“What Do You Want?”: A New Approach to Conducting Exposure and Response Prevention (ERP)

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Abstract: Exposure and Response Prevention (ERP) has demonstrated efficacy for treating OCD and other anxiety disorders. However, a significant portion of clients relapse or drop out. I describe how motivating the client to do ERP by first explaining the client the rationale for ERP might be a significant cause of this failure rate and propose "What Do You Want" (WDYW) as an alternative method of motivating the client.

Exposure and Response Prevention (ERP) has been shown to be a useful therapy for treating anxiety disorders including but not limited to OCD, phobias, and GAD. Using ERP, the therapist guides the client in exposing him or herself to anxiety provoking stimuli without engaging in avoidance, safety behaviors, or compulsions. Through this process the client becomes habituated to the formerly anxiety provoking stimuli and it no longer provokes an anxiety response (Abramowitz, 2006).

Although ERP has been shown to be efficacious (Foa, et al., 2005), perhaps as much as 25% to 50% dropout or relapse (Franklin & Foa, 1998). In this article I hope to highlight a weakness in the internal logic of ERP and propose a solution. I will use transcripts of therapy sessions with a hypothetical client named Billy to illustrate the new approach.

In most ERP protocols the client is given a rationale for doing the exposure. The client is shown how learning theory understands anxiety, mainly how anxiety fuels a negative feedback look which is perpetuated by avoidance and is then shown how ERP can help. Essentially the client is told that although initially the anxiety will spike, eventually they will habituate to the stimuli and the anxiety will go down. This approach of telling the client why exposure is helpful

and how it will work seems self evident, as without a rationale the client would not agree to face the unpleasant and difficult exposure process.

Unfortunately, giving this rationale creates a problem. It gives the client a new safety behavior to use to help avoid the anxiety. Since it has been explained to the client by the expert therapist that after some time in the exposure they will habituate and the anxiety will go down, the client need not experience ‘unbounded’ anxiety. The client can always reassure him or herself that as bad it feels right now, it WILL get better. In this way the client can avoid facing the full power of anxiety that is not expected to recede. As already described in Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999) this can create its own set of problems.

In particular the client is especially vulnerable to relapse if the client has an experience where this new learning is violated. When they experience a situation where they don’t habituate in what they consider a reasonable timeframe and they quit doing the exposure, the clients learning that ‘anxiety will habituate’ is violated. As the whole therapy was built on this point and it is now a key safety behavior in the clients willingness to experience anxiety, this puts the client at a significant risk for relapse. Although the experiential learning from the exposure is still there, since it was accompanied with a safety behavior (the client trusting that the anxiety will habituate), the client has never been exposed to a situation where they fully believed that the anxiety would not ever recede or habituate. Once they do have this experience the whole therapy can collapse and the client relapses. An excellent example of this is found in a recent case study (Abramowitz & Arch, 2013).

Another problem with ERP done with a rationale is that many clients with OCD suffer from an personality style that carries an inability to come to operational certainty. An inability to trust themselves and their experiences so they can act on what they know. And so they are

perpetually left paralyzed, stuck with not knowing, and stuck choosing inaction by simple inertia. When the therapist educates the client, the therapist is also subtly invalidating the clients direct experience and replacing it with a wisdom from outside the client. Essentially asking the client to mistrust their own intuitions and truth the therapist instead. While this may not be a problem with most clients, with OCD clients this is often a large part of their psychopathology and so one risks exacerbating that psychopathology by doing this.

And so the question becomes, if we don’t provide a rationale, how do we get the client to do ERP?

Acceptance and Commitment Therapy (ACT) has a novel solution to the problem. Instead of exposure serving to achieve habituation and lower anxiety levels, the exposure is in the service of living ones values. In this way, when the client exposes there is no safety behavior of trusting that the anxiety will go away, rather the client accepts the full measure of anxiety so they can live a valued life (Hayes, Strosahl, & Wilson, 1999).

I would like to propose another model based on fundamental and fascinating paradox found in nearly every therapeutic encounter. When a client comes to a therapist with anxiety and avoidance (or with any unwanted emotion and behavior) there are almost always two components to the client’s avoidance. The first is the clients inner emotional experience of anxiety. When they don’t avoid or do safety behaviors they experience this unpleasant emotion. The second component, as CBT has pointed out, is that the client models reality in such a way that if they don’t avoid or do their safety behavior that they might suffer a poor outcome in reality. The irrational belief.

