Intensive Treatment Program Interview with Dr. Bruce Hyman of the OCD Resource Center in Hollywood, Florida

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1. When did you open your program?

I began a private psychotherapy practice in 1984 in Fort Lauderdale, FI. In 1991 I started the OCD Resource Center as a solo private practice specializing in OCD in 1991. I added the intensive treatment component to the practice in 1995. In 1999 I added associates to the practice and trained them in ERP .Since then, we have seen hundreds of OCD patients in intensive treatment, and over 1000 patients using the standard treatment format.

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

In addition to myself, I have had as many a three full time associates in the practice. Associates must be licensed in psychology, social work or mental health counseling, and have a strong interest in treating anxiety disorders from a cognitive-behavioral perspective. Presently, in addition to myself, I have one full-time associate, Stacy Shaup, Ph.D., a licensed clinical psychologist who was trained by Alec Pollard at the St. Louis Behavioral Institute and has been on my staff for three years. A registered social work intern, Deborah Bichachi, MSW, has a strong interest in CBT for anxiety disorders and works with children with OCD.

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

The intensive component is devoted mainly to treating OCD, but we also treat panic disorder and agoraphobia using an intensive format.

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

The core component of the program involves one-to-one, individual CBT either in an intensive or traditional format. While treatment is individualized to the specific needs of the patient, treatment typically involves three phases: an evaluation phase, an intensive phase, and a follow-up phase. The evaluation phase typically takes two to four clinical hours and involves taking a psychosocial history, clarifying the diagnosis, cognitive-behavioral analysis, and devising the cognitive-behavioral treatment plan. The intensive phase implements that treatment plan and involves multiple times per week exposure and response prevention roughly lasting ten to 15 sessions. ERP typically involves actively accompanying the patient "in vivo" in the very situations where anxiety and avoidance responses are triggered. Response prevention is emphasized throughout the intensive phase. During the follow-up phase, patients are seen for one hour weekly or bimonthly lasting one to six months, depending upon the needs of the patient. Patients are also encouraged to attend our free and ongoing OCD support group for support and encouragement.

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

Treatment planning begins with a brief initial screening interview, usually conducted via phone, to determine appropriateness for our services. If deemed appropriate, the patient is sent an "intensive treatment information packet" that is designed to answer all relevant questions they may have about the treatment process. Upon beginning the program, the patient receives between two to four hours of initial evaluation and treatment planning. At the outset, the patient is required to fill out an extensive evaluation packet that includes several standard OCD evaluation instruments:

The YBOCS and YBOCS checklist
The Compulsive Activity Checklist
The Beck Depression Inventory
Obsessional Beliefs Questionnaire (OBQ-44)
Tic Symptoms Checklist
Disruption of Functioning Index
Insight into Obsessions and Compulsions rating scale

During these sessions, the diagnosis of OCD is confirmed, a psychosocial history is obtained, and an extensive cognitive-behavioral assessment is conducted including the construction of a tentative exposure hierarchy. Additionally, the patient is educated in the basics of the cognitive-behavioral model of treatment and the process of exposure and response prevention using videos and written handouts.

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?

Yes, patients with co-morbid conditions may participate provided that the condition is well controlled and does not interfere with the treatment process. Examples include co-morbid substance abuse and/or the presence of a major depressive disorder. Should the co-morbid condition interfere with treatment, the treatment plan is revised to address the condition. For example, the patient may be referred to an appropriate outpatient treatment provider such as a psychiatrist for medication, or other facility (for say, substance abuse treatment) until such time as the patient is considered ready to engage in treatment for OCD.

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

There are situations where family members' participation is vital to the success of treatment, such as when family members are involved with the patient's symptoms (family accommodation) to a dysfunctional degree. These family members must be helped to disengage from participation in the patient’s OCD problem.

Another situation where family involvement may be vital is when a patient's obsessional fears involve specific family members -for example, the patient who fears possible “contamination" of

her own children. Exposures are designed to trigger those fear provoking situations, for example, allowing their child to touch a "contaminated" object that hasn't be scrubbed clean. Family involvement, in this case, clearly enhances the treatment process.

Out-of-town patients are advised to be accompanied by a partner and/or spouse at least part of the duration of the time that the patient is engaged in treatment. Adolescent patients must be accompanied by an adult during their entire stay.

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

Following the initial evaluation (two to four hours), patients are seen in the intensive phase by their individual therapist for two hours per day, five or six days per week for between ten days 15 days. There is flexibility in extending the patient's stay should it be clinically appropriate.

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

See above

10. Is there a homework or "self directed" component to the treatment?

Absolutely. At the conclusion of each daily two hour individual session, the patient is instructed to carry out three exposure exercises on his/her own, and practice response prevention. These activities are closely monitored by the therapist via a brief telephone "check in" session later in the afternoon. The patient is told that they can call their treating therapist at any time during the duration of their intensive treatment to deal with any problems or issues that arise during self-directed exposures.

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

Relapse prevention strategies are woven into the treatment process from the start.
Patients are told at the outset that the purpose of treatment is not to "cure" their OCD and that they will still have OCD after the treatment is completed. It is explained that the goal of the treatment is to impart to the patient a set of useful cognitive-behavioral "tools" e.g., strategies, beliefs, attitudes and behaviors -to effectively manage their OCD and live a useful and productive life.

Patients are required to engage in self-directed exposure from the first day of the intensive phase, and must devise their own exposure exercises by the end of the first week of intensive ERP .They are taught to accept and expect challenges to their recovery post-treatment, such as situational stress, as well as strategies for managing stress in their lives.

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

Following the intensive phase of ERP, the patient is seen individually for one-hour follow-up/booster sessions once per week for approximately one month to monitor progress and solidify treatment gains. Follow-up sessions may continue for several months depending upon the needs of the patient. Patients are advised to seek out an OCD support group in their locale. Out of town patients are monitored post-treatment via either phone appointments or using online video conferencing technology.

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

No, unfortunately we are unable to provide low cost intensive treatment services at this time.

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)?

We regularly work with patients from out of town. We have arrangements with a local travel agent to assist them to secure lodging in a variety of hotels at a wide range of price points. Patients are responsible for making these arrangements on their own.

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.

I believe that one of the unique aspects of our program is that because we are a small practice, patients can receive very close, individualized care from a bona fide OCD treatment expert. We do not use students or paraprofessionals in any aspect of what we do. Also, the fact that we are located in Florida means that patients can take advantage of some of what Florida offers - beautiful weather and sunshine – which can add a healing element to their treatment experience.