

The Cruellest Cure? Ethical Issues in the Implementation of Exposure-Based Treatments

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Numerous studies have provided supportive evidence for the efficacy of exposure-based treatments for many psychological disorders. However, surprisingly few therapists use exposure therapy in the clinical setting. Although the limited use of exposure-based treatments may be partially attributable to a shortage of suitably trained therapists, exposure therapy also suffers from a “public relations problem” predicated upon concerns that it is cruel and at odds with some ethical considerations (e.g., first do no harm). This article provides an overview of ethical issues and considerations relevant to the use of exposure therapy. It is argued that the degree to which ethical issues become problematic in implementing exposure-based treatments is largely dependent upon the therapist's ability to create an adequately safe and professional context. Specific strategies that may be employed for avoiding potential ethical conflicts in the use of exposure-based treatments are discussed.

THE development and use of exposure-based therapies to treat individuals with pathological anxiety and fear is one of the great success stories within the field of mental health treatment (Frueh, Turner, & Beidel, 1995; Tyron, 2005). Before the 1960s, for example, people suffering from what is now known as obsessive-compulsive disorder (OCD) were routinely treated with various forms of “talk therapy” focusing on trying to understand the supposed “root cause” of the problem, or relaxation therapy aimed at providing an immediate escape from the physiologic experience of anxiety. At the time, OCD was also widely regarded as an intractable condition with a poor prognosis, which speaks to the efficacy of the therapeutic approaches of the day (Abramowitz, 2006).

By the beginning of the 1970s, however, behaviorally oriented researchers were applying learning-based treatments to OCD, which involved helping the affected person to confront stimuli that provoked his or her obsessional fear, while refraining from behaviors (e.g., rituals) that provided an escape from this fear (Rachman, Hodgson, & Marks, 1971). The application of such exposure methods to OCD was, itself, rooted in research with animals (e.g., dogs; Solomon, Kamin, & Wynne, 1953), demonstrating that when exposed to an objec-

tively safe stimulus that provoked irrational fear, the organism encounters the expected initial increase in fear and distress, followed by a gradual diminution of anxiety. With repeated trials of exposure, the initial increase in distress becomes less intense and the subsequent decrease in distress, more rapid (Solomon et al., 1953). This process, routinely referred to as the extinction of fear, is thought to involve a change (correction) in expectations about the dangerousness of the once feared stimulus (Meyer, 1966).

Over the past half century, exposure-based psychological treatments have also been applied successfully in the treatment of other anxiety conditions (e.g., Barlow, 2002), including specific phobias, posttraumatic stress disorder (PTSD), social anxiety, generalized anxiety disorder (GAD), as well as problems that include a strong anxiety component such as body dysmorphic disorder (BDD) and hypochondriasis/health anxiety (e.g., Taylor & Asmundson, 2004). The theoretical basis for this treatment, as briefly described above, is scientifically grounded. Moreover, the empirical basis for the efficacy of exposure is massive, with hundreds of individual studies and dozens of meta-analyses consistently demonstrating large effects on primary and secondary measures of psychopathology (Deacon & Abramowitz, 2004).

Beliefs About Exposure Therapy

Unfortunately, however, despite unqualified theoretical and empirical support, exposure therapy has a serious public relations problem with many in the field of psycho-

therapy (Richard & Gloster, 2007). There are even some practitioners specializing in the treatment of anxiety who hold a *negative* view of this treatment (see Prochaska & Norcross, 1999, for a discussion). Disapproval of exposure often seems to stem from the fact that this set of techniques *evokes* distress (albeit temporary), rather than soothes it, as one might intuitively expect a treatment for anxiety to do. More specifically, as Feeney, Hembree, and Zoellner (2003) and Prochaska and Norcross (1999) have discussed, widespread beliefs about exposure include that its ends do not justify its means; that it is rigid and insensitive to the individual needs of the patient; that it does not work for complex cases; that it is only effective in “ivory tower” research settings and its effects do not generalize to “real-world” clinical settings; that it involves impersonal techniques that are done “to,” rather than “with,” anxious individuals; that it exacerbates symptoms and causes high rates of attrition; and that patients are better off suffering from their anxiety disorder than undergoing this form of treatment. Research by Becker, Zayfert, and Anderson (2004) confirms the presence of such beliefs, particularly among practitioners treating individuals with PTSD.

