

Intensive Treatment Program Description:  
Anxiety Solutions of New England, PLLC in Raymond, Maine  
July 2009

**1. When did you open your program?**

We have been offering our intensive outpatient program for OCD since we formed Anxiety Solutions of New England, PLLC, in March of 2004.

**2. Please describe the staff that work at your program in terms of their backgrounds, credentials and experience?**

*Lee Fitzgibbons, PhD*, Anxiety Solutions' Clinical Director, graduated from the University of Delaware clinical psychology program in May 1996. She specializes in behavioral and cognitive treatments of anxiety disorders (including Exposure and Response Prevention [ERP] for OCD) in adults, adolescents, and children. Her workbook for parents, *Helping Your Child with OCD*, was published in 2003 by New Harbinger Publications. Prior to moving to Maine, Dr. Fitzgibbons worked first as a research clinician at the Center for the Treatment and Study of Anxiety (CTSA) in Philadelphia and then as Children's Program Director at the Anxiety and Agoraphobia Treatment Center (AATC) in Bala Cynwyd, PA. She is a member of the Association for Behavioral and Cognitive Therapy (ABCT), professional member of the Anxiety Disorders Association of America (ADAA), and Scientific Advisory Board member for the Obsessive Compulsive Foundation (OCF). She has presented many workshops and seminars on OCD (as well as anxiety disorders in general) for both lay and clinical audiences including at conferences for all three organizations. She occasionally serves as a clinical supervisor for the OCF Behavior Therapy Institute (BTI) and continues to provide clinical consultation for some BTI graduates who choose to continue with supervision.

*Gordon Street, PhD*, Anxiety Solutions' Business Director, graduated from the clinical psychology program at the California School for Professional Psychology in San Diego (CSPP-SD) in 1998 with an emphasis in child and family psychology. He specializes in behavioral and cognitive therapies for anxiety disorders as well as in family therapy. Dr. Street worked as a research instructor at the Center for Treatment and Study of Anxiety (CTSA) in Philadelphia and then as Outpatient Director for the Children's Crisis Treatment Center in Philadelphia before going into private practice. He is a member of the Association for Behavioral and Cognitive Therapy (ABCT) and professional member for the Obsessive Compulsive Foundation (OCF). He has given many presentations on OCD (as well as anxiety disorders in general) for both lay and clinical audiences including at conferences for both organizations.

**3. Is this program devoted entirely to treating individuals with OCD or will other OCD spectrum disorders or anxiety disorders also be addressed?**

As our name, Anxiety Solutions, suggests, we specialize in treating all anxiety disorders (using evidence-supported - primarily exposure-based, cognitive-behavioral – therapies). We also specialize in anxiety-associated disorders, including “OC spectrum” disorders (e.g., trichotillomania, body dysmorphic disorder).

**4. Please describe the core treatment components of your program (e.g., use of medication, ERP, group therapy, etc.).**

Our first and only line of treatment for OCD is Exposure and Response Prevention (ERP). (Anxiety Solutions does not have on staff nor formal affiliation with any psychiatrist, psychiatric nurse practitioner, nor any other medication prescriber, although we often consult with a patient’s existing medication provider.) Our program is modeled on the program developed by the Center for Treatment and Study of Anxiety. The core treatment is an 18-day program consisting of three days of individual treatment planning and 15 days of individual outpatient ERP. We include cognitive therapy as needed to support ERP and to address interfering issues. We also supplement with family therapy when called for. The program is adjusted and extended for patients who require slower or longer therapy. Because our facility is so small, we are easily able to customize the treatment to suit individual needs.

**5. Please describe the treatment planning process at your program.**

Treatment planning consists of assessment to fully understand the patient’s symptoms in detail, including review of records and questionnaire data, interviews with patient and significant others (e.g., family, previous treatment providers). The second part of treatment planning consists of psycho-education about OCD, building treatment motivation, developing exposure hierarchies, and beginning the monitoring of rituals. This information is used to collaborate with the patient to determine a schedule for the treatment exercises with the goal of reaching the most difficult exercises within the first week of ERP.

**6. If someone has a co-morbid condition, can he or she participate in your program? Will there be treatment for the co-morbid condition? If so, can you give an example?**

We are quite experienced and comfortable in treating many other disorders in addition to OCD. Since OCD is frequently comorbid with depression, ADHD and other anxiety disorders, we believe anyone treating OCD needs to know a lot about treating the most common co-morbid disorders. However, because we do not have a medication prescriber on staff or affiliated with Anxiety Solutions at this time, and because psychiatrists are scarce locally and difficult to access, we would not consider our intensive OCD program

a good match for someone whose medication had not yet been stabilized nor in cases where the patient requires medication management on a frequent basis. Additionally, our OCD intensive program is not well suited to someone who is struggling with suicidal behaviors and may need hospital resources to ensure safety.

**7. Are parents, family members, friends, teachers, etc. included in the treatment? If yes, please describe how.**

We are always open to and consider whether to include significant others (e.g., family members, friends, teachers) in an OCD patient's treatment and, if so, how. It is quite common for significant others to have gotten "sucked in" to accommodating the patient's rituals and avoidance, thereby altering the functioning of the system (e.g., family). Additionally, one or more members often have reacted to the OCD patient with over-controlling or angry behaviors which can exacerbate patient symptoms and contribute to demoralization and depression. Re-establishing "normal" family/system functioning is often a helpful (sometimes necessary) component to the overall treatment plan. Significant others may need help ceasing such accommodation and/or over-controlling behaviors so that such behaviors don't interfere with motivating the OCD patient and/or with implementing ERP techniques. Also, family/systems therapy can be used in repairing damaged relationships. Also, whenever the OCD patient is a young child, we typically will involve at least one parent in the treatment since a parent will probably be needed to help the child with self-monitoring, exposures, response prevention, etc. and so will need to learn, understand, participate in and support the ERP.

