

Intensive Treatment Program Description: The Houston OCD Program in Houston, Texas

June 2009

1. When did you open your program?

In September of 2000, we opened a residential treatment program for OCD at The Menninger Clinic in Topeka, Kansas. In May of 2003, the program moved to Houston, Texas and was closed in December of 2008. However, shortly thereafter in February of 2009, the clinical team of the former Menninger OCD Program formed The Houston OCD Program that provides residential treatment, intensive outpatient program, outpatient therapy and diagnostic evaluations.

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

A multidisciplinary treatment team is assembled for each patient. A cognitive-behavioral therapist, psychiatrist, and mental health counselor compose the foundation of the team. The psychiatrist meets regularly with the patient. Most patients who seek out this level of treatment care have failed multiple medication trials. Hence, previous medication trials are reviewed and assessed for adequacy, and when appropriate, alternative regimens are instituted. The cognitive-behavioral therapist, who designs the individual treatment plan with the patient, provides initial assessments and evaluations. They will also conduct individual behavior therapy sessions. The direct delivery of care is provided by a team of two to three mental health counselors. Their role is to aid treatment delivery, especially to enhance response prevention for patients with severe and treatment refractory OCD. In addition, staff support for medication compliance is available for patients who struggle with taking medication due to specific OCD symptoms. The staff is trained to help patients with OCD to enhance response prevention, block their rituals, assist “ritual free” activities of daily living, and to implement behavior therapy techniques.

Our clinical team includes:

Thröstur Björgvinsson, Ph.D. is a licensed psychologist in the state of Texas with extensive experience in treating depression and anxiety disorders – particularly Obsessive Compulsive Disorder. He developed and directed the nationally recognized Menninger OCD Treatment Program in its entire time of operation, from September of 2000 to December of 2008. He was initially assistant professor and then associate professor at the Department of Psychiatry, Baylor College of Medicine while the Menninger OCD Treatment Program was in Houston. He received his B.A. from the University of Iceland and his Ph.D. in Clinical Psychology from Queen's University, Kingston, Ontario, Canada. He completed his Cognitive Behavior Therapy Internship at McLean Hospital/Harvard Medical School and a Behavior Therapy Fellowship at the OCD Institute, Massachusetts General Hospital/Harvard Medical School. In February of 2009 Dr. Björgvinsson developed and launched The Houston OCD Program, a comprehensive residential treatment program for adults that provided empirically validated treatments to patients with severe Obsessive-Compulsive Disorder and other anxiety disorders. He has given several lectures and conducted workshops nationally and internationally focusing on evidence-based treatments for anxiety disorders and depression.

Susan Heffelfinger, Ph.D. is a licensed psychologist in the state of Texas with substantial experience in treating depression and anxiety disorders – particularly Obsessive Compulsive Disorder. She was an assistant professor at the Department of Psychiatry, Baylor College of Medicine while the Menninger OCD Treatment Program was in Houston. She received her B.A. from Augustana College, Rock Island, Illinois and her Ph.D. in Clinical Psychology from Finch University of health sciences/Chicago Medical School. She completed her internship at Clement J. Zablocki VA Medical Center, Milwaukee,

Wisconsin. At the Menninger Clinic Dr. Heffelfinger functioned as a leading behavior therapist and was active in enhancing the development of both the adult and adolescent programs for severe OCD. She has presented on several conferences and published on evidence-based treatments for anxiety disorders.

Dana M. Powell, Ph.D. is a licensed psychologist in the state of Texas with substantial experience in treating depression and anxiety disorders – particularly Obsessive Compulsive Disorder. From August of 2007 to December of 2008 she was an assistant professor at the Department of Psychiatry, Baylor College of Medicine. She received her B.S. in Occupational Therapy from the University of Tennessee-Memphis, and worked for five years as an occupational therapist. She received her M.A. and Ph.D. in Clinical Psychology from the University of Southern Mississippi in Hattiesburg, Mississippi. She completed her pre-doctoral internship and post-doctoral fellowship through Baylor College of Medicine, working primarily at the Menninger OCD Treatment Program.

