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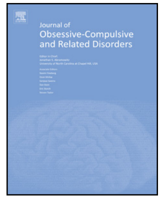

# The Behavior Therapy Training Institute for OCD: A preliminary report

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ABSTRACT

Despite decades of research demonstrating the efficacy of Cognitive Behavioral Therapy (CBT) for obsessive compulsive disorder (OCD), many clinicians have not adopted it into their practice. In an effort to increase the number of trained clinicians, the International OCD Foundation (IOCDF) developed a nationwide intensive training program, the Behavior Therapy Training Institute (BTTI). We report the first data on the BTTI. We emailed a 30-item online survey to all clinicians (N=350) who attended one of twelve BTTI workshops between 2008 and 2011. One hundred and sixty one individuals (53%) responded. Participants reported more than moderate use of all BTTI skills. Expert phone consultation and peer consultation after the training were associated with greater skills use. The most commonly reported barrier to skill use was difficulty integrating the techniques into their practice because of time or an inability to leave the office. The majority of participants also reported an increase in OCD-related referrals after the BTTI. Limitations of this work, suggestions for improvement, and the implications of our findings for broader dissemination efforts are discussed.

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## 1. Introduction

Obsessive compulsive disorder (OCD) is a debilitating psychological condition that affects approximately 2–3% of the population (Angst et al., 2004; Weissman et al., 1994) and often results in significant functional impairment and a poor quality of life (Eisen et al., 2006; Norberg, Calamari & Cohen, 2008; Sorenson, Kirkeby & Thomsen, 2004, Steketee, 1997). Cognitive-behavioral therapy (CBT) is a highly efficacious treatment for OCD (Foa, Franklin & Kozak, 1998; Koran, Hanna, Hollander, Nestadt & Simpson, 2007; Kozak, Liebowitz & Foa, 2000). Despite decades of research demonstrating its efficacy, many clinicians have not incorporated CBT into their practice (Bohm, Bohm, Forstner, Kulz, & Volderholzer, 2008; Freiheit, Vye, Swan, & Cady, 2004; Hipol & Deacon, 2013). In fact, one recent study of community-based therapists found that only a minority of therapists (27.3%) used exposure and response prevention (ERP) with OCD patients (Hipol & Deacon, 2013). Instead, therapists reported using non-specific interventions, such as non-directive supportive psychotherapy, progressive muscle relaxation, breathing retraining, and meditation (Hipol & Deacon, 2013).

The failure to adopt evidence-based psychological treatments into practice is not specific to the OCD community. Indeed, improving the dissemination and implementation of evidence-based treatments in the psychological community is the subject of much academic discussion and research (cf. McHugh and Barlow (2012)), and a major funding priority of the National Institute of Mental Health (NIMH). A major initiative within dissemination and implementation research has been on identifying optimal models for training clinicians to deliver evidence-based treatments (for review McHugh and Barlow (2010)). Traditional instruction methods (e.g., provision of a manual, brief workshops) have proven inadequate (for a review see Oxman, Thomson, Davis and Haynes (1995)). Accordingly, researchers have begun to develop and test alternative training models (e.g., Beidas, Edmunds, Marcus, & Kendall, 2012, Harned et al., 2014; Rawson et al., 2013; Sholomskas et al., 2005).

In an early effort to disseminate CBT for OCD, the International OCD Foundation's (IOCDF) Board of Directors appointed a task force of clinicians and researchers to develop a nationwide intensive clinician training program, the Behavior Therapy Training

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Institute (BTTI) during the early 1990s. Task force members included the following clinicians: John Greist, Gail Steketee, Fugen Neziroglu, Lee Baer, and Alec Pollard (Chair), and then IOCDF Executive Director James Broatch. In developing the BTTI, the IOCDF sought to create a training model that was more intensive, comprehensive, interactive, and clinically useful than traditional workshops, but also shorter and more accessible (geographically and financially) than the few fellowships and externships offering training in the treatment of OCD. The program was developed in 1995 and is presently offered approximately 4–5 times a year at various locations across in the United States. To date, approximately 1000 clinicians have participated in the BTTI (Pollard & Szymanski, 2013).