Beliefs such as those listed above, along with a lack of adequate training, likely contribute to the fact that many practitioners do not utilize exposure-based techniques in their work with anxiety disorder sufferers (Becker et al., 2004; Boudewyns & Shipley, 1983; Fontana, Rosenheck, & Spencer, 1993). For example, in one of the few papers addressing the clinical use of exposure therapy for PTSD, Foy et al. (1996) reported low utilization of exposure within VA clinics, which are major centers for PTSD treatment in the United States. Foy et al. also cited unpublished data by Fontana et al. (1993) indicating that exposure was used to treat fewer than 20% of 4,000 veterans with PTSD, and that it was used as the primary treatment in only 1% of cases. Unpublished data by Kagan et al. (1993) also suggest that, even within a program devoted specifically to delivering exposure therapy for veterans with PTSD, this treatment was successfully implemented in only 38% of cases. A recently reported survey of the Anxiety Disorders Association of America indicated that professional members found exposure-based therapies fairly aversive (Richard & Gloster, 2007).

The negative perceptions of exposure seem to pervade public sentiment as well. In a study of undergraduates and outpatients in a university-based psychotherapy clinic, some routinely used treatments involving exposure (e.g., interoceptive exposure for panic attacks, exposure and response prevention for OCD, and imaginal exposure for PTSD), when presented via vignettes describing the approach, were perceived as unlikely to be helpful, unacceptable, and even unethical (Richard & Gloster, 2007). Others, such as virtual reality exposure therapy for

fears of flying, and gradual in vivo exposure for social phobia, were viewed as more acceptable, helpful, and more ethical (Richard & Gloster).

What factors shape public opinion of exposure therapy? As with beliefs about many health issues (e.g., Taylor & Asmundson, 2004), the media might play an important role in influencing how treatments such as exposure therapy are perceived. Interestingly, despite a dearth of ethical or legal patient complaints lodged against practitioners of exposure techniques (Richard & Gloster, 2007), exposure has been the victim of some bad press. In one particular piece in the *New York Times* (Slater, 2003), for example, exposure is described as “the cruelest cure.” Although the article’s author herself is exposed to the successful use of this technique via direct observation of treatment sessions, patient interviews, and videotapes provided by some of the world’s leading experts on the topic, she quotes other practicing clinicians as stating that exposure is “torture, plain and simple,” and is unacceptable to most patients because they cannot “tolerate that adrenaline-based approach.” She also highlights the story of one particular woman who attempted exposure therapy via a self-help book (without a therapist’s supervision) and found the approach upsetting. Perhaps it is no wonder that many therapists and patients turn away from this form of treatment despite its demonstrated effectiveness.

The present article will discuss the ethical issues that may be perceived as barriers to use of exposure-based treatments in clinical practice. Although specific ethical considerations (i.e., first do no harm) should guide treatment, this article will attempt to challenge mistaken beliefs that exposure-based treatments are harmful. The present article will also illustrate that therapists can prevent ethical conflicts during exposure therapy by creating an appropriate professional context for interacting with patients. Lastly, specific strategies for avoiding ethical conflicts that may negatively impact treatment outcome in the use of exposure-based treatments will be discussed.

Avoiding Harm: Can Exposure Therapy Hurt?

Ethical concerns about the safety, tolerability, and indeed humaneness of exposure therapy are central to objections against this form of treatment. An important goal of this article is to consider these objections in the context of the American Psychological Association’s (APA) *Ethical Principles of Psychologists and Code of Conduct* (2002). The admonition against harming patients appears twice in the APA ethics code, both as a general principle (Principle A: Beneficence and Nonmaleficence; psychologists “take care to do no harm” and “safeguard the welfare and rights” of their patients) and as an ethical standard in human relations (Section 3.04; “Psychologists take reasonable steps to avoid harming their patients/clients” and “minimize harm where it is foreseeable and

unavoidable”). A related general precept is to “respect the dignity and worth of all people” (Principle E). As detailed above, exposure therapy is assumed by some to violate these ethical guidelines. The safety and tolerability of exposure therapy may be determined by examining the outcomes associated with this treatment. Four domains are particularly relevant to this issue: (a) attrition rates, (b) symptom exacerbation, (c) patient preferences, and (d) litigation and ethical complaints directed toward therapists. We examine each domain next.

