (distress in response to disgust; vs. behavioral strategies when high in disgust <u>propensity</u> = likelihood of experiencing disgust in a given situation)		3.26/3.25	+
Interoceptive exposure (given visceral component of disgust)		3.19/3.07	

1/Not helpful at all   2/Only a little helpful   3/Fairly helpful   4/Very helpful

81

Tailoring ERP

Other potential strategies

	Endorsement
Not Just Right:	
Add competing responses (~Habit Reversal Therapy)	57%
Disgust:	
Disgust-incongruent/neutral facial expressions	24%

82

Tailoring ERP

Other potential strategies

Helpfulness

	Adult	Youth	Expertise
Not Just Right:			
Add competing responses (~Habit Reversal Therapy)	2.80	3.08*	
Disgust:			
Disgust-incongruent/neutral facial expressions	2.84	2.92	-

Significant with Bonferroni correction

1/Not helpful at all   2/Only a little helpful   3/Fairly helpful   4/Very helpful

83

Novel strategies: Not Just Right

GENERAL STRATEGIES (n = 7)	N
Cognitive defusion (create distance between self and thoughts)	4
Additional values work	3
DBT skills (e.g., "riding the wave," "urge surfing," radical acceptance, functions of emotions, distress tolerance)	2
Notice and objectively describe physical/NJR sensations	2
INHIBITORY LEARNING (n = 29)	**N**
Emphasize expectancy violation & what was learned (actual vs. anticipated outcomes, e.g., actual vs. expected SUDS, ability to tolerate discomfort, ability to function while in NJR)	8
Focus on mastery and ability to function while in a state of NJR	5
Go out of order on the hierarchy	3

Only 1 mention: motivational interviewing, additional psychoeducation, explore the function and origins of compulsions, take advantage of unplanned exposures, repeat exposures across contexts

84

21

Novel strategies: *Disgust*

GENERAL STRATEGIES (n = 7)	N
"Mastery approach": Enhance mastery and motivation by allowing accommodations (e.g., some compulsions, completing exposures in the company of friends) that reduce avoidance and encourage staying with the discomfort	4
Greater emphasis on concrete goals and patient values	3
INHIBITORY LEARNING (n = 13)	**N**
Emphasize expectancy violation & what was learned (actual vs. anticipated outcomes, e.g., actual vs. expected SUDS, ability to tolerate discomfort, ability to function while experiencing disgust)	5
Go out of order on the hierarchy	2

Only 1 mention: habit reversal therapy, additional psychoeducation, self-compassion & gratitude, take advantage of unplanned exposures

85

Takeaways: Non-Fear-Based OCD

- Most tailoring strategies surveyed were common in this (expert) sample
  - *Even*: 1) more obscure methods from laboratory studies
    - e.g., US Reevaluation (23%), imagery rescripting (19%)
    - 2) *typically* contraindicated in the context of exposure
    - e.g., competing responses (57%), distraction (33%/28%), relaxation (22%/22%)
- Almost all rated at least "fairly helpful"
- Except the two theorized to be contraindicated: forgoing exposure and response prevention altogether

  + Perception that ERP is somewhat to very effective → **Supports tailoring**

86

Takeaways: Non-Fear-Based OCD

- Tailoring ERP may entail only minor tweaks
  - Guiding clinicians on how to target the right thing
    - Through NFB-specific assessment
    - Designing exposures that elicit the relevant emotion
  - Modifying the timescale (e.g., more gradual RP, extending treatment/sessions)
- Other methods represent more radical departures from the traditional ERP model that require rigorous testing
  - Competing responses, distraction, relaxation, allowing accommodations…
  - Integrating cognitive therapy

87

Takeaways: Non-Fear-Based OCD

Highlights relevance of: **#1) Inhibitory Learning**

- De-emphasize 1) within-session habituation (55%/44%; 3.04-3.19)
  - 2) disconfirming feared consequences (53%/39%; 3.19-3.42)

