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## Intensive Treatment Program Interviews

The following interview on the Obsessive Compulsive Disorder Institute at McLean Hospital in Belmont, MA, includes responses from Michael A. Jenike, M.D., the director of OCDI, Deborah Osgood-Hynes, Ph.D., OCDI's chief psychologist and Diane Davey, R.N., M.B.A., the Institute's program director.

**Newsletter:** What inspired you to start the OCD Institute?

**Jenike:** I started working with OCD patients in the late 1970s, and in the early 1980s my colleagues and I noted that some patients' OCD symptoms did not improve despite state of the art behavior therapy and medications.



It seemed that their lives were on hold and consisted of persistent suffering and disability. At that time, I approached our hospital administration to see if they were interested in a residential OCD facility. After about ten minutes of thought, they could not figure how this could be a money-making proposition, so the idea was put to rest. About six years ago, I mentioned the need for a residential facility to the father of one of our patients, and he offered to give some initial funding to help get the facility started. It turned out that McLean Hospital had an open building and was interested in an OCD residential unit. This allowed us to set up the OCD Institute from the ground up.

**Newsletter:** What did you want to accomplish by setting up the OCD Institute?

**Jenike:** We thought that if we could offer more intensive daily behavior therapy that patients might get better. We wanted a facility where we could help the patients who could not function due to persistent and overwhelming rituals that did not respond to conventional treatments.

**Newsletter:** Why did you set up the Institute as a residential treatment center? What led you to believe that OCD could be treated successfully by intensive (almost 24-hour a day) cognitive behavior therapy?

**Jenike and Osgood-Hynes:** We did not know if this was true or not, but we felt it was worth a try. While many people are able to do behavior therapy on an outpatient basis, some could not. We felt that those who were motivated but could not do the behavior therapy entirely on their own

might be able to get some benefit if given the opportunity to have therapists do the exposure and response prevention tasks with them intensively several times a day every day.

**Newsletter:** You're a psychiatrist. What led you to the idea of establishing an intensive treatment program for OCD where medication and cognitive behavior therapy play equal roles? Was it research? Was it clinical experience?

**Jenike:** It was our clinical experience that patients did best with a combination of medication and behavior therapy and that either treatment alone was generally less effective.

**Newsletter:** When you first started practicing psychiatry, OCD was considered a very rare, untreatable disease. What attracted you to it?

**Jenike:** My early years in psychiatry were spent running the inpatient service at Massachusetts General Hospital and also co-directing the Memory Disorders Service where we assessed and managed patients with illnesses, where individuals lost their memories and cognitive abilities, such as, Alzheimer's disease. I first met some OCD patients when I was a resident psychiatrist. I was told that they usually did not get better and that years of psychotherapy were necessary. I found the patients fascinating, but they had a quality that seemed quite unique - their symptoms consisted of pure suffering. The patients were for the most part very nice and competent people, but they were tormented by obsessions and rituals that they knew did not make sense (usually), but nonetheless they felt like they were unwilling slaves to the OCD.

One patient with very severe OCD also had panic attacks; and, with my embryonic knowledge of psychiatry, I knew that drugs called MAO Inhibitors could help panic attacks. I tried this patient on a MAO Inhibitor; and she had a dramatic improvement not only in her panic attacks but also in her OCD. This led me to prescribe drugs for other OCD patients; and many did wonderfully well. The supposedly untreatable OCD got better. I eventually found an experienced behavior therapist willing to help treat OCD patients. Working together, we used both medication and behavior therapy. It became clear to us that the combination treatment worked better for

most patients than either alone.

**Newsletter:** There were intensive treatment programs before you opened the Institute, but none of them were open-ended residential programs only for OCD. Why did you decide that you needed a residential setting devoted exclusively to people with OCD?

