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Current Ethical Issues in Child and Adolescent Psychotherapy

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The *Webster Unabridged Dictionary* [1] defines ethics as 1) "a system of moral principles," 2) "the rules of conduct recognized in respect to a particular class of human actions or a particular group…." These principles and rules are specified further by the American Psychiatric Association and particularized by the American Academy of Child and Adolescent Psychiatry. They serve to bind child and adolescent psychiatrists to a code that supports the professionalism and quality care that are necessary to gain the trust of children, families, and the society at large.

The treatment of children is based upon the precepts of first, to do no harm, second, to do what is in the best interest of the child, third, to protect the privacy of the child's communications, fourth, to respect the child as well as the family regardless of race, religion, socioeconomic status, education, or intellectual level, and fifth, to promote and support the highest level of development and autonomy in the child [2]. Additionally, we must resist pressures to control the child and coerce compliance at the cost of the individuality of our patient or compromise of the best treatment available.

The practice of psychotherapy, whether in the hospital or in the office, requires us to be able to establish rapport with the child or adolescent and with the parents or guardians. The establishment of a safe environment in which the patient can understand our respect for them and our interest in what they have to say is essential for the initiation of a process for evaluation and subsequent psychotherapy. Key to the patient's confidence in the safety of the therapeutic environment is their understanding that their words

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will remain private. Protecting the child's privacy can be a complex and difficult challenge as we work with the parents to learn about their child's development in the context of family dynamics, with the school to evaluate the child's educational strengths and weaknesses, and with the justice system and other agencies to advocate for the child's need. The child and adolescent psychiatrist plays an essential role as the professional who integrates information and informs the child and the family of the options for treatment. Once treatment is recommended, third-party payors can encroach upon the family's and child's privacy with requests for data about the evaluation and the psychotherapy. This further challenges the child and adolescent psychiatrist to provide information that will justify support of treatment while preserving the confidences of the child and family.

Evolving ethical considerations

Some of the ethics-based rules that apply to the practice of child and adolescent psychiatry are clear and generally agreed upon [3]. For example, rules against sexual contact or harsh or abusive treatment are encoded as boundary violations. They are based on the recognition that such experiences traumatize, distorting and injuring the child's trust, self-esteem, and capacity for intimate relationships.

In other realms related to developments in biology and genetics, technology, and social changes, new ethical considerations emerge. Many areas relevant to the practice of psychotherapy are less clear than our basic "rules." For example, the use of the telephone for psychotherapy, audiovisual links for evaluation and treatment, and the use of the Internet and e-mail warrant careful attention and thoughtful consideration of issues relevant to privacy and efficacy.

Respecting boundaries

Psychotherapy with children and adolescents is an alone endeavor. Our experience of the patient's desires and aggressive impulses can induce us to action based on our own needs and conflicts. During any psychotherapy process, subtle instances can arise that pose risk for boundary problems. Work with preschool children offers many examples: the child who wants to sit on our lap or hug us. Sometimes children of this age may remove their shoes, raise their skirt, or want to take off their shirt. Others may want to invite us to their homes or have us attend a social or religious event. In all of these situations, the child and adolescent psychiatrist is challenged to refrain from actions that confuse boundaries and, instead, promote the child's expression of longings and impulses in words. Older children and adolescents may challenge boundaries by posing personal questions, such

as those about marital status or whether we have children. Such questions indicate curiosity and are potential opportunities to understand the child further. Motivations for the questions can be explored without necessarily having to provide an answer to them.

Although there are no hard and fast rules, therapeutic neutrality can be a helpful guide for making our way with the child or adolescent in the psychotherapeutic process. This concept often is misunderstood. It does not mean that the child and adolescent psychiatrist does not care about the child or does not react with feelings to the evolving process. Rather, it refers to the therapist's need to remain ''neutral'' to the conflicts and desires of the child that strive for satisfaction with the therapist. Being ''neutral'' to these means that we neither encourage nor condemn them, but remain interested, wanting to understand their meaning for the child. This construct helps us to secure a position that protects the therapeutic space for the child and child and adolescent psychiatrist, inviting discussion rather than expression through action. It also is relevant to our work with parents or guardians as we strive to be aware of our reactions to them, using this awareness to inform our efforts to understand and help them.

The practice of psychotherapy with children and adolescents presents us with the responsibility to constantly monitor our own reactions to the patient and family and their reactions to us and to the treatment situation. Obviously, everything is not just transference and countertransference. There are outer reality issues and the child's real relationship with the child and adolescent psychiatrist that need to be considered; however, attunement to the patient's perceptions of us and our perceptions of him or her can greatly inform us about the child's conflicts. Sometimes, our reactions to a child, adolescent, or his or her family may be more about us than about them. Knowledge of the sources of our reactions and responses may free us to work more objectively and may restore a therapy process in jeopardy. When the child and adolescent psychiatrist remains puzzled by his or her reactions or the therapy process does not progress, consultation with a trusted colleague may be helpful. Occasionally, seeking treatment for oneself may be the best choice.

Autonomy of older children and adolescents

There is growing recognition by the judicial system of a minor's ability to contribute to decisions based on understanding and objectivity [4]. Whether recognized legally in any given jurisdiction or not, there remain clinical and ethical indications for children and adolescents to participate in decisions about treatment, including their psychotherapy. In addition to being respectful, the working alliance is strengthened when the child or adolescent feels that he or she has participated in an informed decision to pursue psychotherapy, rather than experience it as imposed by others.

Liability for dangerous patients, abandonment, and other current issues

Society's concerns about dangerousness have increased again in response to the recent tragic violence at Virginia Tech (Virginia Polytechnic Institute and State University in Blacksburg, Virginia). The dilemma between duty to the patient and duty to society was the subject of the Pace Law Review published in 1999–2000 entitled "Current Issues in the Psychiatrist–Patient Relationship: Outpatient Civil Commitment, Psychiatric Abandonment and the Duty to Continue Treatment of Potentially Dangerous Patients—Balancing Duties to Patients and the Public" [5]. This review contains extensive discussion of the difficulties predicting dangerous behavior. When working with patients with recognized risks for dangerousness, attentiveness and vigilance should increase when decisions to transfer or stop treatment are made. Although confidentiality and privacy must be considered, the child and adolescent psychiatrist also should be thoughtful and deliberate when contact with a patient with a potential for dangerousness is threatened to be weakened or lost. Erring on the side of safety for the patient, the patient's family, and the community is advised.

Protection of data about the child and family

The child and adolescent psychiatrist's responsibility to protect information about the child and his or her family dates to the Hippocratic oath. The duty to hold in confidence that which is revealed in the context of the doctor–patient relationship evolved in law as a responsibility incumbent upon the physician once the doctor–patient relationship, a fiduciary relationship, is established. The foundation of this responsibility lies in the Latin meaning of fiducia, "trust." A fiduciary is defined as "a person who stands in a special relation of trust, confidence or responsibility in his obligations to others" [6]. It is the physician who carries the responsibility to guard and protect the trust and confidence of his or her patient. Breach of the fiduciary relationship is a key legal condition for modern malpractice.

These principles also serve as the underpinnings of the psychotherapy relationship between the child and adolescent psychiatrist and patient. It is only with the establishment of trust and confidence that a therapeutic space can be created. Within this space, the child or adolescent can feel sufficiently safe to trust in his or her freedom to reveal what he or she thinks and feels without being judged, retaliated against, or violated by breach of his or her privacy.

Communication with parents and guardians

From its very beginnings, the profession of child and adolescent psychiatry has attempted to understand children in the context of their biologic heritage, family, community, and culture, exploring how these interact and influence the child's development. Variability in the relative influence

of each of these forces from child to child has led to the development of a repertoire of interventions, including pharmacology, parent guidance, family therapy, individual therapy, and advocacy in schools and courts. A recommendation for individual psychotherapy usually reflects an appreciation that disturbance in the child's internal world (whether conceptualized as thoughts, feelings, or both) carries its own momentum, despite biologic and environmental interventions, and that these disturbances threaten to distort the trajectory of further development.

Those conducting psychotherapy with children and adolescents encounter unique challenges in their efforts to protect their patient's privacy. Child and adolescent psychiatrists rarely operate in a vacuum sealed from interaction with parents and guardians. When this does occur, it can reflect a parent's trust in the process and respect for their child's privacy or, more ominously, a lack of interest in his or her child's emotional life and an implicit delegation of responsibility for the child's well-being to the child and adolescent psychiatrist. In one situation, the child and adolescent psychiatrist may find him- or herself challenged to protect the privacy of the psychotherapeutic process from parents or guardians who are perceived as too intrusive. In another, he or she may appeal for greater involvement from parents who are perceived as too remote.

Regardless of where on this spectrum the child and adolescent psychiatrist finds him- or herself with a given patient, the ethical principles guiding one's conduct of communication with parents and guardians remain the same. Parents and guardians have rights to be informed about any treatment conducted for their child, including psychotherapy, and to be updated on their child's progress. In addition, a psychotherapy process with a child or adolescent that is too opaque to parents or guardians can elicit distrust sufficient to jeopardize the alliance and risk disruption of the process. The child and adolescent psychiatrist must balance the rights of parents or guardians and the clinical indications for some communication with them against the child's right for reasonable privacy and the clinical need for the child to be able to trust that he or she has sufficient privacy for the process to be effective. The child or adolescent who perceives one's therapist as too open a conduit of information to one's parents is likely to remove critical information from the process, rendering it compromised, if effective at all.

Upon recommending a psychotherapy process, the child and adolescent psychiatrist has the responsibility and opportunity to review with parents or guardians the structure of the psychotherapy frame and, importantly, its rationale. In addition to discussing schedule, duration of sessions, frequency, and estimated duration of treatment, issues relevant to the child's privacy should be addressed. Parents can be reassured that there is regard for their need to be informed about the process intermittently. The importance of such communication can be emphasized to parents who are inclined to be too remote. The frequency of sessions with parents or guardians is a clinical decision, integrating such variables as the age of the child, the severity of the child's problems,

the severity of the parents' issues, the strength of the alliance with the parents and child, and the needs of the parents.

The challenges faced in balancing a child's need for reasonable privacy against the parents' need for reasonable information can be shared candidly with parents or guardians. Parents can be told that their child's confidence in the relative privacy of the process can be critical to its efficacy, but that their need for information also is respected to help them understand and parent their child. The parents also can be reassured that information suggesting imminent danger to their child or others would not be withheld from them. Empathy for the challenges of parenting, avoiding blame, direct acknowledgment of the child and adolescent psychiatrist's time-limited role with the child in contrast to the parents being there for the "long run," communication of hope that improvement in the child's relationship with his or her parents can be a consequence of the psychotherapy, and recognition that no parent can be a therapist to one's own child and remain an effective parent all serve to strengthen the alliance with parents and their comfort with their child's privacy.

The structure of the psychotherapeutic frame also should be reviewed with the child or adolescent. The rationale for periodic contact with parents or guardians can be discussed, highlighting that these contacts in no means abrogate the child and adolescent psychiatrist's responsibility to guard the child's privacy. The child or adolescent should be informed of the frequency of sessions with parents or guardians and should be invited to discuss what one would like communicated before such sessions. Together, the child and child and adolescent psychiatrist can anticipate what may arise in discussions with the parents. The child and adolescent psychiatrist also can provide the patient with an example of how one might frame an issue for the parents, inviting feedback as to whether this example is respectful of his or her privacy. Communication of broader themes that avoid details that the child would deem too personal is advised, eg, "Billy is working on how he can gain independence while still maintaining important ties to you as his parents." The child and adolescent psychiatrist also should offer to review with the child the session with his or her parent or guardian after it occurs. A summary impression of the session can be provided while maintaining reciprocal respect for the parent's or guardian's privacy.

One common challenge to any child's confidence in his or her privacy is a parent's appeal to have time with the child and adolescent psychiatrist at the beginning or end of the child's scheduled time. It is not unusual for a parent to want to report on what a child has done, with the implicit or explicit message that the child and adolescent psychiatrist address the issue in the upcoming session. Sometimes, the parent attempts to have this discussion in the waiting room. These types of communications challenge the confidence that a child or adolescent has in the autonomy of his or her process and privacy. It also disrespects the boundary of the child's time and therapeutic space. Fulfilling the parent's appeal for time at the beginning of the child's session, whether the

child remains in the room or not, inevitably distorts the child's freedom to begin the session with his or her agenda, confusing for the child whether the child and adolescent psychiatrist is the guardian of the psychotherapeutic space or simply the agent of the parent. Meeting with a parent during the latter portion of the child's scheduled time or immediately after the session with the child can collude with the child's fantasy that the child and adolescent psychiatrist is reporting to the parent, constricting the child's confidence that one has privacy in sessions. Discussing issues with a parent in a waiting area is an obvious violation of the child's privacy.

Consideration of why a parent or guardian may press for a portion of a child's session can help to inform the child and adolescent psychiatrist's understanding of the child and parents. For example, a parent's appeal for contact during his or her child's scheduled session can reflect hunger for or envy of the attention being directed at one's child, anxiety about his or her child's privacy with the child and adolescent psychiatrist, or wishes for the child and adolescent psychiatrist to fulfill the role of a missing parent. The solution to the challenge of providing sufficient time to a parent or guardian without violating the therapeutic space established for the child is to structure a parent process separate from the child's time.

Written and verbal communication with parties outside of the family

Requests for information about a child or adolescent in psychotherapy can be abundant. The child and adolescent psychiatrist becomes the gatekeeper of information and guardian of his or her patient's privacy. In *Jaffe v Redmond* [7], The US Supreme Court upheld the patient's privilege with regard to the release of psychotherapy records, reinforcing the patient's right to privacy and the importance of the patient' s freedom to enter a psychotherapy relationship with confidence in the protection of one's privacy. With minors, that privilege becomes the right of parents or guardians unless state law gives that right to the minor before he or she reaches the age of majority; however, parents and guardians may not always appreciate the potential ramifications of releasing information. Even when legal authority to communicate written or verbal information to a third party is granted by a signed release of information, the responsibility of the child and adolescent psychiatrist to consider the ramifications of what is released to whom remains paramount.

The child and adolescent psychiatrist should respond to any request for release of information with consideration of its appropriateness and necessity and the potential impact of what is released on the child, the family, and the psychotherapy process. Child and adolescent psychiatrists are vulnerable to mistakenly think that they must respond to any request for information, absenting their discretion about what is shared with whom. This is particularly the case with requests for written reports, which often contain abundant information beyond the needs that generated the request. These reports also may contain information about family members.

When considering written or verbal communication to a third party, the child and adolescent psychiatrist should discuss the request with the child and the parents or guardian. If the child and adolescent psychiatrist has questions about the necessity of the release or concerns about the potential ramifications of such information, these should be communicated openly. If there is a decision to communicate with outside parties, careful consideration should be made as to what is said or sent, with streamlining of communication to the minimum necessary to achieve the goals of that request. Reports requested by schools, courts, or hospitals should be reviewed carefully, scrutinizing whether the content is congruent with the needs of the request and whether the reports contain information about the child or others that is beyond what is needed. The child and adolescent psychiatrist always should consider the long-term fate of what is released, including whether the setting receiving the material will be able to guard the privacy of these records in ways appropriate for their content. When records communicate more than is needed for the purpose of the request, the child and adolescent psychiatrist can compose a summary letter that includes the information needed and no more. Although less convenient than sending already prepared documents, the duty to protect a patient's privacy always should outweigh such convenience.

Psychotherapy records also should be segregated from the main medical record. Rarely, if ever, should there be a reason to release process. Child and adolescent psychiatrists practicing in settings with centralized records in a medical records office should guard against portals that could allow anyone other than the treating child and adolescent psychiatrist to make decisions as to what is copied and released.

The child or adolescent and their parents or guardians should be involved in discussions about whether to release information and what information should be released. What will not be released should be highlighted, emphasizing that the child and adolescent psychiatrist, as guardian of the psychotherapy process, will not communicate details about the child or family that are not relevant to the needs of the request. Requests for communication with others that are initiated by the child and adolescent psychiatrist also should be discussed with parents or guardians and patients. Ideally, discussions with the child or adolescent should occur separately from discussions with parents or guardians, so that each has maximum freedom to speak openly. Please refer to the article by Recupero elsewhere in this issue for a related discussion of medical communications, including attention to medicolegal considerations.

Ethical and clinical considerations with e-mail and telephone communication

Many of the pertinent issues that child and adolescent psychiatrists face with the availability of electronic communication are discussed by Kassaw

and Gabbard [8] in their 2002 review of the topic. While noting specific situations in which e-mail communication might have a constructive potential, they highlight three areas of ethical concern: "1) problems inherent in the mechanics of E-mail, 2) privacy and confidentiality issues, and 3) the loss of essential elements of the therapeutic action associated with the psychiatrist-patient relationship." All of these issues are relevant to psychotherapy with children and adolescents.

Limitations to the ability to ensure the security of information communicated electronically pose risks to privacy, despite the "illusion of security" that passwords promote. Technological vulnerabilities, together with human error (ie, inadvertent access to files or visibility of screens), provide sufficient rationale for caution against maintaining detailed electronic material related to psychotherapy. Recent incidents gaining national attention involving the theft or loss of electronic information only reinforce the need to avoid electronic preservation of such personal material as that which would exist in a psychotherapeutic exchange.

Conducting psychotherapy through electronic communication also is problematic. E-mail communication in exchange for direct communication in the office deprives the child and adolescent psychiatrist of critical information related to facial expression, body language, and voice tone. Emotion is drained from word text, spontaneity is lost, and the potential to edit communication is maximized. Reciprocally, the patient is deprived of the voice tone, facial expression, and body language of the child and adolescent psychiatrist, essential elements of communication that have a strong influence on the therapeutic relationship, process, and course. Cyber communication also may collude with the child's or adolescent's avoidance of direct communication about particularly important issues, including those related to safety. Electronic communication easily promotes a quality of remoteness in a relationship, contrary to the method and aims of the psychotherapeutic process.

The establishment of e-mail exchange as a forum for communication also distorts the traditional therapeutic space. A reliable time and place for contact and therapeutic work is exchanged for more amorphous cyberspace. Direct contact and visibility is replaced by invisibility. Even scheduled electronic communication concentrated to a reliable time can degenerate easily to more erratic communication that parcels information and dilutes therapeutic intensity. In addition, the fantasy that the child and adolescent psychiatrist as psychotherapist is available on demand is reinforced by irregular communications and responses. The child and adolescent psychiatrist also places him- or herself at risk for missing important messages about safety when precedent is established for e-mail as a sanctioned form of communication. Critical information often is diluted with other messages and affectively may be cold by the time the therapist electronically receives the information or responds. Please refer to the article by Recupero elsewhere in this issue for additional discussion regarding electronic communications.

For similar reasons, the use of the telephone as a regular alternative to direct face-to-face sessions also is discouraged. The loss of the visibility of the patient to the therapist and the therapist to the patient can seriously limit communication and understanding. Issues of key importance are more likely to be avoided. This avoidance may be less apparent to the therapist because of the absence of visual cues. Patient and therapist also can become more vulnerable to competing visual stimulation that detracts from attention to the therapeutic relationship and process.

Hospital psychiatry and the psychotherapeutic relationship

The child and adolescent psychiatrist conducting a psychotherapy process with a patient who is hospitalized faces unique challenges in balancing one's ethical obligation to maintain the privacy of the psychotherapy relationship with the need for open communication in the hospital setting. This is true whether the child and adolescent psychiatrist conducting the psychotherapy also is conducting the hospital treatment or whether hospital treatment has been referred to a colleague. In the latter scenario, it is easier to maintain an identity as psychotherapist, but some liaison to members of the inpatient team will still be likely.

Hospitalization should not mandate loss of privacy in the psychotherapy relationship. Principles for communicating with parents can serve as a guide for what material is communicated to the larger inpatient team. The child and adolescent psychiatrist as psychotherapist can use one's knowledge of the child to enhance the treatment team's understanding of the child without providing more information than is essential. What might be said to the treatment team should be discussed first with the child. As with outpatient treatment, the child and adolescent psychiatrist conducting the psychotherapy should clarify early in one's contact with the hospitalized patient that the therapist cannot hold information directly relevant to the child's safety or the safety of others. If such issues arise, it is best to explore them sufficiently so that, preferably, the child brings this information to the treatment team.

The challenges of practice in a "small community"

The challenge to maintain therapeutic boundaries with patients and their family members is greatest within smaller communities in which paths outside the therapeutic relationship are much more likely to cross [9]. Although the "small community" often is thought of as the small town or more isolated rural area, small communities also are common within larger metropolitan areas. They exist in neighborhoods, school districts, ethnic and religious subcultures, professional groups, work places, and common socioeconomic circles. In addition to the greater challenges maintaining

boundaries and avoiding conflicts of interest within such communities, it also is harder for the psychotherapist to remain relatively anonymous. Far more information about the psychotherapist may enter and influence the psychotherapeutic space, often without the immediate knowledge of the therapist. As a consequence, the patient and the child and adolescent psychiatrist can feel constraints to the freedom that should be inherent to the psychotherapy process.

Overlapping relationships within small communities should be avoided whenever possible. Care should occur when referrals are made that carry potential for conflicts of interest or compromised anonymity. Despite the awkwardness of declining such referrals, it always is best to refer to a colleague when problems are anticipated. In communities so small that an alternative is not available, the child and adolescent psychiatrist who accepts such a patient must maintain additional vigilance to guard the psychotherapeutic space. Discussing these issues with the child and parents at the onset of treatment is recommended. This will help to reinforce the therapeutic frame and avoid misunderstandings about limiting contacts outside the treatment relationship. The child and adolescent psychiatrist also must anticipate that by entering a treatment relationship with that child and parent, social relationships with them will not be possible in the future.

Public encounters

Public encounters with patients pose challenges to privacy and confidentiality and to the child and adolescent psychiatrist's anonymity. Although often unpredictable, some public encounters can be anticipated and avoided. When a child and adolescent psychiatrist is aware that a child or parent may be at an event that he or she attends, one may choose to avoid the event or discuss the potential encounter with him or her ahead of time. In communities in which interface is likely to happen at some time or another, the child and adolescent psychiatrist may anticipate this with one's patient, allowing for some preparation for when it occurs.

Acknowledgment of a relationship with a patient in a public setting can be experienced as a violation of the patient's privacy and confidentiality. A lack of acknowledgment can be experienced as a snub. In general, it is best for the child and adolescent psychiatrist to explain to one's patient and his or her parents that, in the case of encounter outside of the office, one will err in the direction of not acknowledging them unless they initiate an acknowledgment. In the latter case, the child and adolescent psychiatrist should keep in mind that an acknowledgment initiated by a patient or parent, even one that seems overtly extraverted, may result from anxiety rather than any real indifference to their privacy. Given that the child and adolescent psychiatrist is the guardian of the patient's confidentiality, it is best to respond with a socially appropriate response without encouraging much discussion or

introduction of others. In subsequent clinical contact, it is useful to explore the patient's reactions to the encounter, especially if he or she does not bring it up.

Privacy versus secrecy

The *American Heritage Dictionary of the English Language* [6] defines privacy as "the condition of being secluded or isolated from the view of, or from contact with, others." Secrecy is defined as "the quality or condition of being secret or hidden, concealment" [6]. Although there is some overlap in the definitions and common connotations of privacy and secrecy, the terms are not identical for the purposes of understanding the psychotherapeutic relationship. Although information shared within the therapeutic space contains information that can be perceived as secret, its therapeutic purpose is to promote freedom within this space to not hide, rather than to hide, from others for some covert purpose. The US Supreme Court ruling of *Jaffe v Redmond* [7], affirming the patient's privilege for releasing the content of psychotherapy, emphasizes the patient's right to privacy and freedom to seek treatment by trusting in that right. The Court wrote, "If the privilege were rejected, confidential conversation between psychotherapists and their patients would surely be chilled…"

Despite the psychotherapist's understanding of the distinction between privacy and secrecy, children and adolescents, parents, and hospital teams are vulnerable to misconstrue protection of the patient's privacy as a collusion of secrecy. For the child or adolescent to use the psychotherapeutic space freely and optimally, and for the parents or guardians to maintain sufficient trust in the therapist and process, it is crucial to clarify the distinction between privacy and secrecy at the beginning of the treatment relationship and at subsequent junctions when there is evidence that such misunderstandings of this distinction reemerge.

Countertransference

Moore and Fine's *Psychoanalytic Terms and Concepts* [10] includes in its discussion of the term "countertransference" "…feelings and attitudes toward a patient… derived from earlier situations in the analyst's life that have been displaced onto the patient…Others include all …emotional reactions to the patient, conscious and unconscious, especially those that interfere with… understanding and technique. This broad purview might better be designated *counterreaction*."

The construct of countertransference is related intimately to neutrality, defined by Moore and Fine [10] as "…keeping the countertransference in check, avoiding the imposition of one's own values on the patient, and taking the patient's capacities rather than one's own desires as a guide…The

concept also defines the recommended emotional attitude of the analyst - one of professional commitment or helpful benign understanding that avoids extremes of detachment or overinvolvement.''

The relevance of countertransference and neutrality to the ethics of conducting psychotherapy lies in the critical importance of the child and adolescent psychiatrist's attention to his or her emotional reactions to one's patient and one's patient's parents or guardians. Although such reactions are unavoidable and may provide useful information toward understanding patients, it is incumbent upon the treating child and adolescent psychiatrist to exercise vigilance as to how one's reactions might influence one's conduct of the psychotherapy process. When the child and adolescent psychiatrist is aware of an intensity of feelings toward a given child or adolescent or that such feelings have influenced one's behavior toward one's patient or one's patient's parents in ways that deviate from one's usual practice, greater self-scrutiny is warranted. Such deviations in intensity of feelings or behavior also serve as serious warning signs for a potential for boundary violations, placing child and therapist at risk. When this occurs, it is critical to avoid the predictably strong temptation to rationalize what is unfolding. Consultation with supervisors or colleagues is critical to avoid any enactment that is detrimental to all. Common warning signs in the behavior of the therapist include recurrent lateness to sessions, extensions of sessions, touching of patients, gifts to the patient, and contact with the patient outside of scheduled sessions, especially outside of the office setting.

The influence of the child and adolescent psychiatrist's values on one's attitude toward one's patients or one's patient's parents or guardian also warrants vigilance. Child and adolescent psychiatrists will encounter patients and families holding a variety of cultural, religious, and political beliefs that may differ from their own. Respect for their beliefs is essential. In addition, children and adolescents often communicate internal conflict about their beliefs and values. When this occurs, the child and adolescent psychiatrist should refrain from the temptation to interject one's values as a means to assist the child with his or her conflicts. Rather, one should remain respectful of one's patient's dilemma, helping him or her to arrive at his or her own acceptable solutions, even when those solutions may not be consistent with one's own beliefs and values.

More than one therapist

In most cases, it is problematic for a child or adolescent to be engaged in concurrent psychotherapy processes. At a minimum, the patient is at risk for perceiving conflicting and potentially confusing messages from his or her therapists. In addition, in response to perceptions of each therapist, the patient is vulnerable to omitting key aspects of him- or herself from both of the psychotherapy processes. For example, the therapist attempting to address

more central issues may be at risk for being devalued, whereas the therapist farther from these issues becomes idealized. Both therapists, in turn, develop incomplete and potentially distorted views of the patient.

A few treatment situations may allow for concurrent psychotherapy processes. When these are undertaken, vigilance to the potential risks must occur. Some hospital programs provide inpatient therapists other than the child or adolescent psychiatrist treating the patient outside the hospital. When such arrangements exist, sanctioned communication between these therapists is essential so that the therapists' efforts are coordinated and coherent to the patient and family. In general, the inpatient therapist's focus should be on those issues most immediately relevant to the events precipitating hospitalization. Ideally, the outpatient psychotherapist can enhance the inpatient therapist's understanding of the child or adolescent without disclosing nonessential information that the patient has shared in confidence.

Patients who have eating disorders and substance abuse disorders may work with more than one psychotherapist when the roles of each are distinguished clearly. In this situation, the role of one child and adolescent psychiatrist is to focus almost exclusively on the problematic behavior, providing monitoring and support, whereas the other provides a more open-ended, judicious exploratory process as a means to support the patient's overall growth and development, including the navigation of stressors that place one at higher risk for relapse. Here again, ongoing communication between therapists is essential to promote coherence for the patient and family and to minimize the potential drifts toward idealization and devaluation that can occur.

In some clinical settings, one clinician works with the child or adolescent while another works with the parents or guardians. This model protects the integrity of the child's time, especially when the parents or guardians have significant, ongoing needs of their own; however, it does little to enhance parents' or guardians' trust in their child's psychotherapy process unless there is constructive communication with them about that process. This can be done by the clinician working with them, by the clinician working with their child, or by both. Both clinicians should maintain awareness that they are vulnerable to distorted views of the child and parents influenced by what they hear or experience in their respective processes. Ongoing communication between the clinicians helps to protect against this. Each clinician will be challenged to communicate enough to the other to help inform his or her understanding, without disclosing details that violate the child's or parent's reasonable privacy.

Summary

Core ethical principles for the conduct of psychotherapy with children and adolescents transcend times, trends, and jurisdictions. Advances in technology, variations in state law, and the evolution of federal law should

stimulate consideration of how these ethical principles apply to new situations; however, the guiding compass remains the psychotherapist's obligation to create and protect the integrity of the psychotherapeutic space to provide the child or adolescent the freedom to identify, examine, explore, and hopefully resolve the issues that bring one to treatment. Boundaries, privacy, confidentiality, and the patient's autonomy are components of this space. Together, they reflect a basic respect for the patient central to professional conduct and essential to any effective treatment process.

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