

Intensive Treatment Program Interview with Dr. Eric Storch of
The University of South Florida OCD Program in St. Petersburg, Florida
January 2009

1. When did you open your program?

Our program is relatively new, having been opened in July of 2008. We identified a significant need in the state of Florida for specialized OCD care, and were fortunate to have the opportunity to move to the University of South Florida to develop this program.

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

We have a large staff of clinical psychologists, psychiatrists, clinical psychology postdoctoral fellows, and research assistants. In the OCD program, patients receiving cognitive-behavioral therapy (CBT) are seen either by clinical psychologists or postdoctoral fellows under my supervision. All therapists have extensive training and experience in CBT with children, adolescents, and adults with OCD. For example, Drs. Steven Pence and Adina Aldea, both faculty in the program, completed postdoctoral fellowships with me prior to joining the team.

Our team also has extensive experience in working with obsessive-compulsive spectrum disorders such as trichotillomania, Tourette's Syndrome, and body dysmorphic disorder. We take pride in our team's ability to deal with more refractory cases. Both Dr. Murphy and myself have conducted extensive research in treating intractable cases through medication management and CBT. We also have expertise in working with children with Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal infections (PANDAS).

Collectively, our group has published over 80 papers in the past 4 years and received funding from a number of external agencies such as the National Institute of Mental Health, the OCF, and the Tourette's Syndrome Association.

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

Although we specialize in the treatment of OCD and related disorders (such as trichotillomania, body dysmorphic disorder, or Tourette's Disorder), we are open to and able to serve all children and adults with anxiety disorders. The intensive outpatient program, however, is specific to individuals with OCD, as the intervention is particularly tailored to treating this disorder.

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

We believe in an integrated and evidence-based approach in the treatment of children and adults with OCD that includes CBT and medication management. I direct the CBT portion of the program, while Dr. Murphy heads up the pharmacological side of treatment.

We believe that the available scientific evidence strongly supports CBT as the first-line treatment for OCD in both adults and children. For example, the Pediatric OCD Treatment Study that was published in the *Journal of the American Medical Association* concluded that CBT alone or with concurrent medication is the first-line treatment of choice for children and teens with OCD. Among adults, these results have been consistent indicating that CBT was superior to medication treatment alone. Thus, CBT alone or with medication should be considered the first-line approach. We strongly believe in an integrated approach to treatment, stressing a combination of both treatment modalities when appropriate, in order to meet the needs of each individual. In short, our philosophy is to use the interventions that work to maximize each person's quality of life.

Medications are a reasonable option in combination with CBT for moderate to severe OCD. With mild OCD, CBT is the first choice. For some cases of severe OCD, medication may be required as a first line treatment to improve the chance of success with CBT.

We are fortunate to have a wonderful program psychiatrist in Dr. Murphy who understands the roles of both pharmacotherapy and CBT in treating people with OCD. Medical management is based on the unique qualities of the person and his/her family. Obviously, not every person requires medication. In general, we believe that medications specific for OCD are useful for moderate to severe OCD, when anxiety or depression are too severe to allow for a trial of CBT, or when CBT alone has not resulted in sufficient improvement in symptoms. Treatment of comorbid conditions with appropriate medications, such as stimulants for ADHD, may also improve CBT outcomes. Medications for OCD would include serotonin reuptake inhibitors. The FDA approved medications for pediatric OCD would be considered first line. Augmentation strategies with other classes of medications are considered after CBT and two trials of SSRIs have not been successful.

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

We conduct an extensive assessment before and after treatment for each person. This assessment includes a clinical interview with myself or Dr. Murphy, structured diagnostic interview, the Children's Yale-Brown Obsessive-Compulsive Inventory, and various parent-, teacher-, and child-report questionnaires. For adults, the process is quite similar although with age-appropriate measures. With permission, we attempt to gather information from multiple informants, including the patient, his/her spouse, and other significant relations.

Based on a comprehensive assessment, an individualized treatment plan is made for each child or adult when they come to the program. Each person's treatment plan is developed by myself and Dr. Murphy, in conjunction with the person and his/her significant others. We believe in a multidisciplinary approach and thus, meet frequently as a team to discuss cases.

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?

There are times where a comorbid condition may warrant attention prior to the OCD, for example disruptive behavior disorders or depression. In such cases, we address the problem

either prior to beginning CBT (e.g., medication management for depression) or concurrently in treatment (e.g., helping families deal with oppositionality), according to the clinical strategy that would be the most appropriate and effective.

