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Ethical Considerations in Exposure Therapy With Children

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Despite the abundance of research that supports the efficacy of exposure therapy for childhood anxiety disorders and OCD, negative views and myths about the harmfulness of this treatment are prevalent. These beliefs contribute to the underutilization of this treatment and less robust effectiveness in community settings compared to randomized clinical trials. Although research confirms that exposure therapy is efficacious, safe, tolerable, and bears minimal risk when implemented correctly, there are unique ethical considerations in exposure therapy, especially with children. Developing ethical parameters around exposure therapy for youth is an important and highly relevant area that may assist with the effective generalization of these principles. The current paper reviews ethical issues and considerations relevant to exposure therapy for children and provides suggestions for the ethical use of this treatment.

Exposure-based cognitive behavioral therapy (CBT) has been established as the evidence-based psychosocial treatment of choice for anxiety disorders and obsessive-compulsive disorder (OCD) in children and adolescents (Silverman, Pina, & Viswesvaran, 2008). Over 40 randomized clinical trials support the efficacy of CBT for anxious youth and demonstrate that about two-thirds of anxious youth do not meet criteria for their primary anxiety disorder after treatment (Seligman & Ollendick, 2011). Several CBT manuals have been developed to specifically outline treatment procedures for anxious youth, although the core components are similar. Exposure to feared stimuli is arguably the key ingredient of treatment (Silverman et al., 2008).

Despite the abundance of research that supports the efficacy of exposure-based treatments, many therapists hold negative views about exposure therapy or are hesitant to implement the treatment due to their beliefs regarding its ethicality. The need to evoke distress in the client in order for new learning to take place may appear to contradict a clinician's ethical mandate to do no harm and the hope to ameliorate a client's distress (Gunter & Whittal, 2010; Olatunji, Deacon & Abramowitz, 2009). Indeed, research has found that many therapists fear damaging their clients with these procedures (Rosqvist, 2005), especially clients who meet various exclusion criteria for randomized clinical trials, including severe suicidality, psychotic disorders, or any other comorbid diagnosis (Becker, Zayfert, & Anderson, 2004). Deacon, Farrell, and colleagues (2013) found in a sample of over 600 therapists that the average clinician has a moderate degree of negative beliefs about exposure therapy. Surprisingly, even self-reported exposure therapists harbor these negative beliefs (Deacon, Farrell, et al., 2013; Deacon, Lickel, Farrell, Kemp, & Hipol, 2013; Richard & Gloster, 2007). Several myths about exposure therapy are prevalent, including beliefs that exposure therapy leads to high attrition rates and symptom exacerbation (Olantunji et al., 2009) and that exposures do not generalize to the real world (Feeny, Hembree, & Zoellner, 2003). Thus, despite its established effectiveness, many therapists believe that exposure therapy transmits an unacceptably high level of risk.

Given the seemingly contradictory nature of exposure therapy, as well as the out-of-office work often required, there are unique ethical considerations in conducting this treatment. Exposure therapy with children provides an added layer of ethical consideration due to the vulnerability of this population, the fact that they often are not self-referred for treatment, and the possibility that they may not understand the rationale of treatment. In addition, exposure therapy with children requires work with the entire family, who can possibly play a role in limiting treatment effectiveness or maintaining anxiety.

Keywords: anxiety; children; exposure therapy; cognitive-behavioral therapy; ethics

