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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

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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.

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