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HIT-OCD: A 5-Week Integrative CBT/ERP/ACT Protocol With In-Context (Home/Personal-Space) Exposure Support via Videoconferencing

Clinical Framework and Practice-Based Outcomes From Routine Care

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Abstract : Obsessive-compulsive disorder (OCD) is a chronic and disabling disorder for which Exposure and Response Prevention (ERP) is the first line of psychological treatment. However, when practicing there are a number of barriers to implementation. For instance, distress, inadequate adherence and limited to minimal support between sessions. This study evaluated the efficacy of the 5-week, High Intensive Training (HIT)- OCD combining ERP, inhibitory learning principles, Cognitive Behavioural Therapy (CBT), Acceptance and Commitment Therapy (ACT) & Solution- Focused Brief Therapy (SFBT) elements in a sample of adults with OCD. 32 individuals with symptoms of OCD received ERP based HIT protocol through online sessions and daily Whatsapp-based updates & check-ins. Severity of OCD was measured using the Obsessive-Compulsive Inventory-Revised (OCI-R) at beginning (Week 1) and the end (Week 5) of the protocol. Descriptive statistics and Shapiro-Wilk test was conducted, a paired-samples t-test & the Wilcoxon signed rank test were used to evaluate symptom change, and Cohen's d was calculated as a measure of effect size [19]. The clinically meaning change at individual level was calculated using the Reliable Change Index (RCI). A statistically significant reduction in OCI-R total scores from pre- to post-treatment was obtained $t(31) = 7.29$, $p < .001$, $d = 1.29$. For than 50% of the data met the criteria for reliable and clinically significant change. At the individual level (53.1%) met criteria for reliable improvement and (46.9%) achieved significance in terms of crossing from clinical to non-clinical range. In terms of numbers, the proportion of participants scoring from clinical range fell from 68.8% at pre-test to 21.9% at post-test. The data showed no reliable deterioration. The outcomes of HIT-OCD are an acceptable and considered potentially effective protocol of OCD. Replication with controlled designs, larger samples and long-term follow-up can be considered in future studies.

Keywords: obsessive-compulsive disorder, exposure and response prevention, CBT, ACT, brief intervention, hybrid delivery, inhibitory learning, pilot study

1. INTRODUCTION

1.1 Background and Clinical Significance

Obsessive-compulsive disorder (OCD) is defined by the presence of recurrent obsessions and repetitive compulsions that cause significant distress and functional impairment. It has a lifetime prevalence of 2-3% worldwide. Furthermore, one of the leading causes of disability worldwide [1,2]. Until and unless proper treatment is given, the disorder intensifies chronically, significantly affecting diverse areas of an individual's life [3].

The first-line psychological treatment with the strongest empirical support is Exposure and Response Prevention (ERP) which has its foundation on learning theory and cognitive behavioral model of OCD [4, 5]. ERP involves exposure to feared stimuli for clients and systematic prevention of compulsive or safety behaviours facilitating corrective learning and reduction of anxiety

driven rituals. Large effect sizes have been consistently shown for ERP in meta-analytic evidence which is relative to waitlist and active comparison conditions [6].

ERP has strong efficacy but challenges remain for its implementation in routine outpatient care. In the real world, delivery is complicated by distress intolerance, variable motivation, co-morbid symptoms, avoidance, family accommodation, reassurance-seeking, and difficulty with between-session exposure tasks. A central and primary concern is the discrepancy between therapist planned ERP and client actual following through outside of the session. Adherence in between sessions in clinically critical as OCD symptoms are maintained not only by fear-based appraisals but by repeated compulsions, avoidance, checking, reassurance and safety behaviors enacted in everyday life [7,8]. Addressing these barriers, protocol innovations are needed that further extend therapeutic impact beyond the clinic hour, facilitate exposure in context, and build motivational readiness prior to the onset of ERP.

