Clinical Ethics for the Treatment of Children and Adolescents: A Guide for General Psychiatrists

Jerald Belitz, PhD*, Robert A. Bailey, MD

Psychiatric work with emotionally disturbed children is clinically and ethically challenging. Clinical work requires knowledge and appreciation of developmental issues, applicable laws, standard of care practices, and ethical principles. The relatively greater dependence and relatively lessened autonomy of children present complex ethical challenges when clinical care is provided to children. Customary ethical principles of autonomy and informed consent can be very different in their application with children. Common ethical principles such as beneficence and do no harm often are more multifaceted and less straightforward. As a salient example, children rarely refer themselves for psychiatric care. Typically they are brought into care by others, either because of genuine concern for their well-being or because they are causing trouble for others. The treatment objectives expressed by those who refer the child may be quite different from the child’s goal. Indeed, the child may have no wish for treatment, creating a difficult environment in which to develop a motivated treatment contract with the youth. Psychiatrists are ethically compelled to respect and integrate the child’s expressed wishes, the referring party’s expressed outcomes, the child’s maturation needs, and the family’s cultural beliefs about family roles and child-rearing practices. General psychiatrists have the relative luxury of focusing solely on the adult patient, whereas a child’s psychiatrist must consider the needs, abilities, and availability of the child’s parents, family, and school. Such considerations obviously bring new ethical considerations and challenges to the treatment (Box 1).

This article is written for the general psychiatrist whose practice does not customarily include children and adolescents but who has occasion to work with youths who
present with neurobiological disorders or serious emotional disorders that fall under the rubric of childhood psychiatric diagnoses. It discusses the unique ethical considerations that general psychiatrists may not routinely encounter. It reviews ethical concerns related to such themes as informed consent, confidentiality, documentation about other family members, familial and cultural practices, professional competence, mandatory treatment, evidence-based practices, boundary issues, and research practices. The intent is to provide psychiatrists with an enhanced awareness of those ethical considerations, a broad framework for comprehending and addressing those issues, and additional resources for further development. The goal is to help the reader achieve competency, rather than expertise.

CHILDREN ARE DIFFERENT

Children are smaller than adults. This fact is obvious, but the practical and ethical implications are substantial. Being smaller, children are more readily intimidated by adults, even if unintentionally. Adults unavoidably look down at children, and children unavoidably look up at adults. The world is largely designed for adults; so although adults sit down, children must climb up. These simple physical facts both establish and illustrate the relative imbalance of power, influence, and authority between children and adults.

Children are inherently more vulnerable than most adults. The responsibility for assuring ethical action therefore resides more with the psychiatrist than is common with adult patients. Also, psychiatrists may simply acknowledge that adult patients are responsible for the consequences of their actions; however, adults have a responsibility to protect or buffer child patients from more substantial and unintended negative consequences. For example, if a responsible adult patient decides to quit his or her job, that decision may be respected as the patient’s autonomous choice. In contrast, if a young adolescent decides to quit school, questions arise as to how informed a young adolescent is about the consequences of such an act, how

<table>
<thead>
<tr>
<th>Box 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring for children—core ethical issues</td>
</tr>
<tr>
<td>1. Children are inherently more vulnerable than adults.</td>
</tr>
<tr>
<td>2. Children's abilities are more variable and change over time.</td>
</tr>
<tr>
<td>3. Children are more reliant upon others and upon their environment.</td>
</tr>
<tr>
<td>4. Ethical principles and practices in the treatment of adults must be modified in response to the child's current developmental abilities and legal status.</td>
</tr>
<tr>
<td>5. Boundary and role issues are often more prevalent and more complex when caring for children than for adults.</td>
</tr>
<tr>
<td>6. Adult psychiatric practices, and the adult psychiatric knowledge base, do not transfer reliably to the care of children.</td>
</tr>
<tr>
<td>7. Practitioners must develop skills to work with families, agencies, and systems.</td>
</tr>
<tr>
<td>8. It is key to monitor one's own actions and motivations.</td>
</tr>
<tr>
<td>9. Seeking consultation and advice is helpful in difficult situations.</td>
</tr>
<tr>
<td>10. It is essential to maintain an absolute commitment to the safety and well-being of the patient.</td>
</tr>
</tbody>
</table>
compotent the adolescent is to make such a choice, and the degree to which the 
psychiatrist (as well as parents) may be obliged to question or confront such action. 
Children also differ from one another. In a very real way, there is no such category 
as “children.” Infants differ from toddlers, who differ from preschoolers, who differ 
from school-aged children, and so on. Furthermore, within any one group of children 
there is wide variability in size, ability, and maturity. Many children experience signifi-
cant variability among their own maturational abilities—physical, cognitive, emo-
tional, social, and moral. Finally, the individual child may progress and regress in 
the face of various challenges or traumas, being “childish” one day and a “young 
man” or “young lady” the next. Essentially, although adulthood certainly has partic-
ular developmental stages, children manifest much broader developmental and indi-
vidual variability than do adults. As a consequence, the psychiatrist must attend 
much more closely to the state and abilities of the child patient, at times even 
from moment to moment. The child’s ability to engage in particular aspects of 
care, including its ethical aspects, or to move toward particular goals of treatment 
may vary with the child’s immediate developmental abilities, themes, challenges, 
and tasks.

