

Handbook of
**PRIVATE
PRACTICE**

KEYS TO SUCCESS
FOR MENTAL HEALTH
PRACTITIONERS

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OXFORD

CHAPTER 54

TREATING ANXIETY DISORDERS

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We are co-directors and co-owners of the Anxiety and Stress Disorders Institute of Maryland (ASDI) in Towson, a suburb of Baltimore. ASDI is a group private practice that currently includes 20 part-time clinicians, two part-time office staff, two interns in training, and a volunteer exposure therapy aide. We began as an independent group practice in 1992.

THE NICHE PRACTICE ACTIVITY

We specialize in the treatment of all of the anxiety disorders and obsessive-compulsive disorder (OCD). Although these make up the majority of our work, all of our clinicians have varied case-loads that include affective disorders and other co-occurring conditions. Our approach generally integrates aspects of behavioral, cognitive, Acceptance and Commitment Therapy (ACT), and mindfulness-based orientations. After all these years, we've seen so many cases that symptomatic presentations that are unusual for many general psychotherapists may be quite familiar to some in our niche practice.

DEVELOPING AN INTEREST AND TRAINING IN THIS NICHE ACTIVITY

Our origins were at Sheppard-Pratt Hospital in Baltimore in 1978. Before the term "panic disorder" appeared in the diagnostic manual and long before "specialization" was an accepted practice in psychiatry or psychology, Dr. Douglas Hedlund, a service chief, approached the first author

with an idea. He was being lobbied by a middle-aged woman named Zelda Milstein¹ with a unique mission. She had recovered on her own from years of being housebound with agoraphobia using a book called *Hope and Help for Your Nerves* by Claire Weekes. She had given up on many years of failed attempts at psychodynamically oriented psychotherapy, had found Dr. Weekes' books, and wanted to help others who were caught in the same spiral of panic attacks as she had been.

At the same time, Dr. Hedlund had met Dr. Arthur Hardy while on sabbatical. Dr. Hardy had founded an organization called TERRAP (an acronym for "territorial apprehension") after meeting Dr. Weekes. In TERRAP, people approached symptoms directly by facing their phobic situations in the company of a psychotherapist rather than sitting in offices looking for the origins and meanings of their fears. Suddenly, previously refractory cases of agoraphobia were responding to treatment.

In the next months, the first author, Ms. Milstein, and Dr. Hedlund studied this new approach and ended up visiting Dr. Diane Chambless and Dr. Alan Goldstein in Philadelphia, who were piloting a similar direct approach to phobias after publishing a groundbreaking article that reconceptualized agoraphobia as a complication of panic disorder rather than a simple phobia. We took clients into the subway system of Philadelphia to get them anxious deliberately and tried to teach them to think and breathe and react differently to the bodily sensations of panic that they were experiencing. In late December 1978, the Agoraphobia Clinic, housed in the outpatient department of Sheppard Pratt Hospital, was born. Eight agoraphobic women met with the first author and Ms. Milstein while their phobic companion husbands hung out with Ms. Milstein's husband in the hallway. We met once weekly to talk and once weekly to go "in vivo," to face their fears and to deliberately induce symptoms. We used Dr. Weekes' four steps: "FACE, ACCEPT, FLOAT, and LET TIME PASS."

Four decades before "third wave" cognitive-behavioral treatments such as ACT arrived on the scene, Dr. Weekes had developed an ACT-like approach that was effective for people who had struggled with anxiety symptoms for many years. As the evidence base and theories about anxiety disorders treatment have evolved since, we continue to marvel at her prescient thinking.

Within one year, we had two groups going, and within 10 years, we had a staff of 12 psychotherapists, multiple groups and individual therapies, and recovered clients who volunteered as "phobia aides," and we constituted more than a third of the outpatient department. During that time, we did a lot of free public education. We coordinated our public outreach with the national Phobia Society of America, the precursor of the Anxiety and Depression Association of America (ADAA), spearheaded by a small group of advocates and early researchers in the field. We made it onto the *Donahue Show*, *Dateline*, and local talk shows and even into *Cosmopolitan* magazine. Early on, clients were almost entirely self-referred, as they arrived holding an article from a magazine or newspaper, or saw a local or national TV show, or had attended our free public lecture series about the anxiety disorders. Many of the clients were already in other treatment and their doctors were highly skeptical of a psychotherapy they considered simultaneously dangerous and superficial.

There were no graduate training or specialized workshops to learn from, as we ourselves were the pioneers. The national network of clinicians and researchers at ADAA served as our source of creativity and inspiration, and we ourselves were the ones giving early workshops. Interaction with such original thinkers as Donald Klein, MD, Martin Seif, PhD, James Ballenger, MD, Reid Wilson, PhD, David Barlow, PhD, and Jerilyn Ross, MA, the inspirational first president of ADAA, kept

us abreast of new developments in the field. It was exciting to be part of the beginning of a whole new field.

In 1992, when the hospital was undergoing financial stressors as it tried to adapt to the onslaught of managed care, a generous severance package was offered to professional staff. We (the co-authors) decided to separate ourselves from the hospital and begin our own private practice group. We met with our psychotherapists and virtually the entire staff decided to resign their hospital positions and embark on the journey together. The hospital administration offered us rental space on campus with a year's free lease. With the hospital's blessing, our clients all came with us. So we began with many advantages.

JOYS AND CHALLENGES RELATED TO THIS NICHE ACTIVITY

It is gratifying to work with anxiety disorders and OCD because most sufferers improve significantly and are grateful for the change in their lives. Because anxiety disorders are stress-sensitive and recurrent, we sometimes see people periodically over many years and truly know them; because of the genetic component, we sometimes know families across generations. We have been proud to be part of the explosion in interest and useful knowledge about anxiety disorders and OCD over the past 30 years. And because we are specialists, we often see clients who gained little from traditional therapies and are seeking additional help. Our goals are often larger than simple symptom relief. They include a more profound change in the client's relationship with his or her own mind and body.

The challenges are few: the minority of sufferers who don't respond to our best efforts to provide evidence-informed treatment and the financial and insurance limitations that are familiar to all out-of-network clinicians. Providing behavioral exposures may require longer than usual sessions, odd hours of operation, more electronic communication, unusual arrangements, and extra planning time than the standard 45- or 50-minute in-office sessions. If someone needs to drive over the Bay Bridge repeatedly, that can be a whole day; if exposure to an evening theater event is needed, or a visit to an Alcoholics Anonymous group accompanied by a psychotherapist, logistics can get complicated. Scheduling may need to have more flexible time built in.

BUSINESS ASPECTS OF THIS NICHE ACTIVITY

We remain in the same location on the Sheppard Pratt Hospital grounds to this day, renting 19 offices and a few hours of conference room meeting space. We had virtually no startup money so our business model was as low risk as we could make it, keeping overhead expenses low. We hired just two part-time employees (an office manager and someone to manage billing and client records), and that is all we have to this day. The original furnishings were slightly used and bought

in bulk. Our brochure was a self-produced trifold. Our offices are comfortable but modest. The owners paid ASDI for their own office rent and we still do. As co-owners, we chose to keep each of our own solo practice's finances independent from ASDI to preserve our own autonomy and to preempt potential conflict about unequal financial contributions. ASDI is a management services entity that provides administrative support, screening and referrals, office space, and collegial support to our clinicians.

Many of the policies and practices of ASDI were grounded in our experience of being part of a larger bureaucratic system—in other words, we wanted to do things differently. All ASDI psychotherapists are independent contractors who receive a percentage of collected fees. Although this has been critical for minimizing financial risk, it can provoke scrutiny by the Internal Revenue Service (IRS), so we have carefully detailed the agreement in writing per IRS checklists defining the issue (see https://www.angelo.edu/services/sbdc/documents/library_resources/IRS%2020%20Factor%20Test.pdf.) A caution to others who want to consider this mode of practice: beware of the IRS. We recently came through an extensive audit with flying colors, but only because we were meticulously careful to follow IRS guidelines as to what constitutes an employee and what is a true independent contractor. Probably the factor that helped the most was that most of our psychotherapists also work in other locations, as college faculty, in other agencies, or in their own private practice location. We provide space to work in and patients to see, but we do not pay for their malpractice insurance and we do not set their hours or have productivity requirements. Review the current guidelines very carefully or the IRS will call your contractors “employees” and your costs will be completely different, including the possibility that you will need to pay employment taxes that were not previously paid but now deemed due (IRS, n.d.).

The aspect of work that was most important to us as a group was *individual autonomy*. To that end, we have tried to make the experience of our psychotherapists highly autonomous. This means that we offer rather than assign cases. Hours are set by the psychotherapists themselves, with the only limitation being shared office space. Any psychotherapist can turn down any case for any reason, such as not having the perceived expertise, not wanting another difficult case, or not wanting to work another evening hour.

Psychotherapists can develop their own mini-specialties such as emetophobia or trichotillomania or blood-injury phobia. Psychotherapists can develop other modalities based on their own special interests (e.g., a Fear of Flying program; a Social Anxiety/Improv Group; mindfulness meditation classes; use of FreeSpira, a biofeedback system for treating panic-related chronic hyperventilation). Some cases are shared by, for example, a family therapist, an individual psychotherapist, and an intern doing home visits involving exposure therapy. Such teams are developed spontaneously according to the needs of individual cases. Teams can also be arranged in some circumstances to provide nearly daily, intensive outpatient work.

Another value at ASDI is to have as little bureaucratic demand as possible. This means one *voluntary* staff meeting per week with attendance encouraged by emphasizing collegial and educational aspects rather than ASDI housekeeping. In contrast to our background as hospital employees, ASDI has no committees, no taskforces, and no productivity reports, expectations, or deadlines. Documentation, other than that needed for billing and that required by law, is at the discretion of the psychotherapist and remains the psychotherapist's property. Group and individual case peer consultation is available as well for everyone. In addition to individual and group

supervision, trainees are encouraged to sit in on intakes, exposure therapy outings, home visits, and groups run by more senior clinicians.

Professionals in the community refer to us because of our reputation and 35 years of experience. There is a large network of primary care physicians who know us. Sheppard Pratt sends us anyone who calls with anxiety or OCD. The emergency department in the community hospital next door sends us their panic attack patients. There is also by now a large network of local mental health professionals who have been trained by us in workshops, ongoing consultation groups, internships, and lectures.

More than half of our referrals are now self-referrals via the Internet. Our website (www.anxietyandstress.com), which portrays our range of expertise and years of experience, generates requests for help or appointments every day. Many of these are people who cannot afford to see us, but we reply and, if necessary, refer everyone who contacts us. All clients are screened in a 10- to 15-minute, free telephone screening by one of us co-directors, and we have developed a reputation for giving free brief consults to clinicians in the area. We believe that our unreimbursed time is a continuing investment in ASDI branding and reputation building. We no longer do any print, radio, or TV advertising as it is no longer worth the price. We are listed in professional directories such as the ADAA, the Association of Behavioral and Cognitive Therapies, the International OCD Foundation, *Psychology Today*, and the Maryland Psychological Association.

Once a client has been accepted for treatment, the screening co-director offers the case to one or more psychotherapists and the one who is "matched" calls the client personally to make a first appointment. There is no appointment secretary, as we want the whole process to be individualized for both client and clinician. We do have an answering service that takes calls and forwards them to us around the clock. In an old-fashioned twist, we two co-directors still carry a beeper and are on call for the whole group for emergencies.

Originally, we participated as "in-network providers" for selected third-party payers. But as diminishing reimbursement, collection problems, and demoralization seriously threatened ASDI's future, we gradually left all such contracts. Some of us still participate with Medicare; however, for our psychotherapists to be willing to accept poorly reimbursed Medicare referrals, ASDI takes only a token portion of the fee. For all other clients, we collect payment at the time of service. Patients pay by cash, check, or credit card since we have not yet moved to other payment strategies that are still evolving. We issue monthly, generated statements so that clients may seek reimbursement from their insurance companies. In keeping with the value of autonomy, we do not offer a practice-wide sliding scale. Rather, any psychotherapist is at liberty to reduce the fee of any client from our standard fees, based on his or her own clinical and financial judgment. Their percentage of that which is collected remains the same, so most psychotherapists have some pro bono or low-fee clients at their own discretion. Our trainees see low-fee or no-fee clients in exchange for their training.

Our business model has not created wealthy owners; rather, our profits essentially pay for our administrative hours at about the same rate as we would be paid for clinical hours. We deliberately chose this model rather than a high-volume contract-with-all-third-party-payers practice with clinicians as full-time employees. Although potentially more lucrative, we felt such a practice entailed more risk, given the whims of third-party payers, as well as much more aggravation. It also seemed the antithesis of our values emphasizing autonomy, individualized treatment, and quality of life. Admittedly, this model means that more than half of the people who contact us cannot

afford our services, either out-of-network or out-of-pocket, which does not jibe with our social conscience. So we co-owners still participate with Medicare and provide occasional pro bono services. We supervise interns who provide low-fee services. Daily we help callers with referrals to in-network care.

In the years since 1992, we have grown and expanded. We are multidisciplinary, including psychologists, social workers, licensed professional counselors, pastoral counselors, nurse specialists, and a training director. Over the years we have attempted to have a psychiatrist on board, but the economics of this are prohibitive so we have a network of local private practitioners to whom we refer on a regular basis.

In summary, we believe that nurturing shared, specialized expertise among a group of like-minded clinicians, promoting the autonomy of those clinicians so that turnover is rare, and keeping our overhead low have been the primary reasons for ASDI's continuing success. Our local and national reputation as a specialty practice and our willingness to train and consult with local clinicians serve as low-key marketing that keeps the flow of referrals coming.

DEVELOPING THIS NICHE ACTIVITY INTO A PRACTICE STRATEGY

The best place to learn about this kind of niche practice is to attend the national conferences of the ADAA and the International OCD Foundation (IOCDF) and spend a lot of time networking. These are smaller, more personal conferences than the annual meetings of the Association for Behavioral and Cognitive Therapies or the American Psychological Association. Both ADAA and IOCDF offer day-long workshops on special topics at their annual meetings, and IOCDF offers a three-day intensive training in OCD treatment. Individual or group supervision with a specialist in anxiety disorders and/or OCD can be arranged with our practice and is readily available in most other population centers.

Developing this niche also should include designing a comprehensive website with downloadable free information about anxiety disorders and OCD, with links to other notable websites, resources, and self-help literature. We have always maintained collegial rather than competitive relationships with other groups and professionals who specialize in the same field, maintaining cross-referrals and consultations and occasionally collaborations. This applies locally, regionally, and nationally. There are enough patients to go around. In addition, if there is someone with this specialty but who is also willing to be on insurance panels and be medical assistance providers, we maintain a steady flow of referrals to them of patients who cannot afford to see us.

FOR MORE INFORMATION

We recommend that those interested in pursuing this niche practice read the books in the resources list. Useful websites include the Anxiety and Depression Association of America (<http://www.adaa.org>) and the International OCD Foundation (<https://iocdf.org>).

NOTE

1. Zelda Milstein, who openly discussed her clinical history, was an inspiration to many in her 40 years working as Maryland's first paraprofessional exposure therapist. She was working until shortly before her death in 2015.

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