Attrition Rates

Critics of exposure therapy often assume that such an “intolerable” treatment must result in unacceptably high attrition (dropout) rates in therapy (Leahy, 2007). Hembree et al. (2003) tested this assumption by reviewing studies of prolonged exposure for PTSD, which is often considered the most aversive application of exposure therapy. In this empirically supported form of exposure, the patient “relives” his or her trauma by deliberately recounting the traumatic event, such as being assaulted, raped, or being the victim of a natural disaster. Outcomes from 25 clinical trials yielded no differences in dropout rates between prolonged exposure (20.6%), exposure combined with cognitive therapy or anxiety management (26.0%), and Eye Movement Desensitization and Reprocessing (18.9%). As noted by Hembree and Cahill (2007), attrition rates for prolonged exposure for PTSD are comparable to those observed in exposure therapy with other anxiety disorders, and are lower than dropout rates associated with pharmacotherapy.

Symptom Exacerbation

A harm-related outcome commonly attributed to exposure therapy is its perceived potential to exacerbate psychopathology symptoms, particularly among individuals with PTSD. Foa et al. (2002) directly investigated this issue by examining symptom exacerbation during the course of prolonged exposure. Although the majority of PTSD patients did not experience worsening of their symptoms, a reliable temporary exacerbation following the start of imaginal exposure did occur in a minority of individuals. Importantly, patients whose symptoms initially worsened were not at increased risk of either attrition or treatment nonresponse. Thus, symptom exacerbation during exposure appears both uncommon and of little prognostic value. Therapists who shun exposure therapy due to concerns about its capacity to make patients feel worse would do well to attend to this finding. The results of Foa et al. also support the practice of informing patients that exposure is likely to provoke temporary initial distress, but that experiencing this type of fear will eventually prove beneficial following repeated practice.

Patient Preferences

Despite the reservations of some *practitioners*, exposure therapy appears to be held in generally high esteem by *patients*. Compared to pharmacotherapy, anxiety patients perceive exposure-based CBT as more acceptable and more likely to be effective in the long-term (Deacon & Abramowitz, 2005; Norton, Allen, & Hilton, 1983). The same can be said of parents of clinically anxious children (Brown, Deacon, Abramowitz, Dammann, & Whiteside, 2007). Moreover, exposure therapy is rated as at least as acceptable, ethical, and effective as relationship-oriented psychotherapy and cognitive therapy by undergraduate students and agoraphobic patients (Norton et al., 1983). Among patients completing CBT for panic disorder, *in vivo* and interoceptive exposure are perceived as highly useful despite lower ratings for likeability (Cox, Fergus, & Swinson, 1994). These findings suggest that common therapist reservations about the inherently unethical and undesirable nature of exposure therapy are not shared by most on the receiving end of this treatment. To explain these findings, Richard and Gloster (2007) proposed that compared to dispassionate observers (including therapists), anxiety patients might be less intimidated by the prospect of experiencing heightened anxiety during exposures because such symptoms are simply temporary exacerbations of familiar and long-standing emotional responses.

Litigation and Ethical Complaints

Exposure therapy is sometimes viewed as unsafe for *therapists* by posing a risk-management problem. Will the crossing of boundaries inherent in out-of-the-office exposures (i.e., “exposure field trips”) lead to an inappropriate dual relationship? Will the therapist be sued for malpractice if a patient decompensates during exposure therapy? Concerns of risk management problems associated with exposure are typically marked by (a) fear of legal risk, and (b) actual legal risks posed by inadequate or incompetent therapy.

In our experience (both as trainees and now as professionals), supervisors, colleagues, and administrators have occasionally expressed concerns about the legal risks and issues associated with conducting exposure therapy. It is important to consider, however, that aside from being empirically supported, exposure merely provokes anxiety which is (a) no different than what anxiety disorder patients are already experiencing, and (b) part of the body's natural defense mechanism (i.e., the *fight-or-flight* response) and therefore not inherently dangerous. Taking a different approach, Richard and Gloster (2007) attempted to address these issues by searching the legal record for court cases involving exposure therapy. Their exhaustive search criteria failed to identify a single

instance of litigation related to this treatment. Similarly, none of the 84 members of the Anxiety Disorders Association of America surveyed by Richard and Gloster had heard of any legal action or ethics complaints specifically regarding exposure. It should be noted that a survey approach to obtaining data about ethical and legal issues is not without obvious limitations. Unknown, for example, is whether such complaints have been filed but dismissed or settled out of court. Despite such limitations, the available evidence seems to suggest that exposure therapy is safe and tolerable, and that it carries little risk of actively harming patients (or therapists).

