Who's the Boss? Ethical Dilemmas in the Treatment of Children and Adolescents

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Providing psychiatric care to children and adolescents raises a distinct set of ethical issues and challenges. Interests at stake may include patient autonomy and well-being, parental values and preferences, and the collective welfare of the family. When caring for adults, physicians may consult the American Medical Association's Code of Medical Ethics, as well as guidelines within their own specialties, such as the Principles of Medical Ethics of the American Psychiatric Association. Similarly, psychiatrists working with younger populations may seek direction from the Ethics Manual of the American Academy of Child and Adolescent Psychiatry (AACAP), which offers guidelines and resources (1, 2).

Child and adolescent psychiatry is a dynamic field, and the ethical issues that providers are likely to confront often reflect evolving technologies and societal norms. These may include novel forces such as social media; concerns stemming from sexualization and access to illicit drugs; and developments in the nature of the modern family related to divorce, adoption, advanced reproductive technology, same-sex parenting, blended households, and gender transition. A psychiatrist treating children and adolescents can expect to see ethical issues arising from social and technological trends in his or her practice and should be prepared to address them. This column provides vignettes related to such changes as a means of exploring underlying ethical concepts in the field.

THE AUTONOMY OF MINORS

Adults with capacity generally have a right to render their own medical decisions. The same is not necessarily true of minors. Parents have broad discretion to steer the medical care of their children and to override the wishes of their offspring, although they are limited in their ability to reject certain forms of life-saving and life-preserving care (3). Some states recognize the concept of "mature minors," unemancipated adolescents who have a clear enough understanding of their illnesses to render their own choices for specific conditions (4). In addition, most jurisdictions have a mechanism for minors to emancipate themselves under certain circumstances, such as marriage or economic independence. Finally, some jurisdictions grant minors of certain ages the power to make decisions regarding sensitive issues such as mental health, reproduction, substance use services, and the treatment of sexually transmitted diseases (5). These laws vary considerably from state to state. Providers should educate themselves regarding the laws in the jurisdictions where they practice.

Conflict may arise when the parent and child disagree regarding the course of care or when both parent and child have religious or cultural values inconsistent with the recommendations of allopathic providers. For instance, a child may want to be vaccinated against COVID-19, whereas his parents may object; or a Christian Scientist adolescent may refuse chemotherapy for a treatable cancer with the agreement of his parents, because such treatment violates their religious beliefs. In some cases, family meetings and ethics consultation can prove effective in resolving such conflicts, whereas other cases in which parents refuse essential interventions will require involuntary treatment as directed by a court order (6).

ETHICAL ISSUES REGARDING CONSENT AND ASSENT

Physicians caring for minors increasingly distinguish between *assenting* to treatment and giving informed *consent*. *Assent* means a willingness to accept the treatment offered. The patient may or may not possess formal decisional capacity to render a decision about treatment yet still agrees to the proposed treatment. In contrast, *consent* requires that the patient displays formal decision capacity regarding the proposed intervention. Informed consent may only be given by patients who are competent and of legal age to do so. When it comes to consent and assent, whenever possible, it is important that the provider procures the consent of the guardian and the assent from the patient before making a decision regarding their care. The degree of assent, and how it is expressed, will often depend on the age of the patient (7).

Although minor patients usually cannot give legal consent, they should be involved in treatment-related decisions to the degree possible in accordance with their ability

to understand options and express coherent preferences. According to the AACAP Code of Ethics, assent should be sought from minors before treatment, whereas "the right of proxy consent" for the minor generally belongs to the legal guardian(s) (8). The code states that "[t]he psychiatrist shall, whenever reasonably possible, obtain the assent of the minor and the consent of the legal guardian prior to engaging in actions involving the child or adolescent" (8).

ETHICAL ISSUES REGARDING CONFIDENTIALITY

Confidentiality is the obligation of the physician to protect the patient's privacy and to not convey information to other parties without the patient's permission. In child and adolescent psychiatry, patients are fully informed about their confidentiality rights and limitations in a developmentally appropriate manner.