1.2 In-Context Exposure and Generalization

A further implementation barrier is that many salient OCD triggers occur in the client's home, private spaces, or relational contexts- bathrooms, kitchens phones, family interactions, religious spaces, cleaning routines and checking sequences. Conducting ERP only in a clinic setting would reduce the possibility of corrective learning in everyday instances where their behaviors are deeply ingrained. Hence, HIT-OCD an in-context exposure acts like a fundamental and core delivery strategy and not a supplementary one. According to the inhibitory learning theory, treatment outcomes are enhanced when exposed to the feared stimuli in multiple contexts. In this the individual gradually learns to endure without resorting to compulsive rituals [9].

1.3 Videoconferencing based therapy style- ERP tool

HIT-OCD selectively uses videoconferencing when it is clinically beneficial for in vivo exposure, response-prevention coaching, monitoring ritual-prevention fidelity, and identifying accommodation patterns as they occur in daily life. Videoconferencing online sessions help the therapist connect the dots of clinic-based learning with the real-world symptoms with context. This positions videoconferencing not as a substitute for in-person care but as a feasible means to bridge the gap between clinic-based learning and real-world symptom contexts. It particularly indicates if symptoms are strongly tied to private spaces, home routines, or checking rituals that cannot be meaningfully replicated in the clinic — including clients who cannot travel due to distance or severity of illness (for example, clients who spend several hours in compulsive bathroom routines).

1.4 Daily Check-In Intervention

A daily check-in and monitoring of progress was done by the therapist with the recognition that the doubting nature of OCD encourages a high frequency of urges to seek reassurance, certainty and clarity. If not supported, these urges will take clients down the rabbit hole of compulsive reassurance seeking from non-certified sources or internet browsing, thus reinforcing the OCD loop. In HIT-OCD, the therapist is reliable source of support, who helps clients surf such urges with compassion and accurate information – without giving direct reassurance – thus strengthening the therapeutic relationship while avoiding accommodation. Daily contact also helps to overcome the adherence fragility of the early treatment phase when motivation is most susceptible to high anxiety. Real-time triggers and reactions can be precisely monitored and immediately communicated to the therapist, offering specific, context-sensitive guidance for the subsequent days.

2. RATIONALE FOR HIT-OCD

To directly address the implementation barriers described above, the High Intensity Training Integrative Treatment for OCD (HIT-OCD) was developed. It is a 5-week structured therapist-led outpatient protocol that combines ERP with inhibitory learning principles [9], CBT-based cognitive restructuring, ACT-based defusion and values work [10], SFBT-informed preferred-future construction [11], motivational enhancement, identity reconstruction, and systematic relapse prevention. HIT-OCD also includes daily WhatsApp contact with the therapist and selective use of video-conferencing for in-context exposure, to improve adherence, accountability and generalization.

This protocol believes that the disorder is a continuous loop or cycle of : intrusive thoughts that can elicit catastrophic or fear-based interpretations, which lead to anxiety or bodily distress. As a consequence of that, it further drives compulsions, reassurance-seeking, avoidance, and safety behaviours, that provide short-term relief. Further encouraging, negatively & hindering corrective learning. Five linked mechanisms of change are theorized to disrupt this cycle: (a) Insight and Formulation – helping the client identify the obsessional fear, the compulsive pattern and the sustaining belief; (b) Cognitive and Experiential Reappraisal – challenging and reducing OCD-based predictions through restructuring and behavioural experiments; (c) Identity and Behavioural Activation – assisting the client to act from an OCD-free, values-aligned self, rather than from the fear-driven self; (d) graded ERP with response prevention – confronting feared stimuli while systematically not engaging in compulsions, safety behaviours and reassurance-seeking; and (e) generalization and maintenance – embedding ERP as a lifestyle practice and preparing the client for future triggers without relapse into compulsions.

2.1 Aims and Hypotheses

The present pilot study aimed to: (1) describe the rationale, structure, and theoretical foundations of HIT-OCD; (2) evaluate pre-to-post changes in OCD symptom severity in a sample of 32 adults; and (3) examine the proportion of participants achieving reliable and clinically significant change.

The main hypothesis are as follows:

H1: If there is any statistical difference in pre & post treatment of the HIT-OCD protocol.

H2: More than 50% of the sample would achieve reliable improvement as indexed by the RCI;

H3: Majority of the sample who began in the clinical range would cross to the non-clinical range at post-treatment

H4: Effect sizes would be in the moderate-to-large range.

