

Ethical issues in child and adolescent psychotherapy: a clinical review

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Abstract

Child and adolescent psychotherapy has made great progress in recent years. With this progress, ethical issues have emerged that need to be addressed in the Indian setting. This article looks at various ethical issues in child and adolescent psychotherapy specific to Indian practitioners. The involvement of parents in psychotherapy often blurs therapeutic boundaries and issues related to confidentiality. Practitioners working in hospital and school settings are faced with similar problems. The advent of the internet and e-mail has resulted in new concerns for psychiatrists, related to communication via those media. Issues related to parenting, culture and development patterns, along with personal issues for the therapist, have been discussed.

Introduction

Ethics is defined as a system of moral principles and rules of conduct recognised with respect to a particular class of human actions or a particular group (1). Ethical issues in child and adolescent psychotherapy and psychiatry have been addressed by organisations related to child psychiatry, worldwide. These rules and regulations bind child and adolescent psychiatrists to a code that supports quality care for the proper treatment of child and adolescent psychiatric problems. These rules are essential for the betterment of children, their families, and society at large.

When a psychiatrist comes face to face with treating a child or an adolescent, the general approach lies in doing what is in the best interest of the child – protecting the privacy of the child's communications, and respecting the child as well as the family regardless of race, religion, socioeconomic status, education, or intellectual level, while promoting and supporting the highest level of development and autonomy for the child (2).

The practice of child and adolescent psychotherapy, in both inpatient and outpatient settings, requires the clinician to establish and maintain rapport with both the patient and his or her parents or guardians. This is essential for the initiation of an intervention and subsequent psychotherapy sessions. Protecting the child's privacy can be a challenge as we work with parents to learn about their child's development in the context of family dynamics; with the school to evaluate the child's educational strengths and weaknesses, and with the justice system and other agencies to advocate for the child's need (3). The child and adolescent psychiatrist plays an essential role as the professional who integrates, educates, counsels and informs the child and the family of the options for treatment.

Some of the ethics-based rules that apply to the practice

of child and adolescent psychiatry are clear; most clinicians are aware of them and have a consensus about them. For example, rules against sexual contact or harsh or abusive treatment are encoded as "boundary violations". They are based on the recognition that such experiences traumatise the child, distorting and injuring the child's trust, self-esteem, and capacity for intimate relationships. In other realms related to developments in biology and genetics, biotechnology, neuro-imaging or invasive procedures, psychological testing, educational assessments and social changes, new ethical issues emerge (4).

The therapeutic boundary with children and adolescents

Psychotherapy for children and adolescents is a daunting and difficult task. During any psychotherapy process, subtle issues arise that may pose a risk involving boundary problems. Work with preschool children offers many examples, such as, for example, the child who wants to sit on our lap or hug us. Sometimes children of this age may remove their shoes, raise their skirts, or want to take off their shirts. Others may want to invite us to their homes or have us attend a social or religious event. In all of these situations, the child and adolescent psychiatrist is challenged to refrain from actions that confuse boundaries and instead promote the child's expression of longings and impulses in words (5). Younger children may ask us questions about how we are as parents, about our own children and family. Younger children may want us to talk to them daily on the phone to support them, or they may want us to take them out to a movie or to the mall. Older children and adolescents may challenge boundaries by posing personal questions, such as those about our marital status or whether we have children, or about the career choices that our children have made. Such questions may be purely inquisitive and are potential opportunities to understand the child further. Motivations for these questions can be explored without necessarily having to provide an answer to them (6).

Therapeutic neutrality can be a helpful guide to moving forward with the child or adolescent in the psychotherapeutic process. This neutrality does not mean that the child and adolescent psychiatrist does not care about the child, or does not react with feelings to the evolving process. Rather, it refers to the therapist's need to remain neutral to those conflicts and desires of the child that strive for satisfaction from the therapist. The therapist may like children, but must realise that children under his treatment are not his children; they are patients, who must be handled in a just and professional manner (7).

We neither encourage nor condemn child patients and their

behaviour. We remain interested, and want to understand their meaning for the child. It is also relevant to our work with parents or guardians as we strive to be aware of our reactions to them, maintaining neutrality and being non-emotional; even when we recognise that certain approaches or parenting practices by them may be wrong.

Beyond transference and counter-transference, there are outer reality issues, and the child's real relationship with the psychiatrist needs to be considered rather than just the therapeutic relationship. However, it is important to realise that the child patient's perceptions of us, and our perceptions of him or her, can greatly inform us about the child's conflicts. Sometimes, our reactions to children, adolescents, or their families may be more about us than about them. Knowledge of the sources of our reactions and responses may free us to work more objectively; this may in fact restore a therapy process in turmoil. When the child and adolescent psychiatrist is stuck or confused and the therapy process does not progress, it would be prudent to consult a senior trusted colleague (8).

