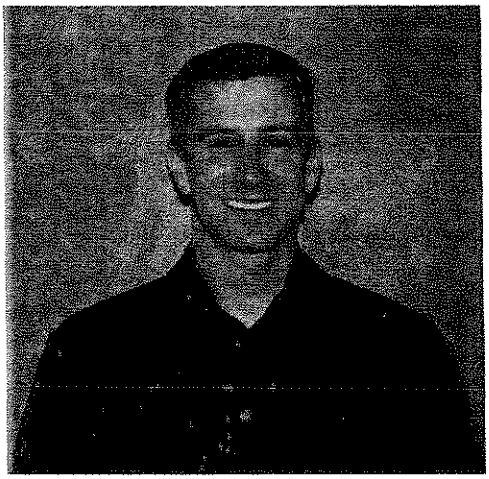
Chapter 2
The Ethics of Exposure Therapy for Anxiety Disorders

Brett Deacon



Brett Deacon is Associate Professor in Psychology at the University of Wyoming, and specializes in the nature and treatment of anxiety disorders.

B. Deacon (✉)
Department of Psychology, University of Wyoming, 1000 E. University Ave.,
Laramie, WY 82071, USA
e-mail: bdeacon@uwyo.edu

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2.1 The Ethics of Exposure Therapy

Ethical principles dictate that therapists avoid harming their patients. The admonition against harming patients appears twice in the American Psychological (2002) 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 (Sect. 3.04; "Psychologists take reasonable steps to avoid harming their patients/clients" and "minimize harm where it is foreseeable and unavoidable"). Despite its safety and tolerability, the unique requirements of exposure therapy sometimes place patients at greater emotional and/or physical risks than many traditional forms of verbal psychotherapy. For example, exposure can involve the remote but real potential for harm when patients handle animals, touch "contaminated" objects such as garbage cans, and vividly recall traumatic memories. Does exposure therapy subject patients to an unacceptably high risk of harm? What are the ethical considerations associated with this treatment?

The effectiveness of exposure-based cognitive-behavioral therapy (CBT) is one of the great success stories in the history of mental health treatment. Hundreds of clinical trials and dozens of meta-analytic reviews have helped establish this treatment as the most empirically supported psychological intervention for the anxiety disorders (Deacon & Abramowitz, 2004; Olatunji, Cisler & Deacon, 2010). Exposure-based CBT approaches are prominently represented on the American Psychological Association's list of "well-established treatments" (Chambless & Ollendick, 2001). Clinical practice guidelines published by the American Psychiatric (2011) and the National Institute for Clinical Excellence (2011) recommend exposure-based CBT approaches as first-line anxiety treatments. An accumulating body of outcome studies suggests that the effectiveness of this approach when applied in community settings with real-world patients is comparable to its efficacy in highly controlled laboratory environments (Stewart & Chambless, 2009). Relative to pharmacotherapy, exposure-based therapy typically produces similar short-term benefit and superior long-term maintenance of treatment gains (e.g., Barlow, Gorman, Shear & Woods, 2000). Exposure therapy is also more cost-effective than pharmacotherapy (Heuzenroeder et al., 2004), more acceptable and preferable to patients and their caregivers (Brown, Deacon, Abramowitz & Whiteside, 2007; Deacon & Abramowitz, 2005), and results in less patient attrition (Huppert, Franklin, Foa & Davidson, 2003). Taken together, these observations make a strong case for exposure-based CBT as the treatment of choice for anxiety disorders. Indeed, this treatment may have more scientific support than any other psychotherapy of any kind, for any problem.

Yet despite its documented effectiveness, exposure therapy techniques are rarely used by practicing clinicians. To illustrate, Foy et al. (1996) reported that exposure therapy was used to treat fewer than 20% of 4,000 veterans with PTSD in the Veteran's Affairs healthcare system, and that it was the primary method of treatment in only 1% of cases. In a sample of over 800 licensed doctoral-level psychologists, Becker, Zayfert and Anderson (2004) found that fewer than 20% of respondents reported using exposure therapy to treat clients with posttraumatic stress disorder (PTSD). Indeed, exposure was not widely utilized even among trauma experts with

specialized training in this approach. More broadly, the majority of patients with any anxiety disorder do not receive evidence-based psychotherapy (Stein et al., 2004); indeed, psychodynamic therapy is received as often as CBT (Goisman, Warshaw & Keller, 1999).