Mechanism hypotheses, to be tested in future controlled research, proposed that reduction in OCD belief conviction, increase in ERP adherence, increase in willingness to tolerate uncertainty, reduction in reassurance-seeking, and strengthening of OCD-free identity would each mediate symptom improvement.

3. METHODOLOGY

3.1 Participants

Thirty-two adults meeting DSM-5 criteria for OCD were given therapy, through Psychology Delhi Company Platform by two RCI-Registered Psychologists (Clinical). The inclusion criteria required 1) participants to be aged 18 or older, 2) possess symptoms of OCD according to the OCD-R assessment [12], 3) possess at least intellectual-level insight into their OCD [13], 4) be able to use WhatsApp and Google Meet for daily contact and video sessions, 5) and be proficient in Hindi or English. Exclusion criteria includes- 1) any active suicidal ideation 2) psychotic or bipolar disorder 3) substance-use disorder 4) Neurodevelopmental condition (autism, intellectual disability) 5) lack or absence of insight into the nature of OCD symptoms.

Table 1 : Participant Demographic and Clinical Characteristics at Baseline (N = 32)

Characteristic	n	%	M (SD)
Gender: Male	[18]	56.25%	
Gender: Female	[14]	43.75%	
Age			
18-24 years	[10]	[31.25%]	
25-34 years	[13]	[40.62%]	
35-44 years	[4]	[12.5%]	
45-54 years	[4]	[12.5%]	
55+ years	[1]	[3.13%]	
Baseline OCI-R Total			27.7 (13.03)
Pre-test clinical range (≥ 21)	[22]	[68.8%]	
Pre-test non-clinical range (< 21)	[10]	[31.3%]	

Note. OCI-R = Obsessive Compulsive Inventory-Revised.

3.2 Measures

Obsessive Compulsive Inventory-Revised (OCI-R).

The OCI-R [12] is an 18-item self-report assessment to understand symptoms of OCD. Items are rated on a 5-point Likert scale (0= Not at all to 4= Extremely), computing a total score ranging from 0-72. A total score ≥ 21 is typically used as a clinically elevated cut-off [12]. The shows good internal consistency ($\alpha = .81-.93$) and an adequate convergent and discriminant validity [17]. The test was administered twice- week 1 (pre-treatment) and after completion of the HIT-OCD protocol in Week 5 (post-treatment).

3.3 Research Design

The study is a one-group pretest-posttest experimental design to examine the feasibility and effectiveness of the HIT-OCD protocol 5-week intervention. Individuals were considered through the consecutive sampling from the clinic service of Psychology Delhi website. All 32 individuals were assessed before and after the completion of the protocol.

3.4 Procedure

Written informed consent was obtained from each participant in accordance with the Declaration of [14]. Participants were informed of their right to withdraw at any time without penalty, and data confidentiality was assured.

Following consent, the therapist took an initial clinical evaluation, administered the OCI-R, and commenced the five-week HIT-OCD protocol. Participants were engaged in weekly structured therapy sessions supplemented by daily WhatsApp messages for homework review, accountability, and in-the-moment guidance. Video-conferencing (Google Meet) was used when clinically indicated for in-context exposure, particularly when symptoms were linked to home or private environments inaccessible during clinic sessions. The OCI-R was re-administered at the end of Week 5.

3.5 The HIT-OCD Protocol

HIT-OCD is structured across five sequential phases corresponding to five weeks of treatment. A condensed phase-by-phase overview is presented in Table 2; the theoretical foundations and delivery principles are described below.

