



Cognitive Behavioral Therapy, Digital And AI-Powered Interventions for OCD and Related Disorders

Sabine Wilhelm, Ph.D.

Donovan-Chien Family Professor, Harvard Medical School

Chief of Psychology, Massachusetts General Hospital

Director, Center for OCD and Related Disorders, Massachusetts General Hospital

Director, Center for Digital Mental Health, Massachusetts General Hospital

DISCLOSURES



**Research support Koa Health, Scientific Advisory Boards:
Koa Health, One Mind, Noom, Jimini Health**



Royalties from Elsevier Publications, Guilford Publications, New Harbinger Publications, Springer, and Oxford University Press.



Speaking honoraria from various academic institutions and foundations, research award from the National Alliance on Mental Illness



Salary support from MGH, MGH Psychiatry Academy



OBSESSIVE-COMPULSIVE DISORDER (OCD)

Either obsessions or compulsions:

Obsessions

1. Recurrent intrusive unwanted distressing thoughts, urges or images (made mistake, sexual, blasphemous)
2. Individual tries to suppress or neutralize them



Compulsions

1. Repetitive behaviors, mental acts (e.g., checking, praying)
2. Aimed at preventing distress, or preventing harm (but excessive/not realistically tied to harm prevention)

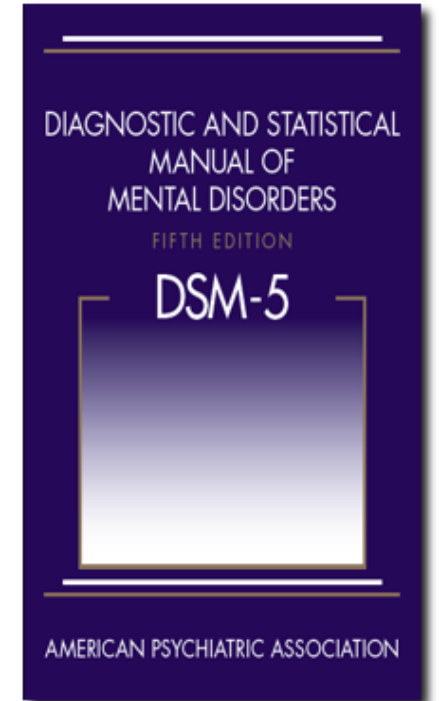


Time Consuming (e.g., take more than 1 hour per day) distressing, and/impairing

Avoidance

OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

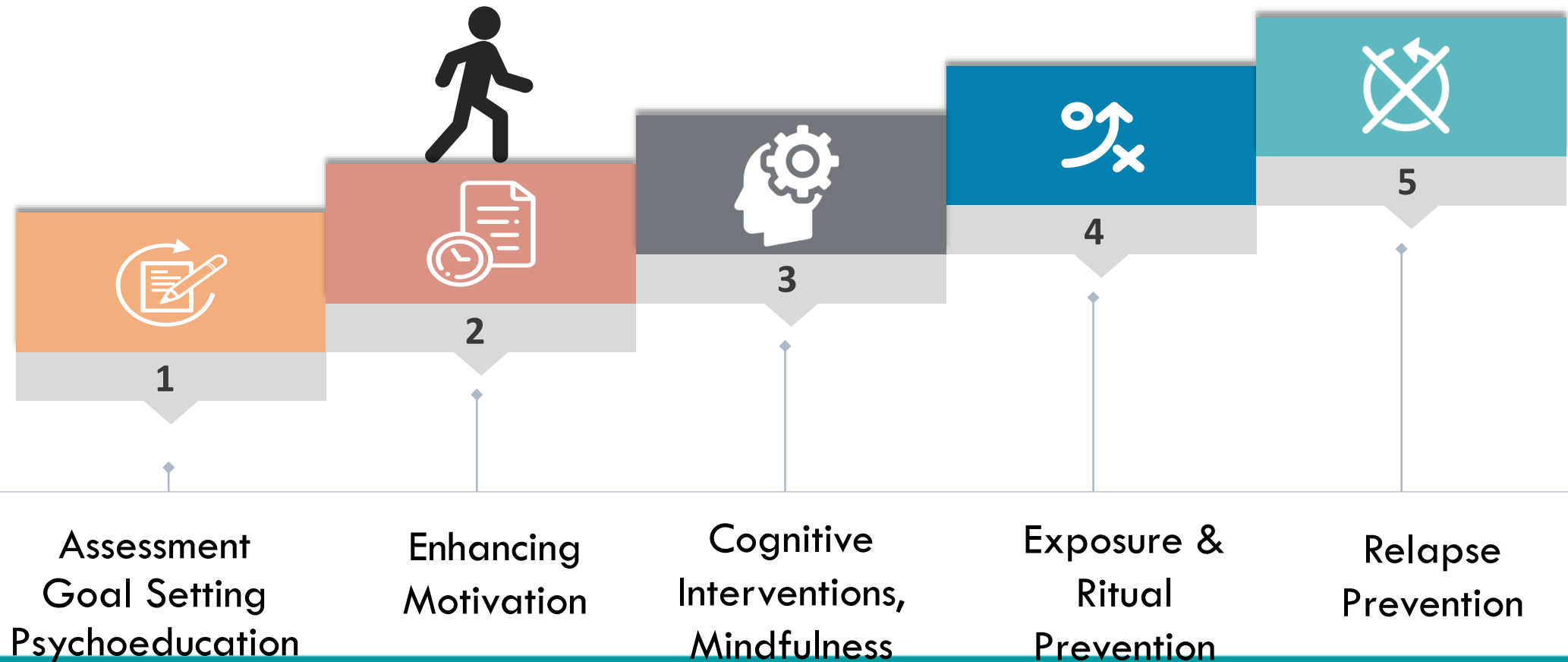
- **Obsessive Compulsive Disorder**
- **Body Dysmorphic Disorder**
- **Hoarding Disorder**
- **Trichotillomania (Hair pulling disorder)**
- **Excoriation (Skin picking) disorder**
- **Other obsessive-compulsive and related disorders**



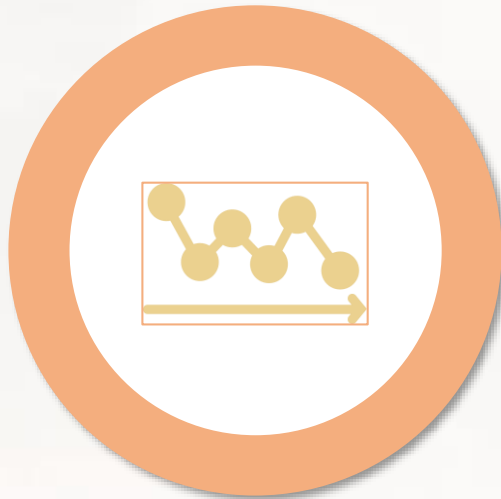
CURRENT TREATMENTS FOR OCD

- 1 Cognitive Behavior Therapy (CBT)**
- 2 Pharmacotherapy (Serotonin Reuptake Inhibitors)**
- 3 More severely ill patients: CBT + Pharmacotherapy**

COGNITIVE BEHAVIOR THERAPY: STRUCTURE



COGNITIVE BEHAVIOR THERAPY: DURATION



Varies, depends
on severity,
~8-26 sessions



Booster sessions
after treatment
has ended

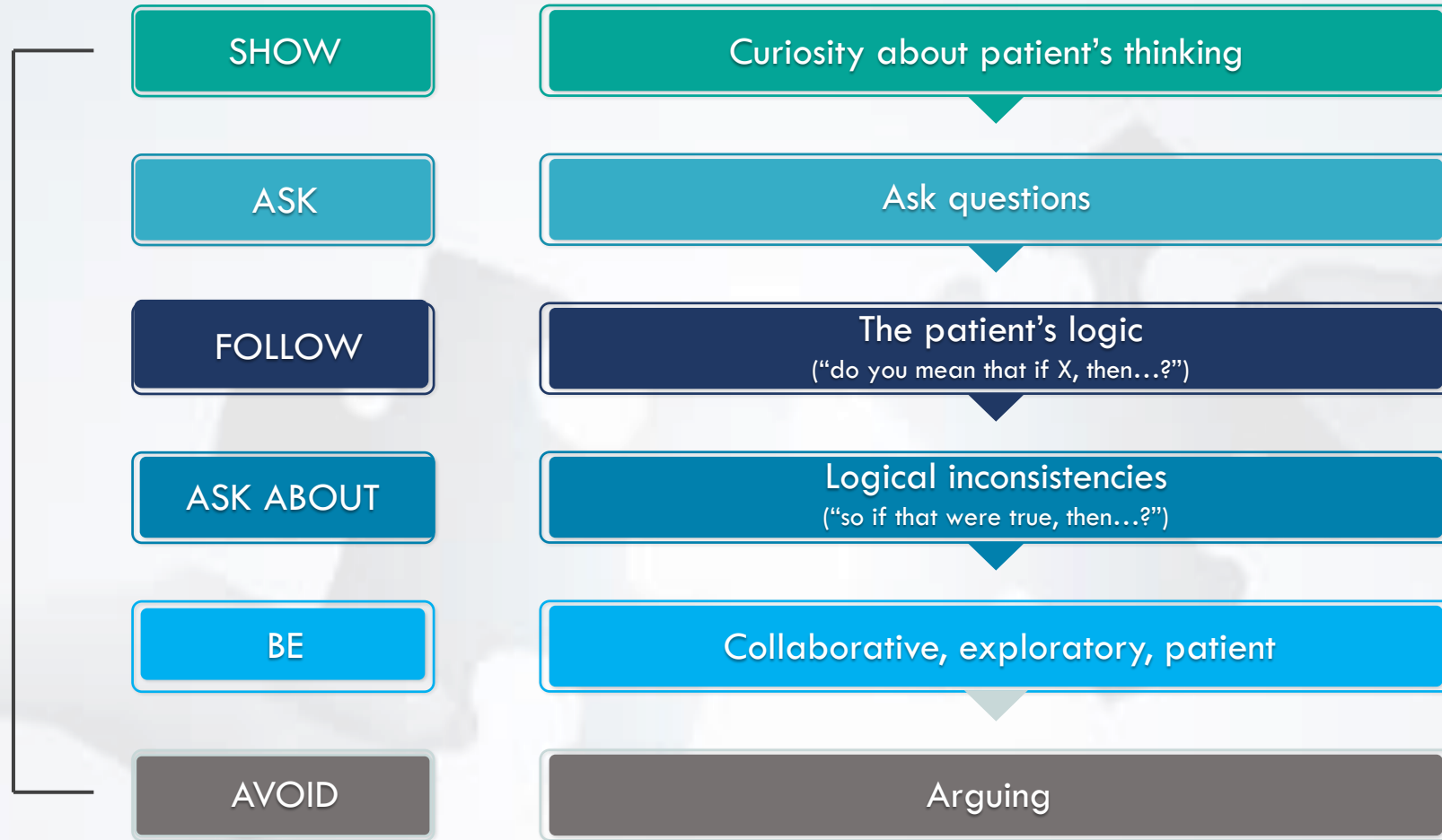


Fade the frequency
of booster sessions
slowly

OCD MODEL



SOCRATIC DIALOGUE



THOUGHT FORM

Name: _____

Date _____

Situation/ Trigger	Intrusion	Interpretation a) write interpretation b) rate belief in interpretation (0-100%)	Emotion a) specify emotions b) write strength of emotion (0-100%)	Compulsions/ Avoidance a) rate urge to neutralize or avoid (0-100) b) specify rituals or avoidance	Rational Response a) write rational response to interpretation b) rate belief in rational response (0-100)	Outcome a) re-rate interpretation (0-100) b) specify and rate subsequent emotions (0-100)
Holding my baby	I am going to smash her head against the wall	If I am thinking that I might smash her head, I'm going to do it (90%)	anxious (85%)	urge (100) Gave baby to husband right away.	This is just a thought. I have had this thought over a thousand times and I never acted on it...This shows me that thoughts cannot cause actions (70%)	a) 35 b) anxious (20%)

Adapted from J. Beck (1995)

ACCEPTANCE OF INTRUSIVE THOUGHTS

Examples



Clouds
in the
sky



Leaves
Floating down
the river



Fish swimming
in the
ocean

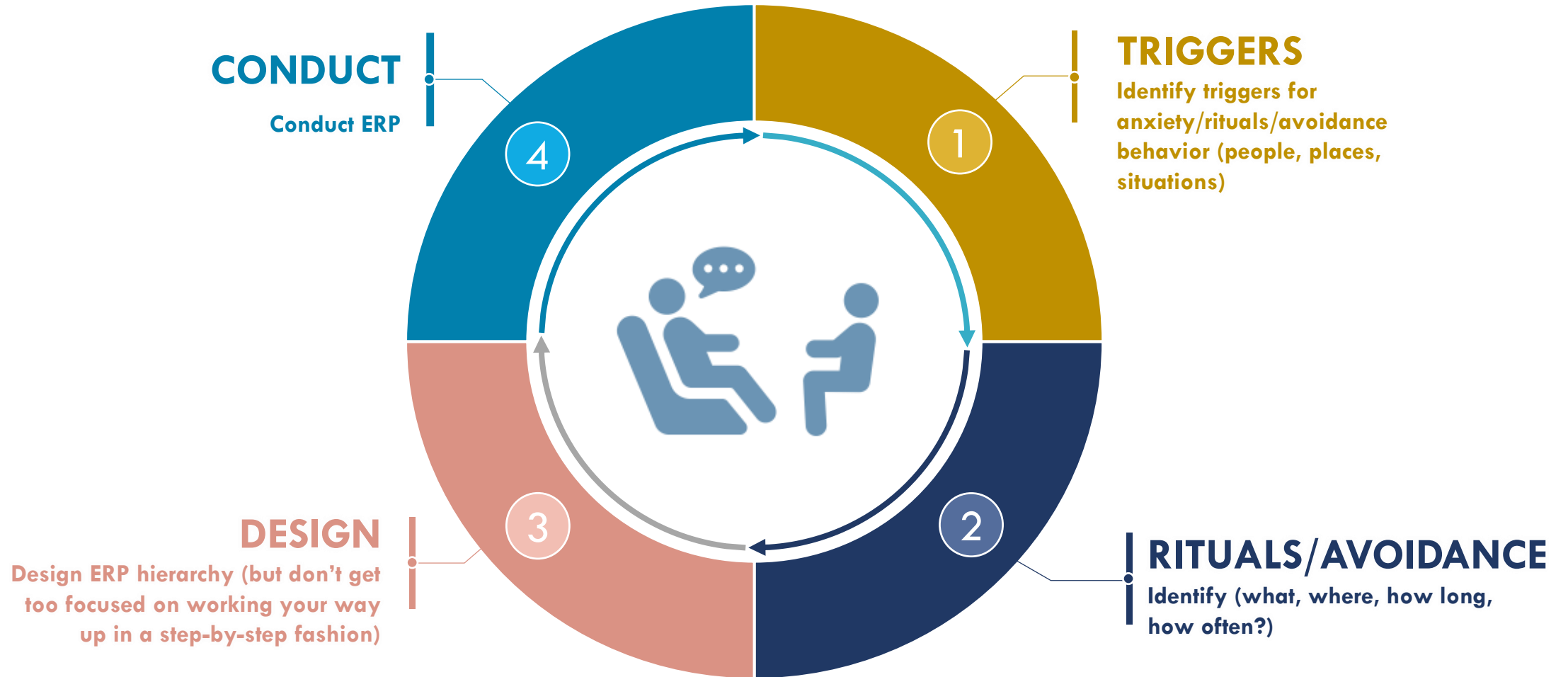


Wiley Coyote
And
train tracks



Allow the train
to arrive &
leave the
station

EXPOSURE & RESPONSE PREVENTION



EXPLAIN HOW EXPOSURE WORKS



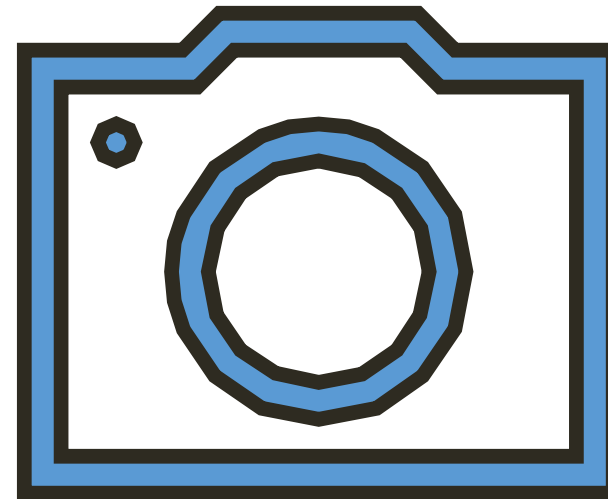
T: “Exposure will help you go into situations you currently avoid, like...
[Give examples]. You might be anxious at times, but you can learn to tolerate the anxiety.”