The present manuscript is the first to report on the BTTI as a vehicle for the dissemination of CBT for OCD. We conducted a brief retrospective survey of clinicians who completed the BTTI between 2008 and 2011 with several specific aims: (1) to characterize the clinicians who have enrolled in the training, (2) to examine self-reported implementation of the skills learned in the training and factors predictive of self-reported implementation, (3) to summarize self-reported barriers to implementation of the skills learned in the training, (4) to determine if attendees believed that participating in the BTTI lead to an increase in referrals, and (5) to identify areas for improvement and future investigation. We did not have specific hypotheses regarding the characteristics of the clinicians who attended the BTTI. We hypothesized that participants would report at least moderate use of the BTTI skills after the training. Additionally, consistent with the literature suggesting that post-training consultation can significantly enhance training (Beidas et al., 2012; Edmunds, Beidas, & Kendall, 2013; Webster-Stratton, Reid, & Marsenich, 2014) we hypothesized that those participants who engaged in post-training peer or expert consultation would demonstrate the highest levels of self-reported skill use. Based on prior work demonstrating that discomfort making patients anxious can interfere with the implementation of exposure therapy (Deacon et al., 2013) we hypothesized that this would be the most common self-reported barrier to implementation. Finally, because the BTTI, is hosted by the IOCDF, which is a major source of treatment-related information for patients, we hypothesized that participation in the BTTI would lead to increased clinical referrals. We hope that by examining this ongoing and popular program we may contribute to our collective efforts to improve clinician training which may in turn increase the availability of evidence-based care for patients in need.

## 2. Method

### 2.1. Participants

All clinicians ($N=350$) who attended one of twelve BTTI workshops held between July of 2008 and October of 2011 were invited to participate in the survey. One-hundred and eighty-six individuals (53% response rate) began the survey and 161 completed the survey (87% completion rate). Respondents reported providing clinical care in 35 states, in addition to Canada. Approximately one-third of responding clinicians held a Ph.D. (36.6%), and almost half of all clinicians held a master's degree (22.4% M.S.W.; 22.4% M.A./M.S.). The remainder of clinicians held a Psy.D. (11.8%), an M.D. (2.5%), an R.N. (1.8%), or an education specialist degree ($<1\%$). One clinician did not report his or her highest degree. The majority of participants were psychologists (43.5%), followed by social workers (19.4%), mental health counselors (15.6%), marriage and family therapists (7.0%), other professionals (3.2%) and psychiatrists (2.2%). On average, respondents earned their professional degree 12.8 years (SD=9.08) prior to completing the BTTI and had 14.2 years (SD=8.28) of clinical experience at the time of the BTTI.

### 2.2. Procedure

In February of 2012 we emailed a 30-item online survey to all clinicians who attended a BTTI since July of 2008 (email addresses were not available for individuals who participated prior to this date). Questions pertained to participant and practice characteristics, degree of skill use since the BTTI, and self-reported barriers to use. We also asked five open-ended questions designed to solicit participant feedback regarding the content of the BTTI and suggestions for improvement. A copy of the survey is available from the first author upon request. The survey was administered through REDCap (Research Electronic Data Capture), a secure online data capture program (Harris et al., 2009). Based on pilot testing we estimated that it would take respondents approximately 5–10 min to complete the survey. Informed consent was obtained online. Upon completion, participants were given a code which granted them a $25 discount on the annual IOCDF membership fee.

All study procedures were reviewed by the Partners Healthcare Institutional Review Board and the protocol was granted exempt status.

### 2.3. BTTI course overview

The BTTI is a 3-day intensive training for licensed mental health care providers in the fundamentals of CBT for OCD and related disorders (Pollard, 2011). The course is offered approximately 4–5 times a year at various locations across the United States. Continuing education credits are offered for psychologists, social workers, and mental health counselors. The cost of the training is currently $385. Attendance at each training is limited to 30 to maintain a high faculty-trainee ratio and allow for in-depth discussion of individual cases.

Prior to attending the BTTI, participants are asked to read at least one selection from a list of books on CBT for OCD. Additionally, participants are provided a link to a website that includes the Yale–Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989a, 1989b), and a measure of depression, either the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) or the Depression Anxiety Stress Scales (Lovibond & Lovibond, 1995). Participants are asked to administer these assessment instruments to one of their current patients prior to attending the BTTI, and to bring the materials and any other relevant clinical information (with identifying information removed) to the training for discussion.

The first day of the workshop focuses on diagnosis, assessment, theory, and the fundamental components of treatment. First, controversial or confusing diagnostic issues related to OCD are discussed, such as the importance of assessing for mental compulsions. Second, the conceptual model of treatment is presented. Participants review the classic behavioral model that exposure and response prevention (ERP) is based upon, as well as other pertinent theoretical frameworks, such as the cognitive model of obsessions. Third, empirically-supported OCD assessment instruments, such as the Y-BOCS, are discussed, and the speaker reviews how to effectively utilize the Subjective Units of Distress Scale (SUDS) during exposures. Lastly, the speaker uses case vignettes to demonstrate how the cognitive behavioral model can be flexibly applied to the heterogeneous forms of OCD. At the end of the day, additional CBT techniques are presented, such as imaginal exposures.

The second day of training focuses on advanced issues and special topics for clinical practice. Four topics are presented by 2–3

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