Confidentiality is designed to protect the privacy rights of the patient and to ensure that patients will be able to share information with providers without fear of disclosure (9). Understanding the patient's right to a safe and private space is important to the development of an open therapeutic relationship. Often, effective care for a minor patient requires that the patient, her parents, and the psychiatrist are all able to trust one another. This principle of confidentiality must be balanced against safety and policy considerations that might justify a breach. For example, overriding confidentiality may be justified when the safety of the patient or others stands in jeopardy. Similarly, certain legal and public health considerations may justify a breach of confidentiality between minor patient and provider (10).

Case 1, Part 1

Noah is a 15-year-old boy who is referred to your outpatient psychiatry clinic for "erratic behavior." Noah's parents are divorced, with joint custody. He spends his weekends with his father and weekdays with his mother. After a few sessions, Noah shares that he has been smoking cannabis daily for the past 6 months. He first began smoking after his father offered him a cannabis cigarette after dinner during his winter break, on the condition that he not tell his mother. Since then, Noah reports smoking daily when with his father and purchasing cannabis from a "cool kid" at high school with his allowance. However, with summer vacation approaching, he does not think that he can continue to secretly buy or use it without his mother finding out. He begs you not to tell his mother.

1.1. What is the most appropriate thing to say?

A. "I have to tell her. Your mother will find out anyway since you are under her insurance."
B. "I will not tell her without your permission. Can you tell me more about why you want to keep it a secret?"
C. "I won't tell your mother, but only if you tell her today."
D. "I will not tell your mother, but if she finds out I am keeping secrets, your mother may fire me."

Case 1, Part 2

A few days later, you get a frantic call from Noah's mother. She caught him stealing money from her wallet, and he admitted that he was going to buy cannabis with it. Noah is also present and agrees to having his mother present at his next appointment to discuss getting a referral to a clinic that specializes in adolescent substance use. The next day, you receive an angry voicemail from Noah's father, saying that he does not agree with the referral because "there's nothing wrong with a little weed." He threatens to sue you if you continue with the referral, adding "I'm coming to the next appointment so you don't do anything stupid."

1.2. What is the most appropriate next step?

A. Call Noah's father back and tell him that you will take legal action due to his threatening behavior.
B. Since his parents have joint custody and his mother agrees with consultation, make the referral.
C. Call Noah's father back and discuss his reasons for not wanting to pursue consultation.
D. Recommend that Noah's mother seek a sole custody arrangement.

Case 1, Part 3

During your final session with Noah, before he transfers care to a substance use clinic, he shares with you that his father is angry at him for revealing the cannabis use. The previous weekend, his father's girlfriend, Iris, told his father not to share his cannabis with Noah. His father became furious and struck her jaw in front of Noah. Iris went to the emergency room (ER) and required stitches, but she told the ER doctors that she had injured herself falling on the stairs, and Noah's father corroborated her story. Noah says that his father later apologized. His father has never physically harmed him, although he has shouted at him when angry in the past.

1.3. Do you have an obligation to report Noah's father's conduct to the state agency responsible for addressing child abuse and neglect?

A. Yes, because the father has lied to the medical staff in the ER, so he cannot be trusted.
B. Yes, because witnessing intimate partner violence is a form of child abuse.
C. No, because the father did not physically harm Noah.
D. No, unless Noah consents to your calling the agency.

Case 2, Part 1

Jessica, a 15-year-old girl, is referred to your practice by her primary care provider for symptoms of depression and anxiety. During the initial interview, she reports having a sad mood, decreased sleep, lack of energy and motivation, and inability to focus on her schoolwork for the past 3–4 months. She also reports poor self-esteem and anxiety about her appearance, her school grades, her relationship with her parents, and her future college prospects. She denies thoughts about suicide. All of her laboratory results are within normal limits. You diagnose her with major depressive

disorder and generalized anxiety disorder. You educate her about her conditions, and she agrees to take antidepressant medications and to see you for weekly individual psychotherapy. You prescribe fluoxetine 10 mg/day, and slowly increase the dose to 40 mg/day over 4 months.