How can the widespread failure to disseminate exposure therapy to mental health professionals be explained? Certainly, exposure is hampered by the same set of barriers that obstruct the dissemination of evidence-based psychotherapies more generally. Examples include a lack of training opportunities in graduate and internship programs, a tendency to favor clinical judgment over evidence from randomized controlled trials in identifying effective therapeutic techniques, and the perception that clinical scientists working to disseminate evidence-based treatments have failed to attend to practitioner concerns (Gunter & Whittal, 2010). In addition to these more general reservations about evidence-based treatments, exposure therapy is subject to a potent set of treatment-specific concerns. It is commonplace to encounter therapists who fear that exposure will actively harm their patients, or that subjecting anxious individuals to their feared stimuli is tantamount to torture. As a result of such beliefs, even therapists who are aware of exposure's scientific support may reject it in favor of treatments they deem to be less aversive and more "humane". The all-too-common result of this misplaced compassion is the time, effort, financial expense, and continued emotional suffering associated with receiving inadequate treatment.

2.2 Beliefs About Exposure Therapy

Exposure therapy has a public relations problem with many in the field of psychotherapy (Olatunji, Deacon & Abramowitz, 2009; Richard & Gloster, 2007). Condemnation of exposure often stems from the fact that this intervention evokes distress (albeit temporary), rather than soothes it, as one might intuitively expect a treatment for anxiety to do. A closely-related concern is that through its power to elicit negative effect, exposure has the capacity to actively harm patients. More specific negative beliefs are identified below (Cook, Schnurr & Foa, 2004; Feeney, Hembree & Zoellner, 2003; Gunter & Whittal, 2010; Prochaska & Norcross, 1999; Rosqvist, 2005).

Negative therapist beliefs about exposure therapy for anxiety disorders

- Its ends do not justify its means
- It is rigid and insensitive to the individual needs of the patient
- It interferes with the therapeutic relationship
- It does not work for complex cases
- It is only effective in "ivory tower" research settings and its effects do not generalize to "real-world" clinical settings
- It involves impersonal techniques that are done "to," rather than "with," anxious individuals
- It exacerbates symptoms and causes high rates of attrition
- Patients are better off suffering from their anxiety disorder than undergoing this form of treatment

Given such negative and widespread beliefs about exposure, it is little wonder that this treatment is underutilized, even by practitioners who specialize in the treatment of anxiety (Becker et al., 2004). A more detailed consideration of a number of these negative beliefs about exposure appears below.

2.2.1 *Exposure Will Worsen a Patient's Symptoms*

Another undesirable outcome commonly attributed to exposure therapy is its perceived potential to worsen anxiety symptoms. This concern is sometimes voiced by therapists who believe that; for example, patients with PTSD will be "revictimized" by the process of reliving traumatic memories via imaginal exposure. Foa, Zoellner, Feeny, Hembree and Alvarez-Conrad (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 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 failure to improve. Thus, symptom exacerbation during exposure was uncommon, short-lived, 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. (2002) also support the practice of informing patients that exposure is likely to provoke temporary initial distress, but that this experience will eventually prove beneficial following repeated practice.

2.2.2 *Patients Will Drop-Out of Therapy*

Critics of exposure therapy often assume that such a presumably aversive treatment must result in unacceptably high drop-out rates in therapy. This assumption was tested by Hembree et al. (2003), who reviewed studies of prolonged exposure for PTSD (see chapter by Schönfeld & Hoyer in this volume), which is often considered the most difficult-to-tolerate application of exposure therapy. Combined results from 25 clinical trials yielded no significant differences in drop-out rates between prolonged exposure (20.6%), exposure combined with cognitive therapy or anxiety management (26.0%), and Eye Movement Desensitization and Reprocessing (18.9%). Hembree and Cahill (2007) noted that dropout rates for prolonged exposure for PTSD are comparable to those observed in exposure therapy with other anxiety disorders, and are lower than drop-out rates associated with psychotropic medications. Thus, the concern that exposure places patients at higher risk for attrition than other treatment approaches is not supported by the available evidence. The well-established efficacy and acceptability of exposure provides an object lesson in the resilience of anxious individuals, as well as a valuable counterpoint to the

perception that patients with anxiety disorders are fragile and unable to cope with the requirements of exposure therapy.