Autonomy and child psychotherapy

There is a growing recognition that the child psychiatric patient must contribute to decisions based on understanding and objectivity. There are many situations in which, for clinical or ethical reasons, children and adolescents should participate in decisions about their treatment, including psychotherapy. Not only is this respectful, the working alliance is strengthened when the child or adolescent feels that they have participated in an informed decision to pursue psychotherapy, rather than experienced it as imposed by others (9). In the modern era where children are aware and knowledgeable, it is only fitting that they be involved in treatment decisions concerning themselves, when they have the insight and acumen to decide. The judgment to include child patients in such decisions must be made by the child psychiatrist, in the light of parental attitudes, the psychiatric diagnosis and the underlying psychopathology (10).

Confidentiality as a responsibility

The child and adolescent psychiatrist has a strict responsibility to protect information about the child or adolescent and his or her family. This duty starts the instant that the doctor-patient relationship is established. Breach of confidentiality is a key legal ground for modern psychiatry malpractice. These principles also serve as the underpinnings of the psychotherapy relationship between the child and adolescent psychiatrist and the patient. It is only with the establishment of trust and confidence that a therapeutic space can be created. Within this space, the child or adolescent can feel sufficiently safe to trust in their freedom to reveal what they think and feel without being judged, retaliated against, or violated by breach of their privacy (11).

The profession of child and adolescent psychiatry has always attempted to understand children in the context of their biological heritage, family, community, and culture (12). A

recommendation for individual psychotherapy usually reflects an appreciation that there is a disturbance in the child's internal world and that this threatens to distort the trajectory of further development (13).

Issues in India versus the West

In India, more so than in the West, we face problems with regard to confidentiality issues when treating children and adolescents. First, as most children and adolescents are accompanied by their parents to consultations and therapy sessions, parents feel that they have a right to know what is going on within the mind of their child and will not accept it if told that the consultations are confidential. Second, many times parents pay for the treatment and, hence, expect the therapist or clinician to listen to them, as well as reveal all that transpires within therapy between the therapist and their child.

Confidentiality issues in the school setting

Sometimes, it is very difficult for therapists in India to take up child and adolescent cases for therapy or intervention without consent from their parents. This is more so in the school setting, where even a referral to the school counsellor without parental approval is often objected to by many parents (14). Those conducting psychotherapy with children and adolescents encounter unique challenges in their efforts to protect their patient's privacy. Child and adolescent psychiatrists rarely operate in a vacuum, sealed from interaction with parents and guardians. When this does occur – when parents or guardians do not interact with the psychiatrist – it can reflect, in very rare cases, a parent's trust in the process and respect for their child's privacy. In many cases, more ominously, it reflects the parent's lack of interest in his or her child's emotional life and an implicit delegation of responsibility for the child's well-being to the child and adolescent psychiatrist (15).

Autonomy of the child - India versus the West

In Indian society more so than in the West, the belief is that children hide nothing from their parents and that parents must know all when it comes to their child's problems. In fact, it often hurts the parent's ego when the child thinks of going to a counsellor. Parents feel that the child has no confidence in them and prefers to take internal problems outside, rather than keep them at home. In the West, child psychiatrists are better accepted and there are strict laws, about confidentiality and about almost every issue in psychotherapy, which are lacking in developing countries. In India, the notion of a child psychiatrist, and of a child seeking psychological help, is just gaining some recognition and it will be a few more years before a fuller acceptance ensues.

Confidentiality and the therapy process

In one situation, child and adolescent psychiatrists may find themselves challenged to protect the privacy of the psychotherapeutic process from parents or guardians who are intrusive and meddling. In some cases, the therapist may appeal for greater involvement and openness from parents who are

perceived as too cold and aloof (16). Parents and guardians have the right to be informed about any form of treatment given to their child, including psychotherapy, and they must be updated on their child's progress. A psychotherapy process with a child or adolescent that is opaque to the parents may cause dissatisfaction with and distrust of the therapist, resulting in premature termination of therapy.

The child and adolescent psychiatrist must balance the rights of parents or guardians and the clinical indications for some communication with them. Children must be able to trust that they have sufficient privacy for the process to be effective. Children and adolescents may not reveal vital information in therapy if they do not perceive this privacy; they may view the therapist as a middleman who is waiting to reveal information, or complain about them, to their parents (17). This may also be true in the school setting where third parties like teachers and principals may be informed.

Education regarding the therapy process and expressing empathy

Upon recommending a psychotherapy process, the child and adolescent psychiatrist has to review with parents the structure of the psychotherapy frame, the type of therapy, the interventions in mind and, most importantly, their rationale. Issues relevant to the child's privacy and confidentiality should be addressed. Parents can be reassured that they shall be informed about the process and effects of interventions periodically.

