Chapter 10
Ethical Issues When Considering Exposure

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Exposure-based treatments are arguably among the most successful, efficacious psychological treatments for the anxiety disorders (Deacon and Abramowitz 2004). Unfortunately, despite decades of empirical support from clinical trials, the administration of these treatments in real-world clinical practice continues to lag considerably. Although there are a number of reasons for this gap between research and practice (e.g., lack of competently trained therapists, restrictions and insufficient resources in community clinics), misinformation about exposure-based treatments has emerged as a clear barrier and has led to a "public relations problem" for this effective treatment (Richard and Gloster 2007). The public relations problem is based on the erroneous beliefs that exposure treatment is cruel and unethical because it causes undue harm. The present chapter aims to address the ethical issues involved in considering and implementing exposure, including addressing whether exposure therapy causes harm, clinician competency, supervision and training, ethical issues surrounding public exposures, safety issues, disclosure during treatment planning, and the use of exposure therapy with children.

Is Exposure Therapy Harmful to Patients?

Despite the efficacy of exposure-based therapy, many practitioners of psychotherapy view exposure negatively (see Prochaska and Norcross 1999, for a discussion), presumably because exposing patients to feared stimuli evokes acute distress rather than mitigates it. However, it should be noted that mitigating anxiety is usually the end-result, both within sessions and across sessions. Beliefs about exposure among

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practitioners in the community include that it is insensitive to the needs of the patient; that its ends do not justify its means; that it does not work for complicated cases; that it does not work in real-world clinical settings; that it exacerbates symptoms; that it is done "to" a patient, rather than "with" them; and that patients may be better off continuing to experience clinically significant anxiety symptoms than undergoing exposure therapy (Feeny et al. 2003; Prochaska and Norcross 1999). Clearly, empirical evidence as well as clinical experience of trained and competent exposure therapists can refute many of these claims (Deacon and Abramowitz 2004). Still, these misperceptions persist.

The American Psychological Association's (APA) Ethics Code explicitly states that psychologists should "take care to do no harm" and "safeguard the welfare and rights" of their patients. Given that objections to exposure therapy are predicated on the ethical concerns about the safety, tolerability, and humaneness of the treatment, it is important to objectively consider whether exposure therapy does in fact cause harm. The safety and tolerability of exposure therapy may be determined by evaluating outcomes associated with this treatment including (a) attrition rates; (b) symptom exacerbation; (c) patient satisfaction and preferences; and (d) ethical complaints and litigation directed toward exposure therapists. A brief review of each of these domains follows.

With regard to attrition, despite popular belief, empirical evidence does not support the idea that exposure-based treatments experience higher dropout rates than in other forms of psychotherapy. In fact, a meta-analysis comparing cognitive-behavioral therapy (CBT), which involves exposure, to placebo treatments found no differences between groups in attrition (Hofmann and Smits 2008). Further, outcomes from 25 clinical trials of prolonged exposure for posttraumatic stress disorder (PTSD), which included imagined exposure to the traumatic event, yielded no differences in attrition across prolonged exposure, exposure with cognitive therapy or anxiety management, or Eye Movement Desensitization and Reprocessing (Hembree et al. 2003). In terms of symptom exacerbation, exposure does require initial increases in fear (presumably needed for fear extinction according to Foa and Kozak's (1986) emotional processing theory). However, this fear increase is temporary. Furthermore, research investigating the belief that exposure produces lasting exacerbation of symptoms found that symptom exacerbation for prolonged exposure treatment for PTSD was uncommon, temporary, and not prognostic (Foa et al. 2002).

Patient preference is an important indicator of tolerability of a treatment. Despite the reservations of some practitioners, patients generally view exposure treatment favorably, with anxiety patients viewing CBT as more acceptable and more likely to demonstrate long-term effectiveness compared to pharmacotherapy (Deacon and Abramowitz 2005; Norton et al. 1983). In addition, parents of anxious children also view exposure therapy favorably for their children. For example, Brown et al. 2007 found that parents seeking treatment for their child's anxiety rated CBT as more acceptable, believable, and effective in the short- and long-term relative to pharmacotherapy. Importantly, patients undergoing CBT for panic disorder perceived in vivo and interoceptive exposure as highly useful and "necessary" despite lower ratings for likeability (Cox et al. 1994), suggesting that patients are willing to tolerate

