

Response to Commentary on Exposure and Response Prevention in the Treatment of Body Dysmorphic Disorder: A Case Series

Exposure Therapy—What Is It That We Are Selling?

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ABSTRACT

This discussion is a response to Muller and Schultz's (2012) thoughtful commentary on our case series on treating Body Dysmorphic Disorder (BDD) in this issue of the *Pragmatic Case Studies in Psychotherapy*. We join Muller and Schultz in their dedication to exposure treatment. We elaborate on their perceptive comments on what exposure is, and how it is presented, applied, and implemented most effectively, in the context of BDD specifically. We conclude by briefly exploring some of the complexities of the theory underlying exposure therapy.

Key words: exposure therapy; Exposure and Response Prevention (ERP); Body Dysmorphic Disorder (BDD); anxiety; case studies; clinical case studies; case study series

It has been a privilege for us to receive, and reply to, the thoughtful commentary on our Body Dysmorphic Disorder (BDD) case-series (Folke et al., 2012) by Muller and Schultz (2012). The authors write in an informed and scholarly way on the nature and clinical application of exposure therapy (also called Exposure and Response Prevention [ERP]). In our view, their perspective on how to overcome treatment obstacles and “sell” the treatment is nicely framed and resonates well with our experience. We may be able to describe exposure therapy in terms of its technical features, theoretical assumptions, and therapeutic intentions. But still, engaging the client in the process is probably the most critical challenge.

To what extent a treatment approach is made available is not solely dependent on empirical support (e.g. Shafran et al., 2009). As Muller and Schultz note, we must also focus on the training of clinicians and on the attitudes of practicing therapists. Overcoming obstacles and “selling” the treatment is not only a task directed at the lay public and potential clients, it is also needed within the profession itself. Also interesting are the questions raised by Muller and Schultz about theoretical issues and mechanisms of change. We see a need to expand the present theoretical knowledge of the processes involved in exposure treatment, not only to keep clinical work in accord with the experimental research on learning-processes, but also to provide useful models to the clinician.

THE IMPORTANCE OF EXPOSURE

We agree with Muller and Shultz that awareness about exposure therapy in both the general public and the profession is spreading. Exposure is being adopted in both the media, where cognitive behavior therapy (CBT) sometimes seems to be synonymous with “confronting your fears,” and in general therapeutic practice. This means that patients are often intellectually prepared for the treatment approach and that therapists of different theoretical orientations will be familiar with the approach. But it also means that therapists may adopt exposure in their treatment as an auxiliary technique rather than as a central feature of their therapeutic practice.

The examples about therapist' negative attitudes towards exposure treatment mentioned by Muller and Schultz are worrisome, although not at all surprising. In fact, it is in line with what has been found by others that in treatments where it should be mandatory, exposure may not be a part of the treatment given (Stobie, Taylor, Quigley, Ewing, & Salkovskis, 2007). Patient attitudes are often pointed to as a problem, but it is more a concern that therapists are ignorant when it comes to a treatment approach that is effective, relatively easy to disseminate, and with broad applicability (Neudeck & Wittchen, 2012). Unfortunately, the media coverage sometimes fails to find a balance between painting a popular picture and addressing the scientific nature of exposure therapy, both in terms of the clients' problems and of the treatment. There are so many superficial “phobia miracle cures” that people may fail to discriminate these from serious, evidence-based treatment approaches.

ENGAGING THE CLIENT

Muller and Schultz briefly define exposure as "confrontation of feared stimuli" (p. 289). Since one of the natural functions of fear is to motivate escape and avoidance, this is a challenging process. In the case of a specific phobia, this is pretty straight forward (e.g., confronting dogs or heights). Our clinical experience is quite on a par with theirs regarding the perceived credibility of exposure-based treatment with patients who are equally avoidant as the sample in our present study and who present themselves with other anxiety disorders. But these are patients who are generally quite content with the idea that they have a difficulty that centers around fear.