Table 1
Ethical Challenges and Recommendations in Exposure Therapy With Children

Ethical Standards	Potential Challenges	Recommendations
Informed Consent and Assent	Exposure therapy may be viewed as harmful, unsafe, or ineffective.	Provide comprehensive information about treatment research, benefits and "side effects," and rationale, describe parents' role.
	Children may not fully understand treatment and rationale.	Describe specific steps in treatment and rational in age-appropriate terms. Use child-friendly and personable analogies.
	Children may be unwilling to engage in exposure therapy.	Empathize with difficulty of exposures. Frame the exposures as hypotheses or suggest a "trial run." Emphasize treatment is at the client's pace. Use motivational interviewing strategies, values work, or work with parents in reducing accommodations.
Competence	Not challenging the client enough.	Examine own beliefs about exposure and what it means for a client to be anxious. Discuss in supervision.
	Not thinking through the logistics or potential pitfalls	Think through the potential obstacles and pitfalls before conducting an exposure and discuss with client or family
	Conducting too challenging of an exposure too early on.	Create anchors for SUDS. Take a calm and accepting approach when an exposure was not successful. Take ownership when not successful.
	A therapist may not be able to be emotionally tolerant to the client's anxiety or may share the same fear of the client.	Determine whether you possess the emotional tolerance to do this work. Keep in mind value of exposure and rationale. Use supervision to discuss discomfort. Conduct exposures to fear.
Beneficence and Nonmaleficence	Minimize risk of exposure therapy and maximize the benefit.	Collaboratively create exposures, chose the next exposure, and agree on specifics of exposure. Think through potential obstacles. Help client understand that there are no guarantees. Anticipate that exposures may not go as planned, emphasize goal of being able to tolerate anxiety. First exposure should be challenging but feasible. Modify exposures that were unsuccessful. Create "above and beyond" top of the hierarchy exposures that fully target core fear but are not truly harmful or unsafe. Consult with colleagues, poll others, consult with other professionals, discuss with family to determine appropriateness of exposure.
Confidentiality	Out-of-office exposures increase risk of confidentiality breaches.	Discuss concerns with client and family before engaging in exposure. Remind clients that they have a right to refuse out-of-office exposures. Takes steps to de-indentify self, such as removing badges, coats, and ties, avoid visibly recording SUDS. Develop a cover story. Conducting the exposure in another neighborhood or a time when there is less likely to be people around.
Boundaries	Boundaries may be more easily blurred when conducting exposure therapy.	Remember that casual conversations and settings outside of the office may be necessary or appropriate in an exposure. Address this issue during consent. Gain approval from parents for all steps in exposure. Consider a cost-benefit analysis when a boundary is informed crossed. Take a neutral stance when asked personal questions by children.

The inaccurate beliefs about exposure therapy and inherent ethical considerations contribute to underutilization of this treatment and to outcomes that are less robust than those in randomized clinical trials (Southam-Gerow et al., 2010). Offering ethical guidelines in the context of exposure therapy can improve the delivery of treatment, clients' experience with exposure therapy, and therapists' comfort and professionalism with treatment. The current paper offers suggestions for practical implementation of exposure therapy with children. Unique ethical issues within exposure therapy with children will be reviewed relative to the standards and principles of the American Psychological Association (APA) Code of Ethics (2010). Specifically, the following issues will be discussed: informed consent; competence; beneficence and nonmaleficence; confidentiality; and boundary setting. Refer to Table 1 for a summary of ethical challanges and recommendations.

Informed Consent and Assent

Psychologists are required to obtain informed consent from clients using language they can understand, and to obtain consent as soon as possible in treatment (APA, 2010). Informed consent is an integral part of exposure therapy. The informed consent process is instrumental in ensuring that the treatment approach, rationale, and ethical considerations are understood by the client and family at the start of treatment. The informed consent process is also consistent with "collaborative empiricism," the process of the therapist and client working together to establish common goals, which has been found to be one of the primary change agents in cognitive-behavioral therapy (Dattilio & Hanna, 2012). A thorough discussion about the treatment and what it entails increases treatment effectiveness, improves cooperation and trust in the therapist, and provides an opportunity for the client to direct next steps in treatment.

There are unique ethical considerations regarding informed consent in therapy with children. State statutes vary regarding the legal age of consent, which ranges from 12 to 16 years of age. The APA Code of Ethics requires that, for "persons who are legally incapable of giving informed consent," such as children, psychologists seek the individual's assent and "obtain appropriate permission from a legally authorized person" (APA, 2010). Thus, while parents legally consent to their child's therapy, the child must assent to take part in treatment. A growing body of research now supports the belief that minors are able to make well-informed decisions and understand possible benefits and consequences, although practitioners should not assume all children are capable of making treatment decisions (Henkelman & Everall, 2001). It may be particularly difficult for children, especially young children, to fully understand what exposure therapy entails and the rationale for treatment. In addition, since children are socialized to obey adults, they may have difficulty refusing an adult's request. In order to increase understanding and the likelihood of adherence to treatment, it is important to make sure the child is an active participant in the informed consent process. This requires describing the specific steps and requirements of treatment and the rationale in age-appropriate terms, assessing the child's understanding of the information shared, and encouraging and answering questions. Child-friendly analogies are often used to help the child understand the treatment and rationale, examples of which are described throughout this section.