discomfort knowing that the treatment will be useful in helping them manage their anxiety. Finally, researchers attempting to shed light on whether therapists administering exposure have been accused of or convicted of causing harm to their patients as a result of exposure were unable to identify a single court case involving exposure therapy (Richard and Gloster 2007). However, legal risk may be posed when untrained or incompetent therapists attempt to conduct exposure therapy. Practitioners should be aware that, as with any treatment, their ethical obligation includes receiving appropriate training, supervision, and experience (APA 2002, 2.01). Thus, assuming therapists who deliver exposure treatment are competent to do so, there is no indication that this treatment poses ethical violations and/or legal risk.

Clinician Competency and Supervision/Training and Awareness of Behavioral Strategies to Augment Exposure Therapy

Despite claims by some practitioners that exposure is easy to deliver; *beneficial* exposure therapy that minimizes harm and is likely to yield the greatest effectiveness requires specialized training, expert supervision or consultation, and practice by competent therapists. Nuances within exposure therapy can make a significant difference with regard to patient experience and treatment efficacy. Experimental psychopathology research clearly demonstrates that there are certain mechanisms that underlie successful exposure therapy (see Bouton 2002). This body of research has identified parameters of exposure therapy that mitigate or augment the efficacy of exposure therapy. For example, training in multiple contexts (Mineka et al. 1999) and the fading of safety behaviors (Sloan and Telch 2002; Powers et al. 2004) augment the efficacy of exposure therapy. Safety behaviors are behaviors used to mitigate anxiety in the short-term, but actually serve to maintain anxiety, presumably by preventing threat disconfirmation. Safety behaviors for someone with a fear of heights, for example, may include avoiding the edge, holding tightly onto the railing, or looking straight ahead instead of looking down. An untrained clinician who is not accustomed to the challenging experience of evoking anxiety in a patient during a session may quickly suggest that the patient engage in safety behaviors in order to mitigate acute anxiety. However, a trained clinician would know that while the judicious use of safety behaviors early in exposure may make exposure more tolerable for some, treatment will be most successful if these behaviors are faded during treatment so that patients can learn that their safety does not depend on the use of the safety aide (Salkovskis et al. 1999). Further, recent evidence suggests that having clients engage in actions that directly oppose their natural threat tendencies (e.g., having a client with a fear of heights jog toward the edge of a balcony with a railing) enhances exposure therapy (Wolitzky and Telch 2009).

In addition, there is mounting evidence that traditional exposure therapy does not always generalize to untrained contexts and that training in multiple contexts is needed to prevent a return of fear (Craske et al. 2006). Thus, a competent exposure therapist may need to move sessions to different locations or use different stimuli

to enhance learning. For example, a patient with a spider phobia may need to be presented with different kinds of spiders, both indoors and outdoors. Further, tying exposure exercises directly to a client's perceived threats and appraisals of harm in a way that allows patients to test and disconfirm beliefs (i.e., cognitive augmentation strategies such as guided threat reappraisal) has been shown to increase the efficacy of exposure therapy (Kamphuis and Telch 2000). For example, a patient with PTSD who believes that imagining the traumatic event will lead to intolerable distress that will not subside and will impair all functioning for the rest of the day, may be encouraged to pay particular attention to whether that prediction comes true, both during and after the exposure. In this case, the patient may be asked to perform specific tasks such as going grocery shopping immediately after the exposure session to gather information that disconfirms beliefs that he or she is unable to function after thinking about the event.

Other Important Competencies

The aforementioned strategies highlight only a few ways in which a competent and knowledgeable therapist might conduct exposure therapy. These issues illustrate the complexities of designing appropriate exposures that serve to enhance threat disconfirmation and inhibitory learning. Therapist competence also includes a solid understanding of the philosophy and approach to exposure therapy itself, which should be conveyed throughout therapy. Presenting the treatment as a collaborative effort increases perceived control in the client, while also increasing the likelihood that this "team" effort will lead to more individualized treatment planning and fostering a therapeutic alliance. In addition, a competent therapist should be able to adequately and confidently present the rationale for treatment, which differs in many ways from what clients typically think of when they imagine what therapy will entail. This includes psychoeducation about anxiety and other emotional processes, training in self-monitoring (Cash and Hrabosky 2003), and an explanation in lay-terms about the basic process of exposure therapy and how repeated exposure to feared stimuli might work to decrease anxiety (e.g., Foa and Kozak's 1986 emotional processing theory; also see Craske et al. 2008 for perspective on inhibitory learning).