Parents can be told that their child's confidence in the relative privacy of the process can be critical to its efficacy, but that their need for information is also respected to help them understand and parent their child. The parents can also be reassured that information suggesting imminent danger – to their child or to others – would not be withheld from them. Communicating empathy for the challenges of parenting, parental feelings, and their anxieties and concerns, and direct acknowledgment of the child and adolescent psychiatrist's time-limited role with the child in contrast to the parents being there, will always serve to strengthen the alliance with parents and their comfort with their child's privacy (18).

The need for parental involvement as well

The structure of the psychotherapeutic frame also should be reviewed with the child or adolescent. The need for periodic contact with parents or guardians can be discussed, highlighting the responsibility to guard the child's privacy at these meetings. It is not unusual for a parent to want to report on what a child has done, with the implicit or explicit message that the child and adolescent psychiatrist address the issue in the upcoming session. Sometimes, the parent attempts to have this discussion in the waiting room. Such communications challenge the confidence that a child or adolescent has in the autonomy of his or her process and privacy. It also disrespects the boundary of the child's time and therapeutic space. Meeting with a parent during the latter portion of the child's

scheduled time, or immediately after the session with the child, can collude with the child's fantasy that the child and adolescent psychiatrist is reporting to the parent, threatening the child's confidence that he or she has privacy in sessions. Discussing issues with a parent in a waiting area is an obvious violation of the child's privacy (19).

Communications to other interested parties

There may be many requests for information about a child or adolescent in psychotherapy or treatment. This is more so in school mental health services, where teachers or the principal may want to know about the child. Sometimes a written report about the child's condition or progress with treatment may be demanded. Child and adolescent psychiatrists become gatekeepers of information and guardians of their patients' privacy. They decide how much to tell, whom to tell and what to tell. The child and adolescent psychiatrist should respond to any request for release of information by considering its appropriateness, necessity and the potential impact of what is released on the child, the family, and the treatment or psychotherapy process.

When considering written or verbal communication to a third party, the child and adolescent psychiatrist should discuss the request with the child and the parents or guardians. Reports requested by schools, courts or hospitals should be reviewed carefully, scrutinising whether the content is congruent with the needs of the request and whether the reports contain information about the child or others that is beyond what is needed. The child and adolescent psychiatrist should always consider the long-term fate of what is released, including whether the person or organisation receiving the material will be able to guard the privacy of these records in ways appropriate to their content. When records communicate more than is needed for the purpose of the request, the child and adolescent psychiatrist can compose a summary letter that includes the information needed and no more (20).

Internet and telephone communications

Many of the issues that child psychiatrists face with the availability of electronic communication have been discussed in a brilliant review on the subject (21). E-mail communication might have a constructive potential, but there are three areas of ethical concern: problems inherent in the mechanics of e-mail, confidentiality issues, and the loss of essential elements of the therapeutic action associated with the psychiatrist-patient relationship. Many times, e-mail communications can be viewed by others, as many teenagers hack into one another's e-mail. This may lead to the public disclosure of confidential information. Talking to children and adolescents via blogs or social networking sites is strictly prohibited for the therapist. The same holds true of chats via messenger or talk networks, as the security of these sites itself raises significant concerns. It is also prudent that any therapist with a presence on social networking sites refrains from adding child or adolescent clients as friends, as this involves breach of the therapist-patient relationship.

Limitations to the ability to ensure the security of information communicated electronically pose risks to privacy, despite the false security that passwords promote. Conducting psychotherapy through electronic communication is also problematic. E-mail communication in exchange for direct communication in the office deprives the psychiatrist of critical information related to facial expression, body language, and voice tone. Emotion is drained from word text, spontaneity is lost, and the potential to edit communication is maximised. Reciprocally, the patient is deprived of the voice tone, facial expression, and body language of the child and adolescent psychiatrist, essential elements of communication that have a strong influence on the therapeutic relationship, process and course (22).

A reliable time and place for contact and therapeutic work is exchanged for the more amorphous cyberspace. Direct contact and visibility is replaced by invisibility. For similar reasons, the use of the telephone as a regular alternative to direct face-to-face sessions is discouraged. The loss of visibility of the patient to the therapist and the therapist to the patient can seriously limit communication and understanding.

Inpatient psychotherapy with children and adolescents

The child and adolescent psychiatrist conducting a psychotherapy process with a patient who is hospitalised faces unique challenges in balancing the need to maintain the patient's privacy with the need for open communication in the hospital setting. Principles for communicating with parents can serve as a guide for what material is communicated to the larger inpatient team. The child and adolescent psychiatrist as psychotherapist can use his or her knowledge of the child to enhance the treatment team's understanding of the child, without providing more information than is essential. What might be said to the treatment team should be discussed first with the child (23).