EXPLAIN HOW EXPOSURE WORKS



T: “During the exposure practices, you can find out if the outcomes you fear really occur. You get firsthand experience if your predictions are accurate or not.”

EXPOSURE SITUATIONS



SARAH - CONTAMINATION

Distressing Situations Worksheet	Distress (0-100)	Avoidance (0-100)
1. Door handles and elevator buttons	45	70
2. Sitting in a bus	55	60
3. Touching money (esp. coins)	70	60
4. Touching trash cans at home	72	60
5. Touching garbage cans outside	78	90
6. Images of becoming terribly ill	85	100
7. Public bathrooms	90	100

SARAH'S RESPONSE PREVENTION PLAN

NO CONTACT with water, except for one 10-minute shower and 2 X 2-minute tooth brushing each day, after using bathroom (20 sec) and when hands are visibly dirty



DO NOT use hand sanitizer



DO NOT change clothes, even if you think they are contaminated



DO NOT ask family members to change when they come in the house



RESPONSE PREVENTION STRATEGIES

1

Stimulus control
(Making it difficult for the ritual to occur)

2

Selective ritual prevention
(Picking your battles)

3

Restricting your rituals
(Watching the clock)

4

Postponing a ritual
(When procrastination is a good thing)

5

Using competing actions

OLIVIA'S ERP HIERARCHY

Distressing Situation	SUD (0-100)	Avoidance (0-100)
Buttering bread while alone	30	35
Listening to loop tape on stabbing son, do not start praying	50	60
Cutting fruit while kids are in the house, do not ask husband to watch me	60	65
Cutting fruit with kids at the table, do not ask husband to watch me/do not ask for reassurance	80	100
Hold son and knife at the same time, do not pray	90	100
Hold son while cutting fruit, do not ask husband for reassurance	100	100

SELECT A MODERATE ANXIETY LEVEL SITUATION

For The First Exposure



Begin with exposure to situations that **provoke distress & avoidance ratings near 40.**

Make patient an **active participant** in deciding on ERP.

BEHAVIORAL EXPERIMENTS

2. COMPARE

3. IDENTIFY



Design

An experiment to test validity
of hypothesis

e.g., “I will show signs of illness in the upcoming week if I touch this doorknob”

“My bad thoughts can harm others”

Compare

Feared and actual consequences

Identify

What you learned from experiment

MOVING FORWARD



PRACTICE

Exposures and
Ritual Prevention
daily



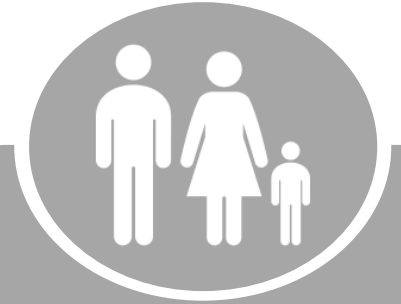
WORK ON

Increasingly
challenging
ERPs



BE

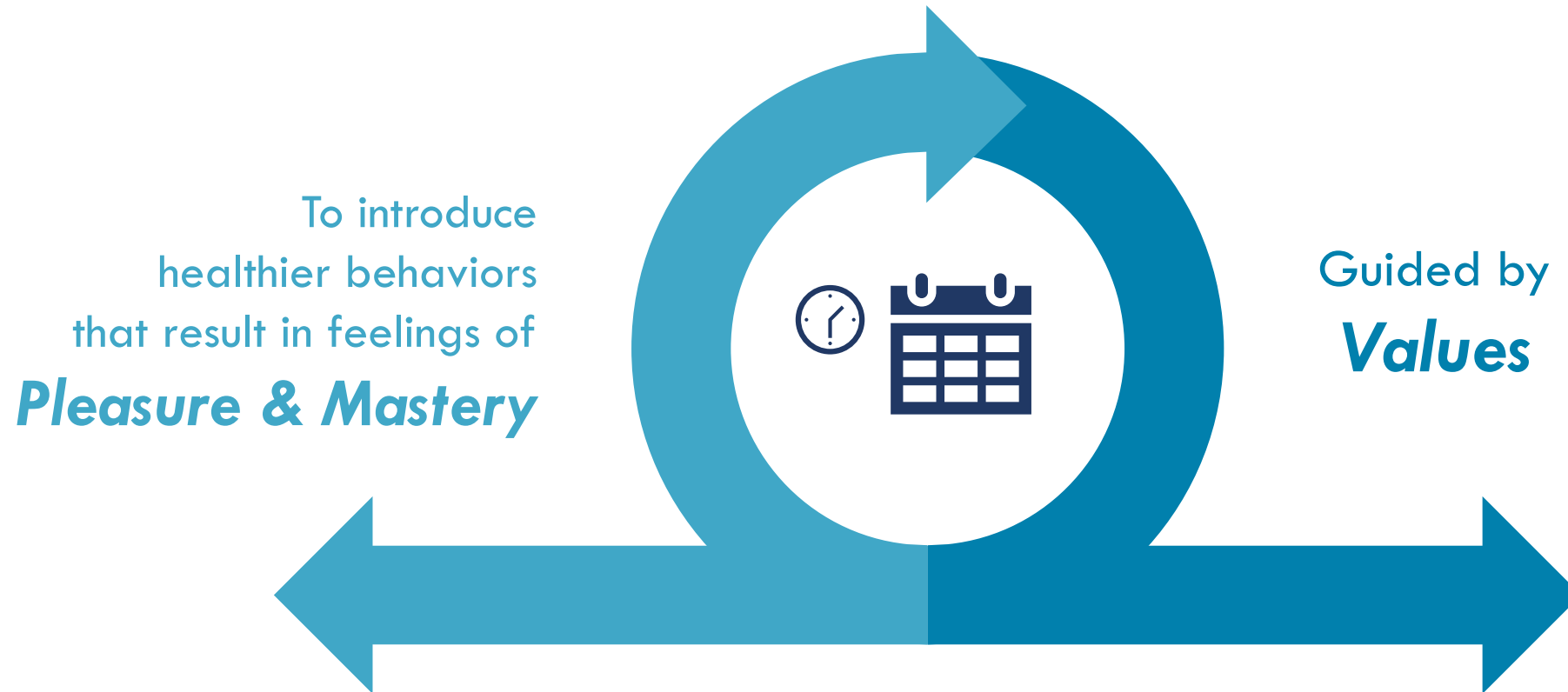
Creative,
leave office,
change context



SHIFT

Responsibility for
designing ERP's gradually
to patient (parents)

ACTIVITY SCHEDULING



RELAPSE PREVENTION

**Plan time
without symptoms/
activity scheduling**

**Learn to differentiate between lapses & relapses;
counter negative thoughts about setbacks;
and handle lapses & setbacks**



**Evaluate unrealistically
optimistic or pessimistic thoughts
about treatment termination**

**Anticipate possible symptom
recurrence & its relationship to
stress, mood & other variables**

COGNITIVE BEHAVIOR THERAPY FOR OCD: OUTCOMES



Between 50 and 75% of patients who undergo CBT are much improved at the end of treatment.

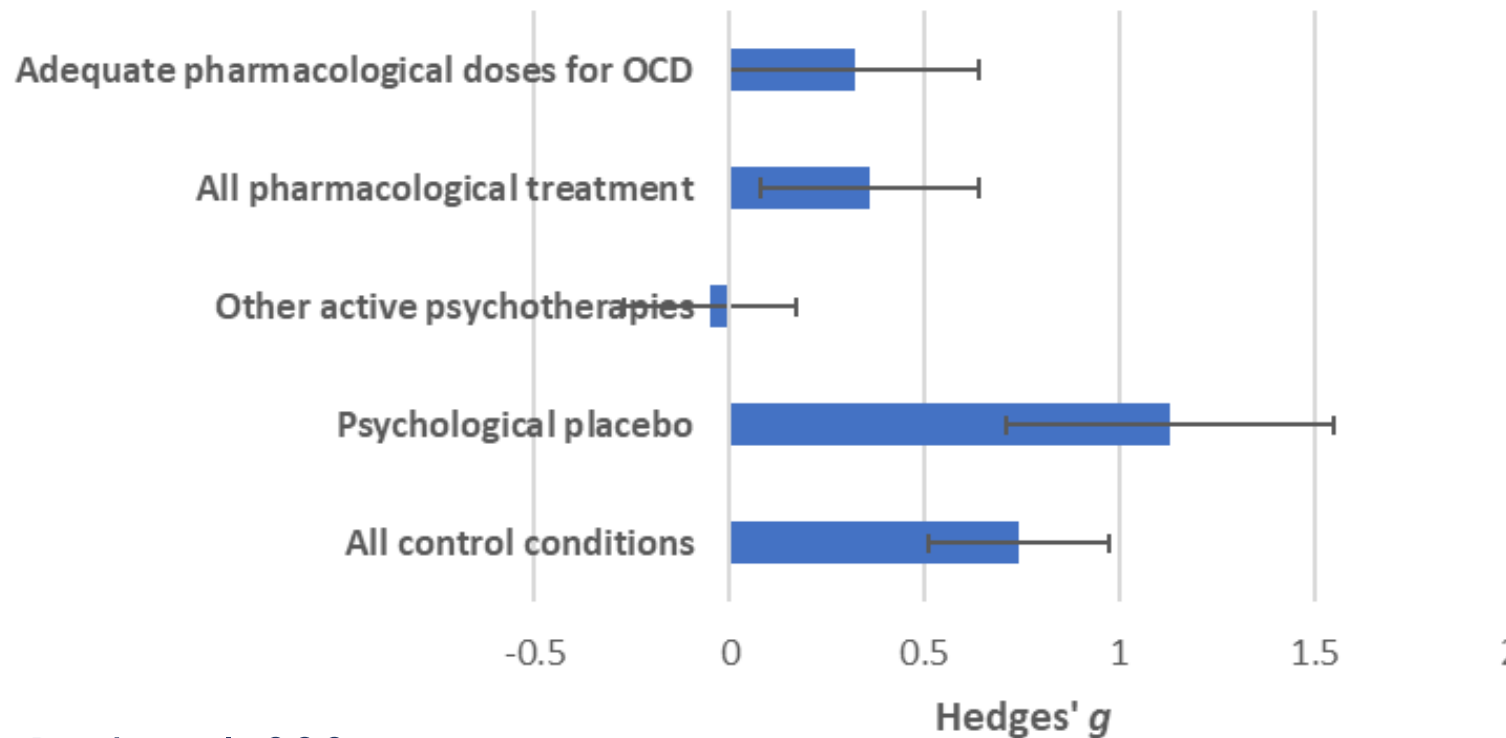


CBT is empirically supported as one of the most effective psychological treatments

Foa et al., (1983)
Ferrando & Selai, (2021)
Ost et al., (2022)
Steketee, Siev, Yovel, Lit, Wilhelm (2019)
Reid et al., (2021)
Whittal et al., (2005)

ENCOURAGING CBT FOR OCD RESULTS

CBT with ERP for OCD compared to:



Reid et al, 2021

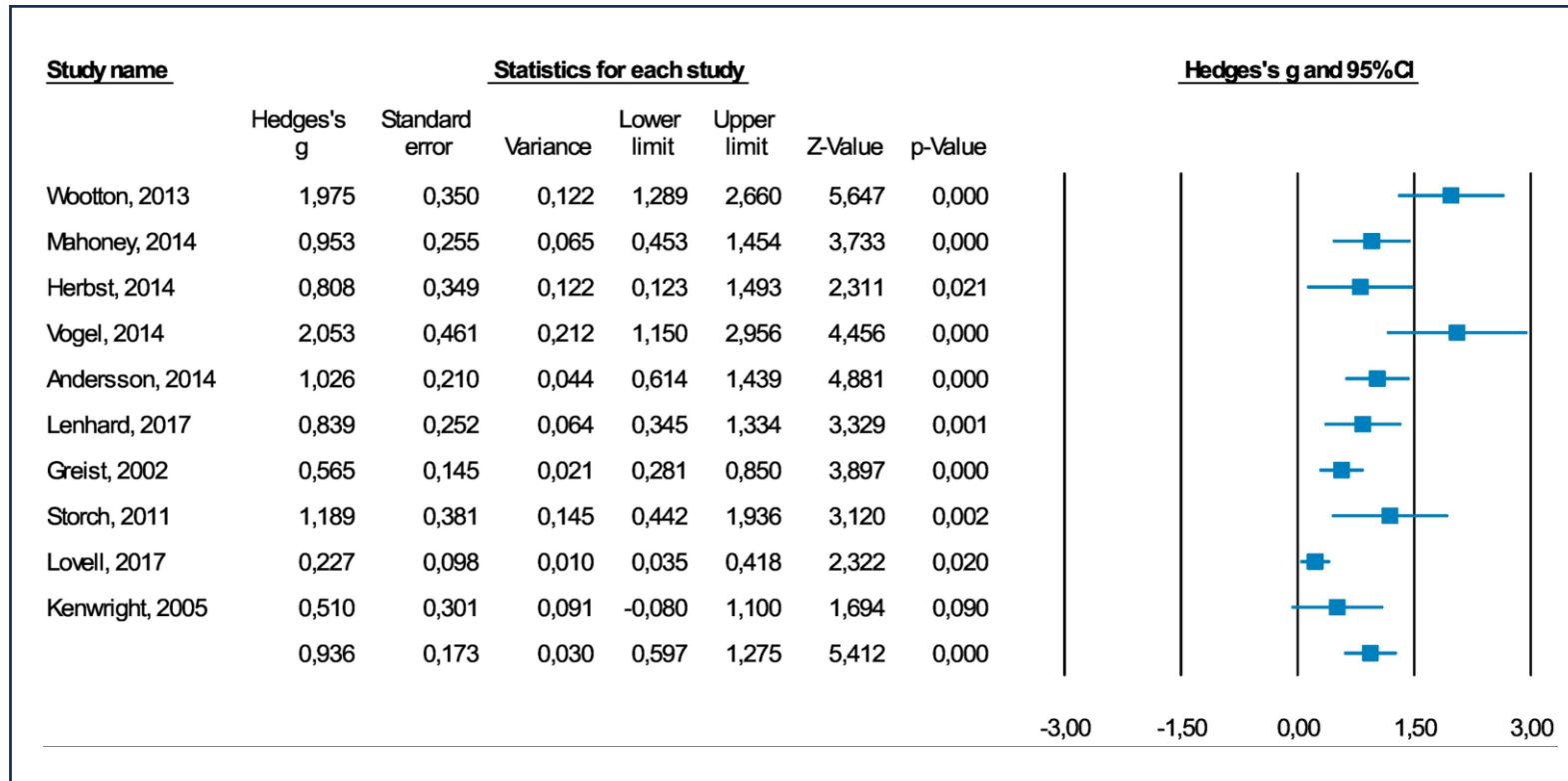
Effect sizes between groups depend on the comparison group (Reid et al., 2021)

Meta-analysis:

- ERP combined with medication is significantly better than medication alone
- Difference between ERP combined with SSRIs and placebo was not significant

(Mao, 2022)

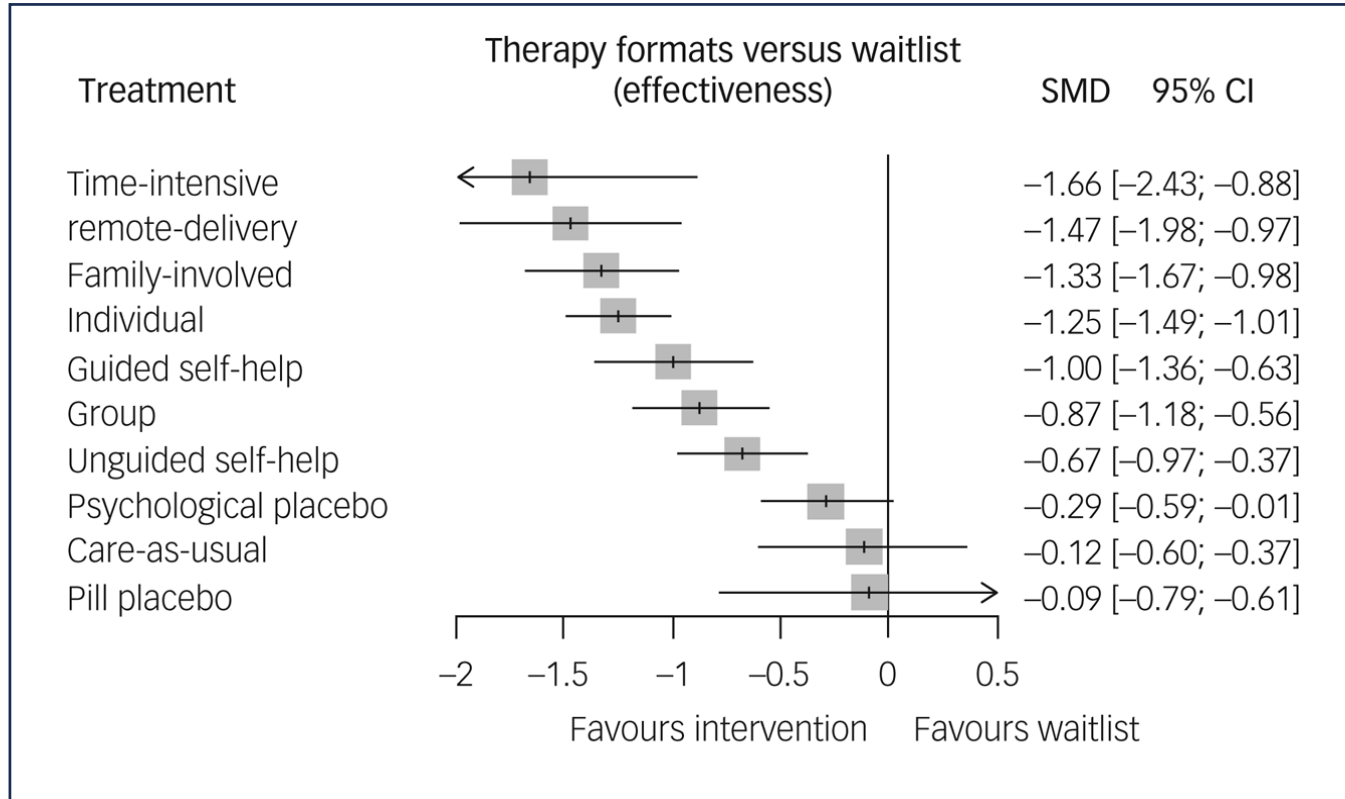
ENCOURAGING CBT FOR OCD RESULTS



No differences in efficacy were found between remotely-delivered CBT and face-to-face CBT for OCD symptoms, depressive symptoms, anxiety symptoms or quality of life

(Salazar de Pablo et al., 2023).

