

2

Children, Adolescents, and Families

William Arroyo, M.D.

Salient issues that have greater relevance in the psychiatric care of children as opposed to that of adults include contexts of development, family, and treatment coercion. (The word “children” will be used throughout this chapter to refer to both children and adolescents, unless otherwise specified.) The ongoing developmental changes in the biological, psychological, and social domains have broad implications for both treatment of the patient and conduct of the psychiatrist. The ethical approach to evaluating and treating children is virtually always in the context of the family, the primary unit of the child’s environment. At times another key participant such as a teacher may be instrumental in providing the child treatment. In one of the remaining frontiers of psychiatry, infant psychiatry, there are virtually always at least two people, i.e., mother and infant, in treatment.

Developmental issues will dictate other aspects of the care provided. A young child, for example, will not generally understand abstract concepts that may be discussed with parents because of the child’s level of cognitive development.

Children are generally reluctant or involuntary participants in the treatment process. The parent desires some change in the child’s behavior or thoughts and hopes that the psychiatrist can accomplish this goal. Children are generally much less informed about psychiatric care than their parents are and oftentimes do not appreciate their parents’

The author deeply appreciates the assistance provided by Diane Schetky, M.D., in preparation of this chapter.



desire to have them change. Thus, engagement of the child in the early phase of psychiatric treatment often requires different strategies from those that would ordinarily be used with adults. These strategies may vary depending on developmental factors. Some adolescents, for example, may be defiant and provocative participants early in the process, whereas a 5-year-old girl may immediately play with the available toys in the office.

This chapter will highlight those issues that residents and other psychiatrists encounter in the early part of their careers in working with children. These include informed consent, psychopharmacology, confidentiality, psychotherapy, boundary issues, and hospitalization. Confidentiality and boundary issues are also discussed in Chapters 6 and 1, respectively.



Informed Consent

Informed consent by the patient is both an ethical and a legal necessity of providing psychiatric care. *Consent* refers to the legal authority to give permission. *Assent* refers to the child's affirmative agreement to participate in the treatment. Obtaining assent from a child becomes more important with increasing age of the child.

An important part of the strategy to engage a child and a family is to explain what activities constitute psychiatric care. The information provided to a parent must, of course, be modified for a child depending on the child's age. However, the same information may be given to a parent as to an older teenager with adult cognitive abilities. Most adults will easily understand the goals of talk therapies but may need more detailed explanations, for example, about the use of play in the treatment of younger children.

Parents hold the right to give informed consent for the provision of psychiatric care to their children under the age of 18, with some exceptions, of which some are noted below. It is generally assumed that when a parent brings in a child for a psychiatric evaluation or treatment, consent is implied. Although this may, in fact, be true, informed consent provided by a patient has evolved into a formal process. Specially designed forms completed by patients (or their parent if the patient is under 18) signify their possession of the necessary information about the proposed care, alternative treatments, and risks versus benefits. Com-

pletion of such forms indicates their voluntary acceptance of such care and their competence (or intellectual capacity) to make binding decisions about their lives.

While parents have the legal authority to give informed consent for medical care to their children under the age of 18, in special circumstances, state statutes may designate legal authority for giving consent to others (Behnke et al. 1998). Such exceptions include situations involving emergencies, emancipated minors, and adults who have had their parental rights legally curtailed or modified, among others. In addition, state laws vary in certain instances, e.g., abortion, transplants, and psychopharmacology. However, statutes relevant to informed consent do not preclude obtaining assent from a child about the care to be provided.

Children of Divorced Birth Parents

An increasingly common challenge for psychiatrists who treat children of divorced birth parents is the issue of legal custody. A parent with legal custody has the legal authority to give informed consent relating to psychotherapy and the administration of psychotropic medications. Both parents of a child may each have legal custody in most states. It behooves every psychiatrist who treats children of divorced parents to identify the parent with legal custody. The involvement of both birth parents (and sometimes both stepparents) in the treatment of a child may be clinically and ethically indicated. It is unethical to submit to family court a professional opinion on the parenting capability of each of the divorced birth parents without interviewing each of them. A psychiatrist must insist on interviewing each of the parents before agreeing to provide an opinion.