The therapist should be sure to provide clear and accurate information on what treatment entails, the research and the potential benefits and "side effects" of exposure therapy, as well as alternative treatment options. Specifically, the family should be informed that the child will likely experience an increase in anxiety during treatment. However, by facing anxiety-provoking situations, the child will improve the ability to tolerate anxiety and eventually be able to do what previously was avoided, so that anxiety is no longer in control of him or her. A helpful analogy to describe improving the ability to tolerate anxiety is to compare it to jumping into a cold pool and eventually feeling warm as your body acclimates. The therapist should also describe that anxiety-provoking situations will be faced gradually, just like learning to swim by starting at the shallow end and gradually moving to the deep end as one becomes a better swimmer and feels more comfortable. It is important to convey that treatment necessitates working out of the client's own comfort zone; otherwise, the child will not progress in treatment.

While informed consent and assent are typically obtained at the beginning of treatment, the discussion of consent and assent should be continually revisited. A child may negotiate or revoke his or her assent with regard to a specific exposure. In that case, the therapist should work with the client in order to modify the exposure to one in which he or she is willing to participate. The therapist should inform the client and family during the first session of their right to terminate treatment at any time. The potential risks to confidentiality should also be explained during the initial informed consent process and throughout therapy. This issue is explored further in the subsequent section on confidentiality.

As part of the discussion on the components of treatment, the therapist should explain the amount of out-of-session work required and the significance of homework completion to treatment outcome. A helpful analogy is to compare treatment to learning to play an instrument or playing a sport, particularly one in which the child is involved in, to demonstrate the benefits of regular practice between lessons or games in order to gain proficiency. The client and family should understand at the start of treatment that homework

compliance is integral to the success of the therapy, and that the more work they accomplish between sessions, the faster they likely will be able to successfully complete treatment.

Next, boundaries and expectations should be discussed with parents regarding their role in therapy. Parents can be great supporters for their children and aid in their therapy; however, they also often unintentionally maintain their child's anxiety. Parents should be taught to provide encouragement and support for their child during and between exposures. They also should be aware of behaviors that may be accommodating anxiety and unintentionally reinforcing anxiety, such as allowing the child to avoid places and things that cause anxiety, or participating in the child's rituals. For instance, one of the authors worked with a parent who allowed her child to miss softball lessons when another child she regarded as "mean" was attending. Although the parent believed she was acting in her child's best interest, she was in fact reinforcing and maintaining anxiety by allowing avoidance. Of course, avoidance can be helpful at times to prevent likely negative outcomes. For instance, if the child has bullied the client, it may be warranted to avoid the child in unsupervised situations in order to ensure her safety. Another example is a request from a parent that their child take tests in a separate room due to test anxiety. If the anxiety significantly affects the child's ability to demonstrate his or her knowledge, allowing for these accommodations may be helpful in the short term. However, these avoidant behaviors ultimately should be targets for intervention and eventually decreased.

Furthermore, parents should be taught how to balance maintaining an empathic, supportive approach towards anxiety, while also maintaining appropriate expectations for their child's behaviors. Often parents of children with anxiety disorders provide more accommodations than they would for a child without anxiety. Parents can be taught to convey that children have certain responsibilities, such as going to school and doing their chores, for which they should still be held responsible; thus, they should either be meeting these responsibilities or actively working on them in treatment. Parents should be discouraged from tolerating behaviors that would be unacceptable from a child without an anxiety disorder.

On the other hand, parents should be warned to refrain from being "OCD or anxiety police" who "catch" their children engaging in avoidance or rituals. They should also be discouraged from deciding on exposures for their child, surprising their child with an exposure, or pushing their child to do something they are not ready to do. For instance, "contaminating" a child's bedroom without telling the child or agreeing upon the exposure first might lead to intense, intolerable anxiety, increased rituals and avoidance, and a setback in treatment. Instead, parents should act as cheerleaders and encourage and support their child in conducting exposure homework, resisting rituals, and facing anxiety in daily life instead of avoiding. They should focus on praising compliance with homework and attempts to face anxiety or resist rituals. Parents should be discouraged from punishing or shaming their child for engaging in avoidance and rituals, or for not succeeding in an exposure exercise.