Perhaps a more important issue is the legal risk posed by *inadequate* or *incompetent* exposure therapy. Despite the misconceived notion by many practitioners that exposure therapy is uncomplicated, there is an abundance of experimental psychopathology research highlighting mediators and moderators that contribute to the complexity of the mechanisms that underlie successful exposure-based treatment (see Bouton, 2002). For example, if not applied in the proper context, there is evidence that safety behaviors (strategies used to perceive and subsequently avoid feared outcomes) employed during exposure-based treatment can be detrimental to treatment outcome (Sloan & Telch, 2002). Practitioners need to be aware that exposure therapy is difficult and complex; thus, therapists attempting this treatment should be adequately trained and/or supervised by a competent exposure therapist (APA, 2002, 2.01 [a]). Castro and Marx (2007) observe that “part of protecting client welfare means ensuring that the therapist is both intellectually and emotionally ready to provide adequate and appropriate treatment for each client. Exposure therapy is not only difficult for the client, it is challenging and strenuous for the therapist. In fact, it is not uncommon for the strong emotional responses of the client during exposure therapy to evoke secondary distress in the therapist” (pp. 164-165). This observation suggests that emotional tolerance as well as competency needs to be considered before utilizing exposure therapy.

Minimizing Risk: Strategies for the Safe Implementation of Exposure Therapy

Despite its safety and tolerability, exposure therapy might place patients at greater risk than many traditional forms of verbal psychotherapy. Obvious examples include handling snakes, touching “contaminated” objects such as garbage cans, and vigorous hyperventilation. Although when conducted properly these exercises involve acceptably low levels of risk, exposure therapists must carefully consider the patient's safety when designing and implementing exposure practices. Under what circumstances does a prospective exposure task involve unacceptable levels of risk? What steps can the therapist

take to decrease the probability of psychological and/or physical harm?

Informed Consent

The process of informed consent is critical to evaluating the perceived harmfulness of exposure therapy and decreasing the probability of harm. Consistent with the APA ethical mandate to obtain informed consent in psychotherapy (Section 10.01), exposure therapists must obtain patient consent as soon as possible in treatment. In fact, the very nature of exposure therapy ensures constant vigilance to the process of informed consent. Treatment manuals (e.g., Abramowitz, 2006) explain how each new exposure practice is described in advance by the therapist and agreed to by the patient before it is undertaken. Informed consent is an ongoing process and patients may, and often do, negotiate or even revoke their consent during exposure therapy sessions. Informed consent for a particular exposure task may be discussed several times each session; for example, consent for an *in vivo* exposure may be negotiated both in the office while planning the exposure and subsequently in the natural environment immediately prior to initiating the exposure. To increase the likelihood of patient adherence to anxiety-provoking procedures, exposure therapists often place great emphasis on conveying a clear rationale for exposure and a detailed explanation of its requirements. As a result, exposure therapy is likely an exemplar among psychotherapies for satisfying the ethical principle of informed consent.

Informed consent also provides patients with the opportunity to distinguish exposure as a form of *therapy* from exposure as a form of “*torture*” (as described in the *New York Times*; Slater, 2003). The United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1987, pp. 197–198), defines torture as “...any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.” It is obvious that exposure therapy, in the hands of a competent practitioner, does not constitute torture for several reasons. First, the recipient understands the specific procedures to be used and their probable emotional effects. This is akin to informed consent procedures used for medications that includes potential “side-effects,” including the fact that even if the intervention works properly there may be negative feelings and experiences. Second, the recipient consents to exposure therapy and reserves the right to

terminate at any time. Unlike torture, the patient controls the pace of exposure therapy and no force is ever used to get patients to comply with treatment. Lastly, it is not uncommon for patients to comply with exposure exercises to please the therapist, but it is important to address such demand effects in the informed consent by clearly noting that compliance is for the patient's benefit only.