Encounters outside the therapeutic space

Public encounters with patients pose challenges to privacy and confidentiality and to the child and adolescent psychiatrist's anonymity. Although often unpredictable, some public encounters can be anticipated and avoided. When a child and adolescent psychiatrist is aware that a child or parent may be at an event that he or she attends, he/she may choose to avoid the event or discuss the potential encounter with the child or parent ahead of time. In general, it is best for the child and adolescent psychiatrist to explain to the patient and parents that, in the case of an encounter outside of the office, the psychiatrist will err in the direction of not acknowledging them, unless they initiate an acknowledgment (24).

Counter transference issues

Counter transference has been defined as feelings and attitudes toward a patient derived from earlier situations in the analyst's life that have been displaced onto the patient and may

include all emotional reactions to the patient, conscious and unconscious, especially those that interfere with understanding and technique.

The relevance of counter transference and neutrality to the ethics of conducting psychotherapy lies in the critical importance of the child and adolescent psychiatrist's attention to his or her emotional reactions to the patient, and to the patient's parents or guardians. Although such reactions are unavoidable, and may provide useful information towards understanding patients, it is incumbent upon the treating child and adolescent psychiatrist to exercise vigilance as to how these reactions might influence the conduct of the psychotherapy process. Common warning signs in the behaviour of the therapist include recurrent lateness to sessions, extensions of sessions, touching of patients, gifts to the patient, and contact with the patient outside scheduled sessions, especially outside the office setting. Child and adolescent psychiatrists will encounter patients and families holding a variety of cultural, religious, and political beliefs that may differ from their own. Child and adolescent psychiatrists should refrain from the temptation to interject their values as a means to assist the child with his or her conflicts (25).

Clinical supervision for child psychotherapists

In India, we have a few good psychotherapy training programmes but not many focus on psychotherapy supervision. Observer postings, where one sees a senior psychotherapist administer psychotherapy to adults and children, are available, but there are hardly any centres where psychiatrists may take patients for therapy under supervision. Guidelines and rules for clinical supervision, though well formulated abroad, are absent in India for adults, let alone for children. We need to increase awareness as well as improve the training infrastructure to enhance the quality of child psychotherapists and psychotherapy in India.

Conclusion

As noted above, there are many ethical issues governing the conduct of psychotherapy with children and adolescents. Advances in child development, globalisation, the technology age, variations in parenting, religion, cultural factors, social and economic factors, legal requirements, the therapy setting and the therapist's own judgment should stimulate consideration of how these ethical principles apply to various situations. However, the most pivotal remains the psychotherapist's obligation to create and protect the integrity of the psychotherapeutic space in order to provide children or adolescents the freedom to identify, examine, explore, and hopefully, resolve the issues that bring them towards treatment. Child and adolescent psychotherapy, along with the ethical issues involved, are a challenge to any child psychiatrist; but once the challenge is taken up, it needs to be met.

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Consent in terminal sedation

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Abstract

For the majority of patients at the end of life, their symptoms can be relieved through good palliative care. However, for an unfortunate few, these symptoms become intractable despite the best holistic interventions and in such cases terminal sedation is considered. The use of this intervention remains fraught with controversy, particularly around the subject of consent. A clinical scenario is used to propose that under such circumstances, given the physical and psychological stress to which these patients are subject, it is neither useful nor meaningful to ask for the patient's informed consent. Instead, physicians caring for such patients should act in the patient's best interests, in accordance with the Best Interest Principle, to alleviate such suffering.

The concept of consent has evolved from being an ideal to "informed consent," a concept with legal significance (1,2). Informed consent refers to consent when "one is competent to act, receive a thorough disclosure, comprehend the disclosure, act voluntarily and consent to the intervention" (3: 285). This position has led some to refer to it as the sacred cow of medical ethics. In truth its venerability is exaggerated especially when

considering informed consent in the context of conditions that call for terminal sedation. This paper will seek to justify the primacy of the Best Interest Principle in such circumstances, based on the fact that most patients in this state cannot satisfy the basic requirements of informed consent.

Terminal sedation and the duty of palliative care

The term terminal sedation is defined as "the intention of deliberately inducing and maintaining deep sleep but not deliberately causing death in very specific circumstances. These are for the relief of one or more intractable symptoms when all other possible interventions have failed and the patient is perceived to be close to death OR for the relief of profound anguish (possible spiritual) that is not amenable to spiritual, psychological or other interventions and the patient is perceived to have a prognosis of less than 1 month." (4: 257) Refractory or intractable symptoms refer to "symptoms that cannot adequately be controlled despite aggressive efforts to identify a tolerable therapy that does not compromise consciousness." (5: 89) Such a diagnosis is made when "the