Another consequence of the relatively rapid development of children is that small 
actions may have much greater consequences. A small nudge toward health may, 
over time, be of great benefit; on the other hand, a small negative deviation in the 
developmental course early on may be of great consequence by adulthood. As 
a result, the child’s psychiatrist must be especially attentive to the possible negative 
developmental implications of each intervention. Although there may be less tolerance 
for error in treating children, this risk is balanced positively by the fact that children 
often are more forgiving of adults and may reward relatively small investments of 
resources with disproportionate positive outcomes.

Children also are more reliant upon their environment, especially their social envi-
ronment. Children are less able to shape their environment to meet their needs and 
consequently must accommodate themselves to their external world. Indeed, the 
child who is especially assertive in attempting to alter the environment may be 
perceived as presumptuous, willful, or oppositional. Young children depend upon 
adults for the basics of life—food, clothing, shelter—and, fundamentally, their very 
survival. The emotional implications of such dependency and vulnerability cannot 
be overestimated. Additionally, children are psychologically and emotionally depen-
dent on their parents, teachers, and other significant adults. Children are more recep-
tive to adult support and sustenance; however, they also are more susceptible to 
experiencing adults as negating and invalidating. Because of this dependence, 
unthinkingly treating a youth as an autonomous ethical agent may be well intentioned 
but may require more than the child can deliver and therefore may go against the 
child’s best interests. As Winnicott perceptively noted, even the adolescent who is 
seemingly striving for autonomy may at times very much need the freedom to be 
immature that is made possible only by a firm and reassuring parental presence. 
This consideration in no way diminishes the importance of respecting each child’s 
integrity and right to assent voluntarily to treatment.

As a rule, children have many more expectations and mandates placed on them by 
society, have a more limited set of adaptive abilities, and are granted fewer behavioral 
options than adults. For example, adults have a relatively broad range of vocational 
options available, each with its own set of advantages and demands; children, 
however, must go to school. Adults may avoid certain behavioral or ethical demands 
simply by avoiding the circumstances in which they arise; children often are unable to 
avail themselves of such environmental and behavioral flexibility.
PROFESSIONAL COMPETENCY

This section addresses the competency of the treating psychiatrist, rather than the child’s decision-making competency (discussed elsewhere in this article). A fundamental principle of medical ethics is that, outside of extenuating circumstances, physicians provide only care that they are competent to deliver. Clinical competency is especially important when working with children, given the greater potential impact on their developing brains and selves and their greater vulnerability.

In areas of abundant resources, upholding this principle is relatively straightforward. In many communities, however, child mental health resources are uncommon to nonexistent, thus creating an “extenuating circumstance.” In communities with scare resources, the general psychiatric practitioner often is pressed into providing clinical care for children who have psychiatric needs. In addition to being clinically challenging, such requests produce ethical challenges.2–4 Similarly, the general psychiatrist practicing family therapy may be implored by a family to provide individual treatment to a specific child. In such circumstances, the general psychiatrist often is practicing at the ambiguous edge of competency and must monitor whether he or she is straying across that edge.