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

Parents and children (and family members if appropriate) are included extensively in determining the treatment plan and throughout the treatment process. With parents, our approach is based on a “Parent as Therapist” model. In other words, we believe that if parents know the theory, nature, and treatment of OCD, then they will be effective figures in maintaining gains and preventing relapse. This education starts in the initial evaluation with the child and his/her family where we provide extensive education about OCD and CBT.

With parent and child consent, we allow any other caregiver of the child (e.g., teachers, relatives, a nanny) to participate in the child’s treatment as well. When teachers have asked to be involved in the past, at minimum we have consulted with the teacher by phone and provided written educational material about CBT for OCD. We also communicate the child’s behavioral goals and coping strategies to the teacher as the child’s therapy progresses. When a teacher is able to attend a session with the child and the child’s family, we welcome the opportunity to have the teacher observe the therapy and ask question about implementing CBT in the classroom.

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

For the intensive program, sessions are held every weekday and last 90-minutes. For the weekly program, sessions are held once to twice per week and last approximately 90 minutes as well.

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?

The average duration of treatment in the intensive program is 3 weeks. That said, sometimes people need more or less treatment depending on the symptom severity or their comfort in dealing with symptoms independently. We are always able to accommodate accordingly. Sometimes we schedule additional intensive sessions and other times patients finish the program early. After finishing intensive treatment, patients are typically followed by a cognitive-behavioral practitioner near their home or we provide phone or in-person follow-up booster sessions.

With regards to the weekly program, people participate in an average of 12-14 sessions. Again, some people finish treatment earlier while others need more time; again, we are able to accommodate the person’s needs and revise the treatment plan accordingly.

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

People are given an average of 60-90 minutes of homework to complete outside of their scheduled therapy sessions.

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

From the onset of treatment, we teach people to identify obsessive thoughts and compulsive behaviors. We also discuss the relationship between compulsive behaviors and maintenance of OCD symptoms. After they understand these basic concepts we ask them to guide their own therapy and make decisions about the things they should be working on outside of the therapy sessions. Prior to completing treatment, we pose future challenges to our patients and ask them to identify three things: 1) how to address an obsession through cognitive ‘talking back,’ 2) what to do if they realize they have been engaging in compulsive behavior, and 3) how to know if s/he needs a therapy “booster session.” We want each patient to be able to: 1) try to use cognitive strategies to address the anxiety and refrain from engaging in the compulsive behavior, 2) stop the compulsive behaviors in the future and perhaps set up some exposure exercises, and 3) return to treatment when steps one and two are not working, and preferably before things get so bad that the patient feels overwhelmed or out of control.

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)?

We strongly advise patients to continue with follow-up care after completing an intensive treatment course. Patients who live in the area can continue treatment at our clinic on a more intermittent basis (e.g., weekly). Those who live greater distances away are either followed through phone contact or are referred to cognitive-behavioral practitioners in their area. If this isn’t possible, we are happy to provide phone supervision for the clinician as needed or phone sessions with the patient. Given the small number of clinicians with expertise in CBT for OCD, providing phone sessions is a common occurrence.

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

Our services are covered by many private insurances. Medicare covers our services within the constraints of Medicare regulations in a teaching hospital. Unfortunately, Medicaid does not cover services by psychologists in Florida. We do offer a substantial discount for people paying out of pocket and also have a number of research studies that people can participate in.

There are a number of ways we can make treatment more affordable for people in need. Regarding housing, families can stay at the Ronald McDonald House, which is within walking distance to our facility. At the House, families of children receiving care at our facility are able to stay at a comfortable, supportive residence near our facility. Participating in research is

another way that we can cut the costs for families. For example, we have several treatment studies that offer free CBT, while other studies provide assessments and evaluations at no cost for participating people. Finally, we are able to offer a 40% discount to those people who do not have insurance to cover treatment costs.

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)?

Both the adult and child programs serve people from all over the world. We have had families come from Europe, Asia, and South America to receive treatment, as well as many from most of the states in the U.S. Although we do not offer an inpatient program, we help families traveling from long distances secure hotel reservations at nearby extended stay facilities. There is also the option of a Ronald McDonald House that is next to our building for inexpensive housing. Plus, the Tampa/St. Petersburg area is a beautiful part of Florida with many outdoor and cultural activities.

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.

We have had a lot of success. Both our child and adult programs have strong empirical support with the vast majority of people, both children and adults, experiencing marked improvements. We have published a number of papers showing that people coming through our treatment program make very positive gains with about 80-85% of children responding well to CBT and about 80% of adults being good CBT responders. Many people report making huge strides in how they function at work or school and in their relationships.