2.2.3 *Patients Will Not Like Exposure Therapy*

Some therapists assume that their patients will dislike exposure therapy, and will instead prefer to undergo treatment that does not entail the distress associated with having to directly confront feared stimuli. This negative perception of exposure appears to pervade public sentiment as well. A study by Richard and Gloster (2007) presented undergraduates and outpatients in a university-based psychotherapy clinic with a series of vignettes describing the application of exposure techniques for different anxiety problems. Some techniques (e.g., interoceptive exposure for panic attacks, exposure and response prevention for OCD, imaginal exposure for PTSD) were perceived as unlikely to be helpful, unacceptable, and even unethical. 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.

Fortunately, 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 credible, 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 et al., 2007). Moreover, exposure therapy is rated as at least as acceptable, ethical, and effective as cognitive therapy and relationship-oriented psychotherapy by undergraduate students and agoraphobic patients (Norton et al., 1983). Among patients completing exposure-based CBT for panic disorder, situational and interoceptive exposure are perceived as highly useful despite lower ratings for likeability (Cox, Fergus & Swinson, 1994). These findings suggest that therapist reservations about exposure therapy are not shared by most patients who receive this treatment. Why do therapists seem to overestimate the extent to which their patients will dislike exposure therapy? Richard and Gloster (2007) suggested that anxious 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.

2.2.4 *Therapists Might Get Sued if They Use Exposure Techniques*

Clinicians who believe exposure to be inhumane, intolerably aversive, or potentially dangerous may also worry about the legal risks associated with the use of these techniques. They might think it is unwise to leave the office to conduct exposures, and have concerns about the types of exposure tasks patients are asked to complete.

In the author's experience, some supervisors and administrators have voiced such concerns, and in some cases have enforced restrictive policies (e.g., prohibiting clinicians from leaving the clinic with their patients) to minimize perceived legal risks. These reservations are typically based on a misunderstanding of exposure, its efficacy, tolerability, and the manner in which it is ethically and competently conducted. It is useful to consider that exposure merely provokes anxiety, which is no different than what patients are already experiencing, and part of the body's natural defense mechanism (i.e., the *fight or flight* response). In other words, anxiety is not inherently dangerous to the vast majority of people, and those who might be harmed from provoking physiologic arousal (e.g., individuals with severe asthma) are not candidates for exposure (see chapter by Einsle and Neudeck in this volume). As such, this treatment would seem to pose little risk for practicing clinicians.

Richard and Gloster (2007) examined the legal risks associated with exposure therapy by searching the legal record for court cases involving this treatment. Their exhaustive search criteria did not reveal a single instance of litigation related to exposure. Similarly, none of the 84 members of the Anxiety Disorders Association of America surveyed by Richard and Gloster reported knowledge of any legal action or ethics complaints regarding exposure. This survey approach, however, cannot rule out the possibility that relevant complaints have been filed, but dismissed or settled out of court. Yet the available evidence suggests that exposure therapy is acceptably safe and tolerable, and that it carries little risk of actively harming patients (or their therapists).

2.3 Strategies for Minimizing Risk

When conducted properly, exposure therapy is an acceptably safe, tolerable, and effective treatment for anxiety disorders. However, exposure therapy inherently involves more risk than most psychological treatments, and 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?