ENCOURAGING CBT FOR OCD RESULTS (VARIED FORMATS)



- In a meta-analysis of 61 RCTs for OCD specifically:
 - **Time-intensive (<4 weeks, >10 therapist hours) found to be most effective relative to waitlist**
 - **Remote-delivery (e.g., Zoom) second most effective**
 - **No statistically significant difference**

(Wang et al., 2026)

BODY DYSMORPHIC DISORDER (BDD)

Preoccupation with perceived physical flaw(s),
(e.g., hair, facial features, or skin)

Compulsions (e.g., mirror checking, surgery seeking)

Time-consuming (e.g., take more than 1 hour per day)
distressing, and/impairing

Avoidance

Low insight, high suicide rate



APA, (2013)

CBT FOR OCD AND BDD

CBT for OCD

Challenging **self-defeating beliefs** (e.g., exaggerated responsibility, over-importance of thoughts)

Exposure to **triggers** (e.g., dirt, germs) without performing compulsions

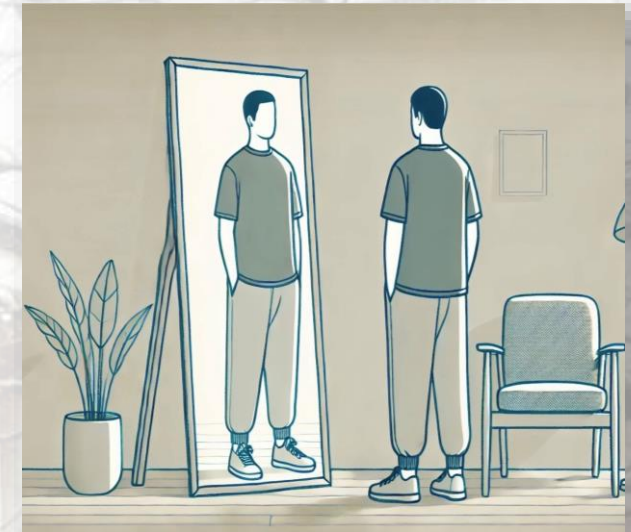
Typically **good insight** into irrational nature of fears

CBT for BDD

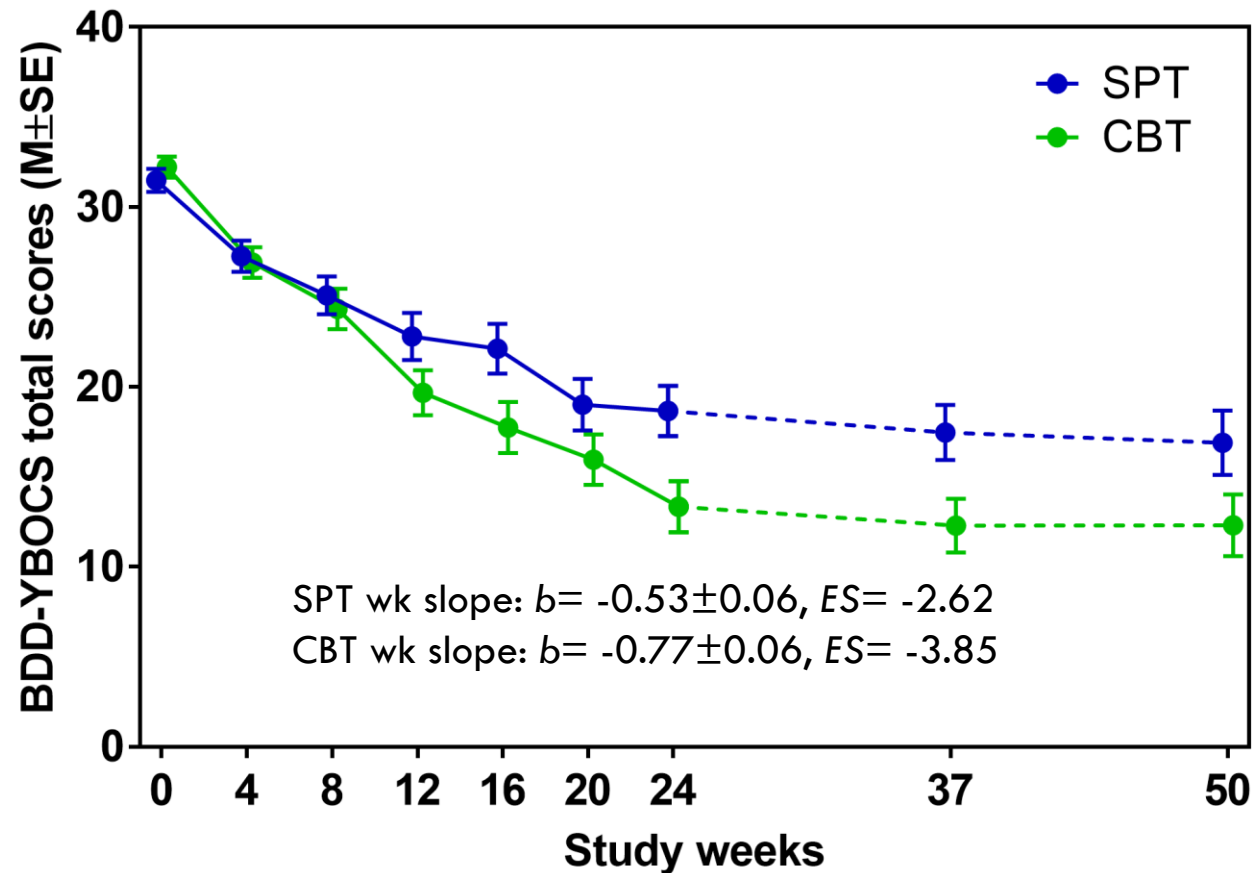
Challenging **distorted body image beliefs**

Exposure to **feared appearance** situations, working with **mirrors**

Often **poor insight**, sometimes delusional thinking about appearance, higher risk of **suicidality**



BDD SYMPTOMS IMPROVE MORE WITH COGNITIVE BEHAVIOR THERAPY THAN WITH SUPPORTIVE THERAPY



Model effects:

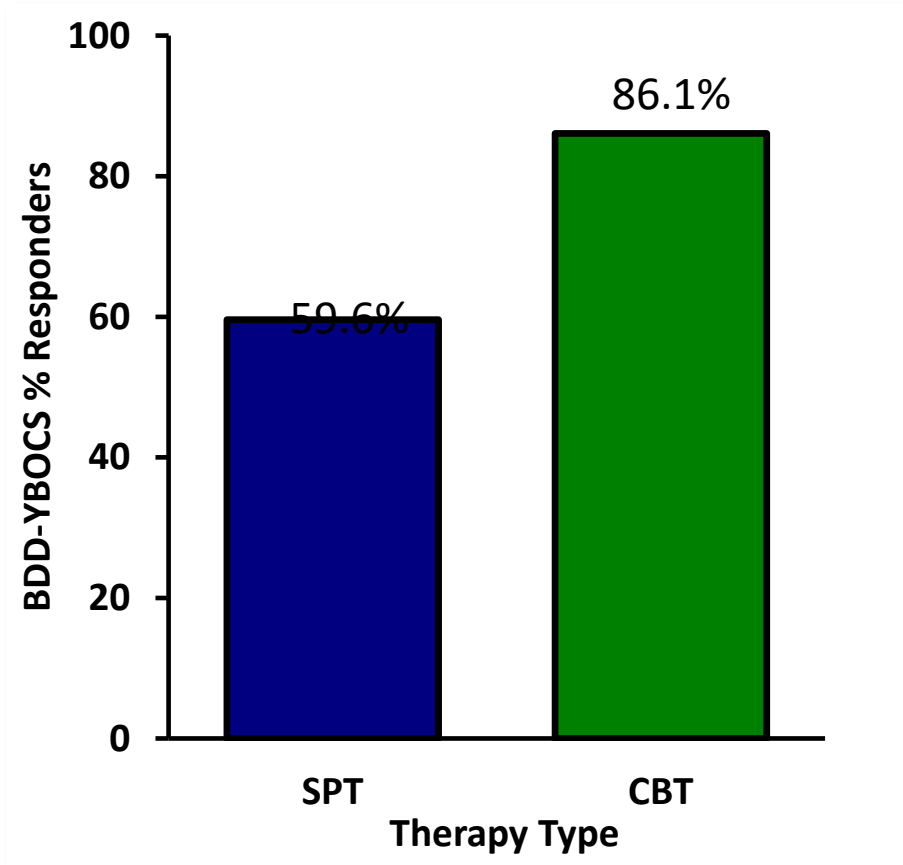
Time = $p < .01$

Time*T_x = $p < .01$

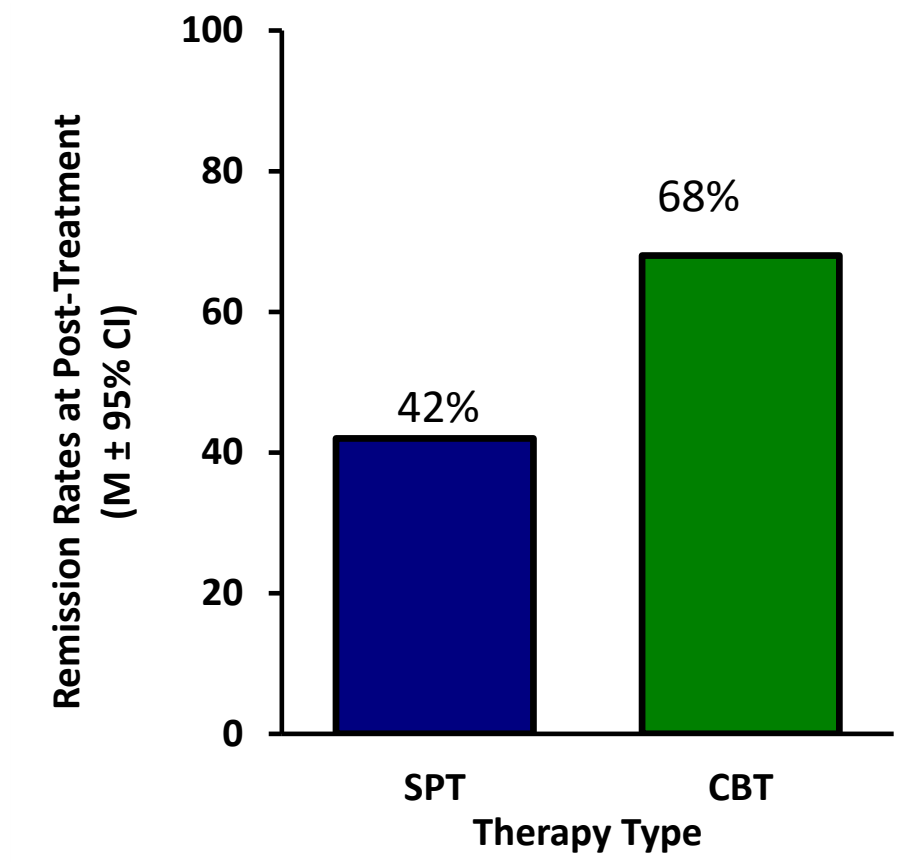
Wilhelm et al., 2019

RESPONSE TO CBT AND SUPPORTIVE THERAPY AT 24 WEEKS

Treatment Completers Only



Remission Rates



HAIR PULLING AND SKIN PICKING DISORDERS

Repetitive pulling/picking resulting in hair loss/skin lesions

Pulling/picking causes significant distress or functional impairment

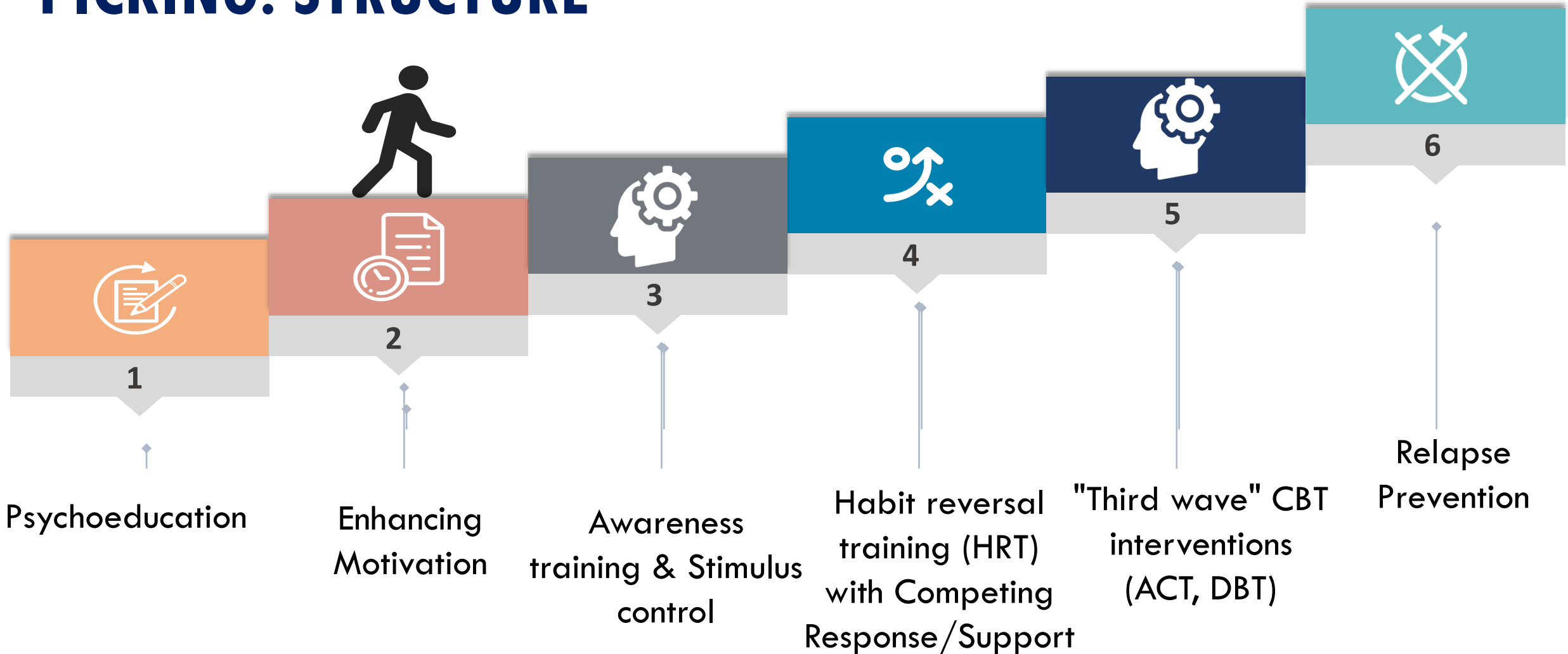
*Triggers may be **internal** (affective, cognitive) or **external** (motor, sensory, environmental)*