In particular, general psychiatrists need to be aware that many interventions that have been validated empirically for adult populations have not been researched in child populations and have no evidenced benefit for youth. For example, the efficacy of tricyclic antidepressants is much less well established in the treatment of child and adolescent affective disorders than in adults.5,6 Thus, reliance on adult-based evidence and experience may lead to care that lacks beneficence or is even dangerous.7

Enhancing one’s competency requires more than a literature review. General psychiatrists are encouraged to engage in all forms of learning opportunities, including workshops, distance learning, and a careful reading of the literature. Because local consultation is likely to be limited, psychiatrists can access resources such as Internet consultation groups (eg, the Physician Access Line at the University of New Mexico Health Sciences Center, http://hsc.unm.edu/som/telehealth/pals.shtml, or the Hopkins Access Line at The Johns Hopkins Hospital, http://www.hopkinshospital.org/hospital/referring.html#hal, telemedicine conferences, or telephone consultation with an academic medical center).

As well as being mindful of one’s own competency, the general psychiatrist must be mindful of the availability and competency of collaborators. In the current health care environment, it is increasingly common for pediatricians to have significant experience in providing psychopharmacological care for their child and adolescent patients, and they may provide useful consultation or collaboration. Similarly, schools are long-experienced in addressing their students’ behavioral issues and can function as important, reliable, and experienced treatment allies. In contrast, the psychiatrist’s professional colleagues cannot be assumed to have the necessary competency to work with children.

Despite the potential difficulty of arranging for a consultation or even for a transfer of care outside the local community, general psychiatrists are asked to consider these measures in situations where their expertise may be especially challenged:

- Acute suicidality, particularly in a young child who may not be cognitively able to understand death
- Multiple psychiatric comorbidities, particularly those that may interact negatively (eg, bipolar affective disorder, conduct disorder and substance abuse)
Polypharmacy or multiple short-term medication trials
Significant lack of response to treatment, particularly with life-threatening disorders such as anorexia nervosa
Mixed psychiatric disorder(s) and neurodevelopmental disorder(s)
Atypical presentation or symptomatology (raising the possibility of a missed psychiatric or somatic diagnosis)
Rare childhood psychiatric disorder(s) (eg, schizophrenia before the age of 9 years)
A primary diagnosis uncommon in an adult practice (eg, childhood disintegrative disorder, separation anxiety disorder)
A child patient who has little or no reliable family or social support
Unremitting anxiety on the part of the treating psychiatrist

The capacity to access consultation when one is uncertain or unclear about the appropriate course of action is the hallmark of a competent and ethical psychiatrist.8

PSYCHOPHARMACOLOGY

Several ethical aspects of child and adolescent psychopharmacology warrant specific mention.9,10 As noted earlier, competency in general psychopharmacology does not guarantee competency in child psychopharmacology. The brain continues to develop through adolescence.11 Neurotransmitter and neuromodulator systems develop at varying rates and change functions.12 Medications with proven efficacy in adults may not demonstrate such efficacy in children.13

Also, many medications that are approved by the Food and Drug Administration for use in adults do not have such approval for children or even for adolescents.14 Child and adolescent psychiatrists frequently find themselves having to practice off-label if they are to care for their patients adequately. As a cautionary note, some data suggest that children have a high placebo response rate15,16 that can complicate both assessment of efficacy for the individual patient and assessment of data from clinical trials, especially for clinicians less familiar with children. In addition to raising complex questions about the ethics of off-label or less well-substantiated use of medications, such practice also may incur increased legal liability. On the other hand, depriving children of potentially valuable treatments raises another set of ethical issues.17

As with many such ethical dilemmas, the psychiatrist’s best recourse is to assess consciously and conscientiously the needs and risks for each particular patient, including the certainty of the diagnosis, the risks of prescribing and not prescribing, one’s own level of competence, and the availability of more expert treatment resources. Such specific and thoughtful deliberation avoids the dangers of overgeneralization and poorly considered care and increases the likelihood of providing the best possible individualized care to the particular patient.

As discussed elsewhere in this article, consent to pharmacologic treatment also varies with the cognitive abilities of the child or adolescent.