Children in Foster Care

Children in foster care are another special group for whom identification of legal authority can be challenging. This authority varies widely from state to state. For example, in some states the dependency court judge has the legal authority, and the assigned caseworker may be able to exercise the consent. In California the legal authority rests with dependency court for psychotherapy—but for psychotropic medication, the authority rested with the birth parent until very recently, when a law was passed that removed such legal authority from birth parents.

The legal authority for psychotropic medication is now under the purview of the dependency court judge. In addition, special procedures and policies have been developed to process requests for the use of psychotropic medications with foster care children in California. Most states do not require similar special requests by physicians for treatment of foster care children with psychotropic drugs.

Emancipated Minors

Emancipated minors generally have the same legal authority to give informed consent that adults have. The determination of “emancipation” is not always easy. Emancipated minors are children of minority age, usually at least age 14 and under age 18, who willingly live apart from parents or guardians with their consent or acquiescence (not necessarily written). These minors can provide their own informed consent for treatment purposes. In addition, emancipated minors manage their own financial affairs and do not derive their primary income from criminal activity. Minors are also emancipated if married or on active duty in the armed forces. Under other special circumstances, some states grant emancipated minors legal authority to give informed consent for mental health services (however, not necessarily for psychotropic medication) at the age of 12.



Psychopharmacology

The increasingly broad range of psychotropic drugs that are routinely used with adults are being used to treat children. However, the relative lack of a substantial database related to indications, benefits, and risks of the use of psychopharmacological agents with children (as opposed to adults) should compel psychiatrists to use a judicious approach to prescribing psychotropic agents to children; such an approach may include more frequent medication follow-ups. Parents often raise questions regarding the Food and Drug Administration’s approved uses of psychotropic medication versus unlabeled uses; this topic may be integrated into the informed consent discussion with patients and their families.

An important developmental issue relevant to this area is metabolic rates. Younger children (prepubertal) often metabolize and excrete drugs faster than do adolescents and adults; children therefore may re-

quire higher doses per body weight than the other age groups. However, developmental vulnerability to toxicity is evident in the use of certain medications, including tetracycline, known to induce tooth discoloration; aspirin, which may cause Reye's syndrome; valproic acid, which may precipitate hepatic failure or increase the risk of developing polycystic ovary disease; and hexachlorophene, which can have an adverse effect on myelin.

The potential developmental risks of long-term effects of a particular mental disorder versus the risks of long-term use of psychotropics must be considered by parents, the treating psychiatrist, and, often, the child.

A frequent clinical challenge is reconciling the desire of the parent to administer medication to effect changes in behavior versus the child's unwillingness to take the prescribed medication. Some psychotic adolescents, for example, will refuse to take antipsychotic medication on a routine basis despite their parents' great desire for them to do so. Some parents have become so insistent that their child take the medication that they devise secret strategies to make their child comply. One such parent of a 17-year-old patient with schizophrenia would place medication in milk or juice at mealtime without the teenager's knowledge to ensure administration of medication; the patient's psychotic thinking went into remission. This strategy backfired when the patient refused any medication, using as a basis for the decision the recent absence of psychotic thinking and anger at the parents triggered by the disclosure of the secret administration. I had previously engaged the parents in lengthy discussions about the risks related to this method of medication administration. Psychiatrists at times may need to guard against participation in similar circumstances that are ethically and clinically problematic.

Nonpharmacological interventions should be given initial consideration for virtually all preschool children. Some, however, may briefly require a psychotropic medication. School-age children may be at less risk for problems due to psychotropic agents than are preschool children and generally will assume more responsibility for the administration of their medication. Although many children at ages 10–12 years are able to engage in abstract thinking according to Piaget's cognitive developmental theory, many have the capacity to express an opinion about their care by about age 7. Therefore, it would be prudent for a psychiatrist to attempt to obtain assent from children as young as age 7 for whom psychotropic medication is prescribed.