The patient responds well to the combination of fluoxetine and weekly psychotherapy. During a recent psychotherapy session, she reports to you that she recently started dating one of the boys in her school who is 18 years old. She reports that the relationship is going well and that they exchange a lot of text messages on a regular basis. She characterizes this as "flirting" and says, "all my friends do that." She reports that they do not exchange any information of a sexually explicit nature in their electronic communications. She requests that you keep this information confidential from her parents, as she has had an argument with her mother about one of her past boyfriends.

2.1. What is the most appropriate course of action?
- A. Agree to keep her relationship confidential and invite Jessica to talk more about her boyfriend.
- B. Inform Jessica's parents about the relationship right away.
- C. Agree to keep this information confidential only if Jessica agrees to tell her parents about the relationship herself on the same day.
- D. Inform both Jessica's parents and child protective services right away.

2.2. Which of the following is true of confidentiality between a minor patient and a psychiatric provider?
- A. Minors and adults have identical rights to confidentiality.
- B. Psychiatrists have an ethical duty to disclose the contents of therapy sessions with minors to their parents if they are asked.
- C. If parents are paying their children's psychiatric bills, they have a right to see their children's medical records.
- D. HIPAA (the Health Insurance Portability and Accountability Act of 1996) applies to both minors and adults.

Case 2, Part 2

You continue to see Jessica for weekly psychotherapy and medication management. Her depression and anxiety have improved significantly. She continues to talk about her relationship with her new boyfriend. During today's session, Jessica shares that, for the past few weeks, along with exchanging regular text messages, they also started exchanging sexually explicit photos and videos of themselves. She reported that this brought them "closer" in their relationship. She said that her boyfriend is not pressuring her to send these photos and that the exchange is consensual. She has not told her friends or parents about this, and she is confident that her boyfriend will keep this private. You know that, in your local jurisdiction, teenagers were charged with the felony of promoting a sexual performance or disseminating indecent material to minors in the first degree for similar behavior. Jessica continues to request that you keep this information confidential from her parents. She mentions that she is afraid that, if her parents find out, they will make her stop spending time with her boyfriend.

2.3. Should you breach confidentiality and inform Jessica's parents right away about this new behavior?
- A. No, because you need to obtain more information from Jessica about the details of this new behavior.
- B. Yes. This constitutes sexting and can have significant legal consequences for Jessica.
- C. No, because you need to confirm this information with Jessica's boyfriend before you can inform her parents.
- D. No. You cannot breach confidentiality because all information exchanged between Jessica and her boyfriend is consensual.

Case 2, Part 3

You inform Jessica's parents about sexting, despite her request to keep this confidential. During the next session, she reports that her parents are upset with her and that she is no longer allowed to spend time with her boyfriend. You educate Jessica about sexting and the potential significant legal consequences and the nuances of confidentiality considering her age and inform her again about all the situations where you might breach confidentiality. You encourage Jessica to bring in her parents with her during her next session for a family session to determine how to proceed to minimize legal consequences. She agrees.

Answers

1.1. The answer is B. A therapeutic answer would both maintain confidentiality and take a nonjudgmental approach to help foster trust with the patient. Exploring Noah's reasons for not wanting to tell his mother at his own pace may help uncover his reasons for using cannabis in the first place. Choice A is incorrect, as regardless of insurance, telling Noah's parents would be breaking confidentiality. C and D are both incorrect, as this language is coercive and could fracture the therapeutic alliance (8).

1.2. The answer is C. Not every set of parents, whether together or separated, will agree on their children's medical and psychiatric care. In cases of joint custody, both parents must agree on whether to pursue treatment for the best interests of the child. If you know that one guardian does not agree with treatment, as long as it is not an emergency scenario, this must be addressed before moving forward (8). Perhaps Noah's father does not understand exactly what a referral entails or has had a bad experience himself. Having an open conversation about the consultation process does not break confidentiality, and it might clear up any misunderstandings that Noah's father may have about

treatment (11). As with speaking to patients, keeping conversation open with parents is the best next step, because it could prevent misunderstandings. Choice A is incorrect, because although legal action may be warranted if the threats continue and/or escalate, this closes off a potential point for conversation. B is incorrect, because at this point it is understood that Noah's parents disagree on treatment. "Taking sides" can only spell disaster for not only the therapeutic alliance but also the family dynamics. D is incorrect, because before getting a third party involved, you as the primary provider should have an open conversation with both parents about treatment first. Otherwise, you again risk putting the therapeutic alliance and family dynamics in undue danger (12).