INFORMED CONSENT

Informed consent is identified as the foundation of ethical health care.18 Before a patient’s consent can be considered informed, the individual must possess decisional capacity, understand the risks and benefits of accepting or declining the treatment and the potential outcomes of alternative treatments, and provide a voluntary and non-coerced decision. Psychiatrists are obliged to recognize the individual patient’s dignity, autonomy, and capacity for self-determination.
Because minors are determined to lack decisional capacity, parents or legal guardians are assigned the responsibility of furnishing informed consent for health care interventions. In respecting children’s dignity, physicians are expected to include them in the consent process and ask the youths to assent to treatment participation. Doing so requires communicating the treatment goals and interventions to the child in a format appropriate to the child’s developmental capacity in the cognitive, emotional, and social domains. Essentially, the youth is accepting the physician’s invitation to participate in the therapeutic process. It is important to replicate this discussion as the child’s functionality improves with age and developmental maturation.

In recent years, legislators and clinicians have recognized the rights of a mature minor, an adolescent who possesses the necessary cognitive and emotional aptitude to provide his or her own informed consent. Empirical research demonstrates that by age 14 years, adolescents manifest emotional maturity, cognitive capabilities, and decisional competence comparable to adults. They exhibit the ability to understand factual issues, potential outcomes, the consequences of each alternative, and the meaning of the decision within the framework of their personal values. Consequently, all 50 states have legislation that grants mature minors the authority to consent to health care decisions related to contraceptives, pregnancy, sexually transmitted diseases, mental health, or substance abuse. Importantly, these statutes do not mandate parental notification. In states that do not explicitly grant mature minors confidential access to mental health care, physicians regularly treat adolescents they appraise to be mature, especially if their state has laws allowing minors to access similar services. Psychiatrists are advised to document evidence of the adolescent’s maturity and the reasoning for their decision to treat the patient absent parental consent.

The Society for Adolescent Medicine emphasizes the merit of allowing adolescents to access confidential services for sensitive health concerns. The Society asserts that many adolescents, especially those who engage in high-risk or dangerous activities, will abstain from health care or refrain from honest communication with their physician. When adolescents are permitted to consent to confidential treatment, the ethical standards of patient autonomy, beneficence, nonmaleficence, and justice are preserved.

Psychiatrists, however, are compelled to use clinical judgment, knowledge of state laws, and professional guidelines with respect to confidential treatment of adolescents. There is contrasting research that questions the capacity of adolescents to provide informed consent independently. Age is an arbitrary delineation of maturity, because not all adolescents achieve developmental milestones at the same rate or sequence. Each specific patient’s capacity to provide voluntary consent should be assessed within the context of the complexity of the decision and the youth’s psychosocial level of development and current mental and emotional status. As an example, substance abuse has been associated with cognitive impairments in the areas of attention, concentration, processing of information, motivation, and perception, and, consequently, damages decisional capacity. Additionally, much of the research demonstrating adolescents’ decisional capabilities has occurred in laboratory settings and may not always generalize to real-world settings, especially when the youth lacks all the relevant information provided in a research environment.

**CONFIDENTIALITY**

With children, the privilege of releasing confidential information resides with the guardian who initially consented to the treatment. Many states also require
adolescents over the age of 14 years to consent to the release of information. Typically, mature minors who have confidentially consented to their mental health treatment can independently allow or deny the release their records. Virtually every state allows exceptions to the principles of confidentiality. Physicians may disclose protected health information with other providers free of any release in situations that are considered medically necessary for the continuity of care or necessary to protect the minor, others, or the public against imminent harm.\(^\text{22}\)

Determining when to share information with parents is, perhaps, the most problematical challenge for a psychiatrist. Several states that sanction confidential treatment for mature minors also allow physicians to communicate with parents when such an intervention clearly is in the best interest of the youth. Conversely, many states permit physicians to deny guardians access to the medical record or protected information if the disclosure is likely to cause harm to the minor. The privacy guidelines of the Health Insurance Portability and Accountability Act\(^\text{22,23}\) authorize health care professionals, when acting in the best interest of the minor, to determine if or when guardians can have access to protected information. Although these regulations direct practice, they require clinical judgment to serve as the pilot.