**Jenike:** In my opinion, the treatment of OCD is quite unique. Many severely ill OCD patients had been hospitalized in general psychiatric units; and most were not helped or even got worse. Psychiatric hospitalization is a huge blow to one's self esteem and should only be considered when other treatments have failed. If an OCD patient is put into a general psychiatric unit that does not know how to treat OCD or is not behaviorally oriented, patients feel worse and even more like a failure.

**Newsletter:** Can you describe OCDI's treatment program? Is there one set treatment program or is there a unique treatment plan developed for each patient?

**Jenike and Osgood-Hynes:** Our overall philosophy is a cognitive behavioral approach, but each person has a treatment plan tailored to his or her particular symptoms. There are groups at the OCD Institute that most patients attend which focus on symptom specific issues as well as general cognitive and behavioral coping strategies. And, each patient also has at least three hours of individually tailored treatment per day.

**Newsletter:** How is a patient's treatment program developed? Who is involved in designing it?

**Jenike and Osgood-Hynes:** Upon admission, each person is assigned a psychiatrist, a psychologist and a social worker. Within the first few days, each member of the team meets with the patient individually to discuss the individual's symptoms. Behavior therapists typically meet with the patient two to three times a week to review treatment progress, create and revise behavioral plans as needed, and assist the patient in doing exposure and response prevention tasks. Psychiatrists typically meet with each patient once a week to assess and revise medication as needed. Social workers might meet with a patient from one to three times a week. Included in the team are the many skilled counselors, who assist every patient with challenging his/her OCD symptoms throughout the day and evening. On-going communication between team members, as well as clinical rounds twice a week, keeps the treatment focused and continually addressing the patient's specific needs.

**Newsletter:** What part do medications play in your treatment protocols? Does every participant in your program have to be on medication? Who determines what medications a patient will try and how or if they

will be augmented and changed?

**Jenike:** The majority of our patients have failed many medication trials. Nonetheless, we review their medication history and current drugs, and try new agents or adjust medications as clinically indicated. Most patients are on medication while at the OCD Institute. For more information on medication, readers can go to: <http://www.mgh.harvard.edu/psychneuro/overall.htm> or the OC Foundation web site: <http://www.ocfoundation.org>

**Newsletter:** Can a patient participate in your residential program if s/he does not want to take medication?

**Jenike:** Yes, occasionally we see patients who do not want medication. We are willing to see if they can follow the CBT program without drugs. However, if it is clear that they cannot do the program this way, we request that they try medication or we have them go back to outpatient treatment.

**Newsletter:** Cognitive behavior therapies, especially, Exposure and Response Prevention, are integral treatments at the OCDI. Do you really have patients doing E&RP 24/7?

**Jenike and Osgood-Hynes:** We have skilled counselors who are at the OCD Institute 24 hours per day. We have a two hour Exposure and Response Prevention group in the morning each day in which a staff member is available to assist patients in performing behavioral tasks with the focus on resisting rituals. We also have an Exposure and Response Prevention group in the afternoon in which the patients are asked to resist their rituals on their own. We have found that patients who do not do exposures and response prevention by themselves, without a coach, before they go home, have a very high relapse rate.

The self-directed exposures are crucially important to get the lasting improvements that patients want. If patients do well at the OCD Institute, but relapse when home, we have not done our job. In addition, patients are asked to generate a weekly contract in which they set goals to work on additional E&RP tasks above and beyond the work they are doing in the daily E&RP groups. While it is unrealistic to expect that people with moderate to severe OCD can challenge each and every OCD urge that comes up 24/7, we do ask that people do a lot of hard work while here.

**Newsletter:** What is the theory behind total immersion in E&RP work at the OCDI?

**Jenike and Osgood-Hynes:** While OCD is clearly a biologically-based disorder, learning principles also influence OCD symptoms. The experi-

ence of anxiety is aversive and uncomfortable; and when anxiety is triggered by an obsession, most people will do anything, such as, performing physical or mental rituals, to try to make it go away. When you feel better by getting rid of an aversive anxiety experience (even if it's temporary), this is called negative reinforcement. The next time you encounter this OCD-triggering situation, you feel the only way to get the anxiety to go down is by doing the ritual you have done before. This causes the rituals to be strengthened and increase in frequency, intensity and duration.

