Excerpts from…

Confidentiality in the treatment of adolescents

(APA Monitor Volume 33, No. 3 March 2002)

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Q: *I work with adolescents, and am not clear about my ethical obligations concerning confidentiality. When treating young children, the issue rarely arises. With adolescents, though, I sometimes struggle with whether to share information with a parent. The issue seems especially pointed when adolescents talk about activities that, while not necessarily dangerous, are illegal, such as shoplifting, the recreational use of alcohol or experimenting with drugs. What to do when an adolescent becomes sexually active, of course, is often a difficult issue. Does the APA Ethics Code provide guidance?*

A: It is most helpful to consider this question from three perspectives: that of law, of clinical practice and of ethics.

The law. The law is a blunt instrument, as the issue of minors and confidentiality well illustrates. Minors generally cannot consent to treatment; a parent or guardian consents on the minor's behalf. There are exceptions. Certain states allow minors whom the law deems especially mature, such as those who are married or in the armed services, to consent to treatment, and sometimes minors may consent to treatment for substance abuse or sexually transmitted diseases. The exceptions are few, however, and prove the rule that the law deems individuals under a certain age (often 18) not sufficiently mature to make treatment decisions.

A parent who consents on the minor's behalf generally has the right to know the content of the child's treatment. This state of affairs changes when the minor reaches the age of majority. Until that time, the law will normally give the parent access to the child's treatment.

Clinical practice. From a clinical perspective, the situation is more complex. An important aspect of treatment is to foster an individual's autonomy, and a great pleasure of treating adolescents is to watch as they come to enjoy their growing independence. One aspect of independence is privacy. As a child grows into adolescence and adulthood, the surrounding zone of privacy should increase, thus making room for a more defined sense of self and a greater sense of autonomy. A paradox thus arises: Good clinical treatment may require what the law generally refuses, that is, a zone of privacy.

Ethics. Can our Ethics Code ease the apparent tension between law and clinical practice?

Standard 4.01, "Structuring the Relationship," states that "Psychologists discuss with clients or patients as early as is feasible in the therapeutic relationship...the nature...of therapy, fees, and confidentiality." Standard 4.02, "Informed Consent to Therapy," states that when an individual cannot provide informed consent (such as a minor), psychologists "consider such person's preferences and best interests." Standard 4.03, "Couple and Family Relationships," states that psychologists "attempt to clarify at the outset (1) which of the individuals are patients or clients and (2) the relationship the psychologist will have to each person."

Three points emerge. First, early in the relationship the psychologist should make clear what relationship she will have to each of the parties. Second, central to that early discussion should be an explanation of how information-sharing will work--what information will be shared, with whom and when, in a manner appropriate to the child's age and understanding. Third, as the child develops, the structure of the therapy may change for clinical reasons. Thus, the changing clinical picture will have ethical implications. The child's greater sense of self and enhanced capacity for autonomy may require greater respect for the child's need for privacy. The psychologist will thus need to revisit earlier discussions and explain that, for clinical reasons, the structure of the therapy should change. Such boundary renegotiation, while complex with certain adolescents and families, is clinically and ethically indicated….

Second, clinical judgment will indicate to what extent maintaining an adolescent's privacy is central to the treatment. It may be, for example, that an adolescent has conflicting wishes about keeping information private. A psychologist may conclude that an adolescent's wish not to have information shared reflects an appropriate separation and so should be honored. Or, a psychologist may conclude that sharing certain information would be helpful; if so, the ethical standards from the section on "Privacy and Confidentiality" give the psychologist permission to do so.

Third, few things carry such potential to disrupt a treatment as an adolescent's feeling that information was shared without his or her knowledge. Regardless of whether an adolescent assents to have information disclosed to a parent, it makes both clinical and ethical sense to tell the adolescent--beforehand, if possible--what information will be shared, and when. Ideally, the adolescent would be part of such conversations.

Fourth, at times a psychologist will be mandated to disclose information. Serious threats of harm must be disclosed in many states. Neglect or abuse falls under mandatory reporting laws. The extent to which the psychologist explains the limitations on confidentiality will depend on the child's age and maturity. Certainly, however, adolescents should be told that serious threats of harm to self or others will not be kept confidential.

Fifth, many of the activities adolescents engage in do not rise to the level of reportable behavior. Nevertheless, some are on the edge and require judgment calls. For this reason, psychologists who treat adolescents will want to have a good working knowledge of mandatory reporting requirements and to be liberal in their use of consultation.

Finally, a psychologist may feel strongly that revealing information to a parent could harm the patient or be destructive to the treatment. A refusal to disclose in such a case, even in the face of a parent's request, may be legally supportable. A psychologist in this position should seek both legal counsel and consultation from colleagues….