2.3.1 Negotiating Informed Consent

Consistent with the ethical imperative to obtain informed consent in psychotherapy (e.g., APA, 2002) exposure therapists must obtain patient consent as soon as possible in treatment. Exposure may be somewhat unique among psychological treatments in that its very nature necessitates constant vigilance to the process of informed consent. Therapists must explain each new exposure practice to the patient, and the patient must agree to proceed before a given task is begun. Informed consent

is thus an ongoing process and patients may, and often do, negotiate or even revoke their consent during treatment sessions. Informed consent for a particular exposure task may be discussed at multiple points during therapy sessions. For example, consent for a situational exposure involving conversing with others in a shopping mall may be negotiated in the office while planning the exposure, in the mall prior to initiating conversations, and between conversations while negotiating the next exposure task. To increase the likelihood of patient adherence to anxiety-provoking procedures, treatment manuals (e.g., Abramowitz, Deacon & Whiteside, 2010) often place great emphasis on conveying a clear rationale for exposure and a detailed explanation of its requirements. Because of the unique demands it places on patients and therapists, exposure therapy is likely an exemplar among psychotherapies for satisfying the ethical principle of informed consent.

Informed consent also provides skeptical clinicians with an 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 et al. (1987), 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" (pp. 197–198). It should be obvious that when provided by a competent practitioner, exposure therapy does not constitute torture. 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 withdraw this consent at any time. Unlike torture, the patient controls the pace of exposure therapy and coercion is never used to force compliance with treatment.

2.3.2 Determining Acceptable Risk During Exposure Tasks

The probability of patients being harmed in exposure therapy can be reduced by understanding how to determine when a given exposure task entails an unacceptably high level of risk. In certain cases, tasks might be clearly contraindicated, such as intensive hyperventilation for a patient with severe asthma, walking through a dangerous area of town after dark for an assault survivor, and touching bathroom floors for a patient whose immune system is compromised. In the absence of clear-cut risks of harm, the following question may be asked 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 min. However, a trip to the local gym reveals many individuals who engage in this level of vigorous exercise without incident. Someone who has been violently mugged might rebuff the suggestion that she return to using public transportation, yet thousands of other city dwellers use such conveniences on a regular basis.

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, fail to wash their hands after using restrooms, and eat finger foods after touching the family pet. 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.

There is no absolute guarantee in exposure therapy, as with life in general, that unanticipated or unwanted outcomes will not occur. Bees sometimes sting. Repeated spinning in a swivel chair may elicit vomiting. 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. At the same time, it is unethical to conduct an exposure task that the therapist determines to involve an unacceptably high probability of an objectively negative outcome (e.g., serious illness, assault, loss of a valued relationship). Therapists cannot possibly anticipate all conceivable low-probability outcomes in any given situation. It is possible that exposure therapy could result in a claustrophobic patient being stuck in a cramped elevator for days, 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 exposure therapy. Indeed, one could argue that a primary goal of this treatment is to help patients learn to accept living their lives, and approaching feared situations, in the absence of such a guarantee. The remote possibility of catastrophe should no more preclude a driving exposure than it should prevent the therapist from driving to work.

2.3.3 *Time Management During Therapy Sessions*

Poor therapist time management during exposure therapy sessions may increase the risk for emotional harm to the patient. Specifically, patients whose high anxiety fails to habituate within the allotted session time during exposure therapy may experience demoralization and express doubts about their ability to benefit from the treatment. To prevent such an occurrence, therapists should schedule longer sessions

(e.g., 90–120 min) to account for individual variation in time to habituation. A recent patient whose anxiety took more than 3 h to habituate while holding a spider illustrates that even 2-h sessions may not allow sufficient time for all individuals to show habituation. Framing exposures as "behavioral experiments" designed to test specific anxious predictions may help patients view exposure tasks as useful, even if their anxiety does not habituate. In this context, the failure of habituation to occur may be viewed as a valuable learning experience (e.g., "I was able to tolerate prolonged, high anxiety without losing control or going crazy").