And so for a client with an airplane phobia, the two components are: 1. The unpleasant anxiety experienced when they get on an airplane 2. The irrational belief that the plane will

crash. And here lies the curious paradox! Most clients do not come to therapy asking the therapist to target the irrational belief. Rather they assume that what they believe is the reality and they are merely coming to ask the therapist to target the anxiety and “make it stop”.

This is bizarre! If indeed I believe that plane stands a high risk of crashing, then it would not be at all in my best interests to fly! In this case the fear is adaptive. It helps ensure that the client stay on terra firma no matter how high the cost may be, as in their belief system it is their very life that is at stake! In essence, nearly every clients request to a therapist for help changing (excluding grief counseling and other scenarios where the client is not coming to change) carries inside of it a deeply illogical structure!

And so what if we expose this anomaly? What happens then?

This is the approach of WDYW (What Do You Want). In this model the therapist provides no rationale and does not ask the client to engage in exposure. Rather, after gathering information as to the clients feared outcome in reality, the therapist challenges the clients wish to make the anxiety go away by pointing out that the anxiety and fear protects that client from the feared outcome. That no matter what we do in the therapy room, the outside reality itself won’t change. And so the therapist then asks one simple question over and over. “What Do You Want?” Do you want that outcome? Or do you want to not have to avoid? When the client responds with his desired outcome, the therapist challenges the client with his own feared outcome. The client then decides what he would like to do.

Here is a hypothetical example. Billy has come to therapy to help with his fear of flying. Billy has not flown in 15 years. When asked, Billy says that he is afraid that the plane will crash. Billy says that he’s coming for therapy to overcome his fear as he is unable to get a promotion at work due to his inability to travel.

Using the above conceptualization we would notice that Billy is asking the therapist to help put his life in danger. As Billy believes that the plane has a good chance of crashing, his fear and avoidance is incredibly logical. So long as Billy does not notice the irrationality of his belief but rather accepts it at face value, he is essentially asking us to help him make a choice that will end his life. In the therapy we will hone in on this bizarre illogic and ask Billy as to what he truly wants.

The following is from the first session after defining Billy’s feared outcome, safety behaviors, and avoidance strategies:

T: Ok Billy. So now that we have all this, imagine for a moment that I had a the magic perfect therapy system, you simply write what you want to be like after you change from therapy on a piece of paper, we put it in the computer, and it creates a pill that you take that creates that new you… what are you writing on the paper?

B: I feel no fear of flying at all.

T: Ok. Sounds good. Here’s the thing. What concerns me. You see, if you feel no fear of flying you’re going to start getting on airplanes. Correct?

B: Yes.

T: Ok. So here’s the problem. Planes do crash. So what if the plane crashes? You’ll die. You want that? You want to die?

B: No!

T: Ok then, so what do you want?

B: *thinks* Well I want to know that the plane won’t crash.

T: I do wish I could help you know that the plane won’t crash. That would be perfect. You would be safe, feel safe, and fly. The issue is, that I’m not *that* good of an agent of change! No matter

what we do in here, I can’t affect the airplanes flying out there. And so I don’t quite know how you we could ensure that they won’t crash, as quite frankly they always can crash. And they do crash from time to time. And so with all that, what do you want?

B: I want to at least believe I know it won’t crash.

T: But what if you’re actually about to board a plane fated to crash?! You believe you’re 100% safe, you aren’t really 100% safe, and then the plane explodes in mid air! Now you’re dead! Do you want that?!

B: No! *sigh* And that’s exactly the problem! I remember watching this documentary on plane crashes, talking about all the causes of plane crashes, and there are so many! And I was thinking “that could happen to any plane I go on”.

T: Exactly! Who wants to die?! And so what do you want?

B: But I can’t live my life this way! My boss said that with my talent and years of service I could easily be regional VP and because of this stupid flying thing I can’t get promoted past supervisor!

T: I hear that. And that stinks. You deserve so much more, you could get so much more, and you have this stupid issue holding you back… And with all that we’re back to the question, what do you want? To get on a plane that might be in a fatal plane crash and get a promotion? So you’ll be a dead regional manager? Or to stay safe and be a living, breathing, supervisor?

B: Neither! I want to be promoted and be safe!

T: How do you figure we do that? I really know of no way to ensure that the planes you go on won’t crash. And so no matter what we do here, no matter how skillful a therapist I may be, the fact remains, planes crash. You saw that in the documentary. And if you get on one, you could be on of the next victims. And so what do you want?