**8. How often do patients in the program meet with staff individually? How long are these individual sessions?**

Patients meet with either Dr. Fitzgibbons or Dr. Street every time they come in for a session. For our OCD outpatient intensive program, that means 2 to 3 hours a day, 5 days a week, for 3.5 to 5 weeks, plus some family sessions if warranted and feasible. For our traditional outpatient program, the frequency and duration of sessions can range from a clinical hour (50 minutes) a week up to three 90-minute sessions a week, depending upon clinical need, patient time and resources, etc.

**9. Is there a set time period for a patient's treatment in the program? What is the overall time commitment to the program (for example, attend daily for three weeks)? How much flexibility is there in extending someone's stay if needed?**

We consider a "typical" outpatient intensive to run 4 weeks of 2 to 3 hour sessions per day, but we have recommended ending treatment early (and saving resources) in cases when the patient's treatment compliance has been poor and/or he/she was not benefitting. In other cases, treatment has been shortened because the OCD patient has, within a week or two, improved significantly enough to no longer warrant continued intensive treatment. In some circumstance we have extended treatment either by adding week(s) to the intensive program and/or by arranging additional follow-up sessions (in person or by phone) after the intensive treatment program has been completed. Home visits can be

arranged to help facilitate re-integration and generalization; however, these services will require significant additional cost.

**10. Is there a homework or “self directed” component to the treatment?**

There is ALWAYS homework, including self-directed (or parent- or partner-assisted) exposures (imaginal and/or in vivo), self-monitoring of rituals, use of daily diaries, etc., as warranted. Typically, two to four hours of homework are assigned daily. We emphasize from the outset that our role is to design the treatment plan and its exercises, and to provide support, instruction, and guidance; but the main work of all exposure-based therapies falls to the patient. We suggest a “coach-athlete” metaphor, emphasizing that little to no improvement can be expected if the patient (“athlete”) is not practicing between “coaching” sessions. When feasible, we will often enlist one of the patient’s significant others to fill the role of “assistant coach” and train them how to provide the patient with guidance between sessions.

**11. Please describe the relapse prevention strategies you use in your program.**

We start preparing patients (especially OCD patients) for relapse prevention from the outset. We make clear to our patients that our goal is to turn them into their own behavior therapists. We teach OCD patients how to design their own exposure exercises and to look for opportunities to challenge themselves, to make this kind of “risk taking” part of their daily routine, their approach to living life. We also emphasize the importance of getting comfortable not just with “normal” risk-taking (e.g., leaving appliances plugged in, showering once a day, checking locks only once before bed) but also with going beyond “normal” (e.g., leaving for an hour after intentionally putting toast down in the toaster, showering once a week and/or going camping, not checking locks at all before bed or even intentionally leaving some windows unlocked) so that – relatively – “normal” becomes easy to maintain. We also teach limits and guidelines for engaging in “normal” daily rituals (e.g., how and when to wash) after the patient has completed our treatment program.

**12. What kind of follow-up do you do for those who complete your program? Will the members or your treatment team be in contact with or willing to consult with the individual’s regular treatment provider(s)?**

For those who live nearby, we often provide follow-up treatment in person for as long as needed. We also offer and recommend attendance of our free Anxiety Support Group so that patients have the opportunity to talk about what has worked for them (since doing so calls for the patients to increase their understanding of what they have learned) as well as to obtain reminders and/or support from others with OCD. For patients who live too far away to easily visit our office, we offer telephone sessions, as needed, and we try to help the patient locate a treatment provider near where they live who is competent in the delivery of ERP and to consult with such treatment providers as necessary.

**13. Do you offer a sliding fee scale or scholarships for those who cannot afford your program?**

Yes. For anyone willing to pay in advance for blocks of 10 clinical hours, we will give a 10% discount per block. That discount may be combined with our sliding-scale, Zero Balance Discount (ZBD) in which we offer anyone willing to pay for sessions no later than at time of service a discount ranging from 17% to 67% depending on family/household income and family/household size.

**14. Does your program only work with individuals who are local or are there arrangements for those who come from farther away (for example, lodging arrangements)?**

There are several motels quite near our facility where people can arrange extended stays either in regular rooms or in efficiency apartments. Our facility is also in a vacation area (Sebago Lakes region of southern Maine) where furnished houses are frequently available for short-term rental. Additionally, our landlord (Olde House Raymond, LLC) has made available for short-term rental two furnished apartments (one 1-bedroom and one 2-bedroom) in the same building as and directly above our offices. This means patients (and their family members) can have unusually convenient access to their therapists for an outpatient intensive program, and Drs. Fitzgibbons and Street can also easily provide pseudo-home visits.

**15. Please add any information you think would be helpful in describing the unique aspects of your program if this has not been covered in the questions above.**

Anxiety Solutions is a true “mom and pop” operation (Drs. Fitzgibbons and Street are married to each other and have two children). We are the ones who answer the phones. We meet with every patient. We try to insure our patients feel welcomed and valued as individuals. Since ours is a small operation, we are very flexible regarding access and availability. We are also located in a lovely, rural, vacation area (not in a major city) which offers lots of outdoor activities (e.g., skiing, swimming, fishing, hiking, sailing) and a small community atmosphere. Our patients tell us they do not feel like “patients” and don’t worry about being lost in the shuffle.