Table 2 : Theorized Mechanisms: HIT-OCD Five Week Protocol based on ERP

Week / Phase	Primary Goal	Key Components	Theorised Mechanism
Week 1: Foundation	Psychoeducation, motivation, insight, recovery identity	Psychoeducation, motivational enhancement, thought records, vision board	Increased readiness; cognitive defusion; identity shift
Week 2: Formulation	Worst-fear identification, OCD-cycle mapping	5W1H functional analysis, fear-belief externalisation, anxiety psychoeducation	Cognitive Appraisal; Generalized Safety Learning
Week 3: Cognitive-Experiential Change	Weaken cognitive errors via experiments and balanced beliefs	CBT restructuring, behavioural experiments, SFBT preferred-future, identity rehearsal	Corrective evidence; reduced reassurance-seeking; self-efficacy
Week 4: ERP and Life Reconstruction	Structured exposure, response prevention, ACT values action	Fear hierarchy, graded ERP, SUDS monitoring, ACT defusion, routine restructuring	Inhibitory learning; compulsion reduction; values engagement
Week 5: Maintenance	Hierarchy completion, relapse prevention, independent ERP	High-SUD exposures, relapse plan, grounding/relaxation as lifestyle	Consolidation; generalisation; self-directed maintenance

Note: ERP= Exposure and Response Prevention; CBT= Cognitive-Behavioural Therapy; ACT= Acceptance and Commitment Therapy; SFBT= Solution-Focused Brief Therapy; SUDS= Subjective Units of Distress Scale

Theoretical Foundations of HIT-OCD

3.5.1 Cognitive-Behavioural Model.

The HIT-OCD finds its foundation in the CBT model of OCD, where intrusive thoughts become clinically relevant especially when dangerous, personally responsible, morally threatening, or needing neutralisation. Compulsions are seen as attempts to manage or control perceived threat. Therefore, the protocol directly addresses distorted appraisals such as inflated responsibility, intolerance of uncertainty, thought-action fusion, overestimation of threat, perfectionism, and catastrophic misinterpretation. These are identified as core maintaining factors in OCD in meta-analytical reviews [4,6].

3.5.2 Exposure and Response Prevention.

ERP functions as the primary behavioural mechanism of symptom reduction in HIT-OCD. The client is systematically exposed to feared triggers while preventing compulsions and safety behaviours. Corrective learning happens when the client learns that anxiety is tolerable, that feared outcomes often do not materialise, that uncertainty can be lived with, and compulsions are not needed for safety. In HIT-OCD, adherence support is treated as an active intervention ingredient: structured homework, daily practice review, therapist accountability, and problem-solving around barriers are built into every phase of the protocol rather than left to client initiative.

3.5.3 Inhibitory Learning.

Following [9], HIT-OCD conceptualises recovery not as the erasure of fear but as the development of new inhibitory learning that competes with old fear associations. Through repeated exposures across multiple relevant contexts, behavioural experiments, and real-life practice, the client accumulates evidence that contradicts OCD predictions and strengthens alternative response tendencies. The protocol's emphasis on in-context home-based exposure via videoconferencing is directly motivated by this framework: context variability during exposure enhances the generalisation of inhibitory learning across environments.

3.5.4 ACT based therapy processes

ACT processes are incorporated from Weeks 3 through 5 to help clients separate from intrusive thoughts, reduce experiential struggle, and act in alignment with chosen values. In particular, cognitive defusion, willingness and committed action are stressed upon. ACT processes provide scaffolding for clients to initiate and sustain exposures even before fear meaningfully reduces — a clinically important function in a brief, five-week protocol where significant anxiety reduction may not be fully achieved within the treatment window [15].

3.5.5 Solution-Focused and Identity-Based Processes.

Week 1 includes SFBT-informed preferred-future construction and identity-building exercises [11]. Miracle-day visualisation, preferred-future scripting, and OCD-free identity rehearsal help the client imagine and practise a life no longer organised around compulsions. This is theorised to strengthen motivational readiness before ERP begins, and to provide a values-based anchor — the OCD-free self — that sustains committed action when exposure distress is high in the later phases of treatment.

3.5.6 Behavioural Activation and Routine Reconstruction.

OCD invariably constrains life to compulsions, ruminations, reassurance and fear management, pushing meaningful activity out of the way. HIT-OCD therefore includes explicit routine restructuring across physical, mental, and social domains in Week 4, with the dual aims of reducing available time for compulsive preoccupation and increasing reinforcement from non-OCD domains of living. This component aligns the protocol with evidence on the role of behavioural activation in disrupting avoidance-based maintenance cycles.