*Can be either **automatic** (e.g., outside of conscious awareness) or **focused** (e.g., specific goal)*

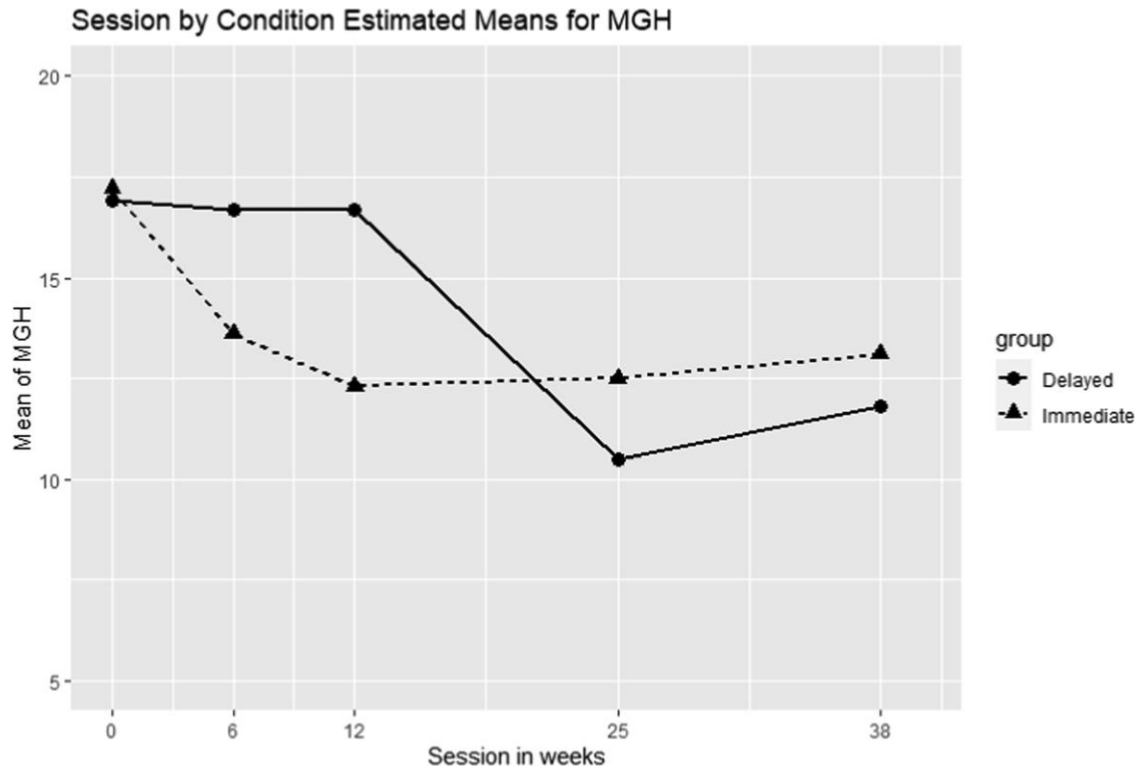
Both negative and positive reinforcement



CBT FOR HAIR PULLING & SKIN PICKING: STRUCTURE



COMPREHENSIVE BEHAVIORAL TREATMENT FOR TRICHOTILLOMANIA



- **Treatment: (N=36): Immediate ComB (12 sessions) vs. Minimal Attention Control (MAC) with delayed ComB.**
- **Outcomes:**
 - **ComB showed significant efficacy for self-reported symptoms (effect size $d = -.78$).**
 - **Immediate ComB led to complete hair-pulling abstinence in 27% of participants vs. 0% in MAC.**

Carlson et al., 2021

HOARDING DISORDER

Difficulty discarding + excessive acquisition

Emotional attachments to possessions

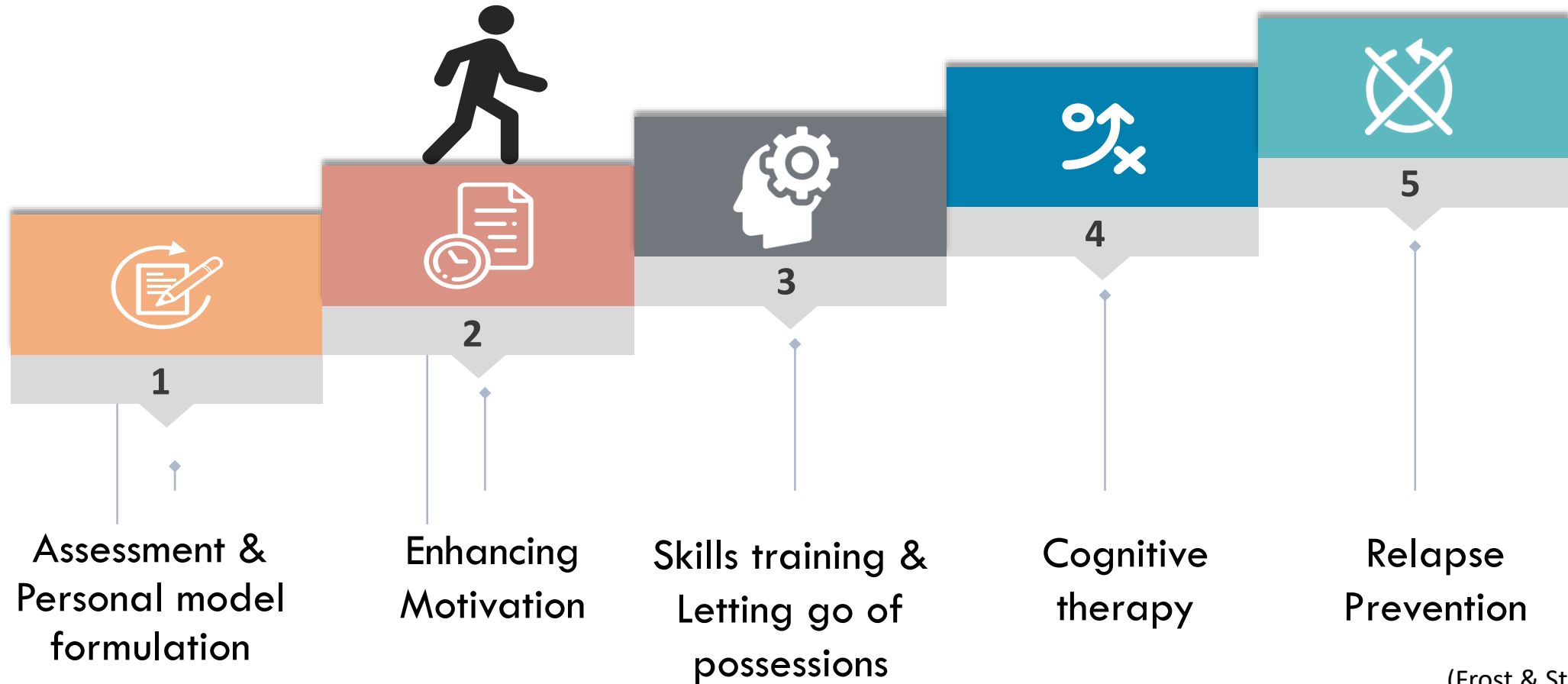
Clinically significant distress or impairment in social, occupational, or other important areas of functioning

Can result in inability to use living areas for intended use

Disrupts activities of daily living, safety issues, eviction

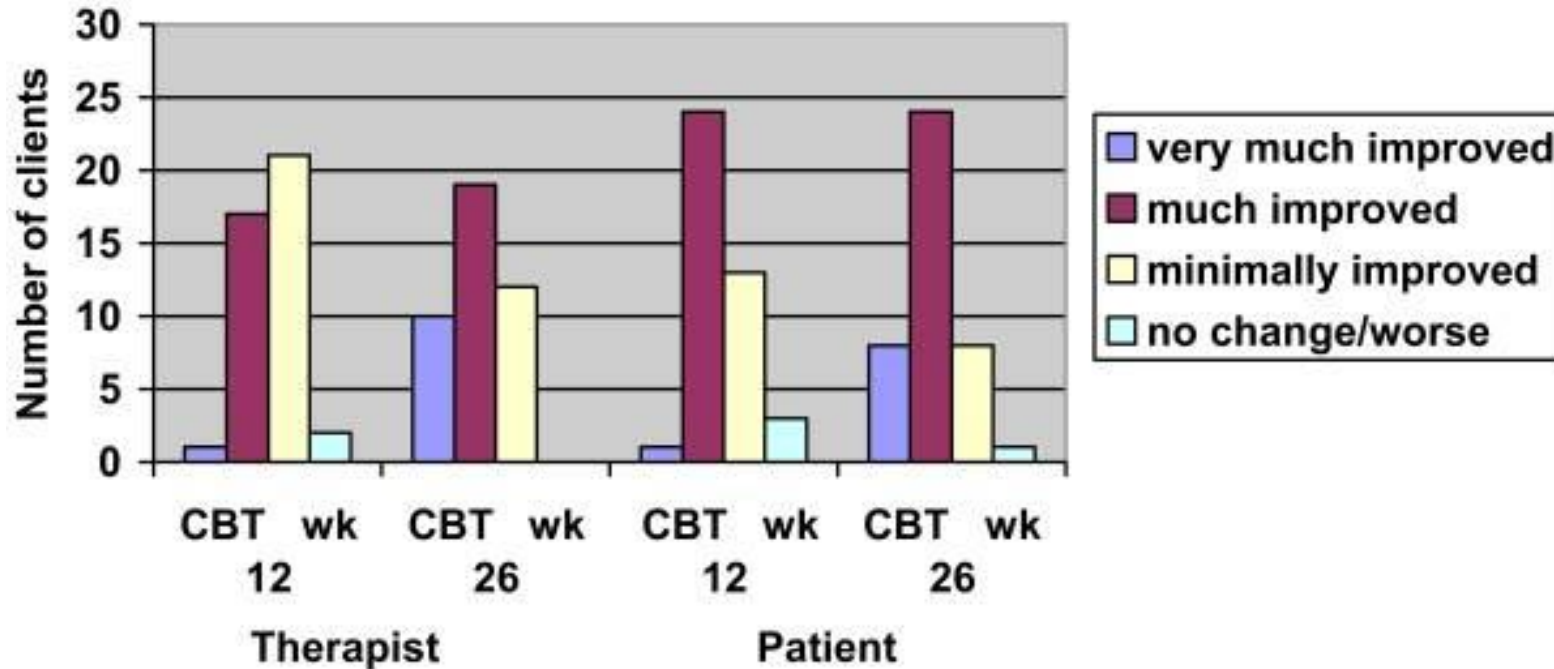


CBT FOR HOARDING DISORDER: STRUCTURE



(Frost & Steketee, 2013)

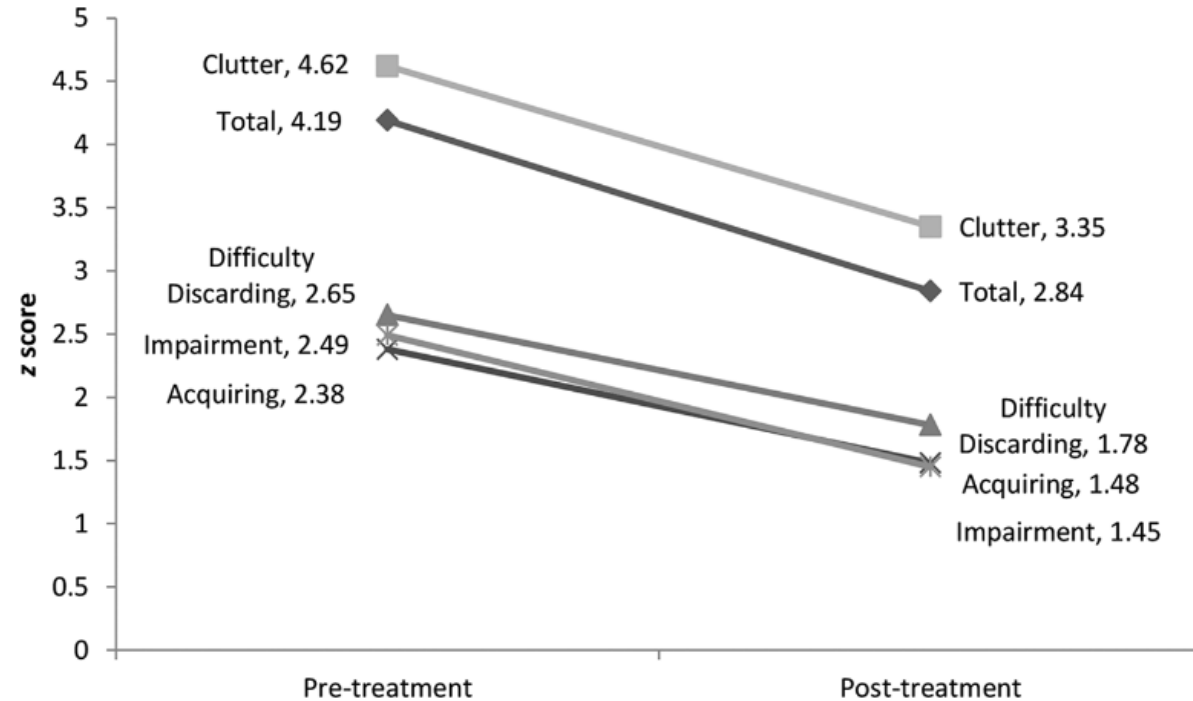
CBT FOR HOARDING DISORDER: OUTCOMES



- **12-session CBT intervention significantly improved hoarding symptoms compared to a waitlist control (N=46)**
- **70% of CBT patients rated as improved by therapists.**

(Steketee et al., 2010)

CBT FOR HOARDING DISORDER: OUTCOMES



- **Meta-analysis examining the effectiveness of CBT for hoarding disorder**
- **All domains showed a significant decrease in severity from pre- to post-treatment**

(Tolin et al., 2021)

COGNITIVE BEHAVIOR THERAPY FOR OCD AND BDD

**Effective for children,
adolescents, and adults**



✓ **Safe, acceptable
treatment for pediatric
OCD and BDD**

Franklin et al., (2008);
Storch, Greenberg, Mothi, & Wilhelm., (2016);
Wilhelm et al., (2016)

**Long-lasting
improvements**



✓ **Patients maintain gains at
6-months follow up**
✓ **Relapse prevention
techniques help maintain
gains**

McKay, Wilhelm et al., (2015);
Snorrason, Wilhelm et al. (2023)

NEW DIRECTIONS



BARRIERS TO CARE

Barriers to In-Person CBT	Smartphone/Internet CBT as a Solution
Limited clinicians specializing in CBT for OCD and OCD spectrum disorders	Scalable treatment options to improve accessibility
Expensive	Inexpensive
Stigma	Positively framed, de-stigmatized entry point

Marques, Wilhelm et al., (2010);
Marques, Weingarden, LeBlanc, Wilhelm, (2011);
O'Neill & Feusner, (2015)

APP DEVELOPMENT

Initial Build

Multidisciplinary team

- Experts in BDD/OCD treatment and research
- Industry experts in technology and user-interface design