Motivation for Treatment

Even with a clear understanding of the rationale for treatment, many clients will still be hesitant or unwilling to engage in exposures. This is often the case in exposure therapy, as avoidance of anxiety-provoking situations is a hallmark of anxiety disorders. Indeed, the therapist should be sure to empathize with how difficult exposure therapy can be and how much work is often required. To increase a child's motivation, the therapist can frame exposures as experiments. The therapist can explain to the child that they will treat the worries or obsessions as hypotheses to test. It has been helpful for several of the authors and their colleagues to ask unwilling clients to attempt a "trial run," in which the client can test out the treatment and then "hire" or "fire" the therapist after three sessions. Essentially, there should be an emphasis on client control. The client should be informed that the treatment would be collaborative, with the therapist acting as a coach who provides guidance and encourages the client to engage in exposures that they believe are beneficial and appropriate. However, the client should not feel forced to engage in an exposure exercise. Clients should be reassured that they would never be made to do something that they do not want to do. The client is always the one who ultimately decides when he or she is ready to do an exposure task.

Motivational interviewing principles or a discussion about values can help to increase adherence and willingness to engage in treatment. The therapist can help clients identify what they are not able to do or missing out on due to their anxiety disorder. Clients can be asked to identify their values and goals and determine whether and how anxiety is getting in the way of living in line with those values or reaching those goals. Sometimes, it is the case that the child perceives that his or her life is not negatively affected by the disorder because parents are overly accommodating the anxiety. The therapist may want to work with parents in gradually reducing their accommodations so that the burden of anxiety-related interference is slowly transitioned from the parents to the child, which may lead the child to be more motivated to engage in treatment.

Competence

The competency standard of the Ethics Code states that psychologists provide services with the clinical population and regarding areas that are within the boundaries of their competence based on their education, experience, or

consultation (APA, 2010). Exposure therapy, while simple in theory, can be complex in application. There are many nuances of the treatment that can lead untrained therapists to provide ineffective or even iatrogenic therapy, such as knowing when to move up the hierarchy of feared stimuli, noticing subtle OCD rituals or anxiety-related safety behaviors, or discerning when reassurance is harmful or helpful.

Specifically, it is common for novice exposure therapists not to challenge the client enough during exposures or overuse distraction and comfort, often because the therapist feels uncomfortable causing the client to feel anxiety. The fourth author described an example early in training in which she was looking at a bathing suit catalog with an adolescent client with sexual obsessions. The author noted the client's visible anxiety and attempted to ease the client during the exposure by making comments about the style of bikinis. In hindsight, she recognized that the client was likely distracted by these comments, and she should have pushed the client to focus on the content of the obsessions. Therapists are encouraged to examine their own beliefs about exposure therapy and what it means for clients to be anxious, particularly with a supervisor who is experienced with exposure therapy.

Another common pitfall is not carefully considering the logistics or potential obstacles of an exposure. For instance, the second author described an example from early on in her training in which she had a client conduct a scavenger hunt in the clinic. The child could not figure out how to get the elevator to work once he was inside of it, and the author heard him anxiously crying without being able to communicate with him.

In addition, conducting overly challenging exposures early in treatment is another common pitfall. An exposure that is too challenging is one that elicits so much anxiety that the client escapes or avoids the exposure, or engages in compulsions or other safety behaviors, rather than successfully enduring the anxiety. Therapists can avoid this by creating accurate anchors for rating exposures using a SUDS scale (Subjective Units of Distress) at the start of treatment, and reevaluating the ratings as needed. Therapists should also thoroughly discuss all significant aspects of exposures with the client before beginning. If an exposure is unsuccessful or more challenging than expected, the therapist is suggested to take a calm and accepting approach. For instance, if a client has a panic attack during an exposure, the therapist can remind the client (and themselves!) that panic attacks are not harmful, that there were no consequences besides experiencing panic, and that the exposure was an opportunity to learn. If a client vomits during an exposure, the therapist can provide a bag and empathy, without overreacting, to avoid inadvertently sending the message that vomiting is dangerous. The therapist should take ownership of his or her role when exposures do not go as planned, frame it as a learning experience, and modify the exposure to attempt again (i.e., "It looks like I underestimated how difficult that one would be for you. I'm sorry. But you were able to handle that and you did it! Now we have a better sense of your anxiety. If that one seemed too difficult for you, will you be willing to try something easier?").

In general, it is suggested that therapists have a solid understanding of the rationale and principles of exposure therapy through adequate training, and should have experience in using the treatment or be supervised by an experienced exposure therapist. Supervision is especially valuable in identifying and preventing pitfalls, creating competent exposures, and processing obstacles and difficulties.