Adolescents will often be the final decision maker as they assume increasing autonomy regarding the self-administration of psychotropic medication. Therefore, psychiatrists must educate such teenagers about the benefits and risks of medication. Psychiatrists should closely monitor this group for side effects relating to weight gain and sexual function, which are often normal developmental concerns even without psychotropic medication. Self-image may be another normal concern of a young adolescent. Peer pressure and the stigma of being “a mental” will also challenge any good psychiatrist.



Confidentiality

Confidentiality is an ethical cornerstone of psychiatry. The tenet of confidentiality breeds the patient’s trust of the psychiatrist, trust that is essential to the psychiatrist’s work. The slightest of breaches may undermine the care of a patient. This issue becomes a bit more complex when working with children than in the treatment of adults (Morrissey et al. 1986; Schetky 1995; U.S. Department of Health and Human Services 1999).

Adolescents, for example, will rarely share their sexual history, substance abuse history, and even their multitude of depressive symptoms with their parents but will do so with a trustworthy psychiatrist, who is perceived as providing a safe environment to discuss these personal issues. Parents who complain that their teenager will not discuss anything with them are hopeful that this type of rapport will develop. Many parents are also eager to have the psychiatrist disclose these details. The dilemma psychiatrists encounter relates to the importance of honoring confidentiality with the patient, who is virtually always identified as the child.

Therefore, it is imperative to discuss confidentiality in a clear fashion with the child and family at the outset of treatment. I generally initiate this discussion by asking if the family members in attendance are familiar with this topic, how it might apply to their specific case, and the legal exceptions (discussed further in this section). I have found in general that 1) a parent agrees not to insist that the psychiatrist give specific details of sessions with, for example, the adolescent; 2) a parent agrees not to review (or obtain a copy of) the medical record for this purpose; and 3) a parent sometimes agrees not to “harass” the adolescent about these details.

These guidelines are rarely contested by the child and family, in large part because the guidelines do not preclude the child from sharing the details of the sessions with parents. These guidelines also do not preclude the psychiatrist from urging the child to share certain information with the parents or from obtaining the child's assent to have the psychiatrist share certain information with the parents. I may negotiate with the child and family at the outset to periodically give the parents a general update of the child's progress, as frequently as after each session; this update should be provided with the child present.

For children below the age of 7 or 8, maintaining confidentiality is important, but it tends to have a different clinical significance than it has with older children and adolescents. Young children are less apt to insist that information not be disclosed to, for example, parents; these children will generally disclose unlimited details of their sessions to their parents. Nonetheless, it is prudent to discuss with young children what the treating psychiatrist hopes to share with the parents before doing so, especially if the psychiatrist has assured the young child about "absolute" confidentiality. In a different circumstance, the treatment of infants dictates that maintaining confidentiality pertains to the mother—or caretaker—and infant dyad. The ethics principle of confidentiality generally applies to the actions and information shared during the course of providing care to a patient, whether care is in the context of a family session or an individual one.

Exceptions to Protecting Patient Confidentiality

There are several exceptions in many states to a psychiatrist's protection of patient confidentiality. These include the threat of a patient's harm to self, the threat of a patient's harm to others, and a suspicion that a patient has been a victim of child abuse. The patient's intent to harm him- or herself is generally the least difficult for psychiatrists to report to parents or authorities. Conversely, a young resident or psychiatrist may be riddled with anxiety and ambivalence the first few times of reporting a patient's intent to harm others or a suspicion of child abuse. Regarding a patient's intent to harm others, notifying a potential victim of possible harm by one's patient is a challenge for most practitioners; sometimes the local authorities will help facilitate this task. In wrestling with the obligation to report a suspicion of child abuse, a common misconception among young (or veteran) psychiatrists is their perception that the act was not truly child abuse. Our eth-



ical and legal obligation, however, is not to determine whether or not abuse actually occurred but to report a suspicion of abuse; the actual determination is made in the judicial system. In reporting a suspicion of child abuse, another common fear is that the patient and family will drop out of treatment; this result is common, and equally common is that the family resumes psychiatric care elsewhere, albeit under court direction.

Nonclinical Factors Affecting Confidentiality

The thoughts and feelings that a patient shares in confidence with the psychiatrist are often entered into a medical record. However, access to these records is not determined solely by the patient or the treating psychiatrist.