Therapists who fail to provide an empirically informed rationale may not necessarily increase risk from an ethical perspective, but certainly may have difficulty engaging the patient in confronting uncomfortable situations if the patient does not understand why he or she is being asked to do so. Further, a competent therapist should provide encouragement and support to patients in order to increase self-efficacy while they undergo exposure therapy, rather than being apologetic for "making them feel anxious" or showing significant concern about their anxiety. In other words, a competent exposure therapist acknowledges the courage it takes to undergo treatment while sending the message that gradual exposure to these feared stimuli is not harmful or dangerous. Finally, competent exposure therapists (and competent therapists in general) are sensitive to cultural issues that may result in

differing presentations and/or emotional responses during the exposure to the feared stimuli.

Supervision and Training

Ideally, a therapist conducting exposure therapy has received substantial supervised training, at either the predoctoral or postdoctoral level, by an expert in exposure therapy. This should include training in conducting appropriate behavioral, self-report, and diagnostic assessments, delivering psychoeducation, training clients to self-monitor their symptoms, creating a graduated fear hierarchy, implementing repeated exposure exercises both in and out of the office to a number of different stimuli and across a variety of clients with different clinical presentations, learning and implementing appropriate exposure augmentation strategies (e.g., cognitive strategies, fading safety behaviors), assigning appropriate home practice, identifying difficulties and challenges (e.g., homework noncompliance, inability to activate fear, mental distraction during exposure) and learning to address these, and importantly, learning to modify, adapt, and individualize exposure therapy to meet the needs of each client. Training may include watching live or video demonstrations by the supervisor or other experts in exposure therapy, as well as participating in role-plays. Supervisors may watch and critique live or video-taped exposure therapy sessions conducted by the trainee.

Failure to watch and critique exposure therapy sessions may have clear ethical implications for the supervisor. More specifically, supervisors may be liable for the harm done to patients by their supervisees. Thus, supervisors need to play a direct role in watching their novice therapists treat patients in order to provide corrective feedback. Failure to *be* observed by a supervisor when a therapist is learning to conduct exposure therapy may also result in poor training. This inadequate training experience could eventually lead to incompetent delivery of services when the therapist is treating patients with exposure-based strategies independently, posing an ethical risk for the new therapist as well.

Despite the overwhelming evidence for the efficacy of exposure therapy for the treatment of anxiety disorders, many graduate programs do not espouse evidence-based clinical training programs. Thus, many clinicians may finish their graduate work without this education and thus may need to seek it once they are professionals in the community. At the very least, in order to comply with APA code requiring that clinicians working outside of their area of competence seek consultation and training (APA 2002, 2.01), clinicians hoping to gain training in exposure therapy should identify a licensed professional with expertise in exposure treatment for anxiety disorders and should consult closely with this expert before and during exposure therapy until competence has been demonstrated. In addition, these clinicians should read the literature regarding exposure therapy efficacy and augmentation strategies, and gain didactic training through continuing education courses, conference workshops, and with their consultant if possible.

