

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

“Selling” Exposure Therapy

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ABSTRACT

Exposure therapy, or Exposure and Response Prevention (ERP), is a well-established treatment intervention for anxiety and related disorders. In their comprehensive case study series, Folke, Von Bahr, Assadi-Talaremi, and Ramnerö (2012) offer not only an excellent review of their treatment for Body Dysmorphic Disorder, but also a thoughtful discussion of the importance and impact of ERP in these cases. Our commentary addresses the concerns the authors raise in their discussion of patient reactions to the exposure component of the therapy intervention. Using examples from the authors' case studies, along with relevant research and clinical anecdotes, we offer suggestions on overcoming some of the factors that may prevent the optimal implementation and application of exposure therapy.

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

We read with great interest Folke, Von Bahr, Assadi-Talaremi, and Ramnerö's article on the application of exposure and response prevention (ERP) for Body Dysmorphic Disorder (BDD) (Folke et al., 2012). The authors' recognition of the importance of exposure therapy in the treatment of this disorder complements the existing research of such BDD experts as Katharine Phillips and Sabine Wilhelm (Wilhelm, Phillips, & Steketee, 2013). As cognitive behaviorally-oriented psychotherapists trained in academic research settings, our clinical mission has been the use of empirically-supported therapies in "real-world" clinical settings and this study appeals to these interests. We are also "die-hard" exposure therapists who believe strongly in the efficacy and effectiveness of this approach, and we were excited to see that the authors specifically address the role of exposure in their study and current paper. We will focus our commentary on the topic of exposure therapy as well.

WHAT IS EXPOSURE THERAPY ANYWAY?

Exposure therapy (also referred to as Exposure and Response Prevention, or ERP) is no longer known solely in the cognitive behavioral therapy (CBT) world. Many psychotherapists have heard of it, if not tried to apply it in some form. The lay public has also had some of their own exposure to it through “reality” television shows such as “Hoarders” and “The OCD Project.” In brief, exposure therapy involves the confrontation of feared stimuli. The most crucial goal of an exposure exercise is the experience of what is known as the “habituation” of acute anxiety (Foa & Chambless, 1978; Foa & Kozak, 1986). Habituation is thought to be the mechanism through which true therapeutic change in anxiety treatment occurs. It involves not only confrontation of feared stimuli, but also engagement with those stimuli until fear is resolved. Studies (e.g., Foa & Kozak, 1986) have found that during an exposure exercise of sufficient duration, patients’ subjective ratings of their fear/anxiety evidenced a curvilinear pattern, with anxiety increasing, plateauing, and declining over time.

Exposure therapy has a central role in the treatment of anxiety disorders today. Studies suggest it is the “most efficacious” intervention for anxiety disorders (Nathan & Gorman, 2007). Exposure is also a component in many “modular” forms of psychotherapy (e.g., David Barlow’s “Unified Protocol” [Barlow et al., 2011]) and Folke and colleagues utilize it as one of the sequential modules in their study. Given that exposure therapy is central to the treatment of anxiety and related disorders, such as BDD, it is important to understand the obstacles that may impede its effective application. In their case study review, Folke and colleagues describe how two of their BDD patients (Ms. E and Ms. F) did not complete the exposure component of the therapy. The authors also mention the initial reluctance of other patients to begin exposure therapy (Ms. A and Ms. B). We agree with the authors that it is important to explore these issues further and, herein, we offer our opinions on this subject.

OBSTACLES TO THE USE OF EXPOSURE

Despite the many years of its use and positive findings about its utility, various obstacles prevent the efficient and effective application of exposure therapy. The authors, both directly and indirectly, make mention of these obstacles in their article. Factors that may impact the use and effectiveness of exposure therapy include therapist training and experience (or lack thereof), therapist attitude toward the treatment, patient concerns about the treatment, and even such practical factors as time allotted to education about the intervention. A number of researchers have considered these factors over the years (e.g., Becker, Zayfert, & Anderson, 2004; Cahill, Foa, Hembree, Marshall, & Nacash, 2006). We believe there is not enough attention paid to these factors by therapists implementing exposure and that this may heavily influence patient outcomes. We also contend that other “social” factors such as professional in-fighting and media representations of exposure therapy may influence the likelihood of therapists utilizing or recommending exposure therapy.