Successful resolution of this dilemma begins at the initiation of treatment when psychiatrists establish whether the patient is the minor or the family and the psychiatrist’s relationship with each family member. The psychiatrist then elucidates the limits of confidentiality in a manner that is congruent with the youth’s developmental level. This discussion includes clarification of terms such as the best interest of the child and behaviors that may entail parental notification, including personal neglect, imminent harm, self-injury, and high-risk behavior. It is respectful to explore with older youth the clinical process by which sensitive material will be shared with parents. More specifically, doing so involves deciding who conveys the information and the context in which the material is shared. This understanding enables the youth to make an independent decision about what and when to disclose information to the psychiatrist.

Children who lack the legal status of a mature minor can be assured a measure of confidentiality when the guardians understand the importance of the therapeutic relationship between doctor and patient and agree to respect the confidentiality that is inherent in that relationship. This understanding is not an enforceable agreement and does not release the psychiatrist from the obligation of acting in the best interest of the child.

**COMMUNICATION WITH THIRD PARTIES**

Unintended disclosures to third parties represent a significant threat to confidentiality.\(^\text{24,25}\) Potential problems associated with documentation and record-keeping should be discussed openly at the onset of treatment. Records often contain personal information about family members and can be shared inadvertently even when a release of information is signed. This problem can be avoided by restricting documentation to relevant details about the identified minor, deleting sensitive material about family members from the medical record before releasing it to another provider, obtaining separate releases of information from each participant, or maintaining discrete records for each participant.

Communications with third parties who mandate treatment for the minor or reimburse the provider for those services can produce violations to confidentiality. Frequently, insurance carriers request clinical details and treatment plans before authorizing payment for services and frequently assume that with payment comes
the right to dictate treatment. Psychiatrists are encouraged to negotiate this potential conflict early in the treatment while preserving collaborative communication and therapeutic alliances with payors. General psychiatrists who work with managed care entities may be familiar with this dynamic. When information is disclosed, physicians are counseled to minimize these reports, including only the information necessary to secure authorization.

Likewise, courts, juvenile justice systems, social services agencies, and schools that mandate treatment for minors may request protected information as evidence of the youth’s compliance or as justification of remuneration for the services. It is essential for the treating psychiatrist to help the payor understand that it is paying for the psychiatrist’s best efforts, which may or may not be completely synchronous with the payor’s agenda. The optimal resolution is an agreement among the child and family, the referring agency, and the psychiatrist that restricts communication to attendance and general information about progress toward the identified goals. Again, the objective is to share the least amount of protected information to sustain medically necessary treatment. If the referring agency demands more protected information than is ethically required, the psychiatrist has the option to refuse services and refer the minor to other providers.

**ASSESSMENT AND DIAGNOSIS**

Because younger children typically have less experience, knowledge, and verbal fluency than adults, psychiatric assessment of children requires increased reliance on supplemental sources of information, including recurrent observation of the child, nonverbal interactions such as play, garnering information from parents, teachers, and other significant adults, and medical histories and other historical sources. It is important for psychiatrists to adjust their language and cognitive level to match the child’s abilities. A comprehensive child psychiatric assessment requires more time than is characteristic of an adult assessment. It also is important to discuss the results of the assessment with the child in a way that is congruent with the child’s cognitive and emotional level of functioning.

As with all psychiatric care, psychiatric diagnosis is fundamental for children. A good diagnosis provides valuable treatment guidance; a poor diagnosis rapidly leads one astray. Children often come to a practitioner with a pre-existing diagnosis, or at least with a hypothesized diagnosis. Obviously, it is important to determine objectively whether that diagnosis is accurate. Also, psychiatric disorders may manifest differently in children than in adults; for example, the broad phenotype of pediatric bipolar disorder may manifest fewer discrete manic or depressed episodes than seen with adult bipolar disorder.26 As noted earlier, psychiatrists must evaluate their level of competency when assessing and diagnosing children and seek consultation when needed.

As with adult patients, psychiatric assessments of children may be put to uses beyond clinical care. Schools may ask for assessments to determine whether a child qualifies for special education. Lawyers or courts may ask for an assessment to determine whether a child’s or adolescent’s actions were willful or were caused by a psychiatric disorder—put differently, and with different implications, whether or not the child is responsible and accountable for those actions. Adoption agencies may request psychiatric screening before adoption. Divorcing parents, their lawyers, or the divorce court may request a psychiatric assessment to determine who should have custody of a child. Managed care entities may wish to know whether they are obliged, under the terms of their contract, to pay for a child’s care. The assessing psychiatrist always
considers whether the child’s best interests are being protected and whether one’s professional competency boundaries are being overly tested.