Safety Issues and Disclosure About Treatment Planning During Treatment

Exposure therapy is regarded as both a safe and tolerable treatment (Olatunji et al. 2009; Richard and Gloster 2007). However, exposure occasionally may place someone at minimally greater risk for distress and discomfort than sitting in a traditional therapy room (e.g., handling snakes, touching "contaminated" objects such as dirty sinks, leaning over the railing on a parking garage, vigorous hyperventilation). It is important to note that, when conducted properly, these exercises pose acceptably low levels of risk. For example, repeatedly inducing bodily sensations associated with fear (e.g., dizziness, heart racing) as seen in interoceptive exposure for panic disorder is not harmful, as these sensations are the same as those experienced during a "true alarm" when danger is present (Stewart and Watt 2008). Still, exposure therapists should be aware of ways in which to decrease the probability of harm. This can be accomplished through informed consent, naturalistic comparisons, and managing unexpected outcomes. For example, a patient with blood-injection-injury phobia undergoing exposure to needles may indeed faint. In this case, the therapist should calmly assess the patient's condition (e.g., take pulse, check orientation when the patient awakens) and provide support (e.g., validate feelings, give the client a glass of water or juice, have the patient lie down until ready to sit and then stand). While doing so, the therapist should normalize the experience and refrain from showing signs of anxiety or excessive concern, as this may send the wrong message to the patient that these situations are in fact dangerous, when they are not. Instead, the therapist should work toward building self-efficacy and encouraging the client to continue with the exposure. In fact, this experience could be reframed as a positive experience for the patient to evaluate the overestimation of the cost or severity of the outcome. Perhaps this patient thought fainting would be a horrible experience, and instead found out he or she could handle it and that it was not as bad as expected.

Informed Consent and Treatment Planning Disclosure

Informed consent is mandated by APA ethical code (APA 2002, 10.01) and is especially important when conducting exposure therapy. The process of informed consent during a course of exposure treatment is ongoing, and therapists should be constantly vigilant toward a patient's willingness and consent to undergo exposure treatment. Patients should always be informed of the nature and process of exposure therapy and should be highly involved in all aspects of decision-making about its use. Because of the collaborative nature of these decisions, such as deciding the order of exposure exercises on a fear hierarchy and choosing specific activities that will take place both in the session and as homework, the use of exposure demands ongoing consent. Each new exposure practice should be described and agreed upon in advance (e.g., Abramowitz 2006), with no "surprises" when a patient shows up to a session. Patients

may, and often do, negotiate or revoke consent, or change aspects of an exposure exercise immediately before or during the session. To increase the likelihood of patient adherence to anxiety-provoking procedures, therapists will often reiterate the treatment rationale, use Socratic questioning or other cognitive strategies to allow patients to come to their own realization that undergoing the planned exposure will ultimately reduce their fear in the long term, and provide encouragement and support in order to increase self-efficacy and willingness to comply without being coercive. For example, therapists might ask a reluctant patient "what do you think you could learn by going through with this exposure?" and "what do you think you would still need to know if you didn't do it?" As a result, exposure therapy engages a client in the process of informed consent more directly than traditional psychotherapy.

Naturalistic Comparisons and Exercising Caution

In most cases, a decision about whether an exposure will pose more than an acceptable level of risk can be made by asking oneself whether some people ordinarily confront the situation in the course of everyday life without adverse consequence. With regard to specific phobia, gardeners, hikers, and outdoors enthusiasts often encounter snakes, spiders, and other insects without harm; joggers often see dogs running around without leashes on; most people have been outside during a thunderstorm at some point; and many people even pay money to go to the top of a skyscraper to see the view from an observation point. Exposures for other anxiety disorders also have patients engage in activities that others typically do without harm (e.g., increasing physiological arousal is often observed at the gym or in sports; many people occasionally refrain from hand washing after touching the ground or using the bathroom, etc.). Thus, an exposure task should be considered to pose an acceptable level of risk if the patient is not at significantly greater risk of experiencing harm than other individuals who engage in similar activities in everyday life. Extending this approach to exposure therapy for PTSD is not without complications given that people ordinarily do not confront war-related trauma or sexual abuse/assault in the course of everyday life. Determination of an acceptable level of risk during exposure therapy for PTSD may require special consideration. For example, if a client is sexually assaulted in an alley at night in an unsafe neighborhood, it may not be appropriate to include an exposure where she returns to the same location. In this situation, an exposure in an alley at night in a safe neighborhood may be indicated.

In situations where an exposure may appear to pose somewhat of a greater than acceptable level of risk, a therapist should consider whether the exposure fits well with the overall case-conceptualization and treatment plan, and evaluate whether the benefits of the exposure (i.e., presumable fear reduction) will outweigh potential costs. For example, patients with emetophobia (i.e., fear of vomiting) may need to include induction of vomiting as a final step in an exposure hierarchy. Although this may appear to involve more than minimal risk, if a patient has an intense fear of vomiting and perhaps believes that something catastrophic will occur should he

or she vomit, it is possible that the case conceptualization warrants this in some instances and that a vomit induction exposure may be necessary to resolve symptoms, particularly in severe cases. Further, occasional vomiting (i.e., not repetitive as seen in some eating disorders), does not in fact entail added risk, as this often occurs naturally when someone has a stomach flu or eats something distasteful to them.