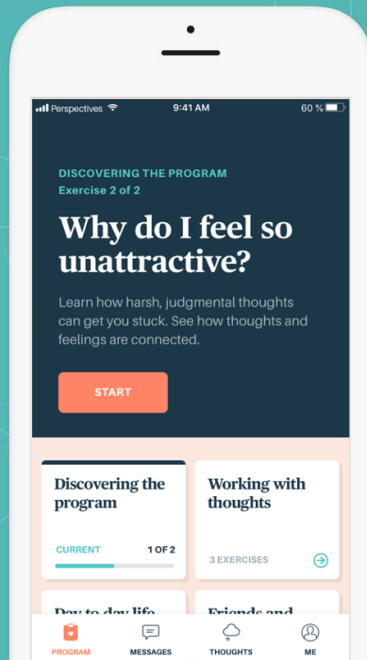
User-Centered Design

Extensive feedback from patient consultants with OCD or BDD

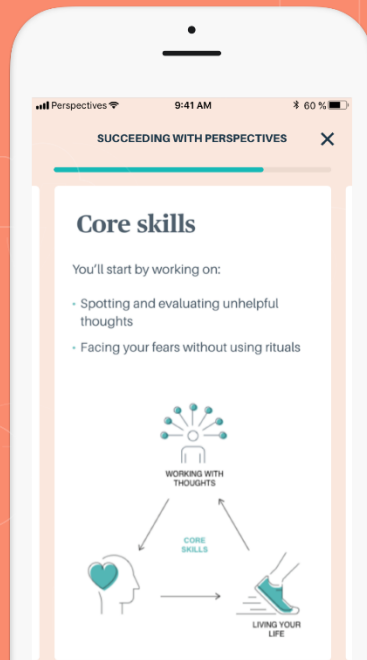


PERSPECTIVES

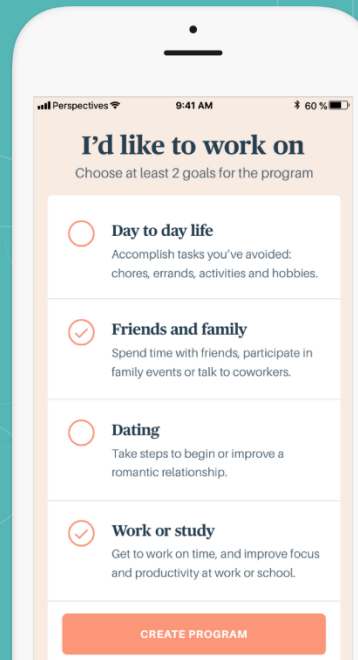
App-based therapy
for body dysmorphic
disorder



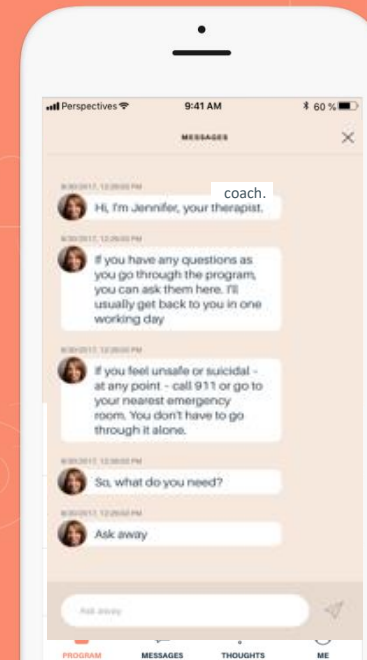
Based on cognitive
behavioral therapy



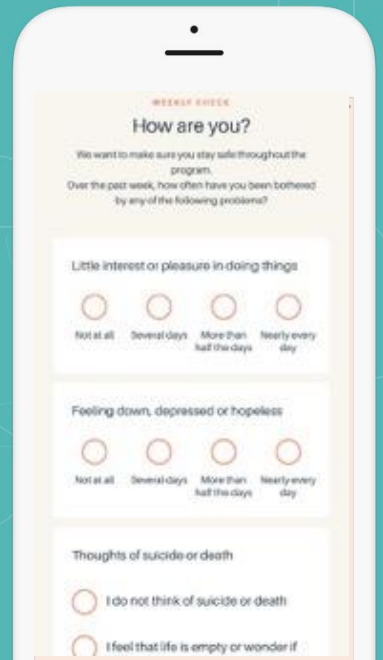
Receive a personalized
program



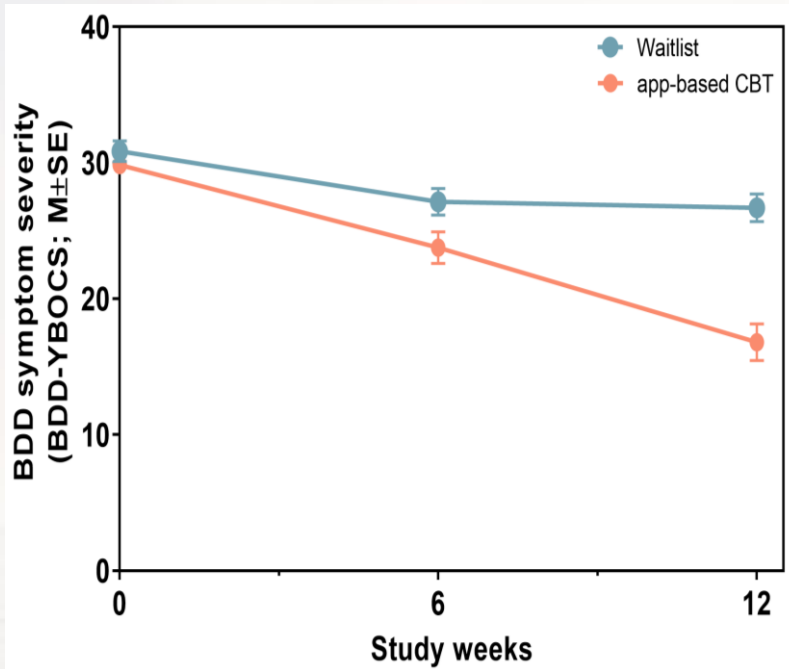
Asynchronous
communication with
coaches



Weekly safety
assessments

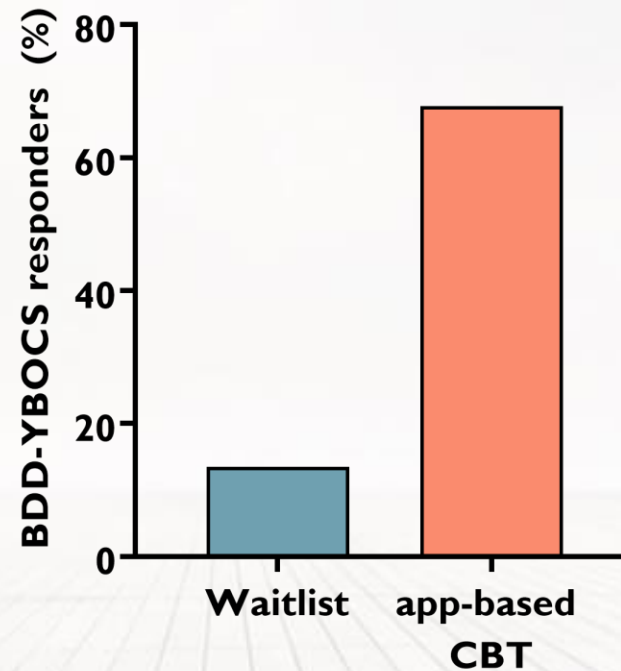


BDD SYMPTOM SEVERITY



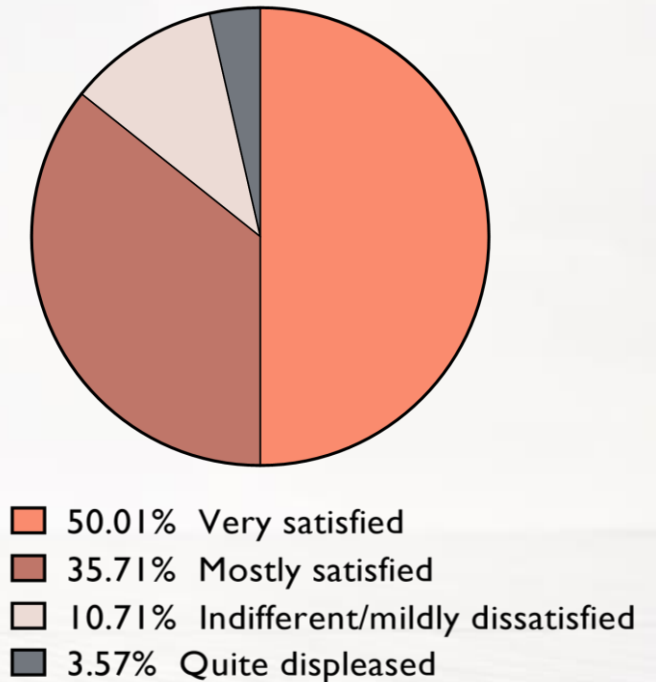
(Wilhelm et al, 2022)

TREATMENT RESPONDERS (COMPLETERS)



treatment response defined as a $\geq 30\%$ reduction in symptoms by week 12

PATIENT SATISFACTION



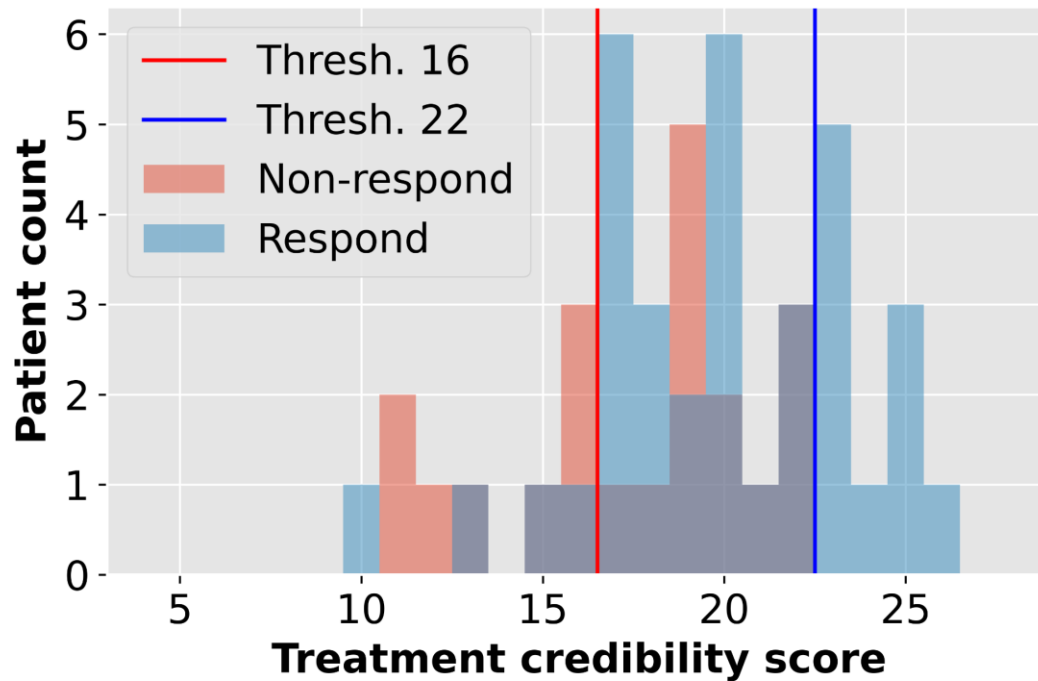
25/28 (89%) would recommend our program to a friend with similar problems

STRATIFICATION

Goal

Determine who should be prescribed app-based treatment

Jennifer Greenberg, PsyD.

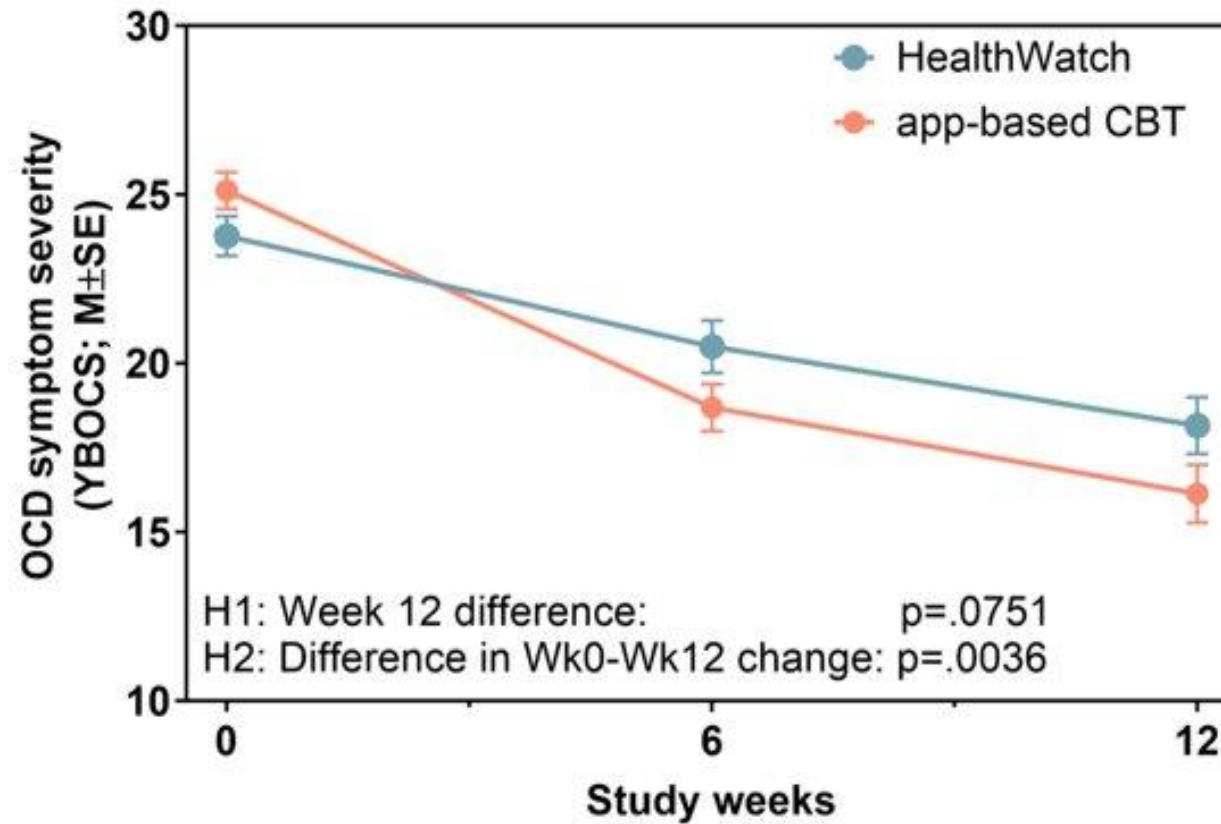


Findings

Treatment credibility chosen as the first feature in all models. Other promising features:

- *Immediate availability of treatment*
- *Gender identity and sexual minority status*
- *Treatment expectancy*
- *Lower severity*

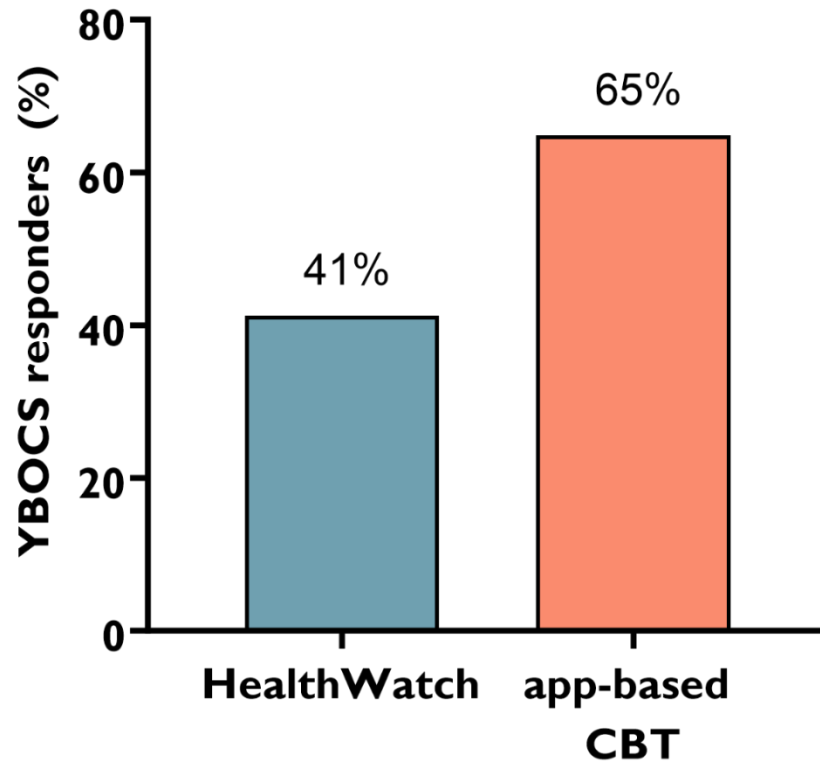
PERSPECTIVES-OCD: OCD SYMPTOM SEVERITY



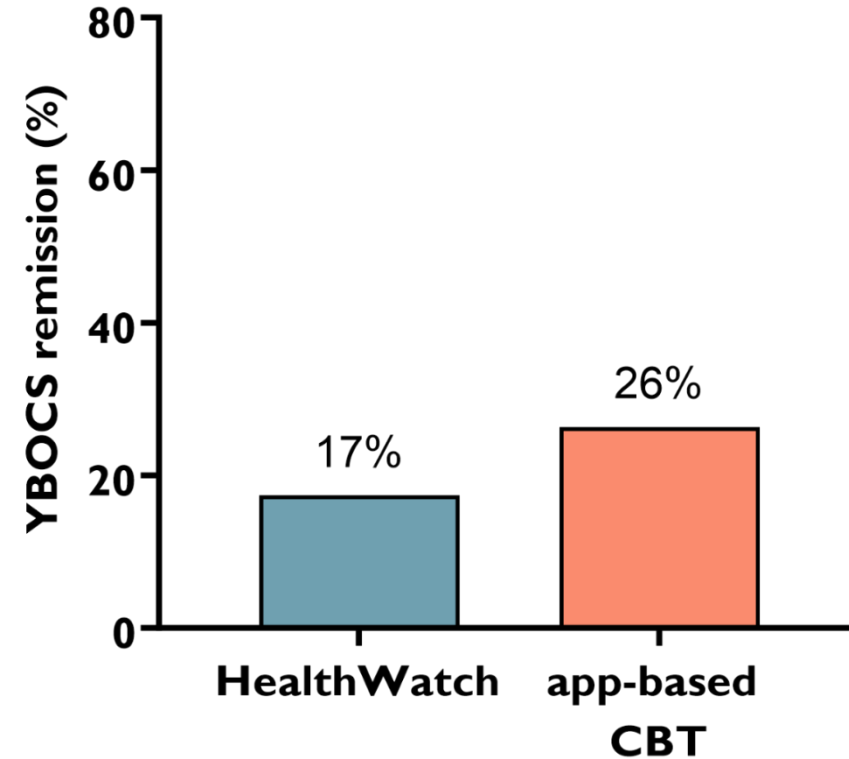
(Wilhelm et al., 2022)