The learning principle behind Exposure and Response Prevention is called habituation. If you allow yourself to sit with the experience of anxiety and not give in to your rituals or avoidance behavior, you are in effect teaching your mind and your body that the anxiety can go down on its own without having to give in to what the OCD is telling you to do. Through this conditioning process, you are reteaching yourself that a previously OCD triggering situation does not have to result in an anxiety response which over time leads to less of an urge to perform the compulsions or avoidance behavior. Through habituation a person can reduce their OCD symptoms.

But the key to all this is repeated practice at facing your fears. This means doing the exposure and response prevention tasks frequently. This is an important principle. The more "behavior therapy moments" you can participate in on a daily basis, and again day after day, the more likely you are to experience habituation and see a reduction in your OCD symptoms. This is why we have people who come to the OCD Institute doing so many exposure and response prevention tasks.

**Newsletter:** How do patients adjust to total immersion in behavior therapy? Do you start gradually with new patients, building up day by day? How do patients acclimate themselves?

**Jenike and Osgood-Hynes:** We take each patient where s/he is. Most need a gradual exposure to the things they fear. Some can jump right in as long as they are in a supportive environment. One of our skilled behavior therapists is assigned to each patient and tailors the plan to the person. There are two approaches to doing exposure and response prevention: gradual and flooding. Both approaches require setting up a fear hierarchy, that is, a list of the various situations that trigger a person's OCD symptoms and listing the level of anxiety associated with not doing it the OCD way. Most people prefer the gradual approach although some prefer to do flooding. The behavior therapist will work with the resident to individualize the treatment approach that will work best for them. Doing exposure and response prevention can be a lot of

hard work so we try to work with the resident to discuss the pace of the therapy process. Many different factors are considered when reviewing how fast or slow one should progress up a fear hierarchy.

**Newsletter:** The OCDI has the reputation of treating the worst cases of OCD. It's the program to get into when nothing else has worked. How do you get people who are totally consumed with OCD rituals and compulsions to begin doing E&RP? Do you do it gradually? Do you start it after the medication seems to be working?

**Jenike and Osgood-Hynes:** As with all tasks, when there are a lot of items on your list of things to accomplish, it's one step at a time. Medication and behavioral treatment occur simultaneously. Behaviorally, we usually start with either the symptom which causes the most dysfunction or interference in a person's life, or possibly start with the area a person feels most motivated to work on reducing. For people that have numerous areas where the OCD impacts their life, we might choose a few areas to start doing the exposure and ritual prevention and put the other areas temporarily on hold before working on them. However, relatively quickly, we will start incorporating more and more areas of OCD symptoms to tackle. Medication management works closely with how people are doing in their behavioral work, and behavioral interventions may be altered depending on what is happening with a person's medication.

**Newsletter:** Is there a set duration for treatment at the Institute? What determines how long someone will stay in the program? Is there a typical period of time people stay at the OCDI?

**Jenike:** When we first opened the OCD Institute, we tried to keep at CBT treatments as long as we could. In fact, we had some patients stay with us over a year. Over time, we noted that if patients had not gotten actively into treatment and started to improve within the first month of treatment, that they were not going to be able to utilize our approach no matter how long we kept them. Thus, early gains predicted long-term improvement. We now carefully assess patients early in treatment and discharge them if they are unable or unwilling to follow our treatment plans. Some patients will not comply at a first admission; and we readmit them later when they are more willing to follow a productive plan. It is clear that the patient is the one who sets the agenda when it comes to determining when they are ready to get better. If a patient is at the OCD Institute for someone else (parents or spouse, for example), he/she often doesn't do well.

**Newsletter:** Most of the other Intensive Treatment Programs we've done interviews on have a set duration. The OCDI doesn't. When is the program

over for a patient? When he or she is "cured? Competent at managing symptoms? Not making any more improvement?