Naturalistic Comparisons

In certain cases, an exposure task might be clearly contraindicated—such as interoceptive exposure for a patient with severe asthma, or exposure to “germs” from a bathroom door for someone whose immune system is compromised. In the absence of such a clear-cut risk of harm, we suggest asking the following question to evaluate whether the risk associated with an exposure is acceptable: *Do at least some people ordinarily confront the situation/stimulus in the course of everyday life without adverse consequences?* The heart-healthy panic disorder patient who fears cardiac arrest may express concern about the safety of briskly walking up and down a stairway for 30 minutes. However, a casual glance around the local gym reveals many individuals who engage in this level of vigorous exercise without incident. The person with social anxiety might be terrified of asking a stranger for directions, but this happens all the time without incident. Regarding contamination-related OCD, many people suffer no ill effects from the routine touching of door handles and trash cans without washing their hands. Some people even occasionally skip showers, refrain from hand washing after using restrooms, and eat finger foods after petting the dog. Regarding phobias, outdoor enthusiasts routinely have close encounters with snakes and spiders without incident, and most everyone has at some point been stuck outside in a thunderstorm without being struck by lightning. An exposure task may be considered to involve acceptable risk if the patient is not at significantly higher risk of experiencing harm than other individuals who engage in the same activity in the course of everyday life largely without incident.

Session Management

Potentially adverse psychological reactions may also occur during exposures. Patients whose high anxiety fails to habituate within the allotted session time may experience demoralization and express doubts about the effectiveness of the technique. This state of affairs may be prevented in some cases by scheduling longer (e.g., 90 or 120 minute) sessions to account for individual variation in time to habituation. A recent patient in one of our clinics who took more than 3 hours to habituate to handling a spider illustrates that even 2-hour sessions may not allow sufficient time for all individuals to habituate. A particu-

larly useful strategy is to frame exposures as “behavioral experiments” designed to test specific anxious predictions. In this context, the patient who fails to habituate during an exposure session may nevertheless view the event as a valuable learning experience (“I didn't lose control or go crazy even after talking about the sexual assault for an hour”).

Managing “Negative” Outcomes

Risk can be minimized by (a) anticipating the possibility that some exposures may not proceed as planned, and (b) framing exposures as a test of probabilities, predictions, and costs. Dogs sometimes bite. Repeated spinning in a swivel chair may elicit vomiting. And as one of us recently discovered, a socially phobic individual may lose count of pennies while paying for a candy bar. In this case, the exposure was designed to test the patient's prediction that he would “freeze up” and be unable to accurately count pennies while purchasing a candy bar. As it turned out, this actually happened. The therapist subsequently attempted, with little success, to convince the patient that this mistake was of minor consequence. Had this outcome been adequately anticipated by the therapist, the exposure could have been framed as a test of the social *cost* of miscounting pennies, thus preparing the patient for the possibility of this outcome and facilitating a more reasoned evaluation of its “badness.” Even better, the therapist could have prescribed purposely miscounting pennies so the social cost could be evaluated separately from concerns about failing at this task.

If an exposure task could conceivably result in an undesirable but reasonably harmless outcome, the therapist should consider framing it as a test of both the probability and cost of the outcome. In this manner, the unintended occurrence of freezing up during a conversation, being negatively evaluated by strangers, or experiencing a panic attack can provide corrective information regarding the actual badness (or lack thereof) of the outcome. Of course, not all possible adverse outcomes can be anticipated by the therapist. It is possible that exposure therapy could result in a driving phobic suffering a fatal car accident, or a flying phobic boarding a plane that subsequently crashes. As in real life, there is no absolute guarantee of safety in any exposure task. However, the remote possibility of catastrophe should no more preclude a driving exposure than it should prevent the therapist from driving to work.