PERSPECTIVES-OCD: TREATMENT RESPONSE & REMISSION (Completers)

Treatment response defined as a YBOCS decrease by 25% or more by week 12

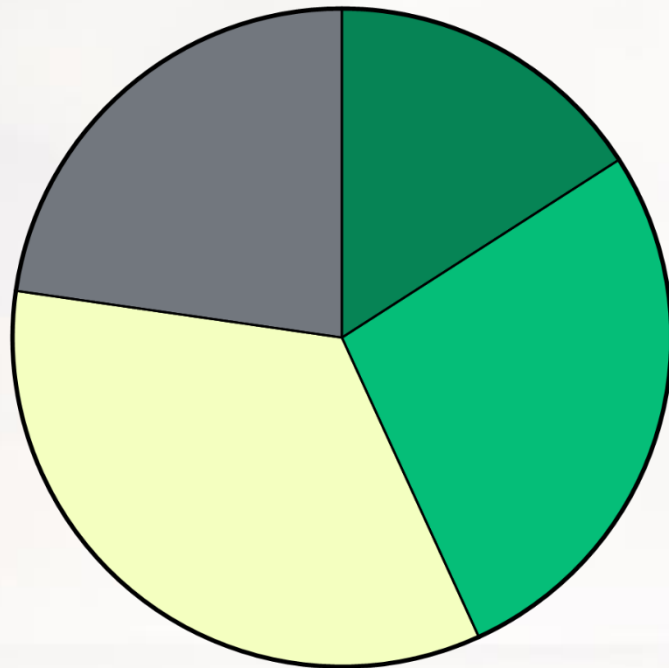


Remission defined either as YBOCS scores ≤ 12 at end-of-treatment (week 12)

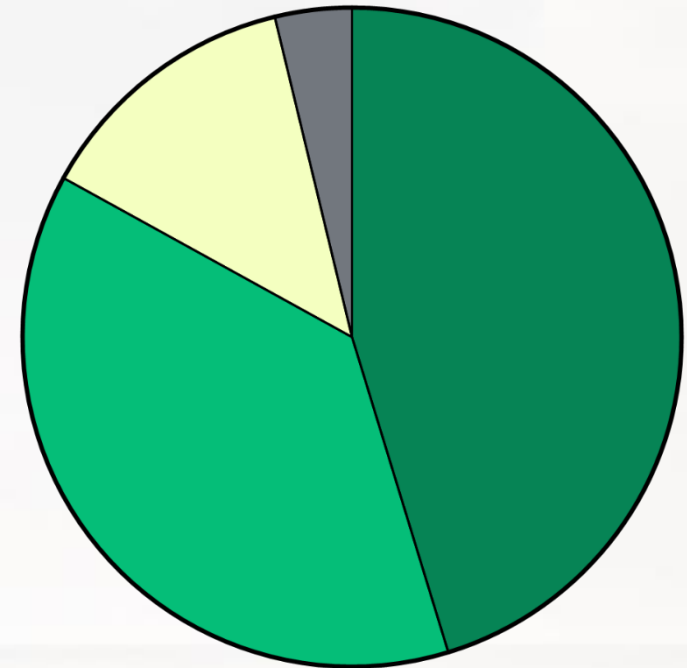
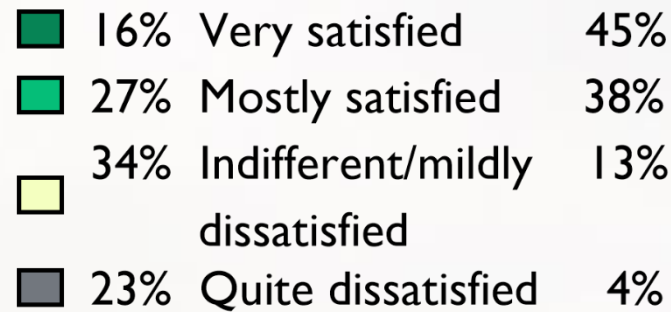


(Wilhelm et al, 2025)

PERSPECTIVES-OCD: PATIENT SATISFACTION RATINGS



HealthWatch



App-CBT

24/44 (**53%**) would recommend HealthWatch and 48/53 (**91%**) would recommend app-CBT to a friend with similar problems.

(Wilhelm et al., 2025)

PAIRING APP-BASED ERP WITH IN-PERSON CBT

Table 2
Observed Outcomes for Clinical Measures

Measure	Baseline (<i>n</i> = 33)		Week 4			Week 8			Week 16		
	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>
Y-BOCS	22.85	4.47	30	16.73	4.43	27	13.96	5.45	20	15.80	6.33
HAM-D	6.21	4.21	30	4.17	3.14	27	4.29	4.54	20	5.65	4.68
QLESQ-SF	48.76	6.29	27	50.48	7.40	25	51.84	7.38	18	51.83	7.82

Note. Y-BOCS = Yale-Brown Obsessive Compulsive Scale; HAM-D = Hamilton Depression Rating Scale; QLESQ-SF = Quality of Life Enjoyment and Satisfaction Questionnaire-Short Form.

8 weeks of Brief Exposure and Response Prevention Assisted by Mobile app (BEAM) with 2-month follow-up

3-5 sessions (90 min) of face-to-face EX/RP + mobile app EX/RP + 5 weekly phone calls

42% responded to treatment (Y-BOCS decreased $\geq 35\%$). At follow-up 35% met criteria for treatment response and 15% met for treatment remission

More research needs to be done to evaluate the efficacy of integrated treatment platforms for cognitive behavior therapies for OCD

Tech-Enhanced CBT Delivery & Outcomes

Digital Mental Health Interventions (DMHIs)

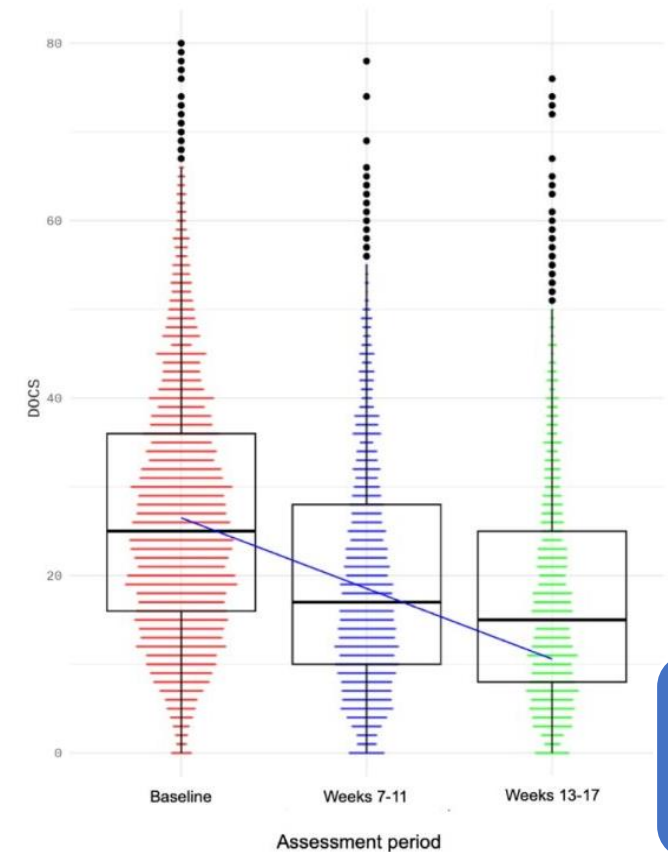
- **OC-Go:** Online ERP tool improved homework compliance in children with OCD (Tuerk et al., 2023).

Telehealth & App

- Digital CBT delivery, while effective, still faces engagement and access hurdles (Feusner et al., 2025).

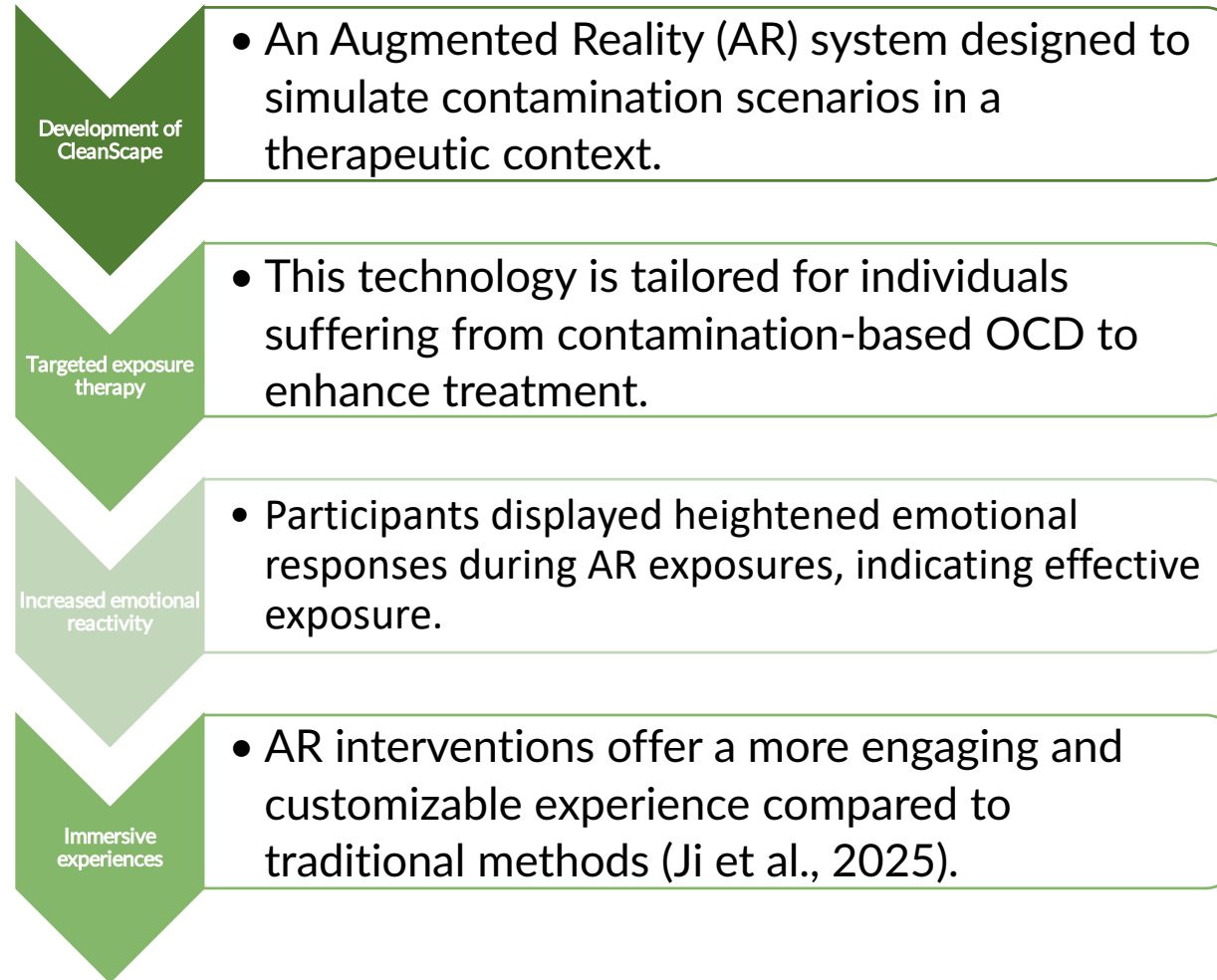


Changes in OCD symptoms with median and interquartile ranges, as measured by the Dimensional OC Scale (DOCS).

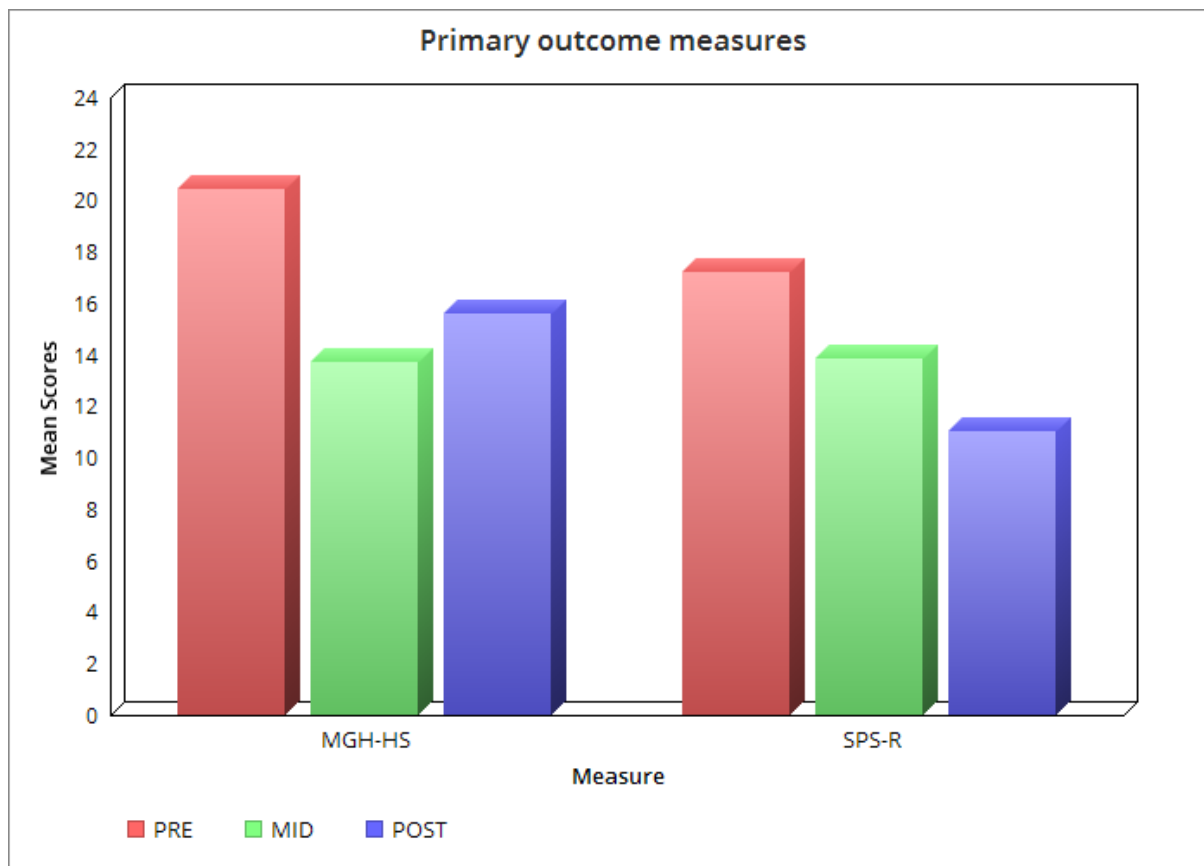


$P < 0.001$ for the effect of assessment period

CleanScape: AR Therapy for OCD



INTERNET TREATMENT FOR HAIR PULLING & SKIN PICKING



- **Treatment: (N=25) 10 weeks of therapist-guided internet-delivered BT (I-BT).**
- **Outcomes**
 - Significant decreases in hair pulling and skin picking severity (effect sizes $d = 0.89$ to 1.75).
 - Results maintained up to 12-month follow-up on most outcome measures.
- **Feasibility**
 - High satisfaction and credibility among participants.
 - Average 7.2/10 modules completed