3.5.7 Therapist Role and Decision Rules

The therapist's role in HIT-OCD is active, structured, and accountability-oriented. The therapist establishes the OCD formulation and treatment goals; identifies triggers, compulsions, avoidance, reassurance, safety behaviours, and family accommodation; assigns and reviews daily practice tasks; and monitors risk, distress, adherence, and relapse indicators. Critically, the therapist systematically avoids providing repeated reassurance or directly resolving OCD doubts, and instead redirects the client toward experiments, exposure tasks, worksheets, and treatment resources.

There are specific decision rules about how the therapist responds to common clinical challenges. When the client seeks reassurance, the therapist validates distress without answering the OCD doubt and redirects to the relevant experiment or response-prevention plan. When anxiety is high, the therapist helps clients differentiate between adaptive regulation strategies that support exposure engagement and compulsive behaviours aimed at reducing distress, fostering a willingness to experience discomfort rather than avoid it.. When homework is not done, the therapist looks into barriers, cuts down on the assignment, and connects practice to the client's values and recovery identity. If family accommodation exists, a gradual reduction plan is devised collaboratively. When an exposure item is too distressing, the hierarchy is adjusted and imaginal exposure is considered as a preparatory step.

3.5.8 Proposed Mediators and Moderators

Several variables are proposed as potential mediators through which HIT-OCD produces symptom change: reduction in OCD belief conviction, increase in insight, increase in willingness to tolerate anxiety and uncertainty, reduction in reassurance-seeking and avoidance, increase in ERP adherence and self-efficacy, increase in values-based action, and strengthening of an OCD-free identity. These mediators represent the theorised active ingredients of the protocol's five sequential phases and are testable in future mediation analyses.

Potential moderators — variables that may influence the magnitude of treatment response — include baseline OCD severity, degree of insight at intake, comorbid depression or anxiety, family accommodation level, client motivation and readiness, between-session practice frequency, OCD presentation subtype, and the availability of a supportive social system.

3.5.9 Fidelity Indicators

To ensure consistent and replicable delivery, the following protocol fidelity indicators are proposed: completion of treatment goal-setting in Week 1; completion of OCD cycle mapping and worst-fear identification in Week 2; assignment and review of cognitive restructuring and behavioural experiments in Week 3; construction of a fear hierarchy and initiation of graded ERP in Week 4; completion of relapse-prevention planning and post-treatment symptom measurement in Week 5; systematic avoidance of therapist reassurance-giving throughout; and weekly review of between-session homework completion. These indicators constitute the minimum fidelity requirements for valid replication of the protocol in future research and clinical settings.

3.6 Statistical Analyses

All analyses were conducted using Jamovi 2.7.30 version [16]. H1 was obtained through the paired-sample t-test comparing the OCI-R total scores at pre- and post-treatment stage. Shapiro-Wilks test was done to understand the normality of the sample. Effect size was calculated using Cohen's d for the paired-samples t-test and rank-biserial correlation (r) for the Wilcoxon test. Cohen's d values were interpreted as small (≥ 0.20), medium (≥ 0.50), and large (≥ 0.80) [19].

Clinically significant change was evaluated using the Reliable Change Index (RCI) [17]. The RCI was calculated using the formula: $RCI = (\text{post-score} - \text{pre-score}) / S_{\text{diff}}$, where $S_{\text{diff}} = SD_{\text{pre}} \times \sqrt{2(1 - r_{xx})}$, and r_{xx} is the Cronbach's alpha of the OCI-R. Participants with $|RCI| > 1.96$ were classified as reliably improved or reliably deteriorated. Clinical cut-off of 21 on the OCI-R was used to evaluate and identify individuals coming under the clinical significance benchmark [12]. OCI-R subscale scores were examined descriptively for pre-to-post change patterns. The alpha level was set at .05 for all inferential tests.

3.7 Ethical Considerations

This study was conducted in accordance with the ethical standards of the institutional review board and with the 2013 Declaration of Helsinki [14]. All participants provided written informed consent prior to enrollment. Participants were informed about the study's purpose, procedures, potential risks and benefits, voluntary nature of participation, and their right to withdraw at

any time without consequence. Data were anonymised and stored securely. No deception was employed. Given the clinical population, risk assessment was conducted at baseline and monitored throughout treatment; participants with active suicidal ideation were excluded and referred for appropriate care.