John Hart, LPC is a Licensed Professional Counselor, employed by the Menninger OCD program as a behavior therapist. He has been affiliated with the Menninger Clinic for nearly two decades, as well as functioning as a private practitioner specializing in anxiety disorders and work-related problems. He was with the Menninger OCD Treatment Program since its inception and has presented nationally and regionally on the nature and treatment of obsessive-compulsive related disorders. He has a wide research interest and has published on evidence-based treatments for anxiety disorders. John is currently one of the list advisors to the Parents of Adults with OCD, which can be found at <http://health.groups.yahoo.com/group/parentsofadultswithOCD>

Joyce Davidson, MD is an assistant professor at the Department of Psychiatry, Baylor College of Medicine. Her clinical specialties include cognitive therapy and psychopharmacological treatments. Board certified in adult psychiatry and board eligible in child psychiatry, Dr. Davidson has been involved in research on schizophrenia and antipsychotic medications. She earned a combined bachelor's and medical degree from the University of Missouri-Kansas City and completed her residencies in general and child psychiatry at the Karl Menninger School of Psychiatry & Mental Health Sciences. In addition, Dr. Davidson has completed cognitive therapy training through the Kansas City Center for Cognitive Therapy. She is the former medical director of the OCD Treatment Program at Menninger and now collaborates with the Houston OCD Program and provides medication management for those who need such services.

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

We treat anxiety disorders such as: Obsessive-Compulsive Disorder, Social Phobia, Generalized Anxiety Disorder, Panic Disorder with/without Agoraphobia, Specific Phobia and Post Traumatic Stress Disorder. In addition, we also treat depression and Obsessive Compulsive Spectrum Disorders such as Body Dysmorphic Disorder (BDD), Health Anxiety/Hypochondriasis, Tourettes Syndrome and other tic disorders, Trichotillomania and Compulsive Skin Picking.

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

The cornerstone of the Houston OCD Program is the Behavior Treatment Plan that specifies the daily exposure and response prevention (E-RP) group sessions (two hours), as well as daily staff-supported/self-directed E-RP sessions (SDE). Additionally, patients design a treatment contract that they review with peers and staff weekly and our patients' report that this is a valuable group experience for them that helps them stay on track with treatment. All other groups in the program are designed to complement the evidence-based E-RP sessions and build patients' skill sets and resilience, as well as foster support and opportunity to practice what they have learned. Treatment interventions and group work are naturally based on the

diagnosis and symptoms that each patient presents. Additionally, we utilize psychopharmacological treatment modalities as indicated.

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

Individualized treatment plans are negotiated between the patient and the treatment team, and re-evaluated on a weekly basis. The core of the treatment contract is the Behavior Treatment Plan, which delineates core problems, specific obsessions, compulsions, avoidances, goals, and specific interventions. This contract builds on a hierarchy that is designed with patients, as well as addresses the unique opportunities that residential care provides. This includes having specific information on the Behavior Treatment Plan about ways to assist patients through their morning and evening routines with minimal rituals, and most importantly how to implement staff assisted exposure and response prevention sessions. The Behavior Treatment Plan is evaluated weekly and is a collaborative endeavor. Patients are active in designing and deciding what OCD triggers to address in each given week. In order to further inform treatment and program development, patients participate in routine weekly data collection about treatment response and symptom severity.

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, we create an individualized treatment plan for every patient that is admitted to our program. This includes specific interventions that need to be implemented for their co-morbid conditions. We do not treat patients that have an active addiction problem, active eating disorder, and/or are actively suicidal.

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

Throughout treatment, staff members provide psychoeducation about OCD and the impact it has on family relationships. They also coach family members on how to work with loved ones to fight the illness and boost recovery from symptoms. It is especially important in the work with patients who live at home to include the family in the treatment. Therefore, the cognitive-behavioral therapist has at least one meeting of either face-to-face, or a phone therapy session, with both the family and patients each week.