(Asplund et al., 2022)

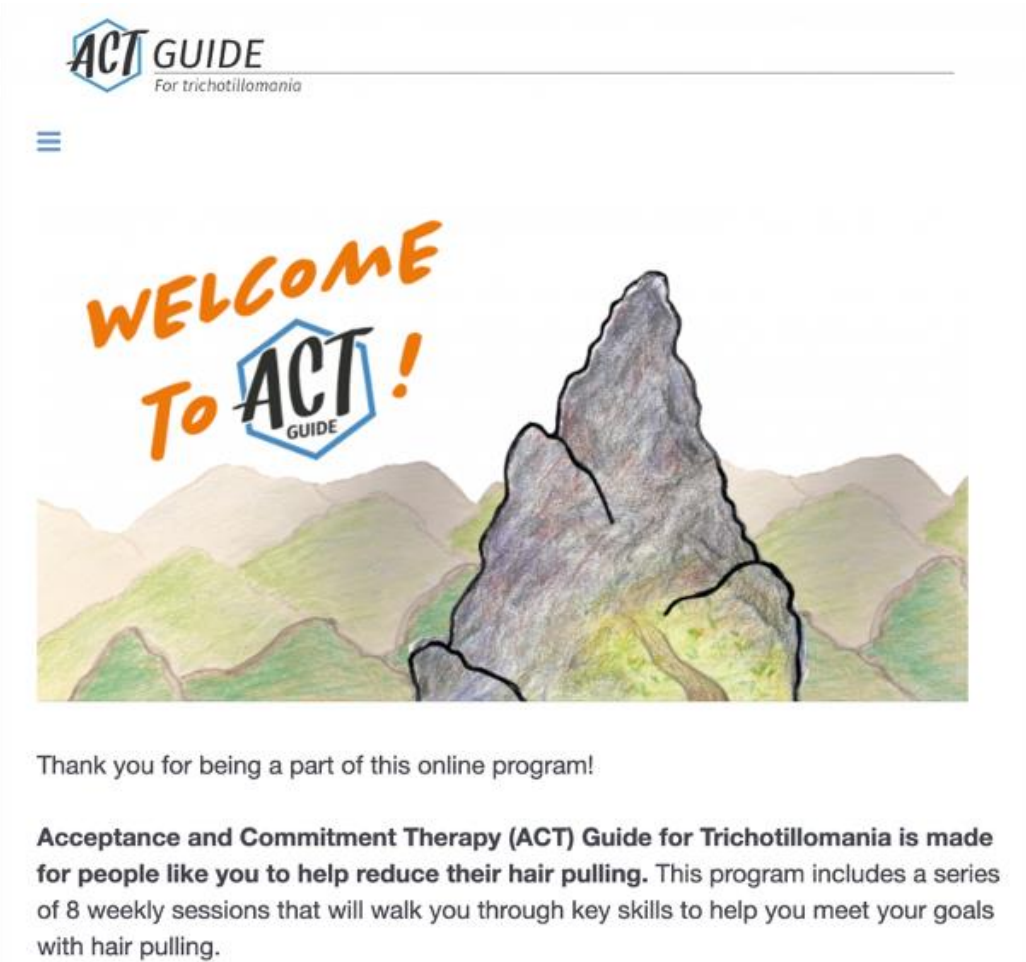
ACT Guide for Trichotillomania (Self-guided)

Study Procedures

- 81 participants → 12 week study
- Randomized into treatment or waitlist
- 8-week intervention
- Minimal coaching provided
- Surveys at baseline, mid, post, one-month follow-up

Main outcomes

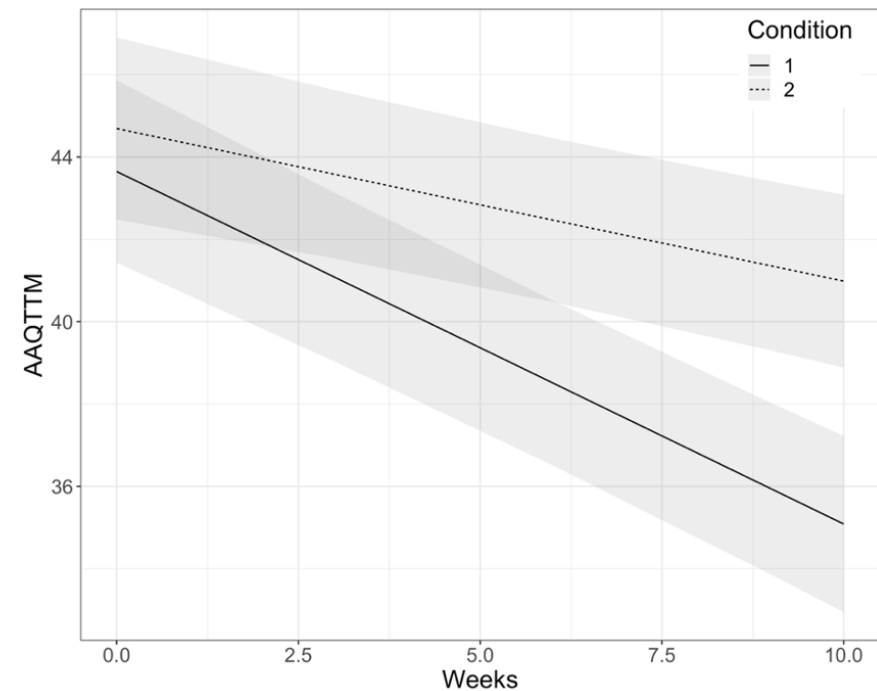
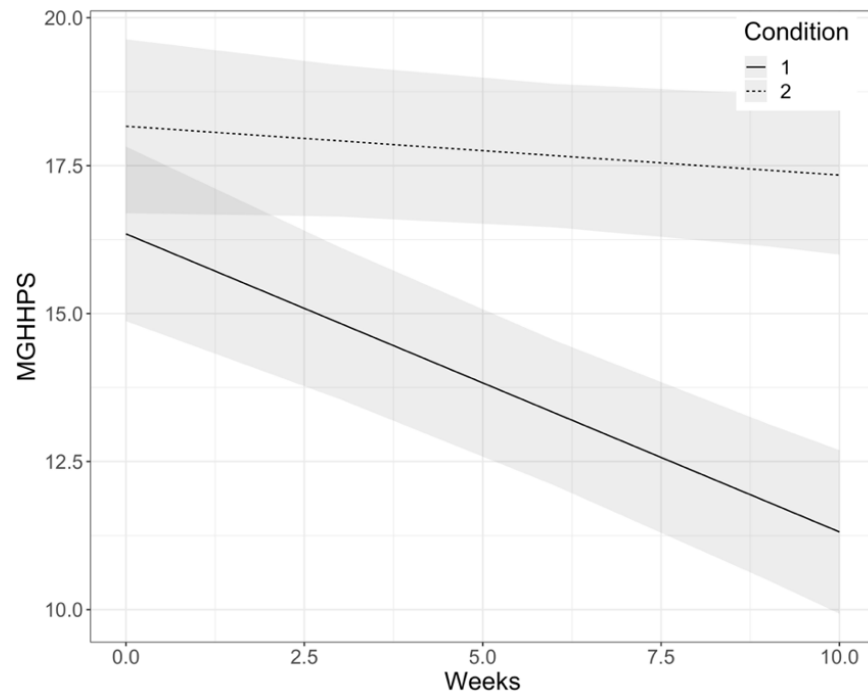
- Hair pulling severity (MGH-HPS)
- Trichotillomania psychological flexibility (AAQ-TTM)



(Capel et al., 2023)

ACT Guide for Trichotillomania (Self-guided)

- Analyses were conducted using multilevel modeling
- Significant difference between conditions (1 = treatment, 2 = waitlist) on both outcomes over time (e.g., time x condition interaction)



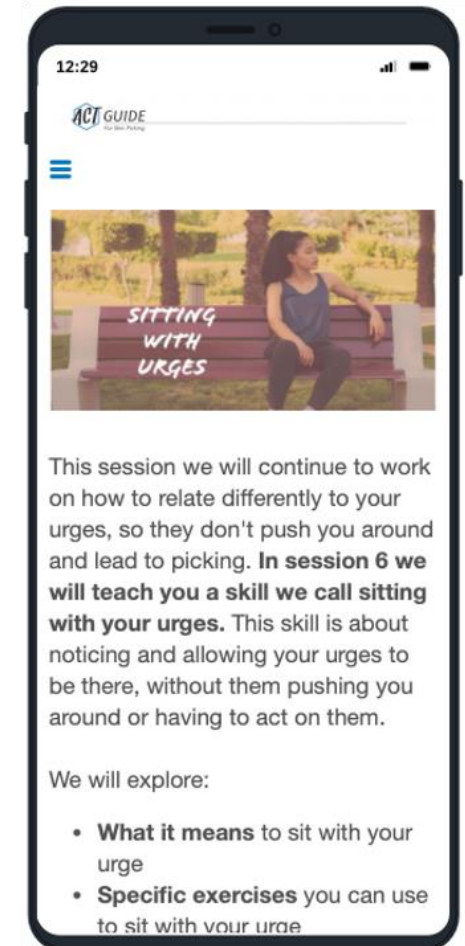
(Capel et al., 2023)

ACT Guide for Skin Picking (Self-guided)

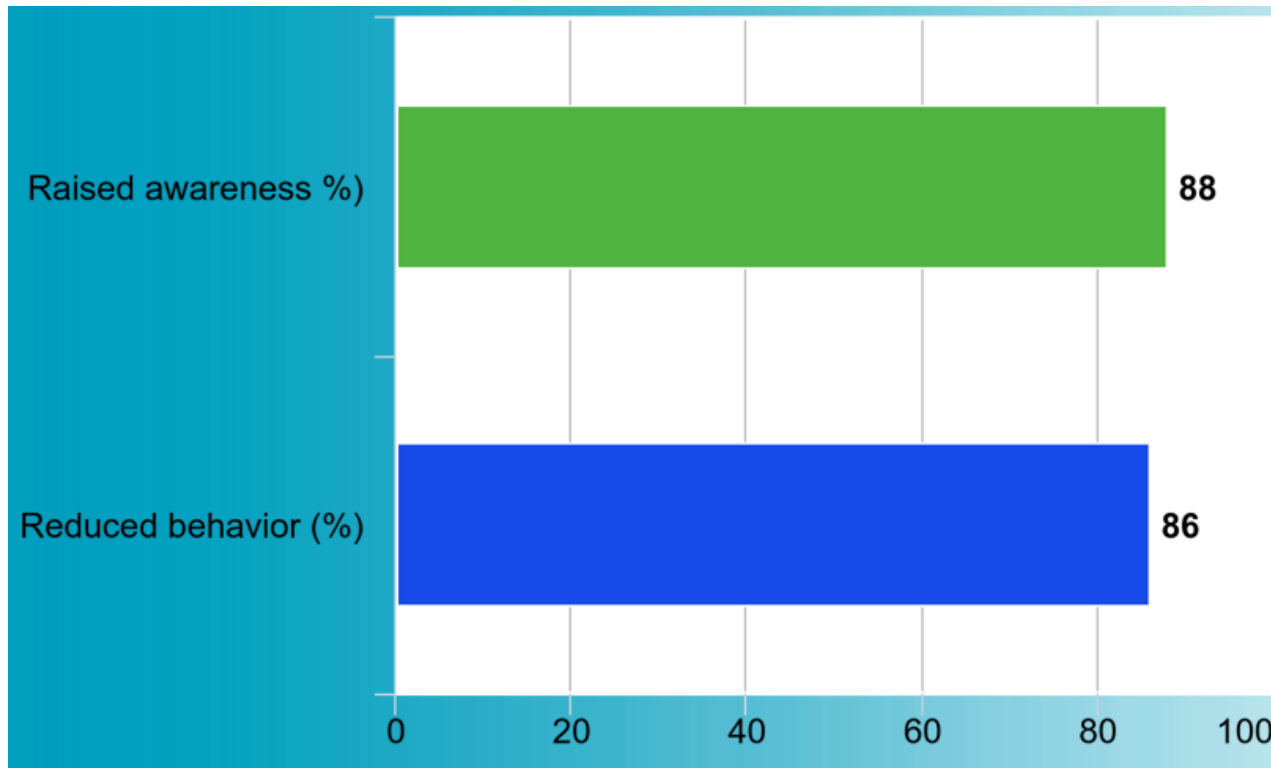
- 8 modules covering psychoeducation, habit reversal training, values, acceptance, cognitive defusion, and relapse prevention
 - 20-30 minutes per module with weekly practice assignments
- ACT Guide programs: <https://cehs.usu.edu/scce/services/act-guide/> or search “ACT Guide Utah State”
 - \$25 for 6 months of access

Randomized Controlled Trial:

- 84 adults with skin picking disorder allocated to intervention or waitlist; assessed at baseline, mid-, post-intervention, and 1 month follow-up
 - **Efficacy:** Significant reductions in skin picking severity (SMD = 0.99) and impairment (SMD = 0.63)
 - **Responder Status:** 58.1% achieved clinically significant symptom reduction post-treatment, 55.8% maintained at follow-up
 - **Psychological Flexibility:** Improvement with moderate to large effects (SMD = 0.49 to 0.82)
 - **Feasibility:** High adherence with 51.2% completing the program, excellent usability (System Usability Scale = 85.6)



NOVEL TECHNOLOGY FOR BFRBs



- **Awareness Technology** for hair pulling (trichotillomania), skin picking (dermatillomania), and nail biting (onychophagia)
- The HabitAware® device and app system showed high usability, acceptability, and effectiveness in reducing hair pulling severity (n=10).



(Stiede et al., 2022)

INTERNET TREATMENT FOR HOARDING DISORDER

Study	Participants	Design and Treatment	Findings
Muroff et al. (2010)	106 adult hoarding online; 155 adult hoarding waitlist	Quasi-experimental study; internet CBT-based self-help groups vs. naturalistic waitlist (WL)	6-month reductions: SI-R: 9%, Cohen's $d = .52$. CIR: 17.5%, Cohen's $d = .47$. CGI: 20%, Cohen's $d = .79$.
Ivanov et al. (2018)	20 adult hoarding outpatient	Pre-post, uncontrolled trial testing group with 16 weekly face-to-face CBT for hoarding sessions plus web-based, between-session therapist support.	At post-treatment: 25% no longer met HD criteria (SIHD); CGI-I: 50% self-rated as “very much” or “much” improved
Fitzpatrick et al. (2018)	12 adult hoarding outpatient	Quasi-experimental design; 12 weeks of office-based group CBT followed by 8 weeks of online therapist-assisted HoPE program (bCBT) vs. 12 weeks of office-based group CBT followed by 8 weeks on a waitlist.	Total participants who received bCBT (N = 10): Improvement on SI-R total at post-group as well as following HoPE program with large effect sizes ($F(2, 18) = 4.86, p = .02, \eta^2p = 0.35$)
Krafft et al. (2023)	73 adults with clinically significant hoarding symptoms	Randomized Controlled Trial: 8-week, 16-session web-based ACT + minimal coaching VS waitlist	SI-R total: Holm-corrected $p = .01$; Difficulty discarding: $\beta = -.74, p = .02$; Excessive acquisition: $\beta = -.78, p = .004$; Functional impairment (SDS): $\beta = -.73, p = .003$; Clinically significant change at post: 11.5% Full-program completion: 13.2%
Chasson et al. (2018)	23 non-treatment seeking adult hoarding participants	Pre-post pilot study to examine the acceptability of pre-post effects of a single 10-min VR immersion intervention	Participants found the VR experience to be positive (easy to use, safe, helpful, non-shaming). Pre-post-test change: Treatment readiness and confidence increased

Applications of AI in OCD Treatment

Automate administrative tasks (take session notes)



Advise clinicians and patients in real-time



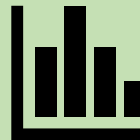
Create case formulations and treatment plans (Nelson et al., 2025)



Simulate CBT-like dialogue with patients (Cruz-Gonzalez et al., 2025)



Integrate passive data to predict patient mood (Nelson et al., 2025)