*So, what **are** you supposed to do? Focus on inhibitory learning targets:*

- Greater emphasis on tolerating discomfort (94%/94%; 3.36-3.48)
- "Other" inhibitory learning modifications (30%/14%; 3.00-**3.55**)
  - Expectancy violation (other types of discrepancies besides feared consequences)
  - Prioritize functioning

88

22

Takeaways: Non-Fear-Based OCD

Highlights relevance of: **#2) ACT**

- Additional emphasis on ACT and/or mindfulness (79%/72%; 3.12-**3.55**)
- Many of the novel strategies were specific ACT strategies: cognitive defusion, values work

Again, speaks to what we can/should focus on if not habituation/fears…

Learning how to get back to one's values & living life while accepting some amount of discomfort

89

Future Directions: Non-Fear-Based OCD

- Generated a list of potential tailoring strategies that (expert) OCD clinicians use & consider helpful
  - Including several new strategies that were not on our radar
- Sets stage for upcoming International OCD Foundation-funded study seeking to develop and pilot the first treatment protocol for Non-Fear-Based OCD

90

Case example: Not Just Right

- Heterosexual, cis-male
- Early 40s (Gen X)
- White/non-Hispanic
- Married with 1 child
- Born in USA (non-indigenous)
- OCD, social anxiety, Tourette's
- No physical disabilities
- College degree & working full-time
- Moderately practicing Catholic

Age and generation
Diagnosis status
Disability & physical health status
Religion and spirituality
Ethnicity and race
Sexual orientation
Socioeconomic status
Indigenous heritage
National origin
Gender identity

91

Case example:

Example triggers & rituals

- Light switches, doors, shower curtain, sink faucet, putting clothes on, plugging in phone
  → repeatedly open/close (on/off) until it feels "just right"
- Mess/disorganization (e.g., blanket folded "wrong"), routine disruptions
- Certain phrases (e.g., "bye bye" should be "goodbye")

92

23

Case example:

Tailoring strategy: Hierarchy & SUDS

Easy	Medium	Hard
• Use light switch once • Put pants on without fixing • Use sink faucet once	• Use remote control wrong • Put shirt on without fixing • Twist doorknob once	• Take shower without fixing the curtain • Fold son's blanket wrong • Plug in phone once

93

Case example

Tailoring strategy: Focus of Exposure

+ *Elicit the Not Just Right feeling*

+ *Acceptance & tolerating discomfort (> habituation)*

+ *Distraction*

+ *Relaxation*

94

Case example

Tailoring strategy: Competing Responses / Habit Reversal Training

Ritual	Competing Responses
Hit the sink until it feels right	Clench fists & lock arms to side of body; wear large foam hands
Say "goodbye" when hear "bye bye"	Clear throat
Shirt on and off repeatedly	Chin tuck
Open/close shower curtains	Tug on resistance bands

95

Case example

Tailoring strategy: Cognitive Reframing

Track automatic thoughts preceding Not Just Right sensation

Emotion	Automatic Thought	Alternative Thought	Re-rate
Irritated -100	[Wife] knew I would be upset when she said "bye bye" instead of goodbye	She probably forgot in that moment and didn't mean to upset me	Irritated - 20

96

24

Time for questions and answers

- Please use the Q&A button to submit your question.
- If we don't get to your question, please feel free to send an email to **webinars@rogersbh.org** and we will follow up with you.

Q&A

97

Where to get additional information...

Resources from the International OCD Foundation (IOCDF):

- "Not just right" OCD fact sheet: https://iocdf.org/brochures-and-fact-sheets/
- Disgust OCD blog post : https://iocdf.org/blog/2023/04/25/disgust-based-ocd-thoughts-on-a-new-treatment-protocol/
- Teletherapy for OCD training: https://iocdf.org/covid19/information-for-therapists/#educationstaycation
- Medications for OCD: https://iocdf.org/about-ocd/treatment/meds/

98

Thank you

- A continuing education certificate for this program will be obtained using the website **CE-Go.com.**
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99

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100

25