In summary, several strategies may be employed to minimize any risk that may be associated with the use of exposure therapy. Exposure therapy is most safe and tolerable when provided by a therapist with adequate education, training, and clinical experience. A necessary condition for competency in the use of exposure therapy is the ability to discriminate unacceptable levels of risk

and the ability to handle challenges and adverse outcomes that may be associated with treatment. Safety and tolerability can also be maximized by integrating exposure therapy into a comprehensive treatment plan that includes psychoeducation, including a theoretical rationale for the use of exposure therapy, and relapse prevention. The informed consent is a particularly important context for educating the patient about the exposure therapy process. By clearly and collaboratively outlining what can be expected, this provides the patient some predictability and control that may reduce associated distress when participating in various exposure exercises.

Boundary Crossings: When Exposure Goes Beyond the Office Walls

Boundary crossings in psychotherapy are deviations from traditional, strict, forms of therapy (Zur, 2005). Boundaries serve the function of creating a therapeutic context that is in the patient's best interest. Examples of boundaries include (but are not limited to) time, place, touch, self-disclosure, gifts, and money (Barnett, Lazarus, Vasquez, Moorehead-Slaughter, & Johnson, 2007). Although numerous boundary crossings may be observed in the context of any psychotherapy, the "only in the office" boundary for psychotherapy appears to be particularly relevant for the practice of exposure therapy. Indeed, the practice of psychotherapy has traditionally been conducted within the confines of office walls. However, exposure treatments often require "field trips" outside of the office and into situations that match the patient's fears. The general concern is that the boundaries inherent in the traditional therapist-patient relationship may become fuzzy once the pair leaves the office for exposure therapy. Indeed, Richard and Gloster (2007) recently found that among professionals with clinical interest in anxiety disorders, exposure techniques of in-vivo exposure, flooding, and imaginal exposure were frequently associated with ethical dilemmas. Importantly, qualitative descriptions of the reported ethical dilemmas revealed that maintaining proper boundaries was the most common ethical issue associated with exposure therapy.

Interactions with patients outside the office have traditionally been considered grounds for dual relationships given risk-management concerns that they may lead to sexual relationships with patients (Barnett et al., 2007). That is, sexual relationships with patients typically result from increasingly inappropriate behaviors that may be viewed as traveling down a "slippery slope" from harmless gestures to inappropriate sexual encounters (Gabbard, 1994). Thus, the conduct of exposure therapy outside the office walls may increase the probability of less formal interactions or chatting about topics that may not be necessarily therapeutic. To discourage clinicians from

stepping on this slippery slope that may lead to inappropriate relationships with patients, the "only in the office" boundary (among others) has been proposed to foster a therapeutic context in which the clinician will provide services that are in the best interest of the patient (Smith & Fitzpatrick, 1995). By not leaving the office to provide exposure interventions, the therapist is prevented from taking that first step onto the perceived slippery slope that may ultimately result in a harmful sexual relationship.

Boundary violations, as implied by the APA standards of conduct, are distinct from the sorts of temporary boundary crossings that might occur for therapeutic purposes during exposure. Harmful boundary violations often occur when therapists and patients are engaged in exploitative dual relationships, such as sexual contacts with current patients. During exposure treatment, however, a therapist might temporarily cross a boundary in order to help the patient confront a feared situation that is not otherwise practical to attempt within the boundaries of the office; for example, going for a drive with a patient afraid of crossing bridges and making a home visit for a patient with fears of entering her laundry room. Although such temporary boundary crossings might represent deviations from traditional forms of therapy, they are not unethical (Pope & Keith-Spiegel, 2008). Despite the concern that leaving the office for exposure therapy (i.e., boundary crossing) may lead to more harmful boundary violations, it is widely accepted that boundaries may be crossed without doing harm (e.g., Lazarus, 1998). In fact, as part of our training to use exposure techniques, we attended sessions with mentors and senior clinicians where it was demonstrated how to tactfully, respectfully, and above all, ethically, cross a boundary temporarily for the purposes of coaching a patient through an exposure task. Thus, boundary *crossings* do not necessarily lead to boundary *violations*; neither do boundary crossings necessarily place the clinician on a "slippery slope" (e.g., Zur, 2001; Zur, 2007).