Therapist Factors

Cahill and colleagues (2006) looked at data on therapist training in exposure therapy. They found a general lack of training in exposure therapy in professional education. They also

discovered that among therapists who had training in exposure therapy approaches, very few had much experience applying it. Additionally, few of the therapists with training and experience were actively using exposure therapy on a regular basis. The researchers found that therapists were reluctant to implement exposure therapy because of a preference for individualized therapies over the manualized therapies that typify exposure approaches, and concerns about patients decompensating during exposure. Becker and colleagues (2004) discovered that inadequate training is probably the largest factor associated with therapist failure to use certain forms of exposure therapy.

Therapist factors must be addressed if exposure therapies are to be applied adequately and effectively. Training is certainly an issue, but unfounded concerns about safety and tolerability must be addressed and corrected. Misunderstandings about manualized therapies abound. As Folke and colleagues demonstrate in their case studies, even structured therapies can be individualized to meet the needs of the individual.

Patient Factors

Folke and colleagues report that the patients in their study had an “almost reflexive, initial skepticism” (Folke et al., 2012, p. 278) about the ERP used as a component in the BDD treatment. While this seems to be the conventional perception of patients’ reactions to exposure therapy, we have actually found that responses are quite varied and run the gamut from very positive to very fearful. We caution clinicians about assuming that patient reactions will *likely* be negative or skeptical. We believe that this expectancy effect on the part of therapists could actually contaminate and unintentionally influence patient reactions.

In a study to be published soon, Elizabeth Hembree of the University of Pennsylvania discusses her compelling research on patients *preferring* exposure therapy over supportive “treatment as usual” for posttraumatic stress disorder following rape or sexual abuse (E.A. Hembree, personal communication, November 19, 2012). In this groundbreaking study, she presented patients with a brief description of both treatments prior to their randomization into one of the two conditions. She found that patients chose prolonged exposure therapy, based solely on the descriptive paragraph of the treatment, more often than the supportive therapy. While their preferences did not influence their placement into the treatment conditions (a topic for future research), this study poses a challenge to the notion that patients will have negative or skeptical reactions to exposure therapy. Our own clinical experiences have been similar: When exposure is presented well, with solid rationale and outcome data, many patients see it as a logical choice.

Other Factors

In 1994, the television show “Dateline” named their clip highlighting very positive coverage of Prolonged Exposure for Posttraumatic Stress Disorder, “Cruelty or Cure?” (Gage, 1994). The widely read *New York Times* newspaper published an article in 2003 entitled, “The Cruellest Cure” (Slater, 2003). This article offered, to the lay public and practitioners alike, a scathing criticism of exposure therapy. Even Joseph Wolpe, the “father” of interventions that evolved into exposure therapy, had concerns about some types of exposure being too intense for

patients (Wolpe, 1958). Despite these persistent criticisms and concerns, decades of research on exposure have consistently found the treatment to be safe and generally well-tolerated by patients (Becker et al., 2004; Cahill et al, 2006).

The field of psychology, which is the “home base” of exposure therapy, has not always been accepting of this treatment approach. Lack of knowledge about exposure rationale and technique may lead to negative attitudes about the treatment among providers. Individuals from non-cognitive behavioral theoretical orientations may not understand the underlying theory and may be opposed to exposure approaches. In a recent personal example, one of us suggested ERP as an intervention for a case another therapist described on an online consultation listserv. Not only did many providers respond that they did not know what the therapy was, a few expressed concerns that exposure would be “too intense” or “harm” the patient. Attitudes like this, promoted in professional forums, may have lasting effects, especially if these attitudes are then conveyed to trainees, patients, etc.

“SELLING” EXPOSURE THERAPY

As therapists, it is our job to essentially “sell” the patient on what we are offering, namely exposure therapy. We need the patient to buy in and, ideally, stay in until the treatment is completed. We must convince them that what we are selling is worth investing in, especially given the emotional “cost” it may entail. We contend that research-based treatment manuals can (and should) do a better job at selling exposure therapy. In the “real-world” application of ERP, we also need to enhance our sales pitch and adjust it as needed. In the present case study, Folke and colleagues describe the need to individualize the standardized treatment to the particular patient. We wholeheartedly support this, especially when it comes to tailoring the exposure message to a particular consumer.

So, how do we sell exposure therapy so that we attempt to overcome the obstacles described above and, most importantly, ensure that the patient buys in? Herein, we offer our suggestions gleaned from years of training in and provision of exposure therapy in various settings (university-based research clinics, urban hospital training clinics, and suburban private practice). Our hope is that these strategies may address some of the concerns that Folke’s group and many other researchers have raised. We contend that these strategies may increase patient willingness to engage in exposure therapy, reduce dropout rates, and, ultimately, improve outcomes. We recognize that this list is not comprehensive and invite other researchers and clinicians to share their experiences, as Folke and colleagues have done, so that we may all improve our work. We hope to research these strategies further and document our findings.