Furthermore, the standard of competency includes not only intellectual competence but emotional competence as well. Emotional competence refers to the therapist's ability to emotionally endure the material present in treatment, use self-care in the context of difficult work, and detect personal biases that may affect their work (Pope & Brown, 1996). Most therapists cannot or should not work with all types of clients and problems, and being able to recognize that a population is outside one's area of competency demonstrates ethically sound practice rather than weakness. The clinician conducting exposure therapy must determine whether he or she possesses the emotional tolerance for exposure therapy, or must develop his or her own emotional tolerance for the work (Olatunji et al., 2009). An effective exposure will and should cause anxiety, and a client's increased or even intense emotional responses can be experienced by the clinician as secondary distress. This is especially relevant when working with children, as it may be particularly difficult to see children upset. In addition, as children often do not initiate treatment or may not fully understand what treatment entails and the rationale behind it, therapists might have even more difficulty experiencing the client's distress. Therapists need to feel comfortable with—or develop a tolerance for—the possibility of their clients experiencing high levels of anxiety and expressing their emotions intensely. Keeping in mind the value of exposures and the rationale of treatment can help therapists to cope with this discomfort. Supervision can be very beneficial in processing this distress and developing this mindset. If therapists find that their vicarious emotional reactions are overly distressing or interfere with their ability to perform as a therapist, they should take appropriate measures, such as obtaining consultation, supervision, or personal therapy. They may want to determine whether they should refer the client to another clinician and if they should temporarily or permanently refrain from exposure therapy.

Likewise, therapists must determine that they themselves are comfortable with the exposure indicated. If the

therapist also fears the client's feared situation or stimuli, or if the therapist would not do the clinically indicated exposure him- or herself, the therapist should either engage in self-exposures before beginning with the client, or refer the client to another clinician (Meichenbaum, 1971). For example, when conducting an exposure with an adolescent boy fearful of cockroaches, the second author spent some time first orienting herself to holding cockroaches. If she did not first conduct a self-exposure, her anxiety may have inadvertently reinforced the child's belief that cockroaches are dangerous. The therapist then shared her experience with the client, so that the client could model how the therapist coped with the fear. Modeling done by someone who is coping with anxiety is often more powerful than modeling done by someone who is already competent in an anxiety-provoking task because the child can more closely align with a model who is having a similar experience (Kendall, Kane, Howard, & Siqueland, 1990).

Beneficence and Nonmaleficence

According to the Ethics Code's principles of beneficence and nonmaleficence, psychologists should strive to benefit their clients, take care to do no harm, and seek to safeguard the welfare and rights of clients and others with whom they interact professionally. In addition, Standard 3.04 states that therapists should "take reasonable steps to avoid harming their clients and to minimize harm when it is foreseeable and unavoidable" (APA, 2010). As reviewed, public objections to exposure therapy mainly concern the safety, tolerability, and humaneness of the treatment. Although there is some risk inherent in any psychological intervention, contrary to popular belief, there is no evidence suggesting there is more harm inherent in planned exposures than there is in any other psychological intervention. Exposures do not cause harm, but rather set up situations in which the client fears that harm will occur. As with all treatments, however, there are steps a therapist can take to minimize the risk and maximize the benefit of exposure therapy.

In line with manualized protocols of exposure therapy for various anxiety disorders, therapists and clients should collaboratively create hierarchy items, choose the next exposure to be conducted, and agree on the specifics of the exposure before proceeding, including the goals, where it will be done, how it will be done, and when and how long exposures will take place. Therapists should take reasonable steps to minimize the risks of the particular exposure, including choosing known stimuli and situations over unknown and considering all potential outcomes and risks before deciding on an exposure. They should also help the client understand that, as in life, there are no guarantees of safety or otherwise in exposures. Olatunji et al. (2009, p. 176) explain that risks can be minimized by anticipating the possibility that exposures may not go as planned and framing exposures as a test of "probabilities, predictions and costs." Furthermore, therapists may wish to consider extended sessions for clients who need extra time to process an exposure (Tiwari, Kendall, Hoff, Harrison, & Fizur, 2013). Nevertheless, they should discuss habituation as an outcome that is possible but not definite, and should instead emphasize the goals of being able to tolerate the anxiety and testing specific anxious predictions while improving functioning (Craske et al., 2008).