Crossing some boundaries may be clinically appropriate and even necessary when implementing exposure-based treatments. It has been observed that for exposure to be optimally effective, it must be conducted under the supervision of a therapist (Abramowitz, 1996), and in a variety of contexts (Powers, Smits, Leyro, & Otto, 2007). In some cases the provision of exposure outside of the therapy walls is necessary so that learned safety is not evaluated to be specific to certain contexts (e.g., "It is OK to touch the floor as long as it's in the therapist's office"). It may also be necessary to extend the duration of the exposure session in some occasions when adequate in-session habituation is not observed. Thus, when conducting exposure interventions, boundary crossings are often an integral part of evidence-based treatment and do not cross the "only in the office" or "only 50-min sessions"

boundary might be detrimental to maximizing the effects of therapy. To illustrate, home-based exposure therapy for a largely homebound patient with agoraphobia is an accepted practice if the individual cannot come to the therapist's office.

Despite the potential advantages of leaving the office for exposure interventions, we also point out that doing so should occur only as necessary. For example, there is no reason to conduct the initial treatment planning sessions outside the office. Moreover, it is imperative to gain the patient's approval before conducting exposure outside the office. Provided the patient is amenable to such an arrangement, the decision to extend exposure therapy beyond the office walls should be based on the need to engineer experiences in which the patient confronts a situation that matches his or her pathological fear. For example, it might be appropriate to take a patient with blood-injection-injury phobia to visit the Red Cross, but it might not be appropriate to take an OCD patient there who does not present with any contamination fears. [Pope and Keith-Spiegel \(2008\)](#) have outlined specific steps for practitioners to consider when deliberating on crossing a specific boundary during psychotherapy that are applicable to exposure therapy. Perhaps the most important step, however, is for practitioners to imagine the best possible outcome and the worst possible outcome from both crossing the boundary and from not crossing the boundary. This cost-benefit analysis should prove to be useful in determining the overall value of engaging in boundary crossings during exposure therapy.

Maintaining Confidentiality While Crossing Boundaries for Exposure Therapy

One of the more important ethical concerns raised when leaving the office with a patient to conduct exposure therapy is confidentiality ([Gottlieb, 1993](#)). Maintaining confidentiality is a core ethical responsibility for clinicians. According to the APA ethics code, "Psychologists have a primary obligation and take reasonable precautions to respect the confidentiality rights of those with whom they work or consult, recognizing that confidentiality may be established by law, institutional rules, or professional or scientific relationships" (Section 5.02). Limiting the conduct of therapy to inside the office is often viewed as a precaution that helps to maintain the confidentiality rights of patients. Indeed, when conducting exposure interventions outside of the therapy office, others may become aware of the therapist-patient relationship without the consent of the patient. This concern is especially true in smaller communities where there is a higher probability of incidental interactions ([Harris, 2002](#)).

Exposure therapists therefore need to be highly attentive to the issue of confidentiality when conducting

out-of-office exposures and should discuss concerns related to confidentiality with the patient. Doing so is consistent with the general practice of obtaining informed consent from the patient about all facets of psychological intervention as well as preparing the patient for exposure therapy. It is, of course, the patient's right to determine if he or she feels comfortable with the potential that others will find out about the therapeutic relationship ([Lazarus, 2001](#)). As [Pulakos \(1994\)](#) has noted, we have observed that whereas some patients are highly concerned about this issue, others are less concerned about confidentiality than are their therapists. If the patient expresses a willingness to conduct exposure outside the office, yet shares concerns about confidentiality, various strategies may be employed by the clinician to maximize the likelihood that confidentiality will be maintained. For example, the therapist can take steps to de-identify him- or herself as a health professional; for example by removing a staff badge, pager, or coat and tie in informal public settings. Clinicians should also refrain from actions that demonstrate to the public the nature of their relationship to the patient (e.g., conspicuously recording SUDS ratings). Running into acquaintances of the therapist or patient sometimes cannot be avoided when conducting exposure therapy in the real world. In anticipation of such interactions, a "cover story" can be crafted so others do not become aware of the therapist-patient relationship. Practitioners are advised to ask their patients to exercise some caution with their cover story. Patients should be informed not to feel compelled to make introductions or offer explanations so as to reduce any risk of further complications. Additional steps include conducting the exposure in a different neighborhood or scheduling sessions during low traffic hours. Still, even when these reasonable precautions are taken, there is no guarantee that confidentiality can be completely maintained, and it is therefore important to make patients aware of this at the outset.