2.3.4 *Therapist Competency*

In addition to the strategies described above, risks can be effectively minimized during exposure therapy by ensuring that exposure therapists are adequately trained (or supervised) and deliver this treatment in a competent manner. Although exposure therapy may seem deceptively straightforward to administer, research indicates that optimal delivery of this treatment requires careful consideration of contexts and other factors that can influence the effectiveness of exposure-based treatment (Powers, Smits, Leyro & Otto, 2007). For example, the mere availability of safety aids (see part four of this volume) during exposure can be highly detrimental to treatment outcome, even if the safety aids are not used (Powers, Smits & Telch, 2004). Therapists interested in using exposure techniques should be adequately trained or supervised by a competent exposure therapist. Castro and Marx (2007) noted 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 indicates that, in addition to skill in implementing exposure methods, competency to conduct exposure therapy requires that therapists have the ability to tolerate the often intense emotional responses of their patients and their own reactions to such responses.

2.3.5 *Therapist Self-Care*

Exposure therapy may pose a risk to the therapist in the form of psychological distress. Such distress is especially likely when conducting imaginal exposure for PTSD, during which the therapist may listen to painfully detailed accounts of truly horrifying trauma narratives. Successfully navigating this demanding work requires exposure therapists to strike a balance between empathy for their patients' pain and maintaining professional distance that allows for therapeutic, professional responses (Foa & Rothbaum, 1998). This balance is difficult to maintain in some instances

as when trauma victims recount particularly terrible experiences during imaginal exposure. However, even the most compassionate therapist must remember that it is his or her job to assist the patient in recovery from clinical anxiety, and losing emotional control is incompatible with this goal. Indeed, patients may draw strength from the therapist's outward expressions of confidence in their ability to tolerate the distress associated with particularly difficult exposures. An important part of one's development as an exposure therapist involves learning to cope with and accept the emotional distress patient's exhibit during particularly challenging exposures. From time to time, unburdening oneself by talking to colleagues, or seeking distraction in the form of other professional or personal activities, is necessary to cope with the unique demands of exposure therapy.

2.4 Maintaining Ethical Boundaries

As described above, some therapists believe that exposure is unethical based on concerns about its aversiveness and presumed capacity to harm patients. However, another source of negative beliefs about the ethics of exposure may reflect concerns about this treatment's potential to create problematic boundary violations and dual relationships. For clinicians whose preferred brand of psychotherapy emphasizes therapist neutrality, passivity, and nondirectiveness, exposure may involve an uncomfortably high level of active engagement with the patient. The idea that such engagement might occur in the context of distinctly unconventional therapeutic activities, such as spinning in a swivel chair or touching objects in public restrooms, likely contributes an additional measure of discomfort. In addition, the practice of leaving the office to conduct exposures may be troubling for therapists who fear that doing so will fundamentally alter the professional nature of the therapeutic relationship. These issues are reviewed below in the context of ethical principles regarding boundaries, and strategies are offered for conducting exposure therapy in an optimally ethical manner.

A *boundary crossing* in psychotherapy refers to a deviation from the typical practice of traditional, strict forms of therapy (Zur, 2005). Therapists have traditionally been encouraged to maintain strict boundaries in order to create a therapeutic context that is in the patient's best interest. Examples of boundaries include time, place, touch, self-disclosure, gifts, and money (Barnett, Lazarus, Vasquez, Moorehead-Slaughter & Johnson, 2007). Among these, the practice of violating the "only in the office" boundary is particularly relevant to exposure therapy. Traditionally, psychotherapy has been conducted without the need to leave the office. Exposure therapy, however, sometimes requires that therapists leave the office with their patients to conduct exposures to feared stimuli that cannot easily be brought into in the office. As a result, exposure therapy for many patients involves at least occasional boundary crossings.

Boundary crossings in the form of out-of-the-office exposures carry the possibility of eroding the strict boundaries inherent in traditional notions of the therapist–patient relationship. Indeed, the conduct of exposure therapy outside the office walls