The first exposure conducted should be one that both the therapist and client agree will likely guarantee success. Success can be defined as any step towards facing anxiety, including eliminating or decreasing a safety behavior, approaching a situation that was previously difficult, or tolerating anxiety in a situation instead of escaping. The first exposure should be something that the client is not already doing, but is confident they can do with some anxiety. Therapists should aim for exposures at any point in treatment that are challenging but feasible. Conducting exposures that are either too easy or too challenging for the client has the potential to cause the client to believe that CBT is ineffective. If a client expresses resistance to the agreed-upon exposure, therapists should use clinical judgment to decide if the exposure might elicit so much anxiety that they may escape the exposure or engage in compulsions or safety behaviors. In this case, the therapist should encourage the client or adapt the exposure with the client as appropriate. If an attempted exposure does lead to avoidance, therapists should then attempt to modify the exposure with the client to make it easier, yet still challenging. This allows the client to still experience the benefits of exposure and reduces the risk of dropout.

There are additional benefits when hierarchy items reflect natural developmental milestones for children and adolescents. For instance, encouraging a child with separation anxiety to attend a sleepover, or encouraging an adolescent who sleeps in his parents' bed to sleep in his own bed, can have huge potential for helping children reach important developmental milestones. Furthermore, children might be more likely to comply with exposures if they are able to see direct relevance to personal or developmental goals.

To achieve and sustain optimal progress, the exposures at the top of the hierarchy should go above what is typically done intentionally, and fully target the core fear, without going too far. Examples of "above and beyond" exposures include singing a song in public to treat social phobia, or eating off of the bathroom floor to target contamination OCD. Exposures that are above what the client normally will face in daily life reduces the chance of relapse by removing the possibility that the client will attribute the lack of harm to avoidance of their biggest fears (Gillihan, Williams, Malcoun, Yadin, & Foa, 2012). They also prepare

clients for any situation related to the fear they might encounter. A colleague of the authors often presents a baseball metaphor to clients to highlight this concept: Baseball players practice hitting balls using a heavier bat than they will use in a game, so that when they are batting in a game, the challenge seems easy in comparison. For instance, if a client is afraid of spiders such that he refuses to go to any grassy area, engaging in an activity outside on grass is a great exposure and will likely significantly improve functioning. However, if this is the final exposure, it does not prepare the client for more difficult situations in which he may encounter a spider, therefore relapse is more likely. Alternatively, holding a tarantula is a true "top of the hierarchy" exposure and is appropriate for a child with a spider phobia. However, irritating a spider that can bite is unsafe, as the risks do not outweigh the benefits, and unnecessary. Furthermore, exposures in which a client purposely gets a question wrong on a test or does something silly in front of confederates or strangers are both beneficial and appropriate. However, purposefully failing a class or acting in a way that may lead to social embarrassment in front of peers are not appropriate exposures, as they have real-world negative implications for the client academically or socially.

The exposures at the top of the hierarchy aim to fully target the core fear; however, they must not be truly harmful, unsafe, or outside what is accepted in the client's religion, culture, or group (Huppert & Siev, 2010). This is in line with Principle E of the Ethics Code, which requires psychologists to be aware of and respect the cultural, individual, and role differences of clients. For instance, a colleague of the authors often provides an analogy from an Orthodox Jewish client with scrupulosity. He likened the therapist asking him to eat a cheeseburger, which is considered not kosher, or allowed to be eaten according to the dietary laws, to asking a surgeon to operate without washing his hands. Further, exposures should not be medically contraindicated. For example, one should consider the safety of doing an interoceptive hyperventilation exposure with a child with panic disorder if the child suffers from asthma.

It is difficult to determine when an exposure is going "too far." One challenge is that there is tremendous variability even among the nonanxious population on what is considered reasonable. For instance, some individuals without OCD find licking the bottom of their shoe abhorrent, while others would find this to be an acceptable exposure. Also, what is indicated as a final exposure for one client may be different for another client. The authors often poll other people in the office to gain data on people's behaviors and the scope of appropriateness. For instance, the first author disagreed with a client on whether children without OCD would put an unlit cigarette between their lips and pretend to smoke it, so they polled children in the building. Data on what other children would be willing to do provided insight on whether his fear was driven by OCD and whether the exposure was reasonable.