Considering the difficulties of assessment, a diagnosis should not be ascertained by the youth’s initial response to a specific intervention. Although it often is tempting to make such a diagnosis, doing so is no more reliable or justified than it is with adults. For example, a positive response to stimulant medication does not confirm a diagnosis of attention-deficit/hyperactivity disorder, because most individuals would respond to stimulant medication with increased attention and enhanced cognitive performance.

ROLES AND BOUNDARY ISSUES

Clinical work with children can present uncertainties associated with potential boundary violations such as accepting hugs from patients, escorting children to the bathroom or assisting a preschooler with toileting, giving food as a reward; buying fund-raising items, accepting invitations to significant events, giving gifts to patients, and restraining out-of-control patients. Clinicians tend to be more flexible with their interventions when working with younger children. Understanding one’s professional perspective on boundaries and childhood developmental issues is vital to maintain a consistently therapeutic relationship with the youth.

Children commonly ask psychiatrists about their personal life and experiences or their personal views on controversial subjects. These inquiries may be innocent questions regarding the physician’s age or more sensitive, and less comfortable, questions about the provider’s religion, views on adolescent sexuality, or history of substance use. The wisest course of action is to maintain focus on the meaning of the question within the context of the patient’s phenomenological world and to provide a response that is congruent with the child’s intent behind the question, therapeutic needs, and emotional and cognitive developmental level. Of course, each psychiatrist establishes and reevaluates his or her professional boundaries concerning self-disclosure before initiating treatment.

Competing world views between the child and parents present unique practice dilemmas. This problem often is manifested at the initiation of treatment when the youth disagrees with the parents’ formulation of the problem behaviors and treatment goals. It may surface later on when the youth divulges beliefs or practices that are not necessarily dangerous or illegal but violate the parents’ moral, religious, or cultural values. A therapeutic alliance may not develop if the youth perceives the psychiatrist as an extension of the parental system. Alternately, the parents may terminate treatment if they perceive the clinician as overly identified with the child. The clinical and ethical task includes facilitating discussion between the child and parent. As indicated earlier, this task incorporates delineating who is the patient and facilitating communication that is contingent on the age and developmental level of the child, the therapeutic needs of the child, and the a priori agreement concerning what and how information will be shared with parents. Similarly, psychiatrists are cautioned to be aware of their own world views about families, discipline practices, and acceptable or unacceptable child and adolescent behaviors so that these standards are not imposed on the patient. When the child or parents are from a culture different from that of the psychiatrist, care should be not taken to assume a shared understanding of roles within the family. Ethical treatment occurs when the provider understands and respects the child’s and the family’s values.

Psychiatrists assume many roles while interacting with children. Psychiatrists frequently are asked by schools, lawyers, courts, adoption agencies, insurance
companies, and others to provide an objective expert opinion about a child. In such circumstances it is important for the psychiatrist to understand clearly whose agent they are and what role they are assuming. In situations in which the psychiatrist’s opinion may have an adverse outcome for the child, such as when a psychiatrist is asked by a court to render an opinion about a child’s mental competency, clarity about role and agency is especially important and should be explained carefully to the child and family. In particular, the psychiatrist should inform the child explicitly when an assessment is done other than for treatment reasons or when the usual standards of patient confidentiality do not apply. Such explanations should be made with consideration for the child’s cognitive and linguistic abilities. Similarly, a research psychiatrist should be clear with the child subject about the differences between research and clinical encounters.

A unique set of boundary issues exists in rural or small communities. Because of a scarcity of resources in rural environments, a psychiatrist may be the sole provider for youths who otherwise would be referred to another clinician. In small communities, families may solicit care from a trusted member of their defined group so that they will feel understood and valued. Most salient is the complexity of managing overlapping relationships with patients with whom psychiatrists regularly interact in the daily routine of community life. It is the psychiatrist’s responsibility to define the therapeutic relationship and the principles of confidentiality and to clarify that clinical discussion cannot transpire with the child or parent in any environment outside the designated clinical time. This explanation requires an open dialogue that acknowledges that the nonprofessional relationship may be affected. Additionally, the physician’s spouse or children may have personal or professional relationships with the minor patient or minor’s family at school, church, recreational, or other community activities. The psychiatrist must practice confidentiality rigorously.