**Jenike:** We generally try to keep patients a maximum of three months. However, patients can apply to me personally to extend their stay if they are still improving and working hard. The last couple of years, it is unusual for a patient to stay past the three-month time.

**Newsletter:** How successful is your program? How successful are you with individuals who have moderate OCD? Moderately severe OCD? Very severe OCD? Totally disabling OCD?

**Osgood-Hynes and Jenike:** We are continually assessing our program and its potential benefit for people with various OCD severity levels and for people with various OCD subtypes. Looking at the data for the past year and a half, across all people who entered the program, 27% said their symptoms were very much improved (reporting an average 61% drop in YBOCS score and a 70% decrease in depression symptoms according to the Beck Depression Index), 42% said they were much improved (reporting an average 35% drop in YBOCS score and a 46% reduction in depression on the BDI), 28 % said they were minimally improved (reporting an average 15% drop in YBOCS score and a 14% reduction in depression on the BDI), 3% said they were unchanged (although they report an average 19% drop in YBOCS score and 1% reduction in depression on the BDI) and <1% said they were minimally worse (reporting a 20% increase in YBOCS score and reporting a depression score that doubled).

Across these different groups, there was no significant difference in YBOCS score or Beck Depression score on admission. As part of our research here at the Institute, we continue to look for predictors of success in treatment. Overall over the past year and a half, 76% of the people who entered the OCD Institute reported at least a 25% or more decrease in their YBOCS score from admission to discharge. This is roughly the same improvement level used in drug studies for the patient to be considered a responder to a drug.

**Newsletter:** You get many patients to go to the Institute who previously had refused all treatment. How do you get them to come to the Institute?

**Jenike:** I often deal with some of the patients prior to coming to the OCD Institute. Some respond to information and encouragement that they can get better. Sometimes I tell them about other patients who seemed hopeless who managed to get their lives back.

**Newsletter:** The Institute is on the grounds of McLean Hospital. McLean is an old and prestigious

mental hospital. Patients can be confined at or committed to McLean. Are patients confined or committed to the Institute? Or is it a completely voluntary program?

**Jenike:** As noted above, our program is totally voluntary and patients are free to leave at any time.

**Newsletter:** The Institute is a freestanding "cottage" on the grounds of McLean. What are the accommodations? Dorms, shared rooms, singles? Do patients sleep, eat and treat in the "cottage"? Do they use the facilities at McLean? Can they leave the "cottage" and grounds at will? Do they have free time during the evenings and on weekends that doesn't involve treatment?

**Osgood-Hynes and Davey:** We are a freestanding cottage on the grounds of McLean Hospital, which looks somewhat like a college campus. Most rooms are doubles, but we do have a few singles and a few triples. Residents primarily eat at the OCD Institute, mostly because it's the most convenient given the busy schedule people have with the different daily groups at the program. People are expected to attend the groups throughout the day but during free time people can do as they wish, either relax at the house, travel to local restaurants or stores, or do some sightseeing in nearby Boston. On the weekends, while we do have a few groups, there is more free time scheduled, and we encourage people to get out and participate in some pleasant solo or social activities.

**Newsletter:** What is the size of the staff at the Institute? Are they psychiatrists, psychologists, and therapists? What's the patient/staff ratio?

**Davey:** Each patient is assigned a treatment team, which consists of a behavioral therapist, a psychiatrist, and a social worker, all of whom meet with the patient individually. In addition, the program also has nurses who assist patients with their medication and other health needs, and counselors who are available 24 hours per day to assist patients in following their individualized plans.

**Newsletter:** Is the Institute staffed 24 hours a day? By what level of treatment provider?

**Davey:** The program is staffed 24 hours per day, 7 days per week. Behavioral counselors, who are college graduates and trained to work with OCD patients, are always available to assist patients.