In contrast, special caution is warranted when there is a medical problem that may preclude the patient from safely engaging in an exposure exercise. For example, patients who are highly allergic to animal dander should not repeatedly pet animals; breathing through a straw to induce feelings of breathlessness is likely to be contraindicated for an individual with severe asthma; someone with a compromised immune system ought not to touch dirty toilets or garbage; and individuals severely allergic to bees and wasps should not be subjected to in vivo exposure given the risk. As most exposure therapists are not trained physicians, any patients with medical conditions that may put them at risk should be first assessed by a physician; the physician should be provided with a behavioral description of the activities that would ordinarily be implemented; and the physician should give medical clearance before beginning exposure therapy. However, it is important to balance the need for this medical clearance with the message to patients that, generally speaking, both the exercises and the anxiety they may induce are in and of themselves, harmless. If medical clearance is not granted, exposure therapy should not be conducted for clients with contraindications. Further, even when medical clearance is granted, the therapist should exercise judgment with regard to the nature and intensity of the exposures and make certain that only those exposure exercises most essential to the treatment of the individual's presenting problem are conducted; and only those for which clearance has been given. Conducting a thorough and careful intake assessment is important for gathering these types of information that will help to determine when medical clearance may be needed or what activities should not be performed.

Managing Unexpected Outcomes

Occasionally patients may have experiences during exposure that do not go according to plan. For example, a patient with a fear of public speaking may in fact lose train of his thoughts, stumble over his words, and have an audience member chuckle at his delivery; a patient with a fear of dogs may work her way up toward petting a large dog at an off-leash park to find that the dog jumps on her and knocks her over; and a patient may experience high levels of anxiety that are sustained throughout the entire exposure session. The way that a therapist frames these experiences can have a tremendous impact on the patient's beliefs and on treatment effectiveness. Although traditional exposure focuses on repeated exposure to the feared stimulus with the goal of within and between-session habituation (e.g., Foa and Kozak 1986), there are other ways to make successful use of exposure therapy, and research suggests that habituation may be sufficient but not necessary for reduction of anxiety (see Craske et al. 2008, for a review). Indeed, a review of the literature suggests that

neither the degree by which fear reduces nor the ending fear level reliably predict treatment outcome. More successful use of exposure therapy may require shifting the focus of treatment from immediate fear reduction toward fear toleration as a primary goal. This view would be consistent with the conceptualization of exposure therapy as the development of competing nonthreatening associations and enhancing the accessibility and retrievability of those associations in different contexts (Bouton 2002).

Setting up exposures as behavioral experiments designed to test a prediction (e.g., the likelihood that something will occur and/or the cost/severity of the outcome if it did occur) allows patients to focus on gathering threat disconfirming evidence. For example, the patient who stumbled over his words and heard a chuckle from the audience might learn that the cost of this experience was not nearly as bad as he expected, and that he was able to move on despite hearing someone laugh; the patient knocked over by the dog may learn that, even though she was knocked over, she did not sustain any injuries and was able to get back up and pet another dog right away. Designing exposures can focus directly on addressing the overestimation of likelihood (e.g., "The spider will bite me if I hold it"). In the highly unlikely event that the spider does bite the patient, this experience can be reframed by the therapist in order to allow the patient to see for his or herself that the experience of the bite was not as horrible as expected.

Explicitly designing exposures to test the cost of an outcome (i.e., addressing catastrophizing) occurring may have a particularly powerful effect and are likely to buffer any unexpected outcomes from other exposure exercises, as patients will likely engage in the spirit of these exposures throughout treatment. For example, giving niacin (following medical clearance) to a socially phobic patient with blushing concerns will produce a high likelihood that others will see the patient's face turn bright red. The test in this case will be for the patient to see whether the outcome is catastrophic. In addition, patients who become frustrated that their fear is not habituating during exposure sessions (another occasional unexpected challenge during exposure treatment) may still benefit from these sessions if it is relevant for them to learn that they could withstand anxiety without any harm, or that they could remain in a situation while anxious without any negative outcomes. Subsequent sessions in these cases may be extended for longer durations, depending on the need of the patient.