BDD is, in our experience, a more complex endeavor for many reasons. BDD is in many cases characterized by delusional beliefs and over-valued ideation (Phillips, Menard, Pagano, Fay, & Stout, 2006). Clients with delusional BDD beliefs do not view their problem as a problem with anxiety, but as a problem due to an actual flawed appearance. Exposure and Response Prevention, on the other hand, is usually understood as an intervention effective in alleviating anxiety, very much in the manner it has been presented above. It is not recognized as a treatment for flawed appearance. Quite naturally these clients will feel reluctant, not only as to whether they can tolerate the distress associated with exposure, but reluctant towards the whole idea of why it could be of any help at all to them. This requires careful tailoring of the rationale that stems from an assumption that it is perfectly natural to feel reluctant and still give it a try.

Muller and Schultz's idea of “selling” exposure therapy, while it has a somewhat provocative tone in the context of psychological treatments, actually clarifies a pivotal task for the therapist. In terms of learning theory, the therapist's task is to create a social and verbal

environment that has the capacity to compete with the aversive stimulus functions in the client's personal life, thereby motivating patients to orient themselves to a life not run by fear but by personal goals and values.

We think that two words that catch the essence of the whole approach are *flexibility* and *presence*. As therapists we must always flexibly adopt the basic treatment approach to the individual client, and we must be present with the client to empathize with their fearful responding, their avoidance, and their response to the process of exposure. Apart from assessing the effects of respondent and operant learning in clients, we also recommend assessing their beliefs and assumptions concerning the nature and consequences of their fears before starting the treatment. Such cognitions should be viewed as an integral part of the factors that may elicit negative affective responses, which also motivate escape and avoidance behavior (Forsyth & Eifert, 1996). Muller and Schultz's recommendation to include patients' preconceptions of treatment in initial clinical assessment is an extremely important point.

TRAINING

A crucial obstacle for implementing and applying exposure treatment lies in therapist training and adherence, and we think there is much work to be done in this area. We have both been students in training facilities in Sweden that adhere more closely to the behavioral roots of the CBT tradition. In these facilities exposure is taught as one of the foundations of CBT rather than as one of its many techniques. In this regard, it is notable that Öst, Karlstedt, and Widén (2012) found that for students undergoing training in one of these facilities where patients are predominantly treated for anxiety disorders and the primary method of choice is exposure, treatment results equal those from the efficacy literature, or in their words,

We conclude that clinically inexperienced student therapists who receive supervision [in strategies like exposure therapy] from experienced supervisors can achieve treatment effects that are on a par with those of experienced licensed psychotherapists (p. 260).

In treatment you need to communicate to patients that it is essential to devote a substantial amount of time to exposure. This message equally applies to educators when creating a clinical curriculum! One of the challenges, as we see it, is for the training to foster an attitude where the therapist turns to the exposure work with ease. There is perhaps no treatment approach more robust and empirically supported over a broad range of problems (Neudeck & Wittchen, 2012). Still, both therapists and educators easily downgrade its role. Our suspicion is that training, even within a cognitive-behavioral tradition, sometimes overemphasizes the development of a certain rhetorical style and underemphasizes more direct, action-oriented, behavioral approaches.

We very much appreciate the Muller and Schultz's idea that therapists working with exposure-based therapies should be "true believers" (2012, p. 291). This may sound controversial to many colleagues' ears. It may evoke associations of ideologically driven clinicians acting in blind faith in the one and only method, discarding anything else. In our conception of "true believers" lies a conviction that when explaining human behavior, whether it is regarded as healthy or as unhealthy, the relation between the individual and context is crucial. It also means

holding the view that in working with this approach, exposure is a core feature of therapy rather than an auxiliary treatment technique.

We also agree with Muller and Schultz (2012, p. 292) on the importance of connecting to the rationale of the therapeutic procedures we use, since it serves the purpose of creating a shared theoretical and methodological narrative for the patient and therapist. This should be seen as a vital component in the establishment of a therapeutic alliance. On the other hand, what we've seen too often, in both our students' and our own practice, is a situation when providing a "rationale" becomes equivalent to the unproductive behavior of lecturing the patient over and over again. Presenting the rationale of exposure typically has to be balanced by a sensitivity to patients' hesitancy and/or their negative reactions evoked by the process of exposure, or sometimes by the mere description of it. Therapists need to be open to these reactions, and they need to be cautious that it may turn out to be unproductive to try to push the client into buying the therapists' idea of the process needed for behavioral change.