1.3. The answer is B. In every state, physicians are mandatory reporters of abuse or neglect of children that they discover during the practice of medicine. It is a nondiscretionary rule, so if providers have a reasonable suspicion of abuse or neglect, they *must* report and are generally shielded from liability for doing so in good faith. Witnessing intimate partner violence is generally considered to be a form of abuse, triggering a report to the state. In addition, providing illicit substances such as marijuana to a minor might trigger such a reporting requirement in some jurisdictions. A is incorrect, as although lying to the medical staff is problematic behavior, it is not child abuse or neglect. Some states do require the reporting of domestic violence, but that would be to different authorities. C is incorrect, as physical harm is not a requirement for mandatory reporting. A wide range of behaviors—including neglect and emotional abuse, if severe—may require a report. D is incorrect, because obtaining a child's permission is not required to report child abuse or neglect.

2.1. The answer is A. Teens increasingly prefer to communicate by cell phone and text messaging (13). Considering that what Jessica described so far does not constitute sexting, there is no reason to breach confidentiality here and inform her parents about this. Sexting in this context is defined as sharing sexually explicit text messages or photos or videos through text messaging or e-mail or through various social media platforms. It would help the therapeutic relationship and support her autonomy to keep this confidential and continue further exploration about her relationship with her boyfriend. B is incorrect, as it would go against patient autonomy. C is incorrect. Although it would be ideal for Jessica to inform her parents about this herself, there is no reason to ask her to do this immediately as this might damage the therapeutic alliance. D is incorrect, as there is no reason to suspect child abuse with the information available so far and, therefore, no need to call child protective services. However, the psychiatrist should explore further the nature of the relationship between the 15-year-old patient and her 18-year-old boyfriend. Although 15 is below the age of consent in many jurisdictions, many states also have so-called "Romeo and Juliet" exceptions that do not criminalize sexual contact between teenagers who are close in age. If sexual contact is occurring and the patient lives in a state where such conduct is illegal, the psychiatrist may have a duty to report this to the authorities.

2.2. The answer is D. HIPAA is a federal law that protects both children and adults from the release of protected health information to third parties except under narrow circumstances. Its provisions apply to both children and adults. A is incorrect. Minors do not have the same rights to confidentiality that adults have, as there are certain situations, such as the danger of self-harm, in which providers may be ethically justified in sharing information with parents. B is incorrect. However, psychiatric ethics and most state laws provide for limited confidentiality for psychiatric services rendered to minors. C is incorrect. Whether parents are paying for therapy sessions or not does not have an impact on the law or ethics of confidentiality; however, if minors use their parents' insurance, it may prove difficult to conceal certain services, such as the prescription of pharmaceuticals, from them in practice.

2.3. The answer is B. The clinician should educate Jessica that this constitutes sexting. "Sexting has become another new social phenomenon with the explosion of social media and smartphones among latency-aged children, tweens, and teens" (14). Further, Jessica should be informed about the major legal consequences of sexting (15). She should be informed that sexting often qualifies as distributing child pornography, and she might be convicted of a sexual offense and be made to register as a sex offender for at least a few decades (16, 17). However, many ethicists are critical of punishing adolescents criminally in cases lacking malicious intent (18). Sexting laws vary widely from state to state and between the states and the federal government. For example, in the State of New York, teen sexting is a felony and requires registration as a sex offender. The potential legal consequences in this situation might constitute an emergency that may warrant breaching confidentiality and informing Jessica's parents right away about this development. A and C are incorrect, as this is a major legal issue with significant consequences, and withholding this from parents any longer to get more information or to confirm it with other sources might invite liability. D is incorrect, as this behavior still constitutes sexting even if it was consensual.

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