B: *thinking* I really don’t know…

T: Excellent! It’s a good thing we didn’t try and take away the fear before we thought this through… So how about you take some time on this. Over the next week think it over, and when you come in for the next session let me know if you want to stay with the fear and stay nice and safe on the ground, take it away and risk that horrible plane crash, or perhaps something else entirely! Does that work for you?

B: Yes.

In this example we clearly see the client’s deep struggle with the paradox as well as his desperate attempts to avoid looking squarely at it. He very much wants to fly, and at the same time he very much wants to not crash. In his current belief system he can’t have both. He has turned to us for the magical solution, and instead of helping him chase this impossible goal, we pass the ball right back and let the client choose what he wants.

Now from session 2:

T: Ok, so did you get a chance to think it over?

B: Yea. I kept trying to work out how to make sure that I would be safe. Things I’ve tried over the years. Read up on the airline industry safety guidelines, work on how a lot of those accidents that happened in the past can’t happen these days, and read the statistics.

T: Oh excellent. And what happened?

B: The thought just kept popping up of “but what if this is the one that goes down”.

T: Mhmm.

B: And I realized that really the only way for me to fly is to risk dying in a crash. And I’m so sick and tired of not getting promoted that I don’t care anymore.

T: So what then do you want?

B: To fly!

T: Even if it turns out that this was the plane that was fated to crash?

B: Well if it's the only way, then yes.

T: Is it the only way?

B: Yes.

T: So you want to fly even if it turns out that this one crashes?

B: Yes.

T: Ok, so imagine standing in that line, about to board the plane, and say to yourself "this plane might crash, planes crash, there are many reasons for planes to crash, and I want to get on the plane anyways. If this one is fated to crash, I want to crash".

B: This plane might crash, planes crash, there are many reasons for planes to crash, and I want to get on the plane anyways. If this one is fated to crash, I want to crash.

T: Excellent, and how do you feel?

B: It's weird… I feel almost this calm energy… Like I'm surfing a wave…

T: Excellent. Now look at that worst case scenario. Vividly imagine it. That plane exploding in mid air. Like that documentary. And tell me do you want it?

B: Yes!

T: Awesome! Say "If that is what will be, I want it!"

B: I want it!

T: Excellent! So when is the next company conference out of town…

This example vividly illustrates how by directly confronting the paradox of the client asking to lose his fear without working on his irrational belief, the client makes his own choice, without needing an external rationale provided by the therapist, without any reassurance or safety

behaviors. An exposure done with no safety net is indeed is the finest and fullest exposure possible.

In essence this approach can be used with other emotions as well, including anger, shame, guilt, sadness, and nearly any emotional or behavioral symptom the client brings to the session. I hope to address those applications in workshops, further articles, and future publications about the method.

Another point worth making is that for the sake of brevity I gave the example of a relatively uncomplicated client. He had a simple fear, with an overt avoidance, with a simple consequence. When there are more layers it takes time to pick apart each layer and approach it in this manner. This includes a thorough understanding of hidden safety behaviors and a deep appreciation of the internal logic, elegance, and structure of nearly any and every emotional experience. This too will be the subject of future works on this subject.

The goal of this method is to purify and simply exposure as a client focused approach so that it need not incorporate externally imposed elements that weaken its effect. When a client fully and completely accepts and chooses his behavior from within their own world, they can often achieve a change that is strongly defended against relapse.

My goal moving forward is to further publish and develop the ideas inherent in this philosophy, as well as design clinical trials to compare the dropout and relapse rates of this therapy compared to traditional ERP using an external rationale provided by the therapist. I hope that the robustness built into this approach from its philosophical core bears fruit in the concrete world of clinical practice.

References

Abramowitz, J. S. (2006). *Understanding and treating obsessive-compulsive disorder: A cognitive-behavioral approach.* Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Abramowitz, J. S., & Arch, J. J. (2013). Strategies for Improving Long-Term Outcomes in Cognitive Behaviorial Therapy for Obsessive Compulsive Disorder: Insights from Learning Theory. *Cognitive and Behaviorial Practice* .

Foa, E., Liebowitz, M., Kozak, M., Davies, S., Campeas, R., Franklin, M., et al. (2005). Randomized, placebo-controlled trial of exposure and ritual prevention, clomipramine, and their combination in the treatment of obsessive-compulsive disorder. *The American journal of psychiatry, 162* , 151-161.

Franklin, M. E., & Foa, E. B. (1998). Cognitive-behaviorial treatments for obsessive-compulsive disorder. In J. G. (Ed.), *A guide to treatements that work* (pp. 339-357). New York, NY: Oxford University Press.

Hayes, S. C., Strosahl, K., & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change.* New York: Guilford Press.