4. RESULTS

4.1 Descriptive Statistics

A pre-test–post-test analysis was conducted to examine changes in obsessive-compulsive symptoms following the HIT-OCD intervention. Descriptive statistics and inferential analyses were performed on OCI-R total scores to evaluate symptom reduction. Table 3 presents OCI-R total and subscale scores at both time-points. Placeholders for subscale means and standard deviations should be inserted from the dataset once available.

Table 3 :OCI-R Total and Subscale Scores at Pre- and Post-Treatment (N = 32)

Scale	Pre-Treatment M (SD)	Post-Treatment M (SD)	Mean Change	95% CI
OCI-R Total	27.7 (13.03)	14.9 (8.41)	-12.8	[-16.22,-9.3]
Washing	4.34 (4.27)	2.16 (3.04)	-2.19	
Obsessing	9.16 (2.44)	5.94 (2.77)	-3.22	
Hoarding	3.28 (2.47)	1.97 (1.73)	-1.31	
Ordering	3.31 (3.03)	1.38 (1.72)	-1.94	
Checking	3.69 (3.16)	1.97 (1.93)	-1.72	
Neutralising	9.16 (2.44)	5.94 (2.77)	-3.22	

Note. 95% CI = 95% confidence interval for mean change.

4.2 Primary Analysis: Paired-Samples t-Test

A paired-samples t-test was conducted that compared the pre-test & post test scores on the OCI-R in regard of the ERP-HIT protocol. The Shapiro-wilk test indicated that the differences between the set of scores was normally distributed, $W = 0.910(n=32)$, $p = 0.11$. OCI-R test scores were significantly higher in pre-test phase($M = 27.7$, $SD = 13.03$) than post-test phase ($M = 14.9$, $SD = 8.41$), $t(31) = 7.29$, $p < 0.001$. The effect size was large, $d = 1.29$. consistent with effect sizes reported in ERP-based intervention studies for OCD. A non-parametric Wilcoxon signed-rank test conducted as a sensitivity analysis confirmed this result, $Z = 528$, $p < .001$, $r = 1.00$. Together, both analyses converge on the same conclusion: the HIT-OCD intervention was associated with a meaningful reduction in OCD symptom severity.

4.3 Reliable and Clinically Significant Change

Reliable Change Index (RCI) analysis was conducted to determine whether individual changes in OCI-R scores exceeded the level attributable to measurement error. Results indicated that 17 out of 32 participants (53.1%) demonstrated reliable improvement following the intervention ($RCI < -1.96$). The remaining 15 participants (46.9%) did not meet the criterion for reliable change. Notably, no participants demonstrated reliable deterioration, indicating that the intervention produced no iatrogenic harm at the individual level. These findings suggest that symptom reductions observed in over half the sample reflected genuine improvement beyond measurement fluctuation.

Table 4: Classification of Individual-Level Change Based on Reliable Change Index (N = 32)

Change Category	n	%
Reliably improved ($RCI < -1.96$)	17	53.1
Clinically significant change ($RCI > 1.96$ + crossed cut-off)	15	46.9
No reliable change ($ RCI \leq 1.96$)	15	46.9
Reliable deterioration ($RCI < -1.96$)	0	0.0

Note. RCI = Reliable Change Index. Cut-off for clinical significance based on OCI-R score < 21 .

Figure 1:

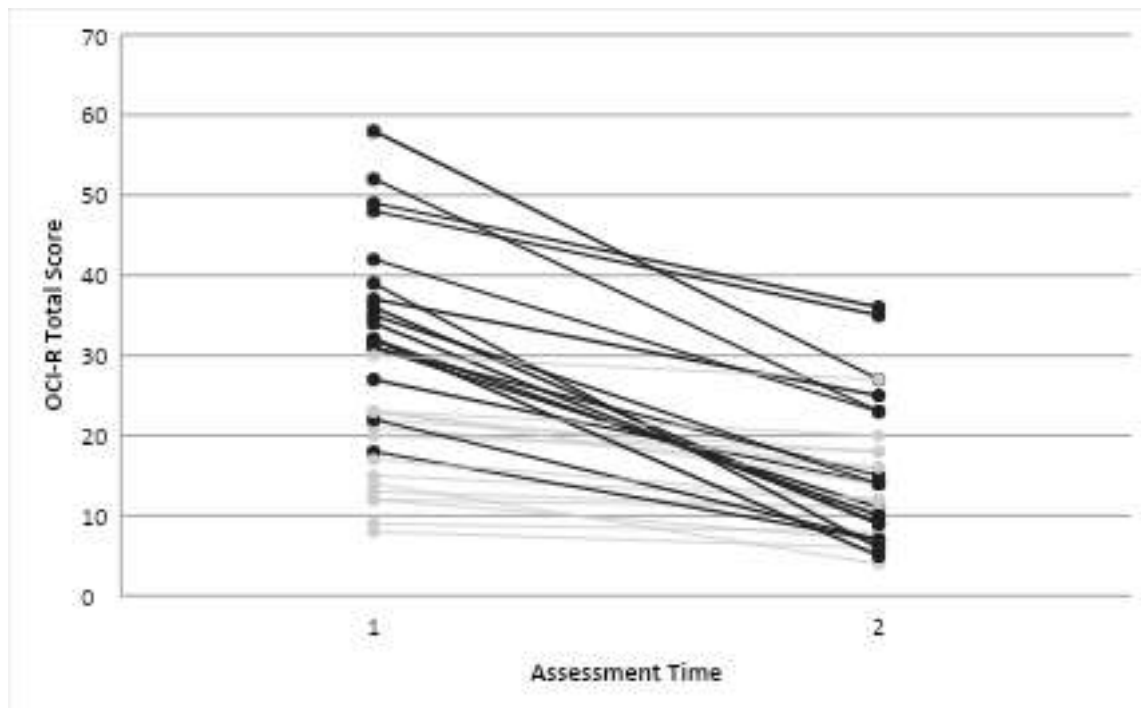


Figure 1. Individual OCI-R total scores at pre- and post-treatment for all 32 participants. Each line represents one participant. Dark lines = participants achieving reliable improvement ($RCI \leq -1.96$; $n = 17$). Light lines = participants showing no reliable change ($n = 15$). All lines slope downward, indicating no participant showed deterioration.

4.4. Subscale Patterns

Clinical significance was examined using the OCI-R clinical cut-off score of 21 [12]. At pre-test, 22 participants (68.8%) scored within the clinical range, while 10 (31.3%) scored within the non-clinical range. At post-test, only 7 participants (21.9%) remained within the clinical range, whereas 25 (78.1%) scored within the non-clinical range. Of the 22 initially clinical participants, 15 (46.9% of the total sample) moved to the non-clinical range, indicating clinically significant improvement. Seven participants remained above the cut-off. Importantly, all 10 participants who began below the clinical cut-off remained there at post-test, and no participant moved from non-clinical to clinical range. These findings indicate a robust, uni-directional shift toward non-clinical functioning across the sample. Table 4 summarises individual-level change classifications. Descriptive inspection of OCI-R subscale scores indicated reductions across all six subscales (Table 3).

5. DISCUSSION

Findings from the present study indicate that HIT-OCD, a five-week high intensity training ERP protocol, was associated with a significant reduction in OCI-R total scores among a sample of 32 adults meeting the DSM-criteria for OCD. These results provide empirical support for H1. These group-level gains were complemented by robust individual-level evidence: 17 out of 32 participants (53.1%) met the Reliable Change Index criterion for genuine improvement, and 15 of the 22 participants who began in the clinical range (46.9% of the total sample) crossed to below the clinical cut-off of 21 by post-treatment. This further proves that H2 & H3 were also accepted. Notably, no participants exhibited reliable deterioration, while the proportion of individuals within the clinical range declined from 68.8% to 21.9% post treatment. These convergent findings — across group-level inferential tests, effect size estimation, individual-level RCI analysis, and clinical cut-off crossing — provide multi-faceted preliminary support for HIT-OCD as a reliable intervention for OCD.