Therapists should also ask themselves several questions before conducting an exposure that they think may be risky: *Is the anxiety still causing some limitations? Can I reasonably increase the difficulty of the exposure task and have the benefits outweigh the negatives? Would I do this exposure? Would someone without anxiety do the exposure, even if they don't normally? Is it worth it to engage in this behavior given the potential risks?* Olatunji and colleagues (2009) also suggest asking yourself: *Do at least some people confront the situation/stimulus in their everyday life without adverse consequences?* If the answers to all of these questions are yes, then the exposure is likely appropriate. If the exposure appears risky, therapists can further ask themselves how central to treatment it is for the client to be able to engage in that specific behavior and consider whether there is another way to target the core fear and minimize the potential negative consequences.

It is also important to have an open dialogue with clients and families to negotiate what is necessary and appropriate for the final exposures. A suggestion is to ask clients to name the one thing that if they were able to do, they would feel they could do anything. A cost-benefit analysis can help determine whether the added consequences of an exposure outweigh the benefits. In addition, therapists are suggested to consult with pediatricians, specialized medical professionals, and religious figures to gain an understanding of typical behaviors with an acceptable level of risk, and acceptable and typical behaviors for a person of that religion. They may wish to consult with an attorney to determine what is legally permissible. Research is also recommended to obtain accurate data. For example, a colleague of the first author researched appropriate thunderstorm safety to help determine what is a reasonable exposure for a client with a thunderstorm phobia. Finally, therapists should utilize supervision or consultation to aid in deciding what is and is not necessary to ask of a client. The authors often consult with one another in the practice to gauge whether an exposure is reasonable.

Confidentiality

According to the APA Ethics Code (2010), psychologists have a "primary obligation and must take reasonable precautions" to protect confidential information. Confidentiality is an important issue for exposure therapy because it frequently entails leaving the office to conduct out-of-office exposures. These exposures may result in a risk that others may identify the person as a client undergoing therapy without the consent of the client. There are added complications with children, as many exposures might take place where there are other children, who will often not be as inhibited as adults to

ask questions. In addition, it is inherently challenging when an adult is with a child who does not appear to be related to the child, which may elicit attention or inquiry. For these reasons, clients may be hesitant to engage in exposures outside of the office walls; especially in smaller communities or schools where there is a higher probability of interactions among people the client may know. It is therefore recommended that therapists discuss concerns related to confidentiality with the client and family prior to engaging in out-of-office exposures (Olatunji et al., 2009). The therapist should remind the client and family that the child has a right to refuse to participate in out-of-office exposures if he or she or the family does not feel comfortable with the potential that others will find out about the therapeutic relationship. Clients and their families should be informed that despite reasonable precautions taken to maintain confidentiality, there is no guarantee that confidentiality can be completely preserved, and the family can decide whether they want to take that risk or find a different exposure that can be done inside of the office.

In order to maximize the likelihood that confidentiality will be maintained, the therapist can take steps to deidentify him- or herself as a health professional. Olatunji and colleagues (2009) suggest removing staff badges, coats, and ties in informal settings and refraining from actions that might suggest to the public the nature of the relationship to the client, such as visibly recording SUDS ratings on a notepad. Therapists can perhaps take notes on a cell phone to record SUDS and other nonidentifying information. Therapists are advised to develop a plan with the client in anticipation of running into acquaintances of the therapist or client when conducting exposure therapy outside of the office. A "cover story" can be constructed with the client and family in case this situation occurs. For example, if conducting an exposure with an adolescent on a college campus, one can say that they are gathering data for a statistics course. The therapist and family also should be prepared to answer follow-up questions. Furthermore, the therapist should discuss with the client and family beforehand how he or she will be introduced to others if warranted. For instance, the therapist can be introduced as a family member, a family friend, a coach, or a teacher. While some families may be more comfortable with this approach, clients should be informed not to feel compelled to make introductions or offer explanations since it may induce further complications. Additional precautions include conducting the exposure in another neighborhood or scheduling sessions when there are likely to be less people around.

Boundaries

Professional boundary issues have been found to be the second most frequently reported ethical dilemma by psychologists (Pope & Vetter, 1992) and by graduate students (Fly et al., 1997). Boundary issues are important to consider in exposure therapy, in which it is often necessary to accompany the client outside of the office to create exposure situations that are more naturalistic. This may involve getting in the car with a client, going to a public place such as a store, or making a home visit. Once out of the confines of the office, the boundaries in the traditional therapist-client relationship may become fuzzy as conversations may become more informal and the setting more casual.

