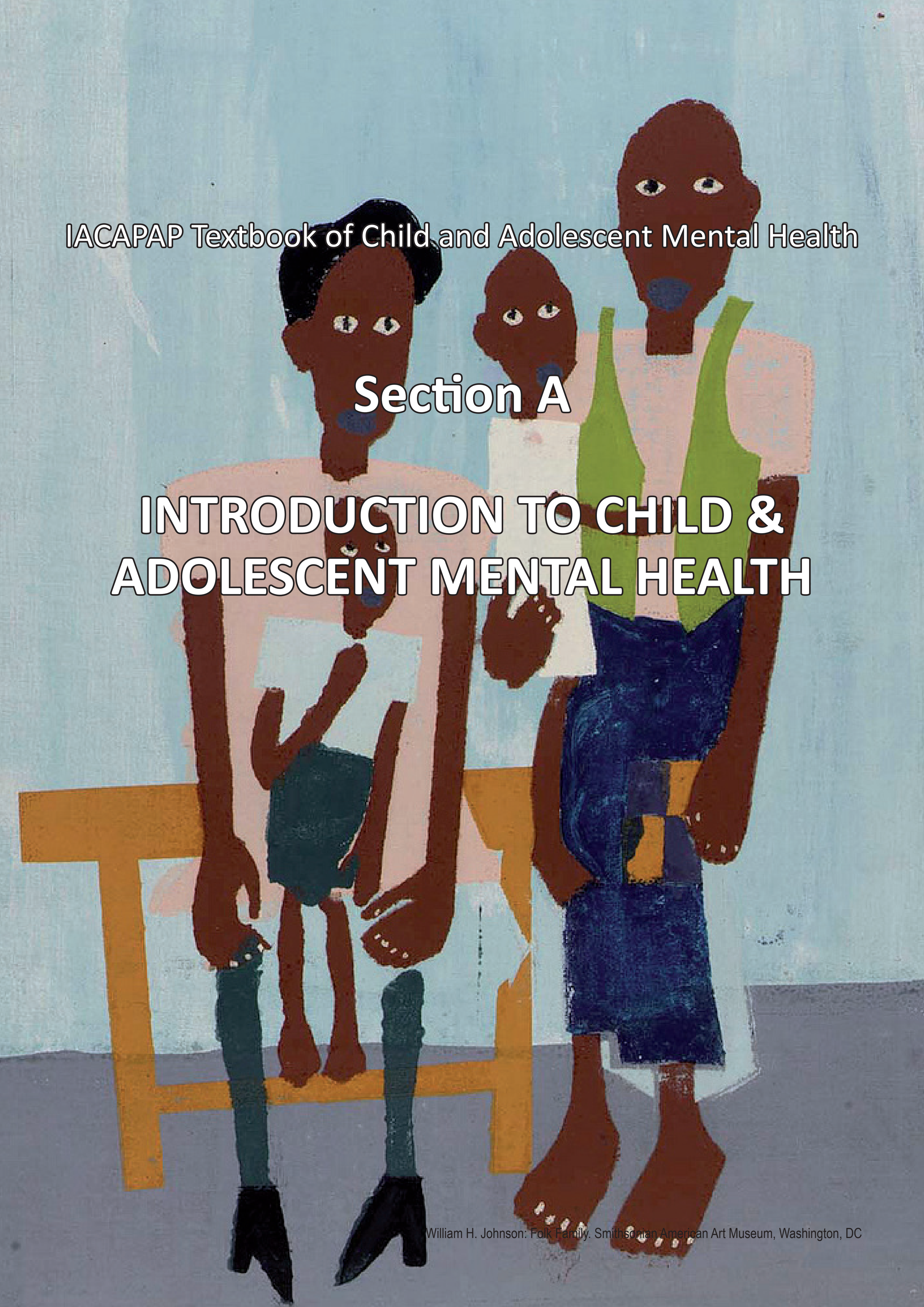
IACAPAP Textbook of Child and Adolescent Mental Health

Section A

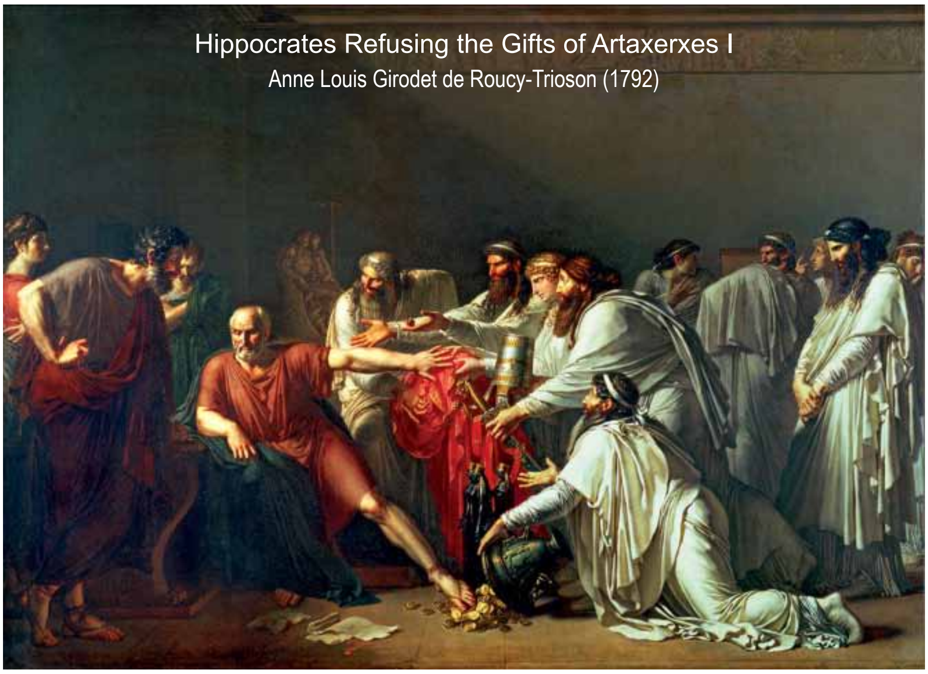
INTRODUCTION TO CHILD & ADOLESCENT MENTAL HEALTH



William H. Johnson: Folk Family. Smithsonian American Art Museum, Washington, DC

ETHICS AND INTERNATIONAL CHILD AND ADOLESCENT PSYCHIATRY

Adrian Sondheimer & Joseph M Rey



Hippocrates Refusing the Gifts of Artaxerxes I

Anne Louis Girodet de Roucy-Trioson (1792)

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Conflict of interest: none declared

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"Of moral purpose I see no trace in Nature. That is an article of exclusively human manufacture – and very much to our credit"

Thomas Huxley

In a thoughtful and deliberate move, the opening chapter of the first IACAPAP textbook of child and adolescent mental health focuses on the relationship between ethics and the field. While this chapter focuses on medical practitioners, most of the ethical issues discussed apply to all mental health professionals (e.g., psychologists, social workers, nursing personnel, therapists) treating children and adolescents. Unless otherwise specified, "child" is used to mean all people younger than 18 years, "parent" represents parents and guardians, "child psychiatrist" means child and adolescent psychiatrists, and "child psychiatry" means the discipline of child and adolescent psychiatry.

Thomas Henry Huxley (1825-1895) by Carlo Pellegrini ("Ape") 1759-1840. Dibner Library, Smithsonian Institution.

Child psychiatry is a subspecialty of psychiatry, and psychiatry is a medical specialty. The profession of medicine is intrinsically designed to do battle with whatever ails the human body and mind, and it attracts practitioners who are so inclined. If one were to define ethics as that intellectual line of inquiry focusing on the rightness and wrongness of human behaviors (American Heritage New Dictionary of Cultural Literacy, 2005) then medicine is an exemplar among the professions in that, as a vocation devoted to benefitting both the individual and collective human condition, it is founded and based on trying to do "the right thing". Thus, the medical profession and its practice seem clearly based on an ethical perspective. If only, however, matters could be viewed so simply. In fact, the study of ethics most commonly focuses on the complexities of the human condition which, by definition and experience, is usually composed of gray, complicated and murky areas. Only rarely does an ethical inquiry seem to offer stark black and white contrasts. That makes the examination of ethical questions interesting.

Psychiatry, more than any of the other medical specialties, attempts to focus equally on mind and body (Slavney, 1993). Ideally the specialty strives to integrate the two, as their functions are both mediated by the brain. Thus, psychiatry's perspective embraces the individual patient's cognitive, affective, interpersonal and behavioral processes, while simultaneously functioning in familial, social, cultural, economic, religious, educational and political contexts. Child psychiatry, a subspecialty of general psychiatry, focuses on individuals spanning the ages of infancy through adolescence, with many practitioners extending that range through young adulthood. The development of the child implies growth and maturation in various spheres, including the physical body, cognitions, affects, behaviors, and abilities to judge situations. Insofar as children have not as yet attained adult capacities in these areas, they require the protection and nurturance of guardians. In the main parents fill that role, but at other times familial relatives, government agencies, or other designated individuals provide the settings for youngsters to mature. Unlike their counterparts who limit their work to the treatment of adult patients, child psychiatrists usually devote their efforts not only to the youngsters but to the caregiving adults as well, who often provide information that the child is unable or unwilling to do. Working with two generations and their interactions, however, often provides witness to mutual conflicts which, in turn, can trigger ethical dilemmas.

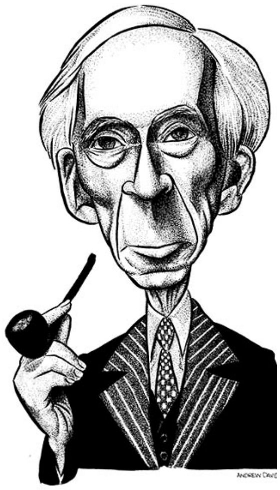
ETHICS AND THE LARGER CONTEXT

Theoretically, solutions to ethical quandaries would be distinguished from other responses to these dilemmas by two distinct features. First, the solutions would be universalizable, i.e., arrived at independent of the circumstances in which they emerge and thus applicable in all contexts. Secondly, these objective "universalist" resolutions would trump personal and group motivations.

But, in fact, are these assertions axiomatic? In order to arrive at a well-reasoned and just resolution, in contrast to the judicious or prudent one, can one legitimately ignore context, be it political, economic, cultural or religious? On the face of it, that would seem unlikely. When contrasting, for example, the environments in which citizens of technologically-advanced democracies live with those of poverty-ridden, war-dominated, totalitarian autocracies, it is difficult to imagine applying identical ethical reasoning approaches in both settings and arriving at identical resolutions. Adding to the confusion are countries that have mixes of these elements, e.g., those whose current economic development may outstrip that of the established industrialized democracies but whose political architectures are largely dominated by "top down" perspectives. Stark examples of contrasts facing child psychiatrists serve to illustrate this: the luxury of the ethical dilemma of whether to prescribe a proprietary medication rather than a generic one, when for-profit insurance companies or government-approved formularies bring pressure on the child psychiatrist to prescribe the latter, contrasting with a child psychiatrist's desire to prescribe an antidepressant – any antidepressant – in a country that lacks many basic necessities, not to mention an adequate supply of psychotropic medications; the ethics of resisting the subtle pressure of a prosecutor's office to "waive" a juvenile offender's family court case to adult criminal court versus the threat from a government's military arm of a child psychiatrist's loss of livelihood, or worse, should a child psychiatrist refuse to admit a psychiatrically healthy individual, who has run afoul of political or police officialdom, for treatment to a psychiatric hospital (LaFraniere & Levin, 2010); the ethics of providing care to a recently bereaved child, surrounded by loving relatives with adequate or better financial resources, versus the provision of care to orphans, whose parents and adult relatives were murdered by a warring faction, now sheltered and living together in a youth dormitory (Stover et al, 2007; Williamson et al, 1987).

"I think we ought always to entertain our opinions with some measure of doubt. I shouldn't wish people dogmatically to believe any philosophy, not even mine"

Bertrand Russell



Bertrand Russell (1872-1970)

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Writing about the ethics of child psychiatry with an international perspective means considering an enormous range of administrative, political, religious, cultural and economic contexts (Leckman & Leventhal, 2008). Do these stark differences in turn imply that ethical reasoning should be approached differently depending on context? In theory, the answer is no. It would appear that identical reasoning methods ought to be used in all contexts. The settings, however, most definitely need to be considered in the attempt to arrive at the most useful resolutions, and those considerations might well result in contrasting final choices in seemingly similar cases.

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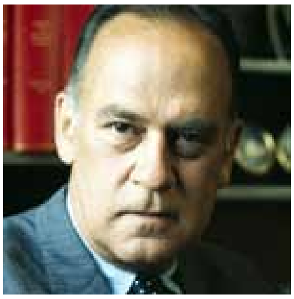
HISTORY OF CHILDHOOD

Optimal development of children is crucial to all societies, as the offspring will become the societies' adults who, they hope, will carry on the groups' traditions and values. According to predominating views of Western history, after infancy, children were viewed for millennia as little adults (Aries,1962; DeMause, 1974). They were considered the property of their parents who, in return for providing the youngsters with food and shelter, were entitled to the proceeds of their labor. Inklings of the need for education, beyond that of vocational apprenticeships, began to be felt during the 17th century. Accompanying that development, conceptualization of childhood as a stage of human development separate from that of adulthood began to emerge. During the past 100+ years, concentration on childhood as a unique developmental stage has proceeded apace. During this time laws have been established mandating school attendance, protecting against child labor, facilitating and supporting the functioning and health of families, creating juvenile justice systems with unique approaches to legal procedures, and mandating reports of the abuse and/or neglect of children to governmental authorities (Enzer, 1985; Graham, 1999). As governments progressively took on responsibilities for children's welfare, the medical profession similarly evolved. Pediatrics first appeared as a specialty in the late 1800s; child psychiatry, as a subspecialty of psychiatry, began to emerge in the 1930s/40s (Musto, 2007). In the USA, the American Academy of Child Psychiatry was founded in 1953. During the past half-century, childhood itself has been subdivided more narrowly, while expanding its purview to now include the stages of infancy, toddlerhood, preschool, school-age, and adolescence (this last time frame further subdivided into early, middle and late stages). Thus, the conception of childhood has evolved over time from that of a relatively undifferentiated mass to the current one of substantial differentiation, distinguished by narrow age spans and differing needs and abilities. While all the stages share in common the requirement for adult-supplied nurturance, these fine-tuned differences, as will be seen later, often play a significant role in ethical considerations.

"Ethics is knowing the difference between what you have a right to do and what is right to do"

Potter Stewart



Potter Stewart (1915-1985) was an Associate Justice of the US Supreme Court

PROFESSIONALISM AND CHILDREN

Medical ethics comprises a large subset of medical professionalism. The concept of professionalism extends beyond matters directly affecting patient care, and speaks to the general comportment of the physician (Gabbard et al, 2011; Wynia et al, 1999). As much of a physician's behavior affects patient care, indirectly if not directly, the boundaries between ethics and professionalism can become hazy. Taking a broad view of the child psychiatry practitioner, child psychiatrists possibly are attracted to their work with children because they sense a vulnerability in youngsters that draws on their latent desires to nurture, protect, and educate. While those factors undoubtedly work in the youngsters' favor by facilitating good patient-doctor relationships, the potential pitfalls in those relationships also are many. For example, practitioners may find themselves physically or emotionally attracted to patients' guardians or to the patients themselves; indulging in rescue fantasies; feeling the urge to provide special favors for specific patients or their families; or desirous of soliciting patients' families for funding of designated projects. While such thoughts and fantasies should be understood as not unusual accompaniments of practice, acting on them in ways that prove deleterious to the patient would be unprofessional. By contrast, as the cardinal principle of ethical medical practice, the child's safety, welfare and interests must be the practitioner's paramount concern. Such a principle mandates that, under no circumstances, should a child psychiatrist exploit a child patient or the child's relatives by violating professional boundaries. These boundaries are both literal and figurative limits, created precisely to forestall such behaviors (Gabbard & Nadelson, 1995; Schetky, 1995). Instead, the child and its guardians should be able to expect, with certainty, that the child psychiatrist will conduct all mutual exchanges honestly, transparently, with integrity and fidelity.

CODES OF ETHICS

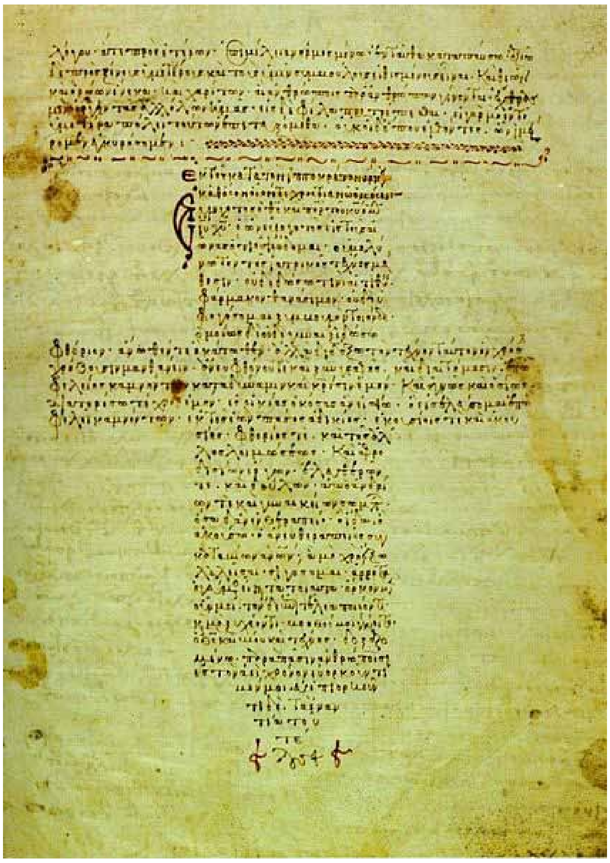
Throughout the millennia of existence, all human societies have designated certain citizens as its healers. More recently, these individuals were titled its physicians, or doctors. Throughout these many centuries, the medical practitioners, inhabitants of disparate societies situated in countries encompassing the entire globe, have created innumerable codes of ethics to guide their professional behaviors. The vast majority of these codes, despite emanating from societies differing starkly from each other along ethnic, religious and geographic lines, share common foci and concerns. Thus, the following principles are addressed in most of the codes:

- Primacy of respect for human life
- Physician responsibility for the well-being of the patient
- Admonition to help or, at least, do no harm; and
- An emphasis on virtue and duty.

Attention is often directed as well toward these specific issues:

- Equality of care independent of the patient's financial standing
- Expectation of setting appropriate fees
- Employment of legitimate methods to establish diagnoses, including clinical observation and sound reasoning
- Consideration of whether, and when, to provide treatment; if treatment, the employment of legitimate therapies
- The confidential nature of the patient-physician relationship
- Prohibition against sexual relationship between physician and patient; and
- Imposition of punishment or sanctions in the event of inept technical performance or code violation.

International codes, adopted by medical organizations, initially appeared in formal mode during the 20th century. The World Medical Association's International Code of Medical Ethics, first produced in 1949 and revised most recently in 2006, outlines the general duties of physicians as well as their responsibilities to patients and colleagues (World Medical Association, 2006). Emphasis is placed on the need for competence, honesty, dedication, avoidance of bias and/or exploitation, respect for confidentiality, collaboration, and, interestingly, the obligation of physicians to obtain care for themselves in the event of personal mental or physical illness. Similar global thinking led to the establishment of several psychiatric codes and declarations on a pan-national scale. The World Psychiatric Association's Declaration of Madrid (1996), building on the prior Declarations of Hawaii (1977) and Vienna (1983), created international ethical standards and guidelines for psychiatric practice (World Psychiatric Association, 1996). In addition to the discussion of such basic elements as the practitioner's responsibility to the patient, the need to maintain knowledge of current scientific developments, protection of participants in research, confidentiality, and maintenance of professional boundaries, specific attention is also paid to prohibition of participation in torture, death penalty, sex selection, and ethnic and/or cultural discrimination procedures; avoidance of industry- and politically-induced conflicts of interests;



The Hippocratic Oath is an oath historically taken by physicians and other healthcare professionals swearing to practice medicine ethically. It is widely believed to have been written by Hippocrates or by one of his students.

A 12th-century Byzantine manuscript of the Oath (Wikimedia Commons)

and the expectation that sound treatments must be based on valid diagnoses, following the patient's receipt of complete pertinent information and subsequent provision of uncoerced consent. In 1989, the United Nations Convention on the Rights of the Child, with the collective weight of the member countries behind them, established the rights of children to survival, development, protection and participation, including the rights to voice their views freely, be given commensurate deference, and live with their families (United Nations, Centre for Human Rights, 1990) (see Chapter J.7). The United Nations Convention on the Rights of Persons with Disabilities (2006) emphasizes that respect and dignity are to be accorded to disabled individuals of all ages, including children, and embraces the psychiatrically ill, among many others (United Nations, 2007; Stein et al, 2009). The document highlights nondiscrimination and equal access to health care, and emphasizes the right of all disabled individuals to equal inclusion in all aspects of life and its fundamental freedoms. Despite the impressive provenance of these declarations, it is obvious that their implementation varies enormously among the signatory countries. That is to be expected, given grossly differing systems of government. Reassurance, however, comes from the continuing global ethically-based thrust in the direction of greater protections for children and the disabled, and an increased awareness of forces that promote or impede their implementation. In 2006, the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) created guidelines and principles for practitioners in its document entitled Ethics in Child and Adolescent Mental Health, which in turn derived from IACAPAP's resolution "Assuring Mental Health for Children", promulgated in 1992 and further revised in 1996 and 2004 (IACAPAP, 2006). IACAPAP's document itemizes basic ethical principles;

addresses rights of both children and their parents/legal caregivers; reviews consent and assent; and addresses topics including confidentiality, potential exploitation, sexual encounters, honesty, involuntary treatment, gifts from patients or industry, presentation of patient material in publications and professional meetings, research ethics, multidisciplinary collaboration, and the association's guidelines for its acceptance of financial support.

The initial efforts and subsequent revisions noted in these various declarations and guidelines are a function of circumstances and influences that change over time. The American Academy of Child and Adolescent Psychiatry's (AACAP) Code of Ethics serves as an example. Promulgated initially in 1980, revised slightly in 2007 and greatly in 2009, the Code reflects changes in medical knowledge, modes of clinical practice, payments for services, understandings of psychological dynamics, and practices of the pharmacologic and manufacturing industries that evolved over three decades (American Academy of Child and Adolescent Psychiatry, 2009). The most recent revision addresses, directly and comprehensively, issues of third-party influence, expectations of publication of all research study results – positive and negative, conflicts of interest, romantic and/or sexual entanglements with patients and their families, risks of research with children, practitioner self-aggrandizement, and expectations that practitioners will have knowledge of the laws prevailing in the professional's jurisdiction as well as tensions that might exist between the law and ethical considerations. As Beauchamp (2009) notes, "the law is not the repository of our moral standards and values". By contrast, codes of ethics are guidelines for professional behavior and they differ from laws by providing greater flexibility and choices of action. The codes embody standards of professional conduct and the current AACAP code is an example of one that clearly, rather than vaguely, indicates preferred behaviors. For the practitioner who has questions about his or her own or a fellow professional's motivations, inclinations or behaviors, consultation with colleagues and referral to a code's guidelines are arguably the most useful and potentially helpful options.

CHILDREN, ETHICS, AND ETHICAL PRINCIPLES

Children and adults differ from each other in discernible ways. Children are usually smaller, have narrower understandings of historical and external events, are engaged in a continuous process of rapid development and maturation, and require protection by and nurturance from others. Children, however, are not a monolithic group – e.g., the toddler and the late adolescent differ greatly from each other in many of the above-cited spheres, even as they also share these traits in common. Consequent to their ongoing dependence on adults, however, usually they are legally regarded as minors. Thus, significant decisions, e.g., where and with whom they will live, their ability to roam or travel, locales of secular and nature of religious educations, and access to medical care, all reside by law in the hands of their parents/guardians. In countries endowed with effective legal systems, the state has the legal right to intervene in such decisions only in the event that guardians are derelict in providing their children with the basic necessities, i.e., food, shelter and education, or are abusive of the youngsters under their care. These seemingly "self-evident" and generally accepted legal rules are in fact based on the employment of basic ethical understandings which in turn are combined with extensive knowledge of childhood development. While several approaches to moral thought vie for supremacy (Bloch, 2007), fundamental principles undergird the ethics of endeavors with children. Thus, the individual clinician is expected to work toward outcomes that would prove best for the child (*beneficence*), avoid practices that are likely to cause the child harm (*nonmaleficence*), grant respect for the choices and wishes of the individual patient (*autonomy*) and treat all patients under care fairly, equally, and with fidelity (*justice*). This same ethical structure holds for the creation of administrative approaches designed to provide care and protection for large groups of children (Sondheimer, 2010). For example, when planning measures to foster improved mental health efforts in schools (Bostic & Bagnell, 2001; Brener et al, 2007), provide care for children traumatized by war (Betancourt, 2011; Panter-Brick et al, 2011), or innovate programs for juvenile offenders (Holden et al, 2003), it is reasonable to expect that authorities would design their efforts in such ways that the children experience benefit, are not hurt, feel respected, and receive help and protection equally.

These sentiments and approaches envision the ideal, and some clinical and administrative conditions might readily lend themselves to stark and clear right or wrong choices. But reality generally presents conflicts that exist in shades of gray. Viewing children along maturational continua is an obvious illustration. Thus, what may be beneficial for a 16 year old (e.g., respecting the autonomous right to refuse treatment) may not be helpful for the recalcitrant seven year old. Other gray area dilemmas commonly assert themselves as well. For example, given differing perspectives between child and guardian, to whom does the child psychiatrist defer, without ignoring the concerns of the other? When a group (e.g., a family) wants to pursue an agenda favored by the majority of its members, is the minority's dissenting view (not infrequently that of the child patient) to be accorded respect, and how? When does the child psychiatrist pay attention to the needs of an individual patient in the context of limited resources if, from a public health perspective, attention to the community's needs could ultimately benefit a greater number of patients? Often, the ethical principles employed to pursue answers to such clinical or administrative questions conflict with each other, and a reasoning approach must be employed to achieve a desirable resolution. Notably, this process should never imply a pre-ordained outcome.

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ETHICAL REASONING

Clinicians usually perform their work with patients without stopping to question the ethical bases of their actions. This makes perfect sense. The average child psychiatrist is conscientious, has received adequate training and, over time, acquired clinical experience, all of which foster the child psychiatrist's provision of good care in relatively routine fashion. On occasion, however, the child psychiatrist is confronted with confusing or unsettling situations that leave the practitioner feeling uneasy and uncertain as to how to proceed (Sondheimer, 2011). The child psychiatrist's hesitation or discomfort could be due to, e.g., a parent's request to order a urine toxicology screen for her adolescent child while stipulating that the child not be informed of the test's purpose; a child's ambiguous self-harm verbalization that leaves the child psychiatrist uncertain regarding the patient's potential safety; or, an agency's innocent and appropriate request for information about a child which, if divulged, might prove injurious to the patient. When the child psychiatrist consciously focuses on, and does not ignore, his or her own discomfort, the psychiatrist can use the sense of unease as a salient signal to recognize the presence of an ethical dilemma and the need for clear and discerning thought.

The ethical reasoning process follows a consistent pattern. As ethics "is the enterprise of disciplined reflection on moral intuitions and moral choices" (Veatch, 1989), perhaps the most important step in the process is the initial recognition of the presence of ethical conflict and an acknowledgment of the need for a response. Commonly, this recognition follows the child psychiatrist's almost instantaneous affective response of unease or dread, itself followed by a fleeting desire to flee the problem or to hand responsibility for its solution to a colleague. This response comes on the heels of the realization that none of the possible options for intervention stands out as strikingly superior to others, and all potential choices inherently harbor problems. As soon as the "immature" responses pass, it becomes incumbent on the child psychiatrist to rationally examine the matter. Several approaches are useful. In other than extreme situations calling for immediate action, the child psychiatrist should temporize, ask questions, obtain information, and delay choosing an ultimate clinical or administrative option. The psychiatrist is encouraged to reflect on the personal values he or she employs in the reasoning process. Self-inquiry can lead to cognizance of the roles played by the child psychiatrist's upbringing, education, and nonprofessional personal experiences, for better or worse, in his or her considerations of the dilemma. Third, consultation with colleagues is often helpful. While the problematic matter may be new to the child psychiatrist, it is likely to have been encountered by colleagues or addressed in the professional literature. Further, it may help to include the patient and other pertinent principals in the discussion of the ethical conflict, in order that they contribute responsibility for the outcome. Finally, after employing the above stratagems, the child psychiatrist should consider relevant choices and possible consequences, while performing risk/benefit analyses on all. The four core aforementioned ethical principles, and the guidelines provided by the child psychiatrist's national and international codes of ethics, can aid in arriving at an ultimate choice of action. This resolution often proves to be the least harmful, but not necessarily the seemingly optimal.

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SAFETY

Primum non nocere – above all do no harm – is a cardinal tenet of proper medical practice (Smith, 2005). Translating its application to psychiatric care, this fundamental rule emphasizes that the child psychiatrist's paramount concern is the safety of the child (patient). For example, the depressed child recently engaged in suicidal behaviors, whose self-harm ideation continues unabated, is best cared for in a psychiatric institution that provides close and constant supervision, despite the actual and implied infringements on the youngster's autonomy and freedom of movement. Another child, who is depressed but not suicidal, would likely benefit from outpatient care while living at home with his or her family. In both scenarios safety must be addressed as the primary concern, but the respective potential threats to well-being are differentiated, resulting in treatment provision in dissimilar settings. Parenthetically, ethical child psychiatric practice would require that the practitioner be fully aware of the legal protections available to the child that are operative in the practitioner's jurisdiction, in order that infringements on the child's rights are kept to a minimum.

CONTEXT – CULTURE, HISTORY AND ECONOMICS

Context can play a significant role in ethical considerations as differing cultures may regard similar behaviors differently. In the US, for example, the adult who develops garbled and incoherent speech at her suburban, middle-class home, whose previous similar episodes resulted in psychiatric hospitalizations, is likely to again be hospitalized at her family's urging; her similar-aged counterpart, engaged in the same behavior while "speaking in tongues" in a rural, fundamentalist church, is likely to receive solicitous and supportive responses from fellow worshipers. Analogously, the child who verbally disputes a teacher's provocative assertion in a "progressive" school, located in an industrialized society, is likely to receive plaudits for her behavior; by contrast, the student living in a traditional tribal setting, challenging her elders by requesting education ordinarily not permitted to girls, may well be seen as obstreperous, a discipline problem, or spiritually disordered (Robertson et al, 2004). These examples indicate that it is ethically incumbent on child psychiatrists to bring awareness of context, or "cultural competence" (Bass et al, 2007; DeJong & Van Ommeren, 2005; Kirmayer & Minas, 2000), to their clinical considerations. Similarly, available resources often play a significant role. For example, where they are limited, largesse might be considered the institutionalization of a brain-damaged youngster, despite that support being limited to custodial care. A more well-to do environment, by contrast, might be able to provide a variety of educational, recreational and interpersonally stimulating resources, while simultaneously enabling the child to live at home with his family. In each case, the ethically optimal intervention is utilized, but the available resources dictate different choices.

Knowledge of the history of psychiatry is yet another important factor in ethical deliberations. Over the course of the past 100+ years, different large-scale psychiatric movements have held sway. At distinct times psychoanalytic theory, somatic therapies (e.g., electroconvulsive treatment, insulin shock, psychosurgery), pharmacotherapy, community psychiatry, systems theory, institutionalization, deinstitutionalization, and both prevalent and fleetingly present psychotherapies (e.g., group, family, cognitive-behavioral, primal scream, milieu) have vied for visibility with or primacy over the others. Frequently, the integration of several modalities proffered simultaneously has proved most efficacious (The MTA Cooperative Group, 1999; March et al, 2004), the opinions of single therapy adherents notwithstanding. Recent changes in the scientific development of child and adolescent psychiatry have produced an intense current focus on molecular influences and the nature of their interplay with the environment (Rutter, 2010). National economic systems have also changed. Public and private funding of care, including health insurance and payments for clinics and programs provided by both sectors, have varied over time, within and across national borders. These changes constantly affect resources available for the psychiatric needs of children, thus affecting ethical considerations. The gradual or sudden economic changes do not alter the fundamental ethical reasoning approaches, but they do impact the breadth and scope of the child psychiatrist's available clinical considerations and choices.

ETHICS – THE GLOBAL AND THE PARTICULAR

Discussions of ethical dilemmas commonly focus on situations encountered by clinicians during the care of an individual child and/or family. For the practitioner, it is easiest to concentrate on and conceptualize one case at a time. The application of ethical thought, however, embodies the universal, and initial consideration of children from a global perspective is therefore in order. Studies performed in disparate countries indicate a prevalence of mental disorders in 5% to 20% of child populations (Giel et al, 1981; Malhotra, 1995; Patel et al, 2007). Large numbers of children live as displaced refugees (Forbes, 1992), are homeless (Raffaelli & Larson, 1999), have become orphans due to the deaths of parents from AIDS (UNICEF, 2000), and are victims of physical or sexual abuse. On the occasions that well-structured epidemiologic studies are performed, significant numbers of these children are found to suffer with stress-related, depressive, and anxiety-based symptomatology. The majority of these children live in resource-poor countries, harboring few available trained mental health personnel. Beyond addressing the needs of these youngsters for food, mental health and life skills training of educators and primary care providers by child psychiatry consultative personnel is arguably, from an ethical perspective, the most beneficial approach for the children and their often clinically depressed mothers (Fombonne, 2005; Graham & Orley, 1999; Lewis et al, 2001; Omigbodun, 2008).

Clearly, in resource-poor countries, the needs of the many are great. Child psychiatry practitioners world-wide, however, tend to be found predominantly in resource-rich environments. The ethical dilemmas they encounter most commonly arise in the context of care provision for a single child, while the dilemmas themselves are universal and transcend national boundaries. Issues of assessment, diagnosis and treatment; assent/consent/dissent; parent-child conflicts; confidentiality; agency; physician responsibility; boundaries; and advocacy, are among many that deserve examination.

ASSESSMENT AND DIAGNOSIS

Prior to the advent of the third edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-3) in 1980, psychiatric diagnosis in the US was often based on psychoanalytic musings ascribing etiologies to disorders that were purported to stem from disturbed unconscious intrapsychic processes. As these diagnoses were based on theoretical constructs and not on consensually observed phenomena, diagnoses of individuals by the practitioners of those eras commonly conflicted. Furthermore, the "disorder" concept itself, in the absence of biologic tests that might confirm diagnoses (contrasted with, for example, elevated glucose levels associated with diabetes mellitus; elevated troponins, elevated cardiac enzymes, and specific EKG tracings associated with myocardial infarcts), raised the concern of "the eye of the beholder". For example, the disruptive behavior of a child might be viewed by different examiners as a normal variant, symptomatic of an oppositional or conduct disorder, or a reaction to a stressor. Even with well-outlined diagnostic criteria, it is conceivable that diagnostic disagreement could exist among conscientious clinicians, raising questions about the fundamentals of the diagnostic process and accurate definitions of "illness" (Pies, 2007). The lack of confidence in psychiatric diagnoses and poor diagnostic concurrence prior to the 1980s, coupled with fears of "labeling" and prevailing stigma associated with mental illness, led to a sizable number of vocal proponents of diagnostic nihilism. In addition, the opprobrium earned by the misuse of psychiatric diagnoses for political purposes (e.g., the former Soviet Union's creation and employment of the novel diagnosis of "sluggish schizophrenia" in order to forcibly hospitalize and treat political opponents of the regime against their will) highlighted on an international scale the need for a considerably more rigorous diagnostic consensus (Wilkinson, 1986).

The last 30 years, however, have witnessed consensual agreement by psychiatric researchers on progressively more rigorous approaches to groupings of observed phenomena. These have led in turn to more carefully defined diagnostic categories. Close collaboration between the consultants producing editions of the International Classification of Diseases (ICD) and subsequent DSM volumes has been the rule, leading to considerable compatibility between these two "official" versions of psychiatric diagnoses (Sartorius et al, 1993). Thus, the diagnostic process has undergone a transformation permitting collaborators on transnational studies to more comfortably assume that study subjects from countries other than their own satisfy the same inclusion and exclusion criteria. Cautions remain, however, regarding inadequate sensitivity to culture-bound variables (Belfer & Eisenbruch, 2007; Van Ommeren, 2003).

Rigorous diagnostic criteria permit the development of treatments that are tailored to specific diagnoses. When used in this fashion – for the good of the patient – the diagnostic process clearly satisfies a cardinal ethical principle. However, the potential problems of "labeling" and stigma remain as possibly harmful to the child (Pescosolido et al, 2007). The practitioner has little control or influence over how people, other than immediate family, might misuse this information. Particularly in the current era of electronic transmission a diagnosis theoretically could attach to an individual "forever", and relatively unsophisticated societies could become fearful of and devalue a child carrying a psychiatric diagnosis. Ultimately, it is the child psychiatrist's responsibility to provide an accurate assessment and diagnosis in order to better the patient's condition; follow procedures guarding the confidentiality of written materials; and contribute to the education of local societies concerning the prevalence of mental disturbance, prognostic accuracy, treatment efficacy, and the need for familial and community support (Rosen et al, 2000; Thara et al, 2001).

Child psychiatrists should be mindful of various influences that could play roles in the diagnostic process, while maintaining awareness that their efforts will significantly impact the near- and possibly longer-term futures of their child patients.

In recent years, the US has witnessed a striking increase in the incidence of childhood autistic and bipolar disorders. While it appears that, in both cases, these increases are due to a combination of closer scrutiny and greatly expanded diagnostic definitions of these disorders, these developments remind that scientific progress does not occur without struggle, controversy, conflict and mistakes (Angell, 2011; Carey, 2007; Kim et al, 2011; Moreno et al, 2007). In the course of proposed and revised definitions, some children might receive a diagnosis in error while others may benefit from expanded criteria. In addition, increased awareness of the diagnoses of childhood ADHD and bipolar disorder in the international domain may be related to heightened professional education and sensitization of practitioners to these disorders, promoted in part by pharmaceutical companies. Their efforts might well be motivated by the desire to provide benefit to a previously undetected but substantial number of affected children; that the companies stand to gain financially from the marketing of relevant medications in new and

When Rebecca Riley died in December 2006, pediatricians and psychiatrists in the US and across the world were already debating whether preschoolers like the 4-year-old Hull girl could be diagnosed with bipolar disorder and attention deficit hyperactivity disorder (Lambert, 2010). In a lawsuit settlement, the Medical Center defendant agreed to pay $2.5 million to the estate of 4-year-old Rebecca, who died of an overdose of medications, prescribed by a psychiatrist, and over-the-counter remedies (Baker, 2011).

"Riley… was exceptionally young when she was diagnosed [with bipolar disorder], just 2½." "Rebecca was prescribed an antipsychotic medication, a drug used to treat bipolar disorder in adults, and a blood pressure medication that is sometimes used to help hyperactive children sleep." "The psychiatric controversy is over diagnosing children before their teen years. There is virtually no scientific research on children younger than 6" (Goldberg, 2007).

emerging markets is also a pertinent factor. In the end, it is incumbent on child psychiatrists to perform their diagnostic work accurately and with care. They should be mindful of various influences that could play roles in the diagnostic process, while maintaining awareness that their efforts will significantly impact the near- and possibly longer-term futures of their child patients.

TREATMENTS – SOMATIC AND VERBAL

Treatments of the individual child, when indicated, should follow an adequate diagnostic process. Leaving preventive efforts aside momentarily, the current psychiatric knowledge base is limited to the provision of somatic- or psycho- therapies or, often ideally, both. Treatment provision, however, is frequently limited by the locale, surrounding culture, resource availability, and practitioner knowledge. It is incumbent on practitioners to be aware of available resources, the degree of psychological flexibility or rigidity of the individuals to who they provide care, the harm that might befall a child if care is not provided, and the limitations of their own knowledge. The last factor is best dealt with by consultation and possible collaboration with professional colleagues.

Evidence-based medicine should function as the primary foundation for prescribed treatments, but due to a lack of extensive studies focused on children it has limited reach. Studies indicate that certain chemical classes of medications are useful for specific disorders – e.g., stimulants for ADHD; mood stabilizers for bipolar disorder; selective serotonin reuptake inhibitors for major depression and obsessive-compulsive disorders. Such pairings hold similarly true for certain psychotherapeutic approaches, e.g., cognitive-behavioral therapy for phobic disorder; inpatient psychiatric milieu treatment for severe suicidal behavior/ideation. But variability and blended treatments are the norm in the provision of verbal therapies. As well, treatments frequently prove culturally and locale dependent. A recent study of the diagnosis and treatment of ADHD in three resource-rich countries serves as a good example, as it found great differences between the nations with regard to incidence, views of illness severity, and treatment approaches (Hinshaw et al, 2011). Other studies produced findings strongly suggestive of benefits that accrue when psychotropic medications and psychotherapy are both provided in tandem, in contrast to just one or the other, though the ability to provide the two is conditional on the presence of available resources and personnel (The MTA Cooperative Group, 1999; March et al, 2004).

Not infrequently, ethical concerns about somatic and verbally-mediated treatments are approached as if they present dissimilar dilemmas when, in fact, similar concerns apply to both. They each have the potential to produce benefit or harm; risk/benefit analyses should precede the choice of either or both; the potential for uncalled-for clinician aggrandizement is inherent to the provision of either; and the inept provision of the one or the other could easily cause harm. Psychotropic medications, electroconvulsive therapy, and complementary or "natural" medicines all may directly impact developing brain structure, cerebral neurotransmitter receptor complexes, and other body organ systems. The more immediate potential side effects are well-recognized, but the possibility of unleashing long-term ill effects is unclear. Similarly, beneficial or poor psychotherapeutic care is likely to have obvious positive or negative near-term psychological impact, while the long-term effects on psychological functioning, via cognitive incorporation of the experience, is difficult to determine.

Off-label prescribing of medications is common in child psychiatry practice due to the paucity of relevant child-based studies (Baldwin & Kosky, 2007; Bucheler et al, 2002 ; Efron et al, 2003; Hugtenburg et al, 2005). Its consequent potential for benefit or harm is uncertain and variable. Examples include alpha-agonists used as second-line treatments for ADHD; neuroleptics used to treat severe disruptive behavioral presentations; and the use of lithium, anticonvulsants, and neuroleptic medications in the treatment of vastly increased numbers of patients diagnosed, in the recent past, with bipolar disorder of childhood. Similarly, the application of a single psychotherapeutic modality for a range of disorders; difficulties in psychotherapy provision due to a diminished emphasis in training (Tucker et al, 2009); focus on the individual patient at the expense of the family or vice versa; and incorporation of corporal rather than structured restraint methods (even in the context of cultural approval of the former) are all examples of verbally- and environmentally-mediated therapeutic impediments or approaches that could have deleterious impact on some children while nevertheless benefitting others. The innovations and the liabilities contribute to the development of the field by adding to its knowledge base, as they underscore the need for ever-improved training and expansion of the treatment armamentarium. Simultaneously, they highlight the limits of the profession's expertise and the need to rein in diagnostic and treatment hubris.

Off-label

Off-label prescribing means prescribing a medication for a condition or age group or using a form of administration (e.g., oral, parenteral) not formally approved by the appropriate regulatory agencies (e.g., FDA, EMEA). This may vary from country to country.

Off-label prescribing of medications is common in child psychiatry practice due to the paucity of relevant child-based studies. Its consequent potential for benefit or harm is uncertain and variable.

In addition to remedies for diagnosed psychiatric illness, preventive treatment approaches warrant comment (Layne et al, 2008; Sanders, 2002; Silverman et al, 2008). While numerous studies describe treatments of post-traumatic disorders in children, stress inoculation training was designed to block post-traumatic stress responses by its introduction in advance of anticipated stress-inducing situations. Studies describe teacher-mediated group interventions, guided by the instruction of child psychiatrists and other mental health professionals, that employ the stress inoculation training goals of fostering resiliency and psychological strength in groups of children who formerly experienced trauma en masse (Wolmer et al, 2003). While these studies raise an ethical concern, i.e., the withholding of a putatively therapeutic intervention for students comprising the control groups, it appears that child psychiatry involvement in the training of the educators clearly created benefits for the treated youngsters. When preventive and potentially therapeutic undertakings are performed in this manner, larger numbers of children are likely to obtain benefit than would otherwise be impacted in after-the-fact one-to-one care. This approach adheres to the ethical principle of social justice, i.e., by providing benefit to the many in essentially equal fashion. It also provides a clear contrast, in the child setting, for the ethical thought underlying public health models of care with the more traditional perspective of care provision for the individual.

ASSENT, CONSENT, DISSENT AND AGENCY

Assessment, diagnosis and treatment should, with the exception of emergencies, be performed solely with the assent of the child and the consent of the parent/guardian. Legal systems in many countries distinguish between the mental capacities of children and adults, though the chronological age defined as dividing the one stage from the other may vary between different jurisdictions and within nations. Adults are defined as individuals competent to make decisions for themselves and those for whom they are designated as having primary custodial responsibility. Consequently, only they can give *consent* for treatment of the children under their care (Macbeth, 2002). Children, by legal definition, are perceived as lacking the necessary competence to give consent, but they have the psychological capacities to voice *assent* or *dissent* (United Nations Centre for Human Rights, 1990), though how meaningful assent can be assessed is open to question (Koelsch & Fegert, 2010). When parents desire treatment for their child, and the latter assents, psychiatric care ordinarily proceeds without a hitch. However, it is not unusual for parent/guardian-child conflicts to exist about the need for care, with the parent commonly asserting that need while the child resists or refuses outright. It is universally understood that the safety of the child dwarfs all other considerations, thus supporting professional decisions that may abrogate a child's autonomy rights. Typical scenarios include the suicidal youngster or the physically and mentally debilitated anorectic adolescent, psychiatrically hospitalized against their wishes.

It is always incumbent on the child psychiatrist to consider the degree of emotional development and cognitive maturation of the child in question. For example, an oppositional eight year old, who frequently engages in physically assaultive behavior in the school setting, might be brought by parents for a psychiatric evaluation against his will. By contrast, the 17 year old who upsets her parents, by refusing to attend a religious rite, would not seem to require professional services and, rather, her dissent from participation in a proposed psychiatric evaluation would appear to warrant respect and deference. In sum, a child's chronologic age, degree of cognitive and emotional maturity, and concerns about his or her safety require evaluation when weighing the degree of respect to be paid to the youngster's autonomous decision-making capacity. These considerations contribute in turn to the child psychiatrist's goal of choosing the most beneficial approach to a clinical situation. (Parenthetically, it should be noted that similar deliberations prevail with regard to children who might be involved as subjects in psychiatric research, an issue discussed in the research section below).

Age of consent

In most countries, the age of majority is 18 (although it fluctuates between 14 and 21). Age of majority is when the law recognises that minors cease to be considered children (and the responsibility of their parents) and assume control over their own persons and actions. However, in some countries (e.g., Australia, UK), minors (people younger than 18) are able to consent to treatment and to participate in research from the age of 16 or even earlier ("mature minors"). See also Chapter J.3.

Child psychiatrists often field requests or demands from a variety of players with stakes in clinical outcomes. For example, child psychiatrists providing care to juvenile offenders, who were living in foster care prior to placement by the judicial system in a psychiatric facility, will likely field inquiries and demands from involved courts, social service agencies, hospitals and residential treatment facilities, the offending children and their biological and foster families. Often, each entity will have differing and possibly opposing goals and objectives. It is likely that the child psychiatrist would feel a degree of obligation to all – in ethical terms, the psychiatrist could experience a crisis of *agency*, i.e., to which of these entities does one owe allegiance? Ultimately, the principle and concept of *fidelity* dictates that the child psychiatrist's primary responsibility and charge is to engage in *advocacy* for the patient, by pursuing the best or least detrimental outcome for the youngster. Often, that result requires the child psychiatrist to facilitate communication among the various interested parties and possibly to mediate between them. The child psychiatrist's major ethical obligation, however, is to advocate for the patient's interests.

Parents, and countries, periodically engage in highly authoritarian stances. An illustration on the family level is parents who blame their child for familial dysfunction, refuse to engage in family therapy, and subsequently "solve the problem" and defuse the situation by sending the child to a boarding school (Salinger, 1951). An example on the macro level is the city administration that expels a large number of its residents, including the "unstable" mentally ill, to points unknown, describing the citizens as threats to public safety (Spegele, 2011). In both cases, the autonomy rights of relatively defenseless individuals are ignored. Of course, forces exist that are beyond a child psychiatrist's ability to control, but the child psychiatrist as advocate can give professional voice to those interventions more likely to be respectful of individual choice and to produce clinically better outcomes for both small and large groups of patients.

CONFIDENTIALITY

Ordinarily, individuals are accorded privacy rights, implying that they control ownership of their personal information. When such material is communicated to physicians in the course of evaluation or treatment, the physician is ethically (Winslade, 1978) and legally (Simon, 1987) obligated to regard the information as confidential, not to be revealed to anyone without the patient's, i.e., the owner's, permission. Such professional behavior is respectful of a patient's *autonomy*, and avoids the harm (*nonmaleficence*) that would easily ensue, directly to the patient and indirectly to the therapeutic relationship, should a deliberate breach occur.

Maintenance of confidentiality under all circumstances, however, is not an inherent good – such rigid devotion to the concept could conceivably cause harm. Several matters warrant consideration. First, differences between adult and child cognitive abilities suggest that adults have achieved a cognitive maturity that children only attain following continuous maturation through adolescence. Thus, children are perceived as lacking the breadth of understanding presumably available to adults – in the current instance, a solid understanding of confidentiality rights and their possible limits. Consequently, just as children, using identical reasoning, cannot legally *consent* to treatment, only their adult guardians can consent to the release of children's confidential information to third parties. Second, children's psychiatric treatments are most commonly initiated by parents or guardians, presumably with beneficent intent. The parents naturally desire feedback from the physicians about their children, may themselves be directly involved in the treatment, and often express their rights to access information about their children, including possibly confidential material. Third, an understanding of confidentiality, its desirability and its benefits, develops gradually, concomitant with the child's developing sense of autonomy. The preschool and early school-age child would likely be shocked and upset if a practitioner did not provide pertinent information to her parent on the grounds of guarding the child's confidences. For a practitioner to do so could well upset the emotional stability of the patient. It is only as the child matures that it becomes more likely for the child and adolescent psychiatrist to hear patient requests that specific material not be divulged to the parent.

Most commonly, such parent-child struggles over information control come to the fore during adolescence. Adolescents often raise issues that conflict with prevailing parental or societal attitudes and mores or provoke safety concerns. Rhetorically, how is the child and adolescent psychiatrist to address a patient's expressed intent to break into a school's computer system; engage in forbidden sexual activity; experiment with illicit drugs; break curfews; venture with friends into unsafe communities; or engage in covert, potentially dangerous, political activity? Such instances sorely test the clinical muscles of the practitioner, and the internal conflict of respecting or violating the patient's autonomous confidentiality rights is placed front and center.

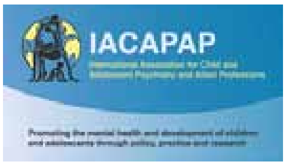
Several principles hold sway. Safety considerations are foremost. Should a psychiatrist perceive an adolescent's imminent threat of danger to self or others, adherence to confidentiality must be violated and guardians or other protective entities informed in order to ensure maintenance of the patient's life and safety of the environment. Short of such frank expressions of suicidal and homicidal intents or behaviors, gray area situations, involving the potential for varying degrees of risk (Ponton, 1997), call for a sensitive evaluation of circumstances with, at best, uncertainty concerning the maintenance or violation of confidentiality rights.

In addition, practitioners can best aid their patients by avoiding entrapment by rigid rules regarding the observation of confidentiality rights. Rather, adoption at the outset of a family- versus an individual-based treatment approach, with "mutual trust" rather than the administration of paternalistic advice serving as the underpinning for the therapeutic relationship, encourages the use of reason, persuasion, tact, and clinical judgment to dictate the degree to which confidential information might be transmitted, if at all, and by whom. Similar collaboration is called for with children and their parents concerning the nature and content of written material to be transmitted to agencies and other care providers. Caution is indicated in light of concerns regarding the potential longevity of such material (Alessi, 2001), as well as its occasional inappropriate release to unintended recipients (e.g., Conn, 2001), both of which should be discussed with the patient and guardian.

Traditional families, living in resource-poorer settings or having immigrated to resource-richer locales, often contrast with families in developed settings by paying less attention to the autonomy of the individual child as they, by contrast, put greater emphasis on the need for the youngster's will to blend into the goals and desires of the family's or clan's adults. In these families, the notion of a child's confidentiality rights may therefore experience great challenge. For example: "Anything my child wants to say can be said, and must be said, with me present – we have nothing to hide from each other." Directly confronting such a stance by trumpeting confidentiality rights is likely to end in a failure to persuade. Rather, acknowledgement of the parent's desire for pertinent information while promoting the potential benefits stemming from respect of individual autonomy, in a model that emphasizes the inclusion of all family members, is more likely to result in the most efficacious and beneficent care for the child. In contrast to differing families, a related study, determining the responses of psychiatrists in three countries to confidentiality scenarios, revealed no significant differences between the practitioners (Lindenthal et al, 1985).

RESEARCH

Because children cannot give consent by themselves, research involving young people poses particular ethics challenges. Notably, there has been a growing appreciation that it is in children's best interests that good-quality research is undertaken – the lack of evidence about the effectiveness of many treatments in the young has already been highlighted and extrapolating to children results found in trials conducted in adult populations is not necessarily valid. To obviate this problem some governments (e.g., the US) provide financial incentives (e.g., by extending the patent period of a drug) if research in children is undertaken. This notwithstanding, research in young people needs to carefully adhere to ethical principles and requirements because of the risks of exploitation. These principles are spelled out in a variety of documents anchored on the Nuremberg Code (which contains research ethics principles for human experimentation set as a result of the Nuremberg Trials following the Second World War) and the 1974 Declaration of Helsinki (Chapter J.7 in this book describes in some detail the implications for research of the United Nations Convention on the Rights of the Child, particularly in low income countries and in communities enduring war or civil strife).



Click on the picture to access IACAPAP's declarations on ethical practice

The IACAPAP's Declaration of Berlin (2004) – Principles of Ethics in Child and Adolescent Mental Health (revised in Melbourne, 2006) – states that "Informed consent to being a research subject should be based on the following Principles:

- It is essential that clinical research involving human subjects is dedicated to promoting health
- The well-being of the research subject has priority over the interests of science and society
- The performance of a research project involving human subjects should be based on a clearly written proposal that is approved by an independent ethical committee which includes representatives of parents and the law
- Participation is voluntary. Any subject can refuse or discontinue participation without pressure, penalty or loss of benefit
- Children and adolescents may not have the capacity to give informed consent to being research subjects. However, their assent must be obtained. Assent should take into account the age, maturity and

psychological state of the child involved. If the child is unable to give assent, the "proxy consent" of a parent or legal guardian is required

- Informed consent requires a statement that a study involves research, and information about the purposes, duration and procedures of the study. It should include a description of the foreseeable risks and discomforts involved, and of the benefits to the subject expected as a result of the research. Alternative treatments should be discussed
- Today much of the prescription of psychotropic medication in children is "off-label". There is an urgent need for pharmacological research in children. It is an ethical mandate that drugs be properly studied in children and their efficacy empirically established before they are widely used. The results of clinical trials should be available to the public even when the trial fails to establish effectiveness empirically. 'No clinical trial is finished until the data are made available'."

Research involving children as participants should always be reviewed and approved by appropriately constituted ethics review committees; this is a requirement for publication in most scientific journals. In the US, Federal Regulations specify the circumstances in which research with children may be approved; i.e., if research:

- *Does not involve greater than minimal risk*
- *Involves greater than minimal risk but presents the prospect of direct benefit to the individual subjects.* In this case the risk is justified by the anticipated benefit and the relation of the anticipated benefit to the risk is at least as favorable to the subjects as that presented by available alternatives
- *Involves greater than minimal risk and no prospect of direct benefit to individual subjects, but is likely to yield generalizable knowledge about the subject's disorder if*:
    - The risk represents a minor increase over minimal risk
    - The intervention presents experiences to subjects that are reasonably commensurate with those inherent in their actual or expected medical, psychological, social, or educational situations, and
    - The intervention is likely to yield generalizable knowledge about the subjects' disorder which is of vital importance for the understanding or amelioration of the subjects' condition.
- *Research which presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of children if*:
    - The research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children, and
    - The research will be conducted in accordance with sound ethical principles.

The use of placebo has been more controversial in children than in adults. While the need for placebo controlled trials is acknowledged, placebos should not be used if there is risk of harm to participants or when an equally safe treatment is available.

Assent

Assent means (Committee on Bioethics of the American Academy of Pediatrics, 1995):

- Helping children gain a developmentally appropriate understanding of the nature of their illness
- Explaining what they can expect (good and bad) with the treatment
- Evaluating children's understanding of the situation, including whether they are being inappropriately pressured, and
- Seeking an expression of the child's willingness to accept the treatment

In the case of participation in research, if children do not have a choice and their refusal or dissent does not count, it should not be pretended that a requirement for assent is to provide a choice. Children need to know if they do or do not have a choice. A requirement for assent protects children from psychological or other harm. Children benefit from knowing what will happen, having a say and being listened to even though they do not have the final authority to make decisions. Seeking assent also respects the child as a person. Part of that is to provide opportunities for children to develop autonomy. However, assent by itself is not sufficient to authorise participation in research.

Dissent

Means that children's objections and distress are taken into account even when the child is incapable of taking part in discussions or deciding. In the case of participation in research trials, dissent does not function only at the point of enrollment. Dissent can be about a child wanting to withdraw from research.


Understanding Consent in Research Involving Children: The ethical Issues

A Handbook for Human Research Ethics Committees and Researchers:

Merle Spriggs
Children's Bioethics Centre

Click on the picture to access "Understanding Consent in Research Involving Children: The ethical Issues"

Parents are the main decision-makers for their children, including participation in research. Parental decision-making is a critical factor in the study of pediatric research ethics, even though it is recognized that parents, as well as researchers, may have interests that conflict with the best interests of the child. The legitimate role of the child in decisions about research participation is also recognized. The ethical concept of assent provides a framework to assist investigators and parents with efforts to incorporate the views of children who are recruited as research subjects. Assent is analogous to consent where participants have a reduced capacity to understand the matter to which they are assenting.

While the general principles about consent to research are widely accepted, there are variations between countries and the issues become more complex in special situations. For example, in Australia and the UK minors can in some circumstances consent to research without additional parent consent when the child is "mature enough to understand". When the young person is of developing maturity and the risk of research participation is no more than discomfort and the aim is to benefit young people and there are additional good reasons not to involve parents (e.g., some internet research), then minors can also consent. Moreover, parent's consent is not always required, for example in situations where seeking parental consent is inappropriate (e.g., if parents are neglectful or abusive) or offers no protection (however, consent from another adult might be required if that adult has responsibility for the child's safety and wellbeing).

Another potentially troubling issue is whether it is acceptable to offer money or benefits to children for participating in research and, if so, in which circumstances (this only arises when cash or valuables are above reimbursement of expenses). Policies about rewards also vary between countries but it would be considered unethical if rewards could lead participants – or those deciding for them – to ignore or significantly undervalue serious risks.

POTPOURRI

As ethical thinking undergirds the structure and practice of child and adolescent psychiatry in its entirety, the range of subjects potentially available for discussion is vast. The most salient have been addressed, and the topics that follow, discussed in brief, are open to investigation in much greater detail.

Conflicts of interest

Third party influence has received considerable media attention in the recent past, stemming primarily from the efforts of the pharmaceutical industry to promote sales of its products, via overt and subtle subsidies and other inducements to physicians (Schowalter, 2008). Such external attempts at influence are exerted as well by health insurance providers, school system personnel, governmental agencies, guardians, colleagues, and financial investors. Internal competing loyalties can stem from interpersonal rivalries, relationships, and intellectual passions, resulting in biased rather than dispassionate judgments (Walter et al, 2010). Commonly, these conflicts emerge in research and publication contexts as well as interpersonal. In all instances, the child psychiatrist is obligated to prioritize the welfare of the patient above the other interests competing for attention. The child psychiatrist's internal conflicting impulses are best handled via transparency, honesty, notification, disclosure, self-examination and self-scrutiny. The acid test is putting oneself in the patient's place and examining the matter from that perspective (Brewin, 1993).

Teaching, training and enforcement

The teaching of ethics is mandated by residency training accrediting bodies (Dingle & Stuber, 2008). Topics commonly reviewed include advocacy, consent/assent, agency, autonomy, research concerns, boundaries, confidentiality, practitioner relationships with health care providers and industry, and the relationship and distinctions between ethics and the law (Sondheimer, 1998).

Conflicts of interest

Conflicts of interest may be inevitable for clinicians because of the multiple responsibilities and relationships that are part and parcel of medical practice. Being subject to competing interests, however, is not necessarily unethical. Maintaining ethical practice is determined by how one handles them. Knowledge of professional standards, recognition of potential conflicts and appropriate disclosure are key steps in this process.

Research funded by the pharmaceutical industry reported in psychiatric journals has been steadily increasing. Moreover, positive outcomes are reported much more often in trials so funded (78%) than in those without industry sponsorship (48%) or those financed by a competitor (28%) (Kelly et al, 2006). The obvious issue arises as to the extent to which industry-funded research influences findings and to what degree one can trust such work.

Conflicts of interest are not restricted to drug trials. For example, The Lancet published in 1998 a study which suggested a link between autism and the measles-mumps-rubella (MMR) vaccine. The report sent shockwaves around the globe as well as frightening parents and medical practitioners. As a consequence, MMR vaccination rates in England declined by 10% in the following 5 years while cases of measles almost quadrupled. A journalist later established that the principal author had not disclosed that the Legal Aid Board had commissioned him to determine, for a sizable fee, if evidence sufficed to support a legal action by parents of children allegedly harmed by the vaccine. The Lancet subsequently retracted the article and the UK's General Medical Council found the lead author unfit to practice. Subsequent research has conclusively refuted any link between the vaccine and autism (Demicheli et al, 2005).

Authorship

The International Committee of Medical Journal Editors (2006) explains that authorship should be based on all the following criteria:

- Substantial contributions to the study's conception and design or acquisition of data or their analysis and interpretation
- Drafting the article or revising it critically; and
- Approval of the final draft.

'Guest', 'honorary' or 'gift' authorship are all considered unethical. A guest author is one who is knowingly listed as an author to influence reviewers or to seek some benefit or professional favor.

Study of one's child and adolescent psychiatry's national code of ethics is recommended. Resources for child psychiatrists faced with ethical dilemmas include ethics committees, institutional review boards, state or country medical accrediting bodies, and individuals with known expertise in ethics. Periodically, complaints of an ethical nature are raised against practicing physicians by a patient's family member or, rarely, colleagues. Such complaints should be channeled in the direction of individuals and committees with ethics expertise, who can then advise concerning the best manner to pursue subsequent steps.

Administration

Child and adolescent psychiatrists treat individual patients. They also direct inpatient and outpatient units, hospitals, and residential treatment facilities; are responsible for small and large research enterprises; and plan care for defined demographic populations of hugely varying sizes. In these roles they are accountable, albeit indirectly, for the welfare and working conditions of patients and staff. To varying degrees, these child psychiatrist administrators will have responsibility for budgeting; determining the needs for various services; credentialing and privileging employees; creating smooth supervisory processes with clear lines of authority; ensuring documentation in medical and other administrative records; and supervising the entire gamut of investigational research, including subject recruitment, obtaining consent, safeguarding confidentiality, data collection and analysis, and dissemination of findings (Sondheimer, 2010). Ethical problems often arise in these spheres of activity. How to fund a new clinical service that is liable to impact negatively on another in the face of limited institutional or governmental financial resources; how to respond to individual staff members who observe organizational protocols to grossly differing degrees; how to approach an institutional review board, some of whose members may be friendlier to a research proposal than others? An ethical reasoning process helps to sort out the conflicts; frequently, concentration on the principle of (distributive) justice helps resolve the conflicts between difficult choices (Sabin & Daniels, 1994).

RECENT AND EMERGING CONCERNS

Genomics

The past two decades have witnessed explosions in knowledge of genetic information, having the potential for decoding children's entire DNA sequences. Much effort has been expended to determine relationships between specific gene sequences and psychiatric disorders. While results to date have not yielded consistent findings, continued investigations will likely produce usable results in the future, possibly leading to changes in diagnostic nomenclature and the introduction of gene therapies. Confidentiality, assent/consent, rights to know and not know of disease presence, authorized versus unauthorized screenings for disorders, and predictions of disease onset are among the ethical concerns raised by the new technologies that will demand ever-closer examination (Appelbaum, 2004).

Psychiatric prodromes

Analogous to the potential of molecular-based genomics to predict the eventual development of psychiatric illness, examination of family trees and clinical observation have led to studies of treatment interventions with adolescent populations at risk for the expression of schizophrenia (McGorry et al, 2009). Similarly, expanded definitions of bipolar disorder have led to the exposure of very young children to mood stabilizing medications, as already highlighted. While such preventive efforts are superficially admirable as they, in theory, have the potential to stave off the development of and suffering from serious mental illness, these efforts are open to much question given the profession's current stage of relative ignorance (Cornblatt et al, 2001). Reliable predictive tools of illness development are not available, determination of preventive treatment effectiveness is not possible, treatment interventions with (neuroleptic) medications could conceivably cause more harm than benefit (especially when prescribed for individuals who, in the first place, would not have need for them), and non-psychotic individuals might be stigmatized (Frances, 2011).

Neuroenhancement

Pharmacologic augmentation of normal function raises related but different issues. Child psychiatrists are comfortable treating illness or distress (e.g., antidepressants for depression; neuroleptics for severe thought disorder) thus improving mood, cognitions and relatedness. While diagnoses are usually based on meeting designated criteria, at times they are employed because signs suggest the possible presence of a disorder. For example, parents seeking to create academic advantages for their child may seek treatment – based on a loose aggregate of attentional impairments – with stimulant medications in order to help their youngster focus all the more intently on tasks. Are these parents seeking unfair advantage? Do such maneuvers diminish the esteem derived from hard work and self-improvement? Will the child psychiatrist consider the potentials for harm, e.g., side effects or fostering of an initial reliance on drugs as aids? Or, might enhancing the child's performance be of overall benefit to the youngster and the larger society (Farah et al, 2004)? Do enhancements of mood and cognitions via prescribed medications differ from the improvements in physical and emotional functioning stemming from joint replacement surgery, Botox injections, and morning cups of caffeinated coffee? Does society distinguish between body and mind, feeling more comfortable with enhancing the former and queasy regarding the latter (while conversely bearing in mind the majority's antagonism toward the use of steroids and "cell-doping" in competitive sports)? Neuroenhancement brings questions of identity, self, free will, and responsibility to the fore, and these questions will surface with ever-greater frequency for parents concerned about their children (Cheung, 2010).

Electronics, social media, and bullying

Psychiatry, following some initial trepidation, has become immersed in the world of electronics (Huang & Alessi, 1996). Practitioners and institutions employ computers for record-keeping, prescribing, billing, scheduling appointments, and communicating; the profession reacts electronically to media coverage; and practitioners design personal web pages, blog, and deal with the use and misuse of a variety of electronic instruments by patients. These new worlds of technology, as was true of all prior eras ushering in wide-spread technological innovations, have the potential for positive and negative impacts for its users. They are best judged by old, traditional ethical criteria; the dilemmas the new technologies raise remain the same, they simply are garbed in novel fashions. In addition to the technologies' heuristic use to child psychiatrists in daily administration, education, research and clinical practice, they offer specific benefits for patients, e.g., the opportunity for pervasive developmentally disordered spectrum children, socially awkward and fearful, to engage socially with others electronically rather than face to face (Panyan, 1984). For many such youngsters, these communications provide a sense of comfortable engagement and, for some, lead to later meetings in person with their contacts. Similarly, many computer programs provide assistance to children with learning and communication disorders.

As with all new technologies, however, they are also open to misuse. Bullying of children by peers is a millennia-old problem, but the perpetrator of the past could always be readily identified. With the advent of current technology, by contrast, cyberbullying permits anonymous harassment of unsuspecting and vulnerable peers, commonly leading to considerable distress and the occasional front-page news article following the suicide of a bullied or "outed" youngster (Boyd & Marwick, 2011). Preventive and post-incident interventions have been created in response but, given children's immature understanding of consequences and the anonymity afforded by electronic communications, these malicious behaviors are likely to continue in a world that currently contains 800 million Facebook members. Psychiatric ethics requires child psychiatry practitioners to be aware of these developments, the potential of electronics to be used for both good and ill, the need to advocate and care for those who have suffered, to educate communities concerning potential benefits and dangers, and to aid in the implementation of relevant school-based intervention programs.

CONCLUSION

Child and adolescent mental health professionals, whether located in well-to-do, poverty-stricken, or middle-class areas or countries, share the same responsibilities – to advocate and provide care for youngsters, commonly the least protected and most vulnerable age group, independent of locale. Ethical considerations, principles, and the ways of thinking about dilemmas, whether arising in clinical, administrative or research contexts, remain the same, independent of locale as well. Available resources in these locales differ markedly, however, resulting in different resolutions to these dilemmas in different geographic settings. The fundamental ethical goals of providing protection and beneficial interventions to children remains the overarching societal and professional expectation of the child psychiatrist. This chapter, focusing on such basic matters as assent, dissent, diagnosis, treatment, confidentiality, and research, coupled with a look at recent developments in the field, has hopefully provided useful food for thought about ethical matters which impact on child and adolescent mental health practitioners, independent of their country of citizenship.

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