Therapists Must Be “True Believers”

Adequate and comprehensive clinician training in exposure therapy is critical. Partial application or use of exposure without linking it to the theory may result in neutral or negative outcomes. Clinicians implementing exposure therapy must understand the origins of the treatment and its theoretical underpinnings to conduct it adherently (Cahill et al, 2006). Sound foundational training will allow the therapist to trouble-shoot obstacles when they arise with patients. They will be prepared to creatively modify the exposure plan as needed and capitalize

on “unplanned” exposures, such as Mr. D’s skin infection episode described by the study authors. Experience and practice also help the therapist “titrate” the exposure experience—to decrease or increase intensity much as the study therapist did with Ms. B—and optimize patient engagement.

To co-opt a term from the Spider-Man comics, exposure therapists must be “true-believers” in exposure to provide a genuine and convincing case for its use to the patient. We cannot back away from exposure when it gets difficult or if the patient becomes upset. If the patient suspects that we waver at all in our conviction, it may shake their confidence and motivation. In keeping with this, we recommend that ERP therapist trainees be encouraged to express their own doubts and fears about the treatment so supervisors can address them. The more practice trainees get, the more likely they are to amass positive patient outcome experiences and very naturally become true-believers.

Assess Attitude and Expectations

We recommend that clinicians assess patient attitude *before* starting exposure education. Ask if they have any preconceived, or even newly conceived, notions of exposure therapy. When we ask patients what they think exposure therapy is, they often describe scenarios that sound similar to “flooding”—a full immersion form of exposure therapy that has been replaced, in most cases, by “graduated” exposure. It is important to demystify exposure if there are any misconceptions at work.

It is also important to assess patient expectations. One of us saw a patient who, after learning about exposure, said, “I think about 30% of this will be really hard and 70% will be much easier.” We were quick to flip these percentages and be very honest with her about just how hard exposure can be, while still highlighting the many benefits of the approach. Inoculating patients early about the hard work involved can be very helpful and keep expectations realistic.

Rationale, Rationale, Rationale

One of our esteemed CBT professors always said, “When providing therapy, if you ever find yourself in doubt, return to the rationale.” This notion is critical in exposure therapy. Providing a sound, convincing rationale for exposure therapy from the get-go is imperative. If the patient seems unsure about the approach, if they are reluctant to proceed (as were Ms. A and Ms. B in the present study), or if they completely refuse to continue, validate their struggle and return to the reasons why you are recommending exposure in the first place. We find that patient-friendly take-home summaries of research on ERP can be very helpful in this effort. We will often assign these readings as homework for the patient and encourage them to return with questions the next session. We keep the data sections brief but include some clear information about outcomes that pertain to the patient’s particular presenting problem. We also ask the patient to “teach” the information back to us and describe the summary. This offers the therapist an opportunity to correct any misunderstandings *before* the treatment is underway.

An important part of presenting rationale is helping the patient understand habituation, the primary process at work in exposure therapy. Foa and Kozak (1986) state that if the patient

disengages from the feared stimuli before adequate habituation, then the fear structure (memory and attentional processes that maintain the fear) will be strengthened rather than weakened. It is critical that this concept be clear to patients before they undergo an exposure therapy regimen. Many anxious patients have informed us that they are not sure that this treatment can help them, because they “do exposures all the time.” However, what they fail to recognize is that they engage their feared situations and stimuli in a tangential or transient manner, and do not allow enough time (or attention) for habituation to occur. For example, an individual with a dog phobia might consider running past a neighbor’s yard where a dog is chained to be an excellent example of an exposure. Obviously such an “exposure” precludes emotional processing of fear and may strengthen beliefs about the danger of dogs. It may even reinforce the avoidance and safety behaviors that help to maintain the phobia (and which the patient swears he could not survive without).

Provide Real-life Examples

If we think a bit, most of us can come up with examples of habituation in our own lives. We may not be able to speak to the experience of habituation of a fear response per se, but most of us can attest that we have “gotten used to” something that was originally distressing to us. We both lived at some point in apartments that featured the melodious sounds of a subway train chugging past underground at various times of the day. At first, the idea of ever being able to sleep in this environment was unfathomable. Within a month or so, the noise blended into the ambient background and was no longer disturbing. Examples like this can be used with patients to introduce the notion of habituation. We contend that patients sometimes need a basic “framework” to understand the more formal and complex notions behind exposure therapy for anxiety. This strategy also provides a reference point for the therapist to bring up to the patient, e.g., “Remember how we discussed getting used to the subway noise? When faced repeatedly with our feared stimuli, our body and brain do something very similar.”