Ethical Issues During Public Exposures

Unique ethical issues arise in the context of exposure therapy compared to traditional forms of psychotherapy. Exposure therapy often includes "field trips" out of the office in order to set up exposure contexts to be as similar to real-life feared and/or avoided situations. For example, social phobia exposures may include going to high-traffic areas like the mall in order to do repeated exposures of approaching strangers or asking "stupid" questions to store employees; going up to the top of skyscrapers and on bridges in the cases of fear of heights; and in panic disorder, going into

crowds, on buses, or driving (when a panic disorder patient is afraid of driving for fear of having a panic attack). When relevant and appropriate, these excursions are an important part of a good course of exposure treatment for anxiety disorders, and are often done in-session as therapist-directed exposures and as self-directed homework. Experimental research has demonstrated that exposure in multiple contexts prevents a return of fear at follow-up (Craske et al. 2006; Mineka et al. 1999). To illustrate, a patient with a fear of dogs is likely to show the greatest generalization of treatment effects when exposure takes place in a variety of real-world contexts such as at dog parks or jogging trails, as opposed to only encountering dogs in the controlled setting of a therapy office.

Taking therapy outside of the office is a unique aspect of exposure therapy that may raise concerns about boundary issues for the novice exposure therapist, particularly one who has been trained in more traditional forms of psychotherapy. Boundary crossings are deviations from traditional forms of therapy (Zur 2005). Although many boundaries have the potential to be crossed in any form of therapy (e.g., self-disclosure, touch, money, gifts), the boundary of "place" (i.e., where therapy is conducted) is most relevant for exposure therapists. Interactions with patients outside of the office have typically been viewed as grounds for dual-relationships given that these relationships run the risk of developing into overly personal and even sexual relationships (Barnett et al. 2007). In other words, avoiding contact with patients outside of the office is viewed as a risk-management strategy in order to avoid a "slippery slope" leading to inappropriate contact (Gabbard 1994). However, it is important to make the distinction between boundary *crossings*, which may deviate from traditional forms of therapy but are not unethical (Pope and Keith-Spiegel 2008) and harmful boundary *violations* which consist of unethical acts such as creating exploitative dual relationships with patients.

Exposure therapy may present temporary boundary crossings, and it is widely accepted that boundaries may be crossed without doing harm (e.g., Lazarus 1998). Certainly the conduct of exposure therapy outside of the therapy office could increase the probability that patients and therapists will engage in informal interactions or chatting about topics that are not relevant to therapy (such as on the way to a site for exposure or during breaks between trials). In addition, driving in the car with a patient who has a fear of driving, going into stores and restaurants with patients while doing exposures to approaching strangers, conducting a home-based exposure session with someone afraid of touching anything in the bathroom or kitchen, flying in a plane with someone who has a fear of flying, or visiting the site of a traumatic event with a PTSD patient all present boundary crossings. However, it is important to note that boundary crossings do not necessarily lead to boundary violations (e.g., Zur 2001). Rather, these excursions outside of the office not only are often the most powerful sessions in producing change in symptoms, but may increase rapport and the therapeutic alliance. Further, research showing that therapist-directed exposure results in more improvement than self-directed exposure (Abramowitz 1996; Öst et al. 1998) suggests that despite the importance of self-directed homework between sessions, in-session, therapist-directed exposure will yield the greatest improvement in anxiety symptoms.

Exposure therapists should be particularly sensitive to the issue of confidentiality in conducting exposures. Maintaining confidentiality is a core ethical responsibility outlined in the APA ethical code. When conducting exposure sessions outside of the private office walls, the potential for others to become aware of the patient–therapist relationship increases. This concern is especially true in small communities (Harris 2002). Concerns about confidentiality should be discussed before beginning any public exposures. If patients are concerned about maintaining confidentiality, therapists can take steps to de-identify themselves as health professionals. In addition, depending on the nature of the exposure, therapists can keep a close distance from the patient. For example, a patient who is afraid of riding public transportation may sit in a different row on the bus than the therapist, and the patient and therapist can predetermine the stop in which they will get off the bus and discuss the next step. Clinicians should also refrain from actions in public that draw attention to the nature of the relationship (e.g., discussing therapy issues loudly or recording subjective units of distress scale [SUDS] in public). Further, the patient and the therapist may choose to plan how they each will respond in the event that either of them runs into an acquaintance during the exposure session in order to maintain confidentiality. This may be particularly relevant on college campuses or in rural or suburban communities.