It is important to distinguish that boundary crossings are not always boundary violations, and boundary crossings in exposure therapy are often clinically appropriate, necessary, and can positively impact the therapeutic relationship (Olantunji et al., 2009; Zur, 2001). For instance, it is ethically sound and beneficial for a therapist to accompany a child to a dog park to work on a fear of dogs, or go with an adolescent to public restrooms to challenge a fear of contamination. Clients who struggle with hoarding or have fears surrounding the home may require home visits for effective treatment of their fears. However, Olantunji and colleagues (2009) highlight that frequent boundary crossings may feel like a "slippery slope," making it easier to conduct a boundary violation. Gutheil and Brodsky (2008) argue that there are no simple answers as to what constitutes a boundary crossing versus a boundary violation. They offer three criteria for assessing whether a boundary violation has been committed: whether what was done was for the client's therapeutic benefit, whether what was done was based on theoretically and empirically informed clinical judgment, and whether what was done was covered by the contract previously agreed with the client.

Many factors must be considered in regard to boundary crossings and violations, including age and gender of the clinician, culture, and the therapy setting (Pope & Keith-Spiegel, 2008). Naturally, when conducting exposure therapy with children, it is appropriate and expected to have informal conversations. Professional boundaries are more lax when working with children, and the guidelines for boundary crossings in adult psychotherapy cannot be applied with a child population (Thomas & Pastusek, 2012). However, boundary issues do still exist in child psychotherapy. Ascherman and Rubin (2008) discuss that young children may challenge physical boundaries by wanting to sit in a therapist's lap or give hugs, while older children and adolescents may ask personal questions of the therapist. Boundaries also need to be considered with the child's family, in which unethical dual relationships can potentially occur. The literature is lacking in regards to boundary crossings in child therapy, and as Thomas and Pastusek (2012) argue, further research and discussion is needed to assist therapists with this ethical issue.

Self-disclosure should also be carefully considered when conducting exposure therapy. Venturing into the community may make a therapist more likely to self-disclose than they would be in the more formal setting of the office. Self-disclosure is not inherently unethical, and can be helpful when used for the benefit of the client rather than for the benefit of the therapist. For instance, it may be appropriate for a therapist to model how to face fears by talking about a fear they learned to face. On the other hand, disclosures that have no clear rationale can lead to the development of a multiple relationship.

In order to decrease the risk of boundary violations, boundary crossings should be addressed with the client and family in the informed consent process. For example, a therapist working with a client with social phobia must initially discuss the potential boundary issues that might arise from going to a local mall or playground (Pope & Keith-Spiegel, 2008). This discussion involves gaining the client and parents' approval and consent for all steps that the trip would include, such as transportation and purchasing items.

Next, while activities such as shopping or playing on a playground with a client are ethically sound and therapeutic if in the context of an exposure, a therapist must be careful about engaging in conversations and activities that are not for the purpose of the exposure. It is important to consider a cost-benefit analysis when engaging in a boundary crossing during exposure therapy (Olantunji et al., 2009).

Further, the therapist should ensure that interactions outside of the office remain professional. Ascherman and Rubin (2008) suggest that therapists take a "neutral" stance when faced with a child's personal questions by neither encouraging nor condemning them, but rather remaining interested and using it as an opportunity to understand the client further. The therapist should routinely be mindful about their growing relationship with the client and family to be aware of any behaviors or exchanges that may have crossed the line. Finally, supervision on this issue can be helpful in order to gain an objective perspective.

Summary and Conclusions

Exposure-based cognitive-behavioral therapy has been established as an evidence-based practice for anxiety disorders and OCD in youth. There are unique ethical considerations when providing exposure therapy, especially with children, and there is a lack of clear guidelines for how to manage these specific issues. Myths and negative beliefs about the ethicality and safety of exposure therapy are prevalent, which contribute to the underutilization of this treatment for anxiety disorders.

The current paper identified various ethical considerations of exposure therapy with children and provided specific guidelines for preventing or navigating these ethical dilemmas. More research, discussion, and guidelines on the ethical use of exposure therapy are recommended to help improve the delivery of exposure therapy in clinical settings and ensure effective, ethically sound treatment. Specifically, further areas of research needed include the process by which clinicians make ethical decisions about exposure in current practice, the types of ethical decisions they confront in exposure therapy, and the link between ethical issues and treatment outcomes and dropout rates. Future work can be helpful in determining how these ethical considerations can be better implemented into training and consultation at the graduate and postgraduate level, and how guidelines such as these can become better developed and formalized.

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