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

The cognitive-behavioral therapist – a licensed therapist in the state of Texas or a supervised postdoctoral fellow – designs the individual treatment plan with the patient and provides initial assessments and evaluations. They will also conduct individual behavior therapy sessions at least twice weekly for 50 minutes and family therapy sessions as needed.

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 estimated length of stay at the outset of treatment is approximately 6 to 8 weeks. Each individual presents with unique struggles. The residential patients attend treatment seven days a week. The patients who attend the intensive outpatient program generally attend five days a week. However, we are able to provide flexibility in scheduling for patients who only need to attend 2 to 3 days a week, or for patients who need a step-down from more intensive treatment.

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

In conjunction with the daily E-RP group, each patient participates in daily Self-Directed Exposure Group (SDE). In this group, patients practice independent implementation of E-RP with the primary objective to enhance independence and empowerment. Anxiety ratings (Subjective Units of Distress Scale or SUDS) are monitored at the beginning and at the end of each group, with the goal to achieve habituation within the session.

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

Discharge and aftercare planning is an ongoing process. As patients near completion of treatment, therapeutic passes from the clinic to the home are scheduled to promote the application of CBT skills, and to facilitate ways to challenge the OCD triggers in their home environment. Every effort is made to find an experienced cognitive-behavioral therapist at discharge, if the patient was not seeing one at admission, in an effort to ensure future success.

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

Once an individual has completed the program, there are several options for follow-up care. For individuals in the Houston area, they can step-down into our outpatient level of care, or we can work in conjunction with previous treatment providers in order to assist in continuity of care. There are also many individuals who benefit from returning for a shorter treatment term, or a booster session, in order to continue to maintain the gains achieved in his/her original treatment stay. We follow-up with all patients to continue post-discharge assessments in order to further evaluate our evidence-based treatment approaches, as well as to provide insight for the patient in his/her current treatment. Additionally, patients who successfully complete the program are invited to return for our monthly mentorship meeting, which provides an enriching and empowering experience for both the mentor and mentee.

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

We have recently begun working on a scholarship program. In this new program format, at the Houston OCD Program, we are accepting donations to our scholarship funds and we are currently outlining procedures to assess the process and criteria through which individuals have access to this fund.

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 offer a full continuum of care, from residential treatment to outpatient treatment. Patients can elect to stay in the residential program and access our 7 day a week programming, or they can stay at any of the several hotels in the area and attend the 5 day a week intensive outpatient program.

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.

The program’s setting fosters an atmosphere for change, while maintaining the milieu and a safe environment where patients and staff work collaboratively toward treatment goals. The staff is attentive to the unique challenges the OCD symptoms put on patients and their families. The cognitive-behavioral therapist conducts individual behavior therapy sessions. Staff assists the patient’s effort to follow his or her behavior treatment plan, especially implementing challenging exposure and response prevention sessions. Supportive staff interactions, as well as groups and activities, are scheduled to maximize the patient’s ability

to follow his or her behavior treatment plan. Patients and staff participate in a group forum community meeting to foster an atmosphere for change and support, and to provide an opportunity to influence program procedures.

The program is based on the conviction that intensive specialty treatment, employing evidence-based treatment protocols, is effective in treating severe obsessive compulsive disorder, other anxiety disorders, and coexisting conditions. In the attempt to achieve maximum benefit for patients, the program adheres to the following assumptions:

1. We use state-of-the-art evidence-based cognitive-behavioral and psychopharmacological treatment modalities (see, Björgvinsson et al., 2008; Björgvinsson, Hart & Heffelfinger, 2007; Davidson & Björgvinsson, 2003; Goodman, Rudorfer, M., & Maser, J., 2000; Osgood-Hynes, D., Riemann, B., & Björgvinsson, T. 2003).
2. We encourage normalization by patient participation in decision-making and provision of services in the least restrictive environment.
3. We design and provide services in a way that supports, educates, and empowers the patient.
4. We attend to the individual's physical, emotional, social, and economic problems.
5. Our long-term goal is to establish healthy functioning individuals and families.