Despite the advantages of conducting exposure sessions in naturalistic settings, it is important to use this deviation from traditional, in-office therapy only when needed. For example, treatment planning sessions or sessions focusing exclusively on cognitive restructuring should remain in the office. Importantly, as discussed above, ongoing consent is essential and it is important to get the patient's approval to do out-of-the-office exposures. Practitioners should ensure that (a) the decision to leave the office is appropriate and consensual; (b) the context for the exposure is relevant to the fear; and that (c) the benefits of entering the situation (e.g., maximizing treatment outcome) outweigh any potential costs. This cost-benefit analysis has been proposed as a strategy for considering boundary crossings in therapy (Pope and Keith-Spiegel 2008). Finally, therapists should exercise judgment with regard to casual interactions. Outside of the office it is important to maintain the same level of professionalism. However, rigidly adhering to strict boundaries in real-world contexts with patients may actually have negative consequences (Lazarus 1994, 2007). Thus, relaxing these boundaries may have a positive impact on rapport, trust, and the collaborative relationship.

Conducting Exposure Therapy with Children

Many of the same ethical issues described above remain relevant, if not more so, when conducting exposure therapy with children. However, additional issues may arise that should also be addressed. First, as with any therapy, parents must consent to their child's treatment, and should be made aware of the specific treatment strategies that will be employed, including the potential for in-session and out of session exposures.

Parental consent should be an ongoing process, and parents should always be part of the decision-making process. Asking parents to transport their children to the sites of these out of office exposures is an important risk mitigating strategy. Second, children should provide assent for exposure treatment and should be educated in developmentally appropriate ways about exposure therapy. As with adults, children should work collaboratively with their therapists to develop a fear hierarchy and should always be informed about (and agree with) what they will be doing in the next session. Third, particularly when working with adolescents, a discussion of what kind of information will be shared with parents should occur, ideally in the first session. Fourth, when conducting exposures, particularly those out of the office, clinicians are encouraged to use their judgment regarding the presence of parents. Just like adults, children can safely engage in exposure treatment without their parents even when exposure is not conducted in the office, and this usually is in the best interests of the children and the family. Education about safety aids and about the potential for parents to interfere with the exposure protocol, as well as validating parents' concerns about leaving their child anxious with someone else may provide parents with the information they need to feel comfortable letting their children engage in exposure without their presence.

Conclusions

This chapter has attempted to shed light on the ethical issues that surround exposure-based treatments. Although empirical evidence demonstrates clear benefits of exposure therapy, misconceptions and misinformation has led to public and professional concerns that this treatment is harmful to patients. However, the information that this chapter has presented provides considerable evidence that exposure therapy is effective, safe, tolerable, and bears minimal risk of harm to patients. In addition, although some practitioners believe that the risk of temporary emotional discomfort often present in exposure therapy places patients at greater risk than other psychological treatments, simply taking the issues of danger and risk into consideration when conducting exposure can significantly decrease this probability of harm.

Although exposure-based treatments are among the most efficacious psychological treatments for anxiety disorders (Deacon and Abramowitz 2004), success is only possible with experienced, trained, and competent therapists. Competent practitioners with the appropriate training are able to maintain the proper boundaries while also presenting real-world opportunities to confront patients' fears. Exposure to stimuli in a real-world contexts has been shown to be highly effective for a wide range of psychiatric disorders, anxiety disorders included (Richard and Gloster 2007). However, legal risks may be increased when untrained or incompetent therapists attempt to conduct exposure therapy by increasing the probability of inappropriate, unethical, and potentially harmful boundary violations. Thus, while exposure treatments can be extremely successful and should be implemented whenever possible, practitioners

should be conscious of their ethical (and legal) obligations to receive appropriate training, supervision, and experience before administering treatment.

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