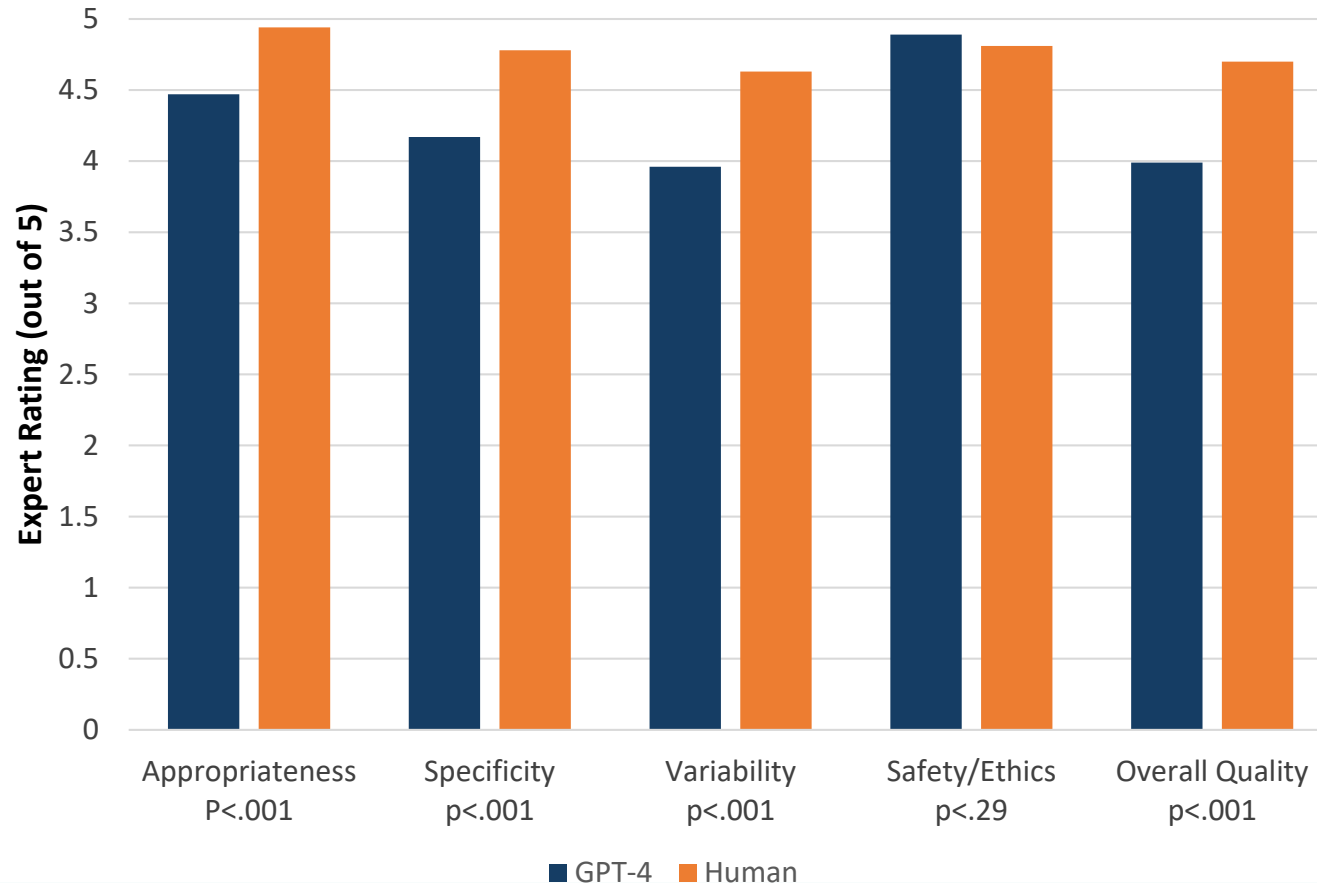


Language analysis to improve timely OCD detection (Kim et al., 2025)



ChatGPT as a Clinician-Facing Tool

Ratings of ERP Hierarchies Created by GPT-4 and Human Experts

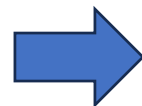


ChatGPT-4 was used to generate ERP hierarchies. Its responses were rated by OCD experts and compared to responses by human clinicians (Bernstein et al., 2025)



AI-Driven Clinician-Facing Tool

How can AI be used to
improve the quality of
OCD care?



- **Clinician-facing AI-Driven Exposure Hierarchy Generator**
 - Assist novice clinicians who may not have enough experience to generate their own hierarchies
 - Provide guidance regarding more complex presentations of OCD
 - Improve the all-around quality of CBT for OCD
 - Improve accessibility to exposure-based care

Tool Development

Tool Conceptualization

- Extensive process with experts in OCD/BDD and LLM/AI tool development.
- Establishing the needs of novice clinicians and how the tool can best serve them and their patients.



Mindful Development

- Creating strict guidelines and sandbox to ensure highest standard of outputs.
- Using expert-generated hierarchies to train the tool.



Iterative Feedback Process

- Substantial testing by development team and feedback from clinicians and patients.
- Comparing the tool's output with expert-generated hierarchies.

ChatGPT as a Patient-Facing Tool

Domain	Subdomain	Score (0 -2)
Credibility	Proposed Goal	0
	Evidence-Based Content	2
	Retention	N/A
User Experience	Personalization & Evolution	1
	Interactive Quality	1
	Feedback Mechanism & Support	1
User Agency	User Autonomy, Data Protection, & Privacy	0
	User Empowerment	1
Equity & Inclusivity	Cultural Sensitivity & Inclusivity	0
	Bias and Fairness	0
Transparency	Transparency	1
Safety & Crisis Management	Safety & Crisis Management	1

OCD Coach, an add-on for ChatGPT, is **an AI tool designed to aid in OCD symptom management**. Its responses to different prompts were scored on the 0-2 FAITA-Mental Health Scale.



Addressing Patient GenAI Use

- **Lack of judgement**
 - **Availability**
 - **Confident tone**
 - **Sycophancy**

- Increased use of AI chatbots as **free** and **accessible** substitute for psychological support
 - ~50% of U.S. adults with self-reported MH conditions reported GenAI chatbot use for psychological support (Rousmaniere et al., 2025)
 - Not trained on clinical models
 - **But why do individuals turn to AI for emotional support?**

(Golden & Aboujaoude, 2026)

GenAI Chatbots & Avoidance

Continued chatbot use for avoidance behaviors has been theorized to lead to...



Interference

with corrective learning
processes



Maintenance

of maladaptive threat
appraisals



Contribution

to persistence/worsening
of symptoms

(Golden & Aboujaoude 2026)

Further Improvements

Design/Policy

A. Guardrails/Monitoring of Repetitive Behavior

B. Provide users with stats on AI use

C. Recruit experts for development

D. Standard regulations

Clinical

A. Clinician's understanding of AI

B. Psychoeducation with clients

C. Personalized instruction protocols

D. Incorporation into Assessment



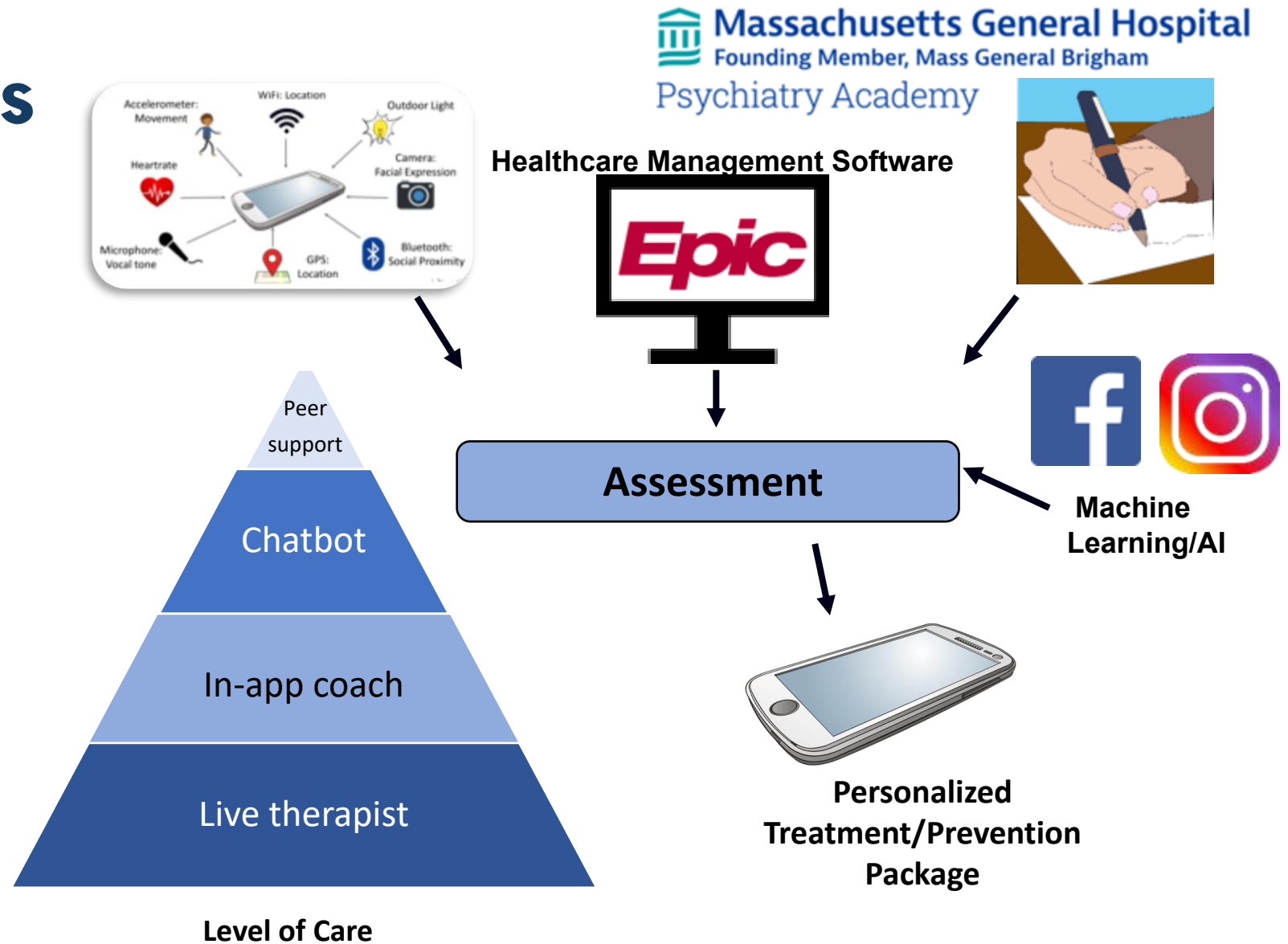
Future Directions

A. Integration

B. Passive sensing

C. Artificial intelligence

D. Broadening the evidence base



Source: Wilhelm et al. 2020



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Summary and Conclusions

- **Mental Health Crisis**
 - CBT for OCDRDs works
 - Most with OCDRDs and other mental health issues are not receiving care
 - Traditional systems of care cannot scale far or fast enough to address the need
- **Technology**
 - Already infiltrating all aspects of our lives
 - Offers scalable approaches to treatment
 - Outcomes are promising
 - Need to minimize risks and maximize benefits for our patients

RESOURCES

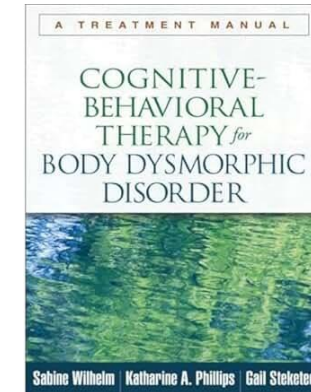
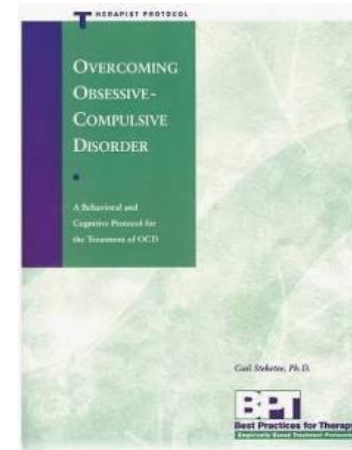
 **Massachusetts General Hospital**
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Psychiatry Academy



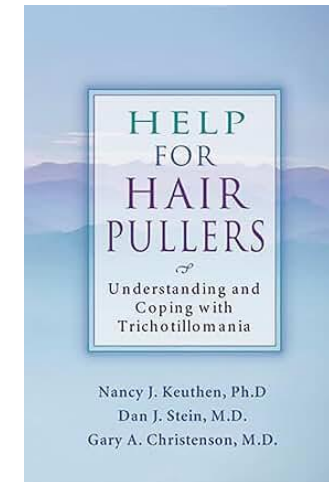
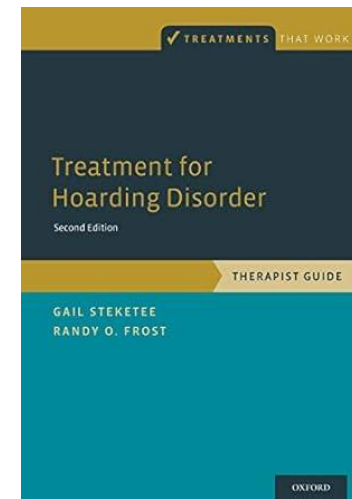
International
OCD
Foundation

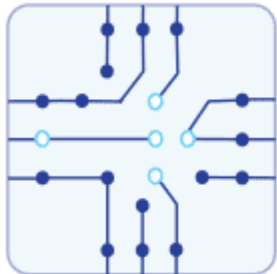
Resources. Research. Respect.

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The Center for Digital Mental Health

- **DEVELOP AND TEST** technologies to prevent, assess and treat mental illness
 - Wearables, sensors, smartphone apps, virtual reality
- **COLLABORATE** with diverse stakeholders
- **IMPLEMENT** evidence-based scalable health solutions to expand the mental health care system
- *Interested in learning more?*
 - Visit our website:
<https://centerfordigitalmentalhealth.org/>



swilhelm@mgh.harvard.edu



Massachusetts General Hospital
Founding Member, Mass General Brigham



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ONLINE COURSES



CBT for Obsessive Compulsive Disorder: An Introductory Online Course

Understand and identify clinical features of OCD and apply skills to treat the different OCD symptom subtypes.



CBT for Body Dysmorphic Disorder

Identify clinical features of BDD, enhance patient motivation, manage treatment pitfalls, apply specific strategies for unique presentations, and much more.



CBT for OCD in Children & Adolescents

How to use CBT for children and adolescents with OCD, including evidence-based interventions such as psychoeducation, cognitive strategies, and more.



CBT & Medication Treatment for Body Focused Repetitive Behaviors

How to use the latest assessment tools and treatment interventions (both CBT and medication) to help patients who suffer from BFRBs such as trichotillomania and excoriation disorder.

See All Course Dates at mghcme.org/cbt

swilhelm@mgh.harvard.edu

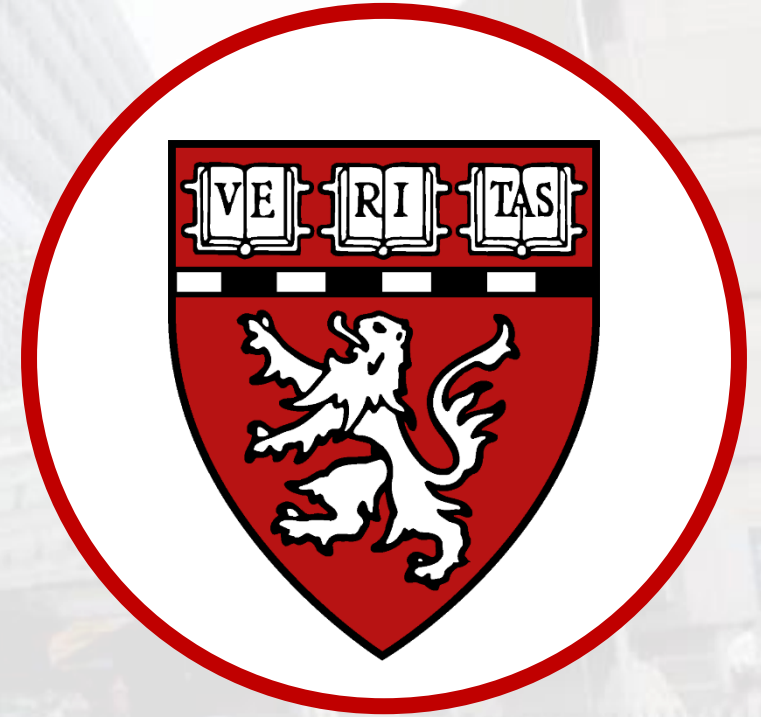
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