PROTECTING CHILDREN AND CHILD ABUSE REPORTS

Psychiatrists who work with children have a special obligation to protect youth from harm. These responsibilities encompass the clinically ethical treatment of youths who may be neglected or abused by their parents or other designated care providers.

Ethical conflicts frequently are associated with disclosures of physical or sexual abuse of a child and the state requirements designating psychiatrists as mandatory reporters. Every state has a statute mandating mental health professionals to report suspected child abuse to an identified state agency. States impose penalties for failure to report and provide immunity from liability against good-faith reports. These reports, however, challenge the principles of confidentiality and threaten the therapeutic relationship. Often, children and parents feel betrayed when a report is made, especially if the limits of confidentiality were not discussed at the beginning of treatment.

Conflicts revolve around the questions of when and how to report. Most states do not define abuse explicitly or establish the norm for suspicion. Providers are encouraged to consult with state officials and trusted colleagues about the community’s paradigms of reportable abuse, particularly concerning physical and emotional abuse. Psychiatrists are encouraged to explore further their own values regarding corporal punishment, shouting, shaming, and other discipline styles before determining whether a child is being abused. Of course, all clinicians are responsible for acting in the best interest of the youth and must report any behavior that crosses their threshold of suspected abuse.
Additionally, the guiding principles are to maintain ethical and legal conduct while using every clinical effort to maintain the therapeutic relationship with the child and family. The decision of how to report depends on the imminent risk to the child. If the youth has endured serious harm or is at risk of serious harm, a report must be made immediately, regardless of the psychological impact on the child or family. Physicians, however, are expected to use their clinical skills to prepare the child for the likely consequences of such a report. In situations of minimal risk, providers need to assess the psychological status of the child and family and the probable effects of the report. One possibility is to help the child and/or parent make the report during the treatment session so that it is incorporated into the therapeutic work. Likewise, the psychiatrist may report in the presence of the child and/or family for the same therapeutic reasons. Or, a report may be made without informing the youth or family.

These obligations also direct treatment practices in a hospital or other setting in which the psychiatrist is clinically responsible for the care provided by allied mental health professionals and paraprofessionals. The psychiatrist has the ethical charge of comprehending the prevailing guidelines related to least restrictive treatment and the working definitions of seclusion, restraint, punishment, and aversive interventions and to ensure that the patients are receiving clinically appropriate and beneficial treatment. This responsibility translates to the preclusion of coercive, punitive, painful, or developmentally inappropriate interventions and the unnecessary use of physical, mechanical, or chemical restraints.

Although nurses and other providers may not report directly to the physician, the psychiatrist has the responsibility of assuring that each patient receives individualized care that is clinically appropriate. Ethical dilemmas may emerge if the physician observes the institution or a particular staff member engaging in harmful practices or failing to employ beneficial practices. To avoid these problems, the psychiatrist may need to provide psychosocial education and consultation to the staff regarding such issues as cognitive, emotional, and moral development, symptomatology of specific diagnoses, and boundary violations; to the administrators regarding such issues as clinical standards of care; and to parents regarding their child’s right to safe and helpful treatment. As in situations discussed previously, a report to a Child Protective Services agency may be warranted.

**RESEARCH ISSUES**

Inherent to psychiatric research with minors is the conflict between gaining essential scientific data about childhood disorders and the need to protect the rights and integrity of the participants. The insufficiency of empirically validated treatments, particularly in the domain of psychopharmacological therapies, denies youth the benefit of evidence-based care. Consequently, untested care can be construed as experimental and unethical in that the interventions may lack beneficence or may cause unintended harm. This situation was recognized by the National Institutes of Health when it established the goal of increasing the participation of minors in research that investigates the treatment of disorders that affect children. This research is intended to benefit children and adolescents who are diagnosed as having specific disorders and to improve the public health status of minors. Children, however, are identified as a vulnerable population that requires specific safeguards to protect them against exploitation and any undue harm. These youths are additionally vulnerable because they have medical, psychiatric, or developmental disorders.
Legal precedent assumes that minors lack the capacity to consent to their inclusion in research. Because consent can be imparted only by the individual partaking in the research, the minor’s participation requires permission by the parents or guardians. The Department of Health and Human Services (DHHS)\textsuperscript{34} guidelines, however, require minors to assent or affirmatively to agree to their participation. The absence of an objection does not translate to an assent. Significantly, children can veto their participation and withdraw from the project at any time during the research protocol. This ability to withdraw essentially protects their right to volunteerism.