Stepping Outside Your Own Fear

While we want to educate the patient about exposure using their own presenting problems, sometimes it is helpful to get the patient to “step outside” him- or herself briefly. We find that using the patient’s own symptoms as the only example may not be as helpful because they are so emotionally invested in and connected to their symptoms. We ask patients to think of other meaningful people in their lives and whether these individuals have ever experienced fear and/or avoidance of something.

In a recent case, we asked a female dog phobia patient who had a young child if her daughter had ever been afraid of anything. She immediately responded with a vehement “Yes!” and said that when her daughter was a toddler she was fearful of Cookie Monster on the TV show “Sesame Street.” We asked if her daughter had gotten over her fear. The patient reported that she had and, with further Socratic questioning, she explained that she sat with her child and watched the show daily until Cookie Monster no longer scared her daughter. The patient herself had given a lovely synopsis of how exposure therapy and habituation work. We then helped her find the parallel with her own planned exposure treatment.

Do Not Neglect Response Prevention

While we use the term “exposure therapy” interchangeably with Exposure and Response Prevention, we are always careful to attend to the response prevention component of the treatment. Folke and colleagues describe Ms. E as having what we would deem “mental rituals” or mental compulsions (thoughts about how she could “find her way out” of her problem). While the treatment plan and formulation attended to these, it is not clear if the actual exposures included monitoring and eventual elimination of mental rituals. If this does not occur, exposures will not have their full impact. One could even argue that the patient may stop exposure because they will not experience the habituation necessary to change the fear response. In addition the patient may not gain the sense of mastery that comes with getting through those early exposures and their motivation to persist with the remaining exposures may diminish.

We encourage all therapists to monitor not only exposures but also compulsions, especially during in-person exposure sessions. We also recommend coaching patients in recognizing the occurrence of mental rituals. We ask, “Are you thinking anything right now that is reducing your anxiety?” If this is the case, we bring the patient back to the fear stimulus repeatedly. Our hope is that they get good enough at this to coach themselves when they are on their own.

Use of “Testimonials”

When we trained with Dr. Edna Foa at her Post-Traumatic Stress Disorder and Obsessive-Compulsive Disorder specialty clinic, clinicians used a video of a news program that featured the successful exposure treatment of a patient as an integral part of the treatment manual. This represents the importance of demonstration and patient testimonial. That video did what none of us eager and knowledgeable therapists could do: explain exposure and the beneficial outcomes from an actual *patient’s perspective*. In this age of abundant media, there are a number of available videos that can be used for this purpose. Many celebrities, from actress Kim Basinger to football player Ricky Williams, have talked publicly on camera about their experiences with anxiety and exposure therapy. With digital video recorders easily accessible these days, clinics can also record their own videos to use with patients.

Another way for patients naïve to exposure to learn about the experiences of other patients is to read written statements, view video clips, or listen to audio recordings of testimonials from those other patients. We have been very pleased over the years when many patients have volunteered to do this without us even asking them to. Most have been so happy with the outcomes of their therapy that they want others to know that this treatment option is available. Folke and colleagues might consider asking the patients who benefitted from their BDD treatment (Ms. A, Ms. B, Ms. C, and Mr. D, and future patients) to leave testimonials of this sort. These can be anonymous, but are often more convincing if done in video format.

CONCLUSION

Folke, Von Bahr, Assadi-Talaremi, and Ramnerö (2012) offer a compelling review of their Body Dysmorphic Disorder treatment case study series. The authors emphasize the impact

and importance of an exposure therapy in the positive outcomes for the patients studied. Many other studies have also demonstrated the efficacy and effectiveness of exposure and response prevention. As clinicians and researchers, it is incumbent upon us to ensure that exposure is implemented and in the best way possible. As Folke and colleagues found, patient reactions, and factors such as motivation and external stressors, may interfere with the application of this important intervention. We hope that the strategies we have offered may assist in breaking down myths about exposure therapy, aid in increasing therapist commitment, and encourage patient participation, adherence, and exposure completion.

We leave you with a quote about confronting fear that we share with our patients as part of a comprehensive phase of psychoeducation on exposure therapy. Many of them report that they find it inspirational and very appropriate to their experience of exposure.

*We gain strength, and courage, and confidence by each experience in which we really stop to look fear in the face... we must do that which we think we cannot.--
Eleanor Roosevelt*

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