Thus, the following may often conflict with the principle of confidentiality: state statutes, state regulations, policies of third-party payers related to disclosure of patient information, and the pervasion of information technology. Most states give legal authority to parents to either review or obtain a copy of the medical record; children generally do not have the legal right to do so. (However, some states make exceptions to accessing medical records. In California, the exceptions in which a child has a right to obtain a copy of his or her medical records occur when the child has the legal authority to give consent for care, such as in the case of an emancipated minor. In addition, a parent or an emancipated minor in California can obtain a copy of a record when a potential detriment to the patient–doctor relationship and potential physical or emotional harm to the child patient exist.) Third-party payers such as managed care plans almost always require varying levels of disclosure of medical records, ostensibly for billing and other administrative purposes. In addition, the influx of information technology, including electronic medical records, has triggered a new series of debates regarding confidentiality and privacy of medical records. In Congress and in state legislatures, maintaining privacy of medical records is a hotly contested issue.



Psychotherapy With Children and Families

The initial experience of treating children and their families often varies widely among psychiatrists in training. Child and adolescent psychiatric

rotations often begin during the second or third year of general psychiatric training. A certain level of comfort and self-confidence has been achieved by the time a resident begins to see children. Residents who have their own children or who have rotated through pediatrics are initially generally more comfortable communicating with children than those who have not. Many residents enjoy the interactions and rotation, whereas others clearly acknowledge their ambivalence and lack of self-confidence in working with children and families. Communicating with young children or adolescents can be very challenging, yet very rewarding.

Setting the goals of psychotherapy with children varies from the standard used with adult patients. Since the child rarely seeks psychotherapy on his or her own, this exercise must generally be conducted in conjunction with the child and parents.

The treatment of a child may present unique ethical challenges. For example, young children who are hospitalized and therefore separated from their families frequently evoke strong feelings of protection and caretaking in newly trained psychiatrists. Similarly, adolescents who have antagonistic relationships with their parents may share a list of conflicts that are historically identical to those a young psychiatrist recently had with his or her own parents. In some instances, these conflicts are ongoing, and the patient's parents may be erroneously blamed by the psychiatrist as he or she identifies with the patient. This countertransference may potentially undermine the delivery of competent intervention. The novice psychiatrist must be able to distinguish between his or her own needs and those of the patient. If this is too difficult, the ethical decision would be to consult with one's clinical supervisor, and subsequent transfer of care may be optimal.

The family as the "patient" may present other ethical challenges. Many parents believe that a child's behavior is under the sole control of the child who fails to appreciate the "ideal" modeling provided by the parents and perhaps other family members. However, there may be instances when the psychiatrist's opinion, based on a thorough evaluation, parallels that of the adolescent, for example, when the adolescent claims the parents are the ones who need to change. It is then the psychiatrist's ethical responsibility to convey this to the parents in a manner that invites them to adopt a new perspective conducive to effective intervention. Then parents may acknowledge, for example, that their constant shouting and arguing trigger similar behavior among their children—the idea originally presented by the adolescent identified by the parents as having "the problem." Subsequently, the psychiatrist



might focus on teaching family members nonaggressive strategies to resolve their differences.



Boundary Issues

Boundary violations with children are varyingly contratherapeutic and, in certain circumstances, illegal. It is atypical for a psychiatrist to provide psychotherapy to a child who does not evoke a broad range of thoughts and emotions either initially or later during the course of psychotherapy. Some may include anger, joy, a tugging at the psychiatrist's parental instincts, and even sexual arousal. These feelings and thoughts are almost always normal responses. The challenge for the psychiatrist is to acknowledge them, to refrain from acting on these urges, and to assess them in the context of the child, family, and optimal clinical care.

One of the more egregious boundary violations is having a sexual encounter with a child patient. Virtually all acts of sex by a psychiatrist with a patient are an attempt by the psychiatrist to meet the psychiatrist's needs or desires. Such exploitation can take the shape of many forms; skin-to-skin contact is not a prerequisite for such exploitation. For example, a rapidly maturing, pubertal 11-year-old girl who is infantilized for a long duration by her parents and has a history of sexual abuse by a male may repeatedly seek close physical proximity to the male psychiatrist. The psychiatrist will need to clearly structure the young adolescent, acknowledge any sexual arousal on his part, and proceed with psychiatric care in an ethical fashion.