Information about the research must be presented to the minor at a level proportionate to the child’s age and developmental level. A child’s capacity to assent is determined by the child’s age, developmental maturity, and psychological state at the time of recruitment. Although children usually are not considered capable of giving assent until age 7 years, younger children have the right to learn about the research and to assent to their involvement.\textsuperscript{6,32,34}

As discussed earlier, the concept of a “mature minor” has emerged recently in the psychiatric, ethical, and legal literature.\textsuperscript{19,36} This concept has been expanded to allow mature minors the opportunity to consent independently to their involvement in a research project. The Institutional Review Board (IRB) that sanctions a specific research trial has the authority to waive the requirement for parental permission, thus permitting mature minors to consent to confidential participation in that specific investigation. Recent Federal regulations\textsuperscript{37} established three criteria that IRBs must follow before granting mature minors this right: that the research involves no more than minimal risk; that the waiver of parental permission will not affect the welfare of the research participant adversely; and that the research project could not be performed practically without the waiver of parental permission.

Research with adolescents who are homeless or who engage in high-risk or illegal behaviors would not transpire if the construct of mature minor did not exist. The Society for Adolescent Medicine\textsuperscript{38} argues that adolescents who engage in substance abuse and other sensitive behaviors will not participate in research unless they are assured of confidentiality. Without the participation of these youths, important data about effective prevention and treatment interventions will not be obtained.

The DHHS systematizes the safeguards necessary to protect minors from the potential harm associated with the research. Risk is determined by appraising the risk to the participant, the benefit to the participant, the benefit to similar children or children in general, and the minor’s capacity to assent. Minimal risk is defined as a situation with risks no greater than those experienced in children’s daily lives, assuming that a daily life represents a safe and caring environment.\textsuperscript{6,23,34} If the study exposes the child to no more than minimal risk, the minor’s participation is acceptable with one parent’s permission and the child’s assent.

When the study presents more than minimal risk, minors can participate if the benefits are greater than the risks. In this circumstance, permission of both parents, when applicable, and the assent of the minor is required. The benefit to the specific participant must be at least equal to that of the other treatments available to children who have the same disorder. Participation can proceed if one parent grants permission, and the child assents. Research that exposes children to more than minimal risk and offers no direct benefit to the participant can proceed only if the study is likely to generate useful data that will benefit other children who have the same disorder. Importantly, the minor must not incur any unpleasant experiences that exceed those routinely sustained in a medical, dental, psychological, social, or educational encounter.\textsuperscript{6,23,34}
SUMMARY

Clinical work—psychotherapy, assessment, consultation, or research—with emotionally ill children and adolescents is challenging, complex, and exceedingly rewarding. Psychiatrists must remain mindful of children’s vulnerabilities but also remain respectful of their rights, regardless of any legal barriers or developmental limitations that exist. To varying degrees, youths are afforded the rights of integrity, autonomy, informed consent or assent, protection of health care information, and participation in research. All physicians who work with children and adolescents are obliged to possess the requisite skills necessary for the provision of beneficial assessments, psychotherapy and psychopharmacology, the protection and advocacy that vulnerable children may require, and the ability to collaborate with families, schools, and other systems in which children regularly function. This work requires self-examination and awareness of one’s values and attitudes about children and families and self-monitoring of one’s motivations and intents during therapeutic interactions. Additionally, psychiatrists are reminded to seek consultation from valued colleagues whenever an ethical quandary presents itself. Finally, while negotiating the multiple requirements of children, families, communities, legal statutes, and professional ethics and standards, psychiatrists must maintain an ardent commitment to the safety and well-being of their young patients.

APPENDIX 1: ADDITIONAL RESOURCES

Readers who wish to pursue this topic further or who wish to consult additional resources may find the following items of use:

8. The Journal of the American Academy of Child & Adolescent Psychiatry regularly publishes 10-year reviews of a variety of topics on child psychiatry.

REFERENCES