may increase the probability of less-formal interactions, some of which may not be strictly therapeutic. Interactions with patients outside the office have traditionally been considered unadvisable as they are seen as laying the groundwork for dual relationships, including sexual relationships with patients (Barnett et al., 2007). From this viewpoint, exposure field trips may be viewed as a step down a "slippery slope" that may lead to increasingly inappropriate behaviors and ultimately exploitative sexual encounters or other dual relationships. To discourage clinicians from traveling down this slippery slope, the "only in the office" rule has been proposed to ensure that clinicians provide treatment that is in the best interests of their patients (Smith & Fitzpatrick, 1995). Within the context of traditional forms of psychotherapy, the "only in the office" boundary is a logical prescription. However, rigid adherences to this traditional notion of boundaries severely restrict a clinician's ability to practice exposure therapy in an effective manner with many patients. Therapists overly concerned with the ethical "slippery slope" of leaving the office to conduct exposure tasks run the risk of engaging in reductio ad absurdum reasoning (i.e., "if I leave the office with an opposite-sex client, a sexual relationship will inevitably develop"). The effectiveness of exposure therapy provides a powerful demonstration that temporarily crossing boundaries for therapeutic purposes is not necessarily unethical or harmful (Lazarus, 1998). Indeed, the failure to do so may be considered unethical, or at the very least suboptimal, in the exposure-based treatment of some patients with anxiety disorders. 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, 2007).

Crossing some boundaries may be clinically appropriate and even necessary when conducting exposure therapy. Exposure is optimally effective when it is conducted in a therapist-assisted manner (Abramowitz, 1996) and when it occurs in a variety of contexts (Powers et al., 2007). For some patients, exposure outside the office is necessary to ensure that safety learning is not conditional on the presence of specific contexts (e.g., "heart palpitations are not dangerous *as long as I experience them in the hospital where emergency medical attention is available*"). When clinically indicated, exposure therapists may cross additional boundaries associated with traditional therapies by extending the length of sessions beyond 1 h, traveling to the patient's home, or involving strangers in the therapy (e.g., as audience members for a public speaking exposure). Such boundary crossings are not by themselves unethical, nor do they inevitably lead to an increasing series of inappropriate interactions with the patient that ultimately results in an exploitative sexual relationship.

The fact that boundary crossings are not necessarily unethical does not mean that they are always ethical. Likewise, the observation that boundary crossings do not necessarily continue down a slippery slope toward sexual exploitation does not mean that this never occurs. Boundary crossings should only occur when the therapist deems them necessary to assist the patient. If all therapeutic tasks can effectively be conducted inside the office, there is no need to conduct exposures elsewhere. Pope and Keith-Spiegel (2008) outlined a number of steps for practitioners to consider when contemplating a boundary crossing. The most relevant of these is for therapists to imagine the best possible outcome and the worst possible outcome

from crossing the boundary and from *not* crossing the boundary. This cost–benefit analysis may be used to determine the overall therapeutic value of engaging in a given boundary crossing during exposure therapy.

2.5 Conclusions

An informed risk–benefit analysis suggests that exposure therapy is generally safe and effective, and is rightfully considered a first-line treatment for anxiety disorders. However, relatively few therapists provide this treatment, and most individuals with anxiety disorders do not receive exposure-based treatment. This chapter reviews a number of negative therapist beliefs about exposure that serve to impede efforts to make this treatment more widely available to patients. Strategies for minimizing the unique risks and ethical challenges associated with exposure therapy are also discussed. It is concluded that therapist beliefs about the intolerable and inhumane nature of exposure therapy, as well as its presumed capacity to harm patients and foster unethical therapist–patient interactions, are not supported by the scientific evidence or the clinical experience of adequately trained exposure therapists. In fact, given well-established effectiveness of exposure therapy, there may be ethical consequences for failing to consider exposure therapy in favor of less effective or unsubstantiated treatments. This is not to say that this treatment is risk-free; indeed, exposure may place patients at greater risk of temporary emotional discomfort than do other forms of psychological treatment. However, by being aware of this possibility and taking steps to manage it, exposure therapists can significantly decrease the risk of harm to their patients while simultaneously providing the most effective psychological treatment available for pathological anxiety.

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Peter Neudeck · Hans-Ulrich Wittchen
Editors

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Editors
Peter Neudeck
Praxis für Verhaltenstherapie
Follerstr. 64
50676 Cologne
Germany

Hans-Ulrich Wittchen
Institut für Klinische Psychologie und
Psychotherapie
Technische Universität Dresden
Chemnitzer Str. 46
01187 Dresden
Germany

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