5.1 Interpretation in Light of Theoretical Mechanisms

The pattern of findings aligns directly with the theoretical architecture of HIT-OCD. The significant reduction in OCI-R scores observed at the group level, and the fact that 78.1% of the total sample scored below the clinical cut-off at post-test, is consistent with the premise that the five phases collectively disrupt the obsession–compulsion maintenance cycle in a stepwise and cumulative manner. The high rate of cut-off crossing (from 68.8% to 21.9% in the clinical range) is particularly notable and suggests that the protocol produced not only has statistical change but functional recovery for a significant proportion of participants. Daily between-session support via WhatsApp was theorised to be a key mechanism addressing the generalisation failure common in standard outpatient ERP [7]. This design feature may have sustained between-session exposure practice, reduced compulsive drift, and reinforced the corrective learning initiated in sessions — all of which align with the inhibitory learning model [9].

The integration of ACT-based defusion and psychological flexibility training [10,15] provides a theoretically coherent explanation for why participants may have been able to engage in ERP despite high initial distress. By helping clients hold intrusive thoughts without treating them as literal commands or threats requiring neutralization, the ACT component may have lowered the activation threshold for initiating and sustaining exposures. The SFBT-informed preferred-future and identity reconstruction work in the early phases of HIT-OCD addresses a known barrier to ERP engagement: the client's difficulty imagining life without OCD

rituals. This is evidenced by the zero rate of reliable deterioration — a finding consistent with the hypothesis that motivational scaffolding and identity work reduced the adversarial stance toward treatment that often precipitates dropout [8].

5.2 Clinical Implications

The present findings carry several practical implications for the delivery of OCD treatment in diverse settings. First, the shift from 68.8% to 21.9% of participants scoring in the clinical range over just five weeks suggests that HIT-OCD offers a clinically meaningful way of treatment within a brief timeframe. In addition to that the Cohen's *d* value also validates H4 empirically. This is consistent with evidence that dose-response relationships in ERP are substantial during early treatment phases, and that concentrated interventions can achieve gains comparable to extended protocols when adherence and between-session practice are well-supported [7]. The HIT-OCD design directly operationalizes this principle by using daily WhatsApp contact and video-based in-context exposure to maintain adherence outside the session hour. Second, the zero rate of reliable deterioration addresses a longstanding clinical concern about ERP-based treatments — namely, that intensive exposure may transiently worsen symptoms. The present data provide no support for this concern within the HIT-OCD structure, which sequences motivational and identity work prior to ERP to ensure adequate readiness before confrontation begins.

Third, the finding that all 10 participants who began in the non-clinical range remained there at post-test indicates that HIT-OCD did not inadvertently destabilize participants with sub-threshold or previously well-managed symptoms. This indicates the clinical relevance of the results from the 10 participants. For practitioners, HIT-OCD provides a clearly structured, five-week, session-by-session framework with embedded decision rules that can be adapted across in-person, online, and hybrid delivery formats. The breadth of the framework — spanning motivational work, cognitive restructuring, ACT-based acceptance, SFBT future-orientation, and ERP — also makes it adaptable to the heterogeneous OCD presentations commonly encountered in clinical practice.

5.3 Limitations

Several limitations must be noted. The pre-post design cannot eliminate threats to internal validity including natural symptoms fluctuations, regressions to the mean and non-specific therapeutic factors. The sample size of 32 limits statistical power and generalizability. Reliance on a single self-report measure (OCI-R) without clinician-administered assessment (e.g., Y-BOCS) or independent observer ratings is an additional constraint. Furthermore, the study was conducted in a single clinic with two therapists, limiting external validity.

5.4 Future Directions

Future research should evaluate HIT-OCD in a randomized controlled trial comparing the protocol to waitlist or ERP-as-usual conditions. Gender based understanding is another implication study that would be considered. Inclusion of clinician-administered OCD measures, process variables (e.g., belief conviction, experiential avoidance, ERP adherence, therapist-rated fidelity), and long-term follow-up (3, 6, and 12 months) would substantially strengthen the evidence base. Mediation analyses examining whether theorized mechanisms (e.g., reduction in OCD belief conviction, increased ERP adherence, reduced reassurance-seeking) account for symptom change are a critical next step.

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