Very young children tend to be more impulsive and may naturally seek physical comfort from a caring and attentive adult. Setting structure primarily for clinical reasons should be considered.

Boundary violations must also be considered with respect to the child's family members. Socializing or becoming intimate with a family member may seriously jeopardize the psychiatric care provided to a child and therefore is unethical.

Spending some time with one's patient outside the traditional settings of hospitals and outpatient facilities is encouraged in virtually all training programs, either during the child and adolescent rotation of a general psychiatric training program or during the more intensive child and adolescent residency. This may take the form of conducting indi-

vidual psychotherapy during a walk in a park or to the local fast-food restaurant in an urban area. Away from the typical clinical setting, psychiatrists should develop an awareness of the boundary issues in these circumstances. First, confidentiality cannot be ensured if the possibility exists of running into, for example, a classmate of the patient. Someone may eavesdrop on the conversation while strolling in the public venue. Second, the selection of the patient with whom to conduct such treatment is also important. For example, selecting a patient from an inpatient service on which the child is a risk for elopement could have dire consequences (including medicolegal ones), as well as ethical implications of competence. Third and last, one must guard against socializing during such activity because socializing with a patient undermines effective treatment. Examples of potential boundary violations are rarely discussed with trainees. Such potential violations should, however, be considered in deciding whether or not a psychiatric trainee or psychiatrist should conduct psychotherapy outside traditional settings. Residency directors should be encouraged to teach about potential boundary violations.

~ **Hospitalization of Children**

The frequency and duration of hospitalizing children have dramatically decreased during the past decade, in large part because of the penetration of managed care throughout the health care industry. In addition, medical necessity criteria, which are virtually always based on adult populations, have limited applicability for some children who require hospitalization. Medical necessity criteria rarely incorporate acknowledgment of differences between adults and children. This recent pendulum swing to rare and short hospital stays has threatened the financial viability of teaching hospitals and the integrity of psychiatric training programs across the nation; significant downsizing and actual closures of teaching hospitals have not been uncommon in the recent past. For-profit and not-for-profit teaching hospitals have been compelled to develop other strategies to stay financially afloat.

Residents in teaching facilities have not been exempt from these pressures. A decision to hospitalize a child at a facility with low occupancy rates and serious financial problems, primarily or in part to “save” the teaching facility, may be unethical for various reasons, in-



cluding a conflict of interest for the psychiatric trainee who decides that his or her need to maintain the training program outweighs the clinical indication for a less restrictive level of care. Similarly, the relative lack of beds in some states may compel a physician to deny hospitalization despite the clinical indication to the contrary. A novice resident or young psychiatrist should consult with a supervisor (or colleague) not only in regard to a decision to hospitalize but also in regard to the relevant ethical considerations.



Conclusions

Ethical standards of conduct relevant to the psychiatric treatment of children are determined primarily by developmental and family factors. Many standards, such as confidentiality and structuring boundaries, are time-honored principles of medical ethics that predate modern psychiatry. Statutes and case law, which frequently change, also strongly influence the psychiatric care of children. Periodic review and updates of all of these factors are imperative to the provision of good care.



References

- American Academy of Child and Adolescent Psychiatry: Code of Ethics. Washington, DC, AACAP, 1982
- Behnke SH, Preis JJ, Bates RT (eds): The Essentials of California Mental Health Law. New York, WW Norton, 1998
- Morrissey JM, Hofmann AD, Thrope JC (eds): Consent and Confidentiality in the Health Care of Children and Adolescents—A Legal Guide. New York, Free Press, 1986
- Schetky DH (ed): Ethics. *Child Adolesc Psychiatr Clin N Am* 4(4), 1995
- U.S. Department of Health and Human Services: Confidentiality of mental health information: ethical, legal, and policy issues, in *Mental Health: A Report of the Surgeon General*. Rockville, MD, U.S. Public Health Service, 1999