In the Best Interests of the Child: Ethical Challenges for Counsellors and Psychotherapists

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Introduction

Working with children is challenging in many ways, not least of all ethically. When health professionals work with children or young people they are, to a greater or lesser extent, also working with at least one parent or guardian. A child rarely presents for therapy without an adult deciding it is necessary for some reason (Koocher, 2008). Sometimes it is a parent or a teacher who wants the child to attend therapy, and sometimes it is a family therapist (Lowe, 2004). Given that young children are not always in a position to give informed consent to treatment such as counselling or psychotherapy, the adults involved are required to act in such a way as to protect the 'best interests of the child'.

This requirement to act in the child's best interests stems from the Convention on the Rights of the Child (CRC), that was adopted by the United Nations in 1989 and ratified by the Australia Federal Government in 1990. The Convention is based on the following core principles:

- the right to survival and development
- respect for the best interests of the child
- the right of all children to express their views freely on all matters affecting them, and
- the right of all children to enjoy all the rights of the CRC without discrimination of any kind (Australian Human Rights Commission, 2012).

Applying these principles sounds easy, but is complex in practice. Deciding what is in the best interests of the child is not always straightforward. The chronological age of the child —her or his level of emotional maturity and ability to understand the consequences of certain actions—may need to be taken into account (McGivern, 2008). This is where the difference between young children, mature minors (who might be between 14 and 16 years old) and young people (aged between 16 and 18 years old) can also be important.

In most instances, parents have the best interests of their children at heart and can be relied upon to make wise decisions on their behalf. Ethical dilemmas are more likely to arise for health professionals when: (a) parents disagree with each other about the child's best interests, (b) parents disagree with the child or young person about the best course of action, or (c) the health professional believes one or both parent(s) to be acting in their own rather than in their child's best interests (Koocher, 2008). Ethical dilemmas also arise

when the counsellor or psychotherapist feels caught between their duty to the child's privacy and their duty to report material disclosed in the session, either to the child's parents or to authorities.

This article brings together theory and practice and, through the use of a typical scenario, draws out ethical dilemmas that clinicians may face in practice. It suggests guidelines for practice drawn from recent literature. Since most issues in working with children and adolescents relate to competence, consent, confidentiality or competing interests (Koocher, 2008) and child maltreatment these will be discussed in turn.

Scenario

A counsellor with a basic counselling qualification works in private practice in a rural town. The counsellor has completed a one-day training course in working with children but has no systemic or specialised training, and no previous experience working with children. A mother asks her to see fourteen-year-old girl, Emily, who is refusing to go to school. The mother doesn't want her daughter to see the local child psychologist because she dislikes her approach. There are no other child therapists in the small town, other than the school counsellor, a male psychologist whom Emily refuses to see.

The counsellor decides to see Emily. Emily's mother doesn't want the counsellor to contact Emily's father for any reason, as they are in the midst of an acrimonious divorce. It becomes apparent that Emily's mother would like to use the fact that Emily needs to see a counsellor to her advantage in the divorce proceedings and wants to keep this secret from her ex-partner. In fact, she asks the counsellor to write a letter for her lawyer saying that it would be better for Emily not to see her father, because he is an 'angry man'.

Once in therapy, Emily reveals that she is thinking about becoming sexually active with her fifteen-year-old boyfriend. She has smoked marijuana on several occasions with her current boyfriend, who is a regular user. She doesn't want the counsellor to tell her mother, who would 'freak out'. She promises the counsellor that she won't do it again. One week she arrives in great distress and describes how she has been raped by her twenty-five-year-old neighbour.

Competence

Working with children is recognised as a specialisation in Australia, and educational and child psychologists are required to study at the postgraduate level. The requirements for school counsellors are stringent and vary from state to state. For example, in NSW, school counsellors are required by the Department of Education and Training (DET) to have qualifications in both teaching and psychology, including having completed an APAC approved postgraduate school counsellor training program and a DET-approved practicum in schools (Department of Education and Training, 2012).

Whilst many therapists are highly trained to work in this area, there may be some counsellors and psychotherapists who work with children, especially in rural areas, without having completed specialised postgraduate training. Those working in private practice are often unregulated and are therefore able to determine their own areas of expertise (Koocher, 2008), like Emily's counsellor. This can lead them into difficulties, particularly given the temptation for clinicians to move beyond their role and level of competence. This is more likely to occur when the clinician believes that child abuse or domestic violence may be occurring within the family (Zimmerman et al., 2009). It is important that health professionals working with children are aware of the limits of their own competence to deal with issues that arise. This awareness may come from additional training, reflexive practice, or from supervision (Goldenberg & Goldenberg, 2013).

It could be argued that working with children is a form of systems therapy, since it requires working with at least one adult. Certainly "psychotherapy with children and adolescents constitutes a kind of forced multiple relationship. The clinician typically has an identified client with a plethora of interested others" (Koocher, 2008, p. 606). These interested others may include parents, grandparents, social workers, school principals, school counsellors, probation officers, and others. It is therefore important for all health professionals working with children to have a thorough understanding of ethical codes and policies related to working with families and systems, be familiar with the process of ethical decision-making, recognise ethical dilemmas, understand when consultation is necessary, and practice within the scope of their competence (Gehart, 2010).

Consent

It is incumbent on the therapist to ask for the child's informed consent to being counselled alone without parents present in an appropriate manner, using child-friendly methods and materials. However, one of the complications of this work is that not all children can give informed consent to therapy. Children are seen to have "increased emotional and psychical vulnerability" (Jenkins, 2012, p. 263), partly for this reason. When they lack the capacity to give informed consent, for whatever reason, this must come from one or both of their parents or legal guardians. However, the clinician also has "a responsibility to consider the best interests of our vulnerable clients" (Koocher, 2008, p. 603).

The other complication is the age at which a child or young person is considered old enough to give informed consent to receive treatment themselves, often without reference to their parents. The law in Australia does not make it clear who is able to give valid consent for medical treatment, such as psychiatric help. According to McGivern (2008, p. 434) "consent to treatment is only valid if it is given by a person who: is competent; has sufficient information to make a decision; and is acting voluntarily", but in the case of a child this is complicated by chronological age, mental and emotional age, level of understanding of consequences, and level of maturity. In practice, decisions made in relation to such issues are often more fluid for children aged between 14 and 16, than for those aged under 14.

This issue is also complicated by differences in state laws in relation to the age at which children are considered to be competent to make such decisions for themselves (e.g. at age 14 in NSW, age 16 in SA). McGivern (2008:443) states that “it is unclear whether in Australia a competent child has the ability to ‘veto’ a treatment decision made by his or her parent (or parents) and/or whether parents can ‘veto’ the decisions of a competent child.” In any case, the therapist has a duty to make every attempt to provide age and developmentally appropriate information regarding their approach to the child. It would not be an adequate defence, if challenged, to automatically assume an inability on the part of the child or young person to give informed consent. This must be sought be the therapist in a developmentally appropriate manner using child-friendly resources (Corey, Corey, & Callahan, 2011; Goldenberg & Goldenberg, 2013).

In most situations, it is important to receive written consent from both parents before seeing a child in therapy. However, there may be exceptional circumstances in which it is deemed to be in the young person’s best interests not to ask for consent from his or her parent(s). This is not a decision to be taken lightly and may be challenged through the court system. However, the Family Law Act (1975) does require that, in considering the best interests of the child that the following be considered: “the views and wishes expressed by the child, the child’s relationship with his or her parents and others, the child’s maturity, sex, lifestyle and background, together with any other facts and circumstances that the court considers relevant” (McGivern, 2008, pp. 451-452).

In the case of Emily, the counsellor needs to decide whether or not Emily is old enough to give informed consent to be counselled alone, and how to negotiate with Emily and her mother about what information the therapist would need to disclose from these individual sessions to Emily’s mother. In this case, as in many, the issues of consent and confidentiality are interwoven.

Confidentiality

Confidentiality raises similar issues, particularly when the children or young people do not want their parent(s) to know that they are seeking counselling. The main ethical dilemma is between the rights of the child or young person to confidentiality versus the rights of parents to information about their children. In the US, this dilemma has been played out in the courts with more conservative states allowing parents full knowledge of their child’s treatment and with more progressive states allowing children and young people to seek treatment without their parents’ knowledge (Gehart, 2010, p. 39).

Confidentiality is seen as fundamental to counselling and psychotherapy in order to establish a level of trust within the therapeutic relationship (Jenkins, 2012). However, for young people, the level of confidentiality that we offer is weakened by the limitations that we place on it. In Australia, some of these restrictions are required by law, such as mandatory reporting of child maltreatment. Others are seen as in the child’s best interests (e.g. informing parents if a child is suicidal or intending to self-harm).

Some therapists argue that privacy from parents, rather than secrecy, is important in adolescence and that it relates to the child's level of maturity since it demonstrates emotional differentiation from parents (Ellis, 2009; Jenkins, 2012). "Clinically, an adolescent is growing in autonomy and independence and wants some level of privacy. Good treatment will foster the conditions that allow this to flourish" (Ellis, 2009, p. 560). Ellis further argues that it is best for the therapist to encourage parents to allow their adolescents some measure of privacy in treatment "as long as the psychotherapist pledges to notify the parent if the child is in danger" (Ellis, 2009, p. 561). However, the author points out that such an agreement between the therapist and the parents is not legally binding and recommends extreme caution when working with parents who are divorced.

Ellis (2009) believes that US psychotherapists have begun to grant children and young people more rights with regard to their mental health treatment, and that court rulings often support the mature minor's right to confidentiality if it is deemed to be in the child's best interest. Weithorn (1983 cited in Ellis 2009: 558) suggested that this involvement in decisions about treatment is:

'consistent with our own legal and ethical principles that respect the human right to self-determination. It contributes to adaptive and healthy psychosocial functioning in children. It may increase their motivation and commitment to treatment, and last, it may facilitate collaborative problem solving between the child, psychotherapist and parents'.

Many of the researchers in this field offer a risk aversive approach to dealing with these issues. Their recommendations include anticipating conflict (especially if the parents are divorced or are in a custody battle over their children), conducting pre-treatment family meetings, clarifying expectations about confidentiality, keeping meticulous records, and asking parents to sign written agreements before therapy begins (Ellis, 2009; Koocher, 2008; Zimmerman, et al., 2009). Some authors recommend asking young persons for informed consent when they wish to make a disclosure and consulting them about the manner in which the disclosure will be made (Geldard & Geldard, 2010).

In the UK, the rights of young people to keep certain information confidential from their parents and to seek treatment themselves has been upheld through the legal system (Jenkins, 2012). Clinicians are often asked to make difficult judgments when adolescents engage in risky behaviour that demonstrates a lack of judgment and immaturity but is not reportable by law (Ellis, 2009). Having a good rapport with both the child and the parents makes these situations much easier to handle.

In the case of Emily, the counsellor needs to make such a judgment about Emily's risk-taking behaviour and about whether to discuss it with her mother or keep the information confidential, in the light of legal and ethical requirements placed on counsellors and psychotherapists. There are some ethically difficult questions that must be answered here. Who should decide whether or not Emily's consensual sexual activity places her at

risk? Does her experimentation with drugs place her in danger? If Emily is unwilling to confide in her mother what, if anything, should the counsellor tell Emily's mother against her will?

Often counsellors are tempted to make judgments about the risk to the child or young person based on their own beliefs and values about what is correct behaviour for children of that age e.g. sexual activity is wrong, drug experimentation can't hurt and so on. The counsellor is a 'thinking/feeling being who brings into the present moment the accumulated weight of the past' (Brennan, Eulberg, & Britton, 2011, p. 73). There is also a 'temptation to think that a good working alliance with a young person necessarily means sitting with them against authority, and thus the temptation to collude with anti-parent positions' (Shaw, 2012), rather than recognising that informing the child's parents may sometimes be in the best interests of the child.

Competing Interests

The issue of competing interests can arise at any time when a parent and a child have differing views. It becomes particularly apparent in cases of divorce or in custody hearings, when parents can become caught up in their own emotional distress and lose sight of what is in their children's best interests. In the worst cases, parents act in their own best interests to the detriment of their children. For example, a family member might demand custody of a child in order to gain financially by receiving a carer's pension, or a parent might request notes relating to the treatment of a child to be used in a custody case, which inclusion in court proceedings may not be deemed to be in the child's best interests (Ellis, 2009). A therapist caught in the middle of such challenging family dynamics inevitably faces ethical dilemmas, as in Emily's case.

The Australian court system weighs up the benefits and disadvantages for children of having contact with both parents, particularly when there has been an allegation of family violence or child maltreatment of any kind. In doing so, the child's point of view needs to be considered and taken into account (Fitzgerald & Graham, 2012). In the US, the courts consider "(a) the child's preferences and needs; (b) the ability of the parent to meet the child's needs; (c) the ability of the arrangements and the respective parents to provide a stable environment, including maintaining community, educational, and social involvements of the child; (d) providing for the other parent to maintain a salutary relationship; and (e) provision for any special needs" (Zimmerman & Hess, 2009, pp. 540-541). Given the complexity of the law, most counsellors are not sufficiently trained to give 'expert' opinions in custody battles, and should not be tempted to overstep their role.

Clinical, forensic or child psychologists are often required to make a child custody evaluation in order to determine which parent should receive custody of a child, but this role is recognised as carrying the inherent risk that the psychologist will eventually have a formal complaint made against him or her (Wilmoth, 2007; Zimmerman & Hess, 2009). It is extremely easy to 'inadvertently engage in unethical practice' when working with divorced families, and the psychologist needs to be familiar with state laws, including

those related to confidentiality, to gain the correct informed consent for one or both parents as required, and to avoid releasing confidential information about the child's treatment against the child's best interests (Zimmerman & Hess, 2009, p. 540).

There has been a shift towards listening to the child's point of view in custody cases in Australia, and this is believed to have positive effects on the children (Fitzgerald & Graham, 2012). In a small-scale study of 19 Australian adolescents who telephoned the researcher, 10 were surprised by their parents' separation and 11 said that they had never been told why it had occurred (Bagshaw, 2007). The author argued that children should have a stronger voice in cases of parental separation, especially when there was ongoing parental conflict, and that services should "ensure that children were provided with appropriate information, therapeutic support, opportunities to have a voice in decisions that affected them, and opportunities to develop their coping capacities" (Bagshaw, 2007, p. 463).

In another small-scale Australian study of 13 children whose parents were going through the courts, most of the children said that they had not been sufficiently consulted. However, some of them explained that they did not want to speak up in court or were highly ambivalent about doing so, for "fear of a parent's response, fear or concern of hurting or distressing a parent, thinking there was not much point (in their experience no one would listen even if they did express a view), and that adults should have responsibility for making decisions" (Fitzgerald & Graham, 2012, p. 496). This study suggests that it is not as simple as just giving children a voice, particularly in highly conflictual situations.

In most cases, it is obviously in the best interests of the child to have ongoing relationships with both parents as part of a healthy upbringing. This can be achieved, provided that the child can have a "safe and healthy relationship with both parents, who also communicate with one another" whether or not the parents are divorced (Zimmerman & Hess, 2009, p. 541).

Child Maltreatment

Across the world, the issue of mandatory reporting of child maltreatment is contentious, with the UK and New Zealand choosing not to enact these laws (Jenkins, 2012; Mathews, 2008) and with Western Australia adopting this law as late as January 2009. In New Zealand, GPs argue against its introduction (Goodyear-Smith, 2012) because of the recognised importance of patient-doctor confidentiality in maintaining the therapeutic relationship and the concern about the impact of false reports on the family:

If GPs face penalties should they fail to report suspected cases … the patient-doctor relationship may be the sole source of positive intervention for at-risk families, and fear of notification to the authorities might deter parents from bringing their children to the practice (Goodyear-Smith, 2012, p. 79).

In the UK, it is believed that mandatory reporting gets in the way of children and young people seeking out certain services, such as pregnancy advice or family planning (Jenkins, 2012).

Australian law is relatively clear on this issue, and health professionals have been mandatory reporters of child maltreatment for many years in some states. South Australia was the first state to introduce mandatory reporting laws in 1993. For details of the law in each state visit the Australian Institute of Family Studies website. http://www.aifs.gov.au/cfca/pubs/factsheets/a141787/index.html.

Australian case law suggests that "failure to report a suspicion of abuse may produce a liability in negligence, regardless of the presence or absence of a legislative reporting duty, where the person with the suspicion owes the child a duty of care" (Mathews, 2008, p. 219). Certainly, it is clear that the rape of a fourteen-year -old, like Emily, would need to be reported to the police.

Sometimes families become embroiled in the issue of child abuse during a divorce hearing. This complicates matters further for all health professionals involved. The courts recognize that "permanency of the family unit, although admirable in purpose, is not always in the best interests of the child" (Sempek & Woody, 2012, p. 437). If the family therapist does become involved in the court system, he or she must act in the best interests of the child.

Discussion of the Scenario

Emily's case presents the therapist with ethical dilemmas in relation to all five Cs: competence, informed consent, confidentiality competing interests and child sexual abuse. The most clear-cut of these is the rape of a child by an adult. The mandatory reporting laws mean that the health worker must report the crime to the police as quickly as possible. In most cases, this can be done with Emily's consent and her agreement that her mother needs to know what has happened. The police will need to be informed regardless of Emily's preferences, and it is inevitable that her mother will find out from them. This will need to be explained to Emily, who will have had the limitations to confidentiality explained to her in the first session.

Clearly the rural counsellor took a risk, in terms of working beyond her scope of competence, in agreeing to see Emily in the first place. She would need careful supervision from an experienced child therapist to avoid the many ethical dilemmas that the case presents. She would be well advised to have a discussion with Emily's mother before therapy began, in order to clarify her role and what she would and would not be willing to do. In that discussion, she could advise Emily's mother that, as a counsellor, she would not be willing to give evidence in court or to make a child custody evaluation.

The counsellor might take a position on whether or not she needed to receive informed consent from both parents, given that Emily could be viewed as a mature minor. This would be a bigger dilemma if Emily were younger or suffering from developmental delay.

As a mature minor, it could be argued that it would be in Emily's best interests to keep some information confidential from her parents and that this would be a sign of her growing maturity, but the counsellor needs to be aware that this position could be challenged in court, and that the requirements differ from one state to another.

Given that Emily is the client and is still a vulnerable child in some ways, the counsellor must act in her best interests at all times. Emily is involved in some high-risk behaviour with her peers, and the counsellor will need to make a judgment about whether or not Emily's parents need to be informed. Certainly, the best outcome would be for Emily to be willing to discuss these issues with her mother and/or her father present and for the family to work together to support Emily in choosing safer behaviour. Of course, such sessions can be challenging to manage but they allow for a valuable exchange of information between family members about change, development, and individual decisions.

It is always easier for the counsellor to choose to preserve the good rapport built up in the therapeutic relationship with the child, by not creating waves. This choice may potentially lead to the risk of an escalation in Emily's behaviour. For Emily's sake, the counsellor needs to bear in mind the importance of preserving family relationships in the long-term, if at all possible.

In order to work through the ethical dilemmas presented by this case, the first challenge for counsellors is to recognise that they are facing an 'ethically important moment' (Guillemin & Gillam, 2004, p. 261) in which there is the potential for them to make a good or a bad ethical decision. This requires a high level of professional reflexivity (Haverkamp, 2005).

Having recognised an ethical dilemma, the counsellor would be well advised to consult widely with the following:

- the current literature in the field;
- the relevant ethical codes for working with children;
- the relevant state law;
- agency guidelines for working with children;
- their peers who have worked with similar cases; and
- their supervisor.

This consultation will enable the counsellor to clarify alternative courses of action, weigh up the potential positives and negatives of each course of action for all those involved, and make a decision between what may be two almost equally undesirable alternatives supported by their supervisor.

Conclusions

Many readers may be wondering whether or not it is worth the risk of working therapeutically with children. In my experience, child therapists find this work deeply satisfying and rewarding and well worth the risks involved. Children and young people can benefit enormously from therapy, which can be transformational.

This article points to some of the ethical dilemmas that the therapist may face. The main ethical dilemmas relate to the five Cs: competence to practice in this field, consent from parents or guardians when necessary, confidentiality for the child versus the rights of the parent(s) to information, competing interests and disagreements between parents and children , and child maltreatment. This is obviously a complex area of work, requiring additional training, good reflexive practices, and thoughtful supervision.

Many therapists are passionate about working in this area and the need for children's voices to be heard, especially when their parents are going through a separation or divorce (Bagshaw, 2007; Castelino, 2009). Children have less power than the adults involved and are often not heard though the chaos of the situation. "Children's voices are often silenced, their understandings are not noticed, credited, or responded to, and they are considered as being passive, without knowledge or perception. Therefore, in working therapeutically with children, it is my [the author's] responsibility to prevent the perpetuation of this silencing discourse" (Castelino, 2009, p. 66).

In working therapeutically with children and young people, the therapist may feel the need to stand up for the rights of the client. It is possible for the therapist to refuse to give evidence in court, if he or she believes that giving evidence would not be in the child's best interests. The therapist can hope that the courts will view this with leniency in any future proceedings (Livermore, 2007, p. 199). However, such actions require fortitude, the courage of one's convictions, and support from a good supervisor and/or workplace.

Certainly, when counsellors and psychotherapists decide to work with highly conflictual families in cases involving divorce or custody battles, they run a higher risk of "incurring ethics complaints and lawsuits" (Wilmoth, 2007; Zimmerman, et al., 2009, p. 539).

The following is a list of suggestions given to minimise risks. The therapist should have:

- an appropriate level of education and ongoing training;
- an awareness of developmental issues in obtaining consent for treatment;
- a pre-treatment consultation with parents to establish an agreement over confidentiality, and clarity about the role of the therapist and mandatory reporting requirements;
- an awareness of, and willingness to, mediate about competing interests between parents and children;
- meticulously kept, separate notes for sessions with different family members, documenting the actions taken by the therapist;
- an awareness of possible countertranference issues, especially in high risk situations involving child maltreatment or domestic violence;
- a clarity about the therapist's willingness to give testimony;
- an understanding of the need to refuse to give testimony beyond the scope of the therapist's role;
- a strong network of colleagues and a supervisor who is available for consultation;
- a good working knowledge of the relevant codes and guidelines for working with children; and

- a willingness to interact with family members, particularly after a serious event such as a suicide (Koocher, 2008; McWhirter, McWhirter, McWhirter, & McWhirter, 2013; Zimmerman, et al., 2009).

With awareness and adequate preparation and training, therapists can be a valuable resource in working with troubled children and young people and help them to work towards a better future.

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