The "only in the office" boundary is partially predicated upon promoting a context for professionalism. When conducting out-of-the office exposure therapy, the therapist must ensure that the relationship remains professional and that the focus remains on preparing for, conducting, and processing the exposure task. However, in most cases this issue poses little problem and it can even be therapeutic if the strictness of boundaries are relaxed during these interactions. Authors have pointed out that rigidly adhering to strict boundaries may even have negative consequences in that it can bypass what is in the patient's best interest ([Lazarus, 1994](#); [Lazarus, 2007](#)). Relaxing strict boundaries during exposure therapy in the real world may foster the therapeutic relationship that allows the patient to make progress. Although not an agent of change per se, a collaborative working relationship (i.e.,

the therapeutic alliance) is necessary for helping patients face their fears during exposure treatment. Relaxing strict boundaries during exposure therapy is certainly not a license to engage in unnecessary boundary crossings. Some casual conversation can certainly be helpful for maintaining rapport and creating a safe atmosphere for expressing potentially distressing emotions. Exposure therapists do not have to be stiff or remote, but they should stay in a professional role at all times.

Conclusions

We have attempted to highlight some important ethical issues that sometimes confront therapists who conduct exposure therapy. Despite the well-established benefits of exposure therapy, a major concern expressed by the public and professionals alike is that this treatment is harmful to patients. Our analysis, however, based on available evidence, highlights that this form of treatment is safe and tolerable and carries minimal risk of harming patients. In fact, we would assert that given its well-established effectiveness, there may be ethical (and legal?) consequences to *failing* to consider exposure therapy in favor of less effective or unsubstantiated treatments. This is not to say there are no risks with conducting exposure therapy; indeed, it may place patients at greater risk than do other forms of psychological treatment. Perhaps the main risk associated with exposure therapy is temporary emotional discomfort and possible challenges to confidentiality when conducting exposures in the real world. Yet, by taking issues of danger and risk into consideration when conducting exposure, clinicians can significantly decrease this probability of harm.

It is unfortunate that ethical concerns related to maintaining proper boundaries may prevent some therapists from employing exposure therapy when indicated (Richard & Gloster, 2007). Effective exposure often requires accompanying consenting patients on field trips outside the office (i.e., temporarily crossing a boundary), which some view as problematic because this might increase the probability of inappropriate, unethical, and harmful boundary violations (Gabbard, 1994). We have pointed out, however, that conducting exposure therapy outside of the office is not inherently unethical and provides patients with an opportunity to confront their actual fears, rather than representations of their fears. Exposure to stimuli in a real-world context has been shown to be highly effective for a wide range of psychiatric conditions, particularly anxiety-related disorders (Richard & Gloster, 2007). Still, therapists should be aware that confidentiality can be compromised when exposure occurs outside the office. This issue should be discussed with the patient as part of the informed consent process. In cases where this is a significant concern for the patient, various strategies may be employed to minimize the likelihood that confidentiality will be compromised.

The ethical issues we have addressed as being potentially relevant to exposure therapy are by no means exhaustive, and additional ethical issues that may arise in the use of exposure interventions will require exercise of sound clinical judgment on a case-by-case basis. Professional boundaries are crucial for maintaining ethical responsibilities as well as for operating in the best interest of the patient (Vasquez, 2007). To minimize to likelihood of doing harm, practitioners must be competent in the use of exposure-based treatments for the disorder in question. Ethical and legal risk can be significantly minimized by referring patients that practitioners feel incompetent to treat to a colleague who has expertise in exposure therapy (Pope & Keith-Spiegel, 2008). Practitioners are also obligated to consider viable treatment alternatives given that not every patient is well suited for exposure therapy (Castro & Marx, 2007). In cases where the use of exposure therapy is clearly indicated, therapists should work to ensure that (a) any boundary crossing is motivated by the patient's treatment needs; (b) any boundary crossing is consistent with the patient's treatment plan; (c) the boundary crossing is sensitive to the patient's diagnosis, history, culture, and values; and (d) the boundary crossing is discussed with the patient in advance to the exposure intervention to ensure his or her comfort with the plan (Barnett et al., 2007). Consideration of these professional issues will likely create a context for which exposure-based treatments can be safely, ethically, and successfully implemented.

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Received: October 30, 2007

Accepted: July 5, 2008

Available online 25 March 2009