**Newsletter:** What is the typical daily routine of a patient at the Institute?

**Osgood-Hynes:** Residents have a busy day at the Institute. First group of the day starts at 8:30

AM. However, many people are already challenging their OCD symptoms as soon as they get out of bed either on their own or with the help of one of our counselors. Each weekday has either 7 or 8 groups, although not everyone goes to each group. Group appropriateness is decided in collaboration with your behavior therapist. There are two 2-hour exposure and response prevention groups per day. There are several groups to teach a variety of behavioral skills. We have two cognitive therapy groups, a relaxation group, a motivation group, and symptom specific groups for people struggling with OCD symptoms, such as, scrupulosity, perfectionism, intrusive violent and sexual thoughts or body dysmorphic disorder. We have groups to help people with family issues and with transition; and we also have groups that help people get some exercise and plan some pleasant leisure activities into their life. There are breaks scheduled for lunchtime and dinner. People have some free time in the evenings and more free time on the weekends. During free time patients can watch TV and socialize.

**Newsletter:** The OCF has just given a research grant to a team of researchers to evaluate the relative effectiveness of office-based versus in-home E&RP treatment. How can residential treatment be effective for OCD patients if their OCD is connected to their home or other places outside of the hospital?

**Osgood-Hynes:** That is one of the challenges when a person comes to the Institute. Most of the time, a person's OCD symptoms span a variety of situations. This lends itself to doing the necessary exposure and response prevention tasks here at the Institute. Very frequently we have people going off campus with staff into the community to face various situations that trigger their OCD. We also have people traveling the various areas of the hospital campus to do their E&RP. If patients live nearby, we have staff go to their home or office to do the E&RP work. For patients who do not live nearby, we ask that they bring items from home or items from work with them into the Institute, or have family members send them specific things that are problematic for them to work on while at the Institute. For many people, the E&RP and habituation process can generalize to situations that are similar. However, treatment generalization does not happen for all people. There are some people whose OCD is only triggered in certain specific situations or with certain items which are only at home or at the office. In these situations, home-based or office-based therapy is definitely the better treatment choice.

**Newsletter:** Do you have a less intensive program at the Institute?

**Jenike:** We have a few patients in a day program at the OCD Institute. However, it is essentially the same program, but patients don't spend

the night. This would not be a good program for patients who have morning rituals that prevent them from getting places on time.

**Newsletter:** Are you and the staff at the Institute doing any research projects that involve the program participants? What are they?

**Jenike:** We very rarely do research projects at the OCD Institute because it is mostly a clinical program. At the main Massachusetts General Hospital OCD Clinic, there are many research investigators and they occasionally recruit willing participants from the OCD Institute.

**Newsletter:** Is the residential program covered by private insurance, Medicare, Medicaid?

Davey: Many private insurances cover treatment at the OCD Institute. The application asks for insurance information and the program staff will help patients check on coverage from their individual insurers. Medicare does cover the cost of the program at 80%. However, because Medicare does not cover room and board charges, these become the responsibility of the patient. There is a sliding scale for these charges based on a patient's income. Massachusetts Medicaid does cover the program, but not the room and board charges. Other state Medicaid programs do not cover the program at all.

**Newsletter:** What other treatment options do you have available for individuals with OCD? A partial program? An in-office weekly program?

**Jenike:** Apart from the day program and full residential program, we have the largest outpatient OCD clinic in the world at Massachusetts General Hospital. We have ongoing evaluations and treatment as well as dozens of research projects aimed at advancing our understanding of OCD in terms of causes, biology and treatment.

**Newsletter:** How does a patient get into the Institute? Does he have to be referred by a treatment provider? Can he self-refer? Can a family commit a member to the OCDI?

**Davey and Jenike:** The patient or referring doctor can contact the program director, Diane Davey, directly at [davey@ocd.mclean.org](mailto:davey@ocd.mclean.org) or 617:855-3279. Since the OCD Institute is totally voluntary, it cannot accept commitments from family members or others. That really would not make sense, as the patient has to be enthusiastic and motivated to utilize the treatments to get better.