

# Collision Between Law and Ethics: Consent for Treatment with Adolescents

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The dilemmas between legal obligations and ethical responsibilities can often create problems in clinical work. The treatment of minors, and particularly adolescents, can present special issues to the clinician that are becoming increasingly frequent and difficult. The issue of informed consent for treatment of adolescents raises serious questions for the clinical practitioner who is faced with both legal and ethical dilemmas in making decisions about treatment. There are an increasing number of cases where adolescents may seek treatment yet are in circumstances that preclude parental consent. This paper uses case material to illustrate some of the legal, ethical, and treatment considerations in the situation of adolescent treatment where parental consent is problematic.

Since minors have legal rights under the Constitution of the United States,<sup>1-3</sup> their treatment often raises difficult legal and ethical questions.<sup>4,5</sup> Conflicting attitudes about the rights of minors are found pervasively among the ranks of mental health professionals.

Mental health professionals participate in developing social policy and informing the legal system about the capacities of minors to give informed consent for medical and psychological treatment.<sup>5,6</sup> While there are an increasing number of authors looking into the question of the capacity of minors to

give informed consent for treatment, there are few investigations that address those special cases in which at-risk minors are denied needed mental health intervention by a legal guardian who refused to allow such intervention.

Principle 3d of the American Psychological Association's (APA) *Ethical Principles of Psychologists*<sup>7</sup> specifically addresses the issue of conflict between laws and APA standards and guidelines. A portion of this section reads:

In the ordinary course of events, psychologists adhere to relevant governmental laws and institutional regulations. When federal, state, provincial, organizational, or institutional laws, regulations, or practices are in conflict with Association standards and guidelines, psychologists make known their commitment to Association standards and guidelines and, wherever possible, work toward a resolution of the conflict.

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This section of the APA Ethical Principles attempts to address the collision between law and ethics for psychologists, but falls short in addressing the specifics of how a clinician might "work toward a resolution of the conflict." In clinical practice, the authors have found that there are many instances when the law is quite clear, and resolution is not possible when the law opposes sound, ethical practice. The clinician is then faced with the very difficult decision of on which side his or her choices will fall: the side of the law, or the side of the ethical responsibility to work in the interest of the patient. In our own practice with inner-city adolescents from very difficult families, and hostile and often dangerous environments, we are faced with this dilemma in circumstances which leave little if any time or room for "working toward a resolution." While both the APA Guidelines for Providers<sup>8</sup> and the APA Ethical Principles<sup>7</sup> address issues pertinent to consent for treatment and issues pertinent to legal/ethical dilemmas, our clinical practice with adolescents finds that there are often instances where the guidelines and principles are not adequate in addressing relevant clinical questions.

This paper will review the legal and ethical implications of the consent issue with special consideration of two clinical cases in which there is a collision between the legal and ethical elements of the decision to treat the adolescent patient. These cases illustrate some of the very difficult dilemmas in making treatment decisions when treating the adolescent patient.

### **Case Examples of Treatment Dilemmas in Treating Adolescents Without Parental Consent**

The following case illustrations come from the clinical work of the authors who serve adolescents in a public program that works with local public junior high schools. Although the therapy program operates independently of the school counseling program, therapists and intern therapists see their adolescent patients on school grounds during school hours. Referrals are generally made by school counselors who have worked with each patient at some point within the context of the school counseling program. Typically, those students who get referred have had numerous referrals to school counselors from classroom teachers, are failing in classes, and having problems with peers. In most cases there is either current abuse or a history of abuse. This population also is characterized by an alarming prevalence of student and/or family drug sales or abuse, and an increasing tendency to carry weapons to school for protection. While the cases presented here raise several ethical issues that the clinician must contemplate, the discussion in this paper will focus on the dilemma pertaining to consent for treatment.

The model of providing psychotherapy to students on school grounds both during and after school hours will likely become one that is increasingly utilized to provide treatment to children and adolescents. Many such programs are funded by state and or federal government funds. Such funding imposes guidelines and restrictions on the treat-

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ment and practice conducted under such conditions. Often the school district or the funding agency will have rules regarding issues such as consent for treatment and confidentiality that may not be in keeping with those same guidelines that would operate in a private practice setting. Thus, the clinician has his or her hand forced by an outside governing body that often makes determinations that profoundly affect both the treatment and the therapeutic relationship. The issue presented here constitutes such a situation where the district and funding agencies may have *carte blanche* policies on parental consent when in fact such policies may not be in the interest of the adolescent, or within the limits of the law.

The cases presented here have the common denominator of the adolescent patient willingly and voluntarily seeking treatment under circumstances that under the law would require parental consent. However, either consent is not available, has been refused by the parent, or in the experience of the adolescent would pose a danger to him or her if the parent was alerted that their son or daughter was seeking psychotherapy.

**Case A: "Kate"** "Kate" is a 14-year-old, black female who is referred to therapy by her school counselor. Kate is the youngest of three children, and now lives at home only with her mother. Her father is deceased, and she has not seen her two siblings in several years.

The referral indicated that Kate was described by her teachers as being depressed, not caring about her work, which was usually above average, and

"wanting to ignore her problems." Several weeks ago she had been found in a school locker room with a razor blade cutting her leg.