THEORETICAL ISSUES

In this final section we would like to raise some conceptual issues associated with three of the important concepts Muller and Schultz discuss. First, as mentioned above, they state that "in brief, exposure therapy involves the confrontation of feared stimuli" (2012, p. 2). In this regard, it's important to note that the stimulus to confront in BDD (e.g., one's nose or skin) is often the same stimulus that individuals spend hours checking and looking at every day. Thus, theoretically it is often difficult to differentiate between confrontation behaviors and avoidance behaviors in BDD. Also, the emotional response to stimuli, in the case of BDD, is not limited to fear. The response often entails feelings of shame, guilt, disgust, anger, and depression, and thoughts of being inadequate, worthless, and unlovable (Veale et al., 1996). These theoretical complexities correlate very importantly with the difficulties therapists counter when formulating treatment plans with BDD patients.

Second, it should also be noted that while "response prevention" is an important component of exposure therapy, preventing responses is not the ultimate goal of treatment per se. Rather, what the therapist tries to motivate the patient to do is to abstain from behaviors that are used in a rigid fashion to over-regulate emotions or behaviors that serve the purpose of avoiding stimuli associated with these emotions. As Muller and Schultz point out (2012, p. 12), these behaviors may well be subtle and not readily detectable by an outside observer, as mentioned over the case of Ms. E in our case series (Folke et al., 2012).

Finally, Muller and Schultz state, "Habituation is thought to be the mechanism through which true therapeutic change in anxiety treatment occurs" (2012, p. 289). We would note that competing theories to habituation for why exposure works have been presented (e.g., Craske et al. 2008). Our working assumption is that exposure can serve many goals, with the process that can be observed in reports of experiencing less and less anxiety frequently one of the more important. This multitude of purposes may be particularly important to emphasize when emotional responding is complex, as in the case in BDD.

In any event, from a pragmatic point of view, the concept of habituation does convey a functional message in getting the patient to stay in and focus on the situation rather than getting

out of it. And asking for repeated estimates of subjective units of discomfort (SUDs) may be an easy and effective way to get the patient to stay present with the fluid qualities of experience. On the other hand, the rather passive connotations of “habituation” may be less desirable, because a process described in terms of decreased emotional responding may well paint a picture of feeling less affect and getting rid of emotions as a goal of treatment. The problem may be that this is the agenda that the patient is already pursuing. We would rather endorse a rationale that stresses stepping outside the constricted personal space defined by fear and avoidance—a rationale that emphasizes the process of learning something new.

One approach that appeals to us is to search for the theoretical underpinnings of exposure therapy in terms of extinction learning (e.g. Powers, Vervliet, Smits, & Otto, 2010). A modern account of extinction learning would stress two things: first, it is not a passive process of unlearning but rather an active process of learning something new; and second, it is a process of creating a more ambiguous meaning of the feared event, allowing for a multitude of functions other than avoidance. Theoretically, we would also like to stress the operant aspects of exposure (Ramnerö, 2012). This would imply that therapy is a means of generating a more flexible behavioral repertoire in the presence of aversive stimuli and aversive contextual cues. Such a repertoire would compete with the predominance of fearful responding and other attempts to avoid aversive emotions, and thereby be accompanied by the experience of less and less fear.

In our view, when practicing this focus on extinction learning could lead to an approach that (a) actively encourages the patient to stay present with the painful thoughts and emotions that are evoked; (b) flexibly elicits behaviors that counter the patient's fearful responding; (c) generates verbal interpretations that are at odds with the patient's self-defeating assumptions; and (d) encourages the patient to acquire a sense of playfulness in the presence of the situational contexts that activate their agony.

In sum, Muller and Schultz's commentary on our case series has been most valuable to us in highlighting themes in the training, application, dissemination, and theoretical underpinnings of exposure therapy with Body Dysmorphic Disorder patients.

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