In the first session Kate appeared as a well-developed, bright, attractive female who was quiet and withdrawn. The most recent occasion of cutting was three weeks prior to the session, and followed the first cutting by only a few days. She said that her mother was aware that she had cut herself and that she promised not to do it again. The mother, who is a Charismatic Christian, encouraged her daughter to pray for healing from those behaviors that were "caused by Satan."

After two initial assessment sessions, Kate was told that it would be necessary to contact her mother to obtain consent for treatment. Kate became enraged, tearful, and stated adamantly that her mother could not be contacted, and could not know that she was in therapy. In the next session Kate sat silently and said that everything for her was fine. She said that if her mother was contacted for consent that she would refuse to come back. While acknowledging that "there was a reason" that she didn't want her mother to know she was in treatment, she refused to share it as long as there was the possibility of her mother being contacted.

**Case B: "Jamie"** "Jamie" is a small, 13-year-old, Caucasian male. He is the middle child of three, with a younger sister who is six, and an older brother who is 19. He lives at home with both of his natural parents and his two siblings.

Jamie referred himself to his school

counselor because as he said initially, "there was something bugging him." The counselor then referred his case to the treatment team for psychotherapy. Several attempts were made to reach Jamie's parents for consent, but they returned no phone calls either before or during Jamie's treatment.

In the first treatment session Jamie presented with a range of affect that included both laughter and melancholy. He was verbal, and seemed to be reaching out for help as he said, "there are things wrong with me, and I wanted to get some help about it." He added, that he had "something to get rid of." He started to cry as he began to talk about his parents who were both drug dealers in the inner-city. Jamie again said that he "had something" and he began to shake. He reached into his backpack and removed a .32 caliber handgun and placed it on a desk next to his chair. He began to cry and said, "I would never use it but I would just want to scare someone. . . . I never know when I might need it." Jamie left the gun with the therapist and stated that he never wanted to see it again.

In the next session the issue of consent for treatment was raised. Jamie did not appear concerned about obtaining consent from his parents, but he was concerned that his parents would not want him in therapy talking about their drug dealings.

Jamie called his therapist the day after talking with his parents about consent. After a brief conversation by phone, an appointment was made to see Jamie right away, as it was clear that he was in

some distress. In the session he said that his parents refused to give consent for his treatment. Jamie again became tearful, and talked about feeling afraid that there would be no one for him to talk with about his problems.

### **Informed Consent: What It Is and the Competence of Minors**

The central components of informed consent are threefold: (1) the consent must be *informed* (made knowingly, or with the knowledge of the consentor that consent is being given), (2) the person giving the consent must be *competent* (able to make a decision from an understanding of the issues involved), and (3) the consent must be *voluntary* (free from coercion, secondary gain, and pressure from extrinsic sources).<sup>5, 9-14</sup> While these three standards remain somewhat vague in their legal implications, they continue to constitute the essence of what we routinely refer to as "informed consent."

An individual knowingly providing consent can have a wide range of interpretation. Some practitioners believe that by a patient's merely walking into the consulting room they knowingly have given their consent to be treated. Others would argue that a patient may only give consent after they have understood and signed lengthy documents that explicitly articulate the parameters of treatment.

The element of the consent process which suggests that a consent must be made with "competence" is perhaps the area of the consent process that invites the most lengthy discussion. This aspect of consent addresses the question of "in-

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forming" the patient about treatment, by providing him or her an adequate understanding of the therapeutic process to ensure that such consent is "informed" and made "competently."

In a recent article by Golub,<sup>16</sup> the question of "informed" consent was examined with recommendations given to clinicians outlining the process which the clinician might follow. The accepted clinical interpretation of what constitutes informed consent is as follows: an explanation of the procedures to be followed and their purposes, including identification of any procedures that are experimental; a description of any attendant discomforts and risks reasonably to be expected; a description of any benefits reasonably to be expected; a disclosure of appropriate alternative procedures that might be advantageous to the subject; an offer to answer any questions concerning procedures; an instruction that the person is free to withdraw his or her consent and to discontinue participation or treatment at any time without ensuing prejudice; and a statement about confidentiality and its exceptions.<sup>15</sup>

As noted earlier, the patient's voluntary consent to treatment is an implicit criterion in the definition of informed consent. Scherer and Reppucci<sup>5</sup> have examined the component of "voluntariness" in some detail. They report that the law regards voluntariness as ambiguous, and argue further that there are no legally based criteria that describe a voluntary action or that action's applicability to all situations.<sup>17-19</sup>

Consideration of "informed consent"

with regard to minors inherently raises the question of that minor's capacity to provide voluntary, informed consent. It has only been within the last decade and a half that the courts have begun to struggle with the question of an adolescent's capacity to provide informed consent. Court decisions involving the minor's provision of informed consent have been largely based on case law, and have not been determined by empirical data. More importantly, there is little empirical knowledge concerning the specific developmental features of a minor's capacity to give voluntary consent for psychotherapy.

Some research has explored the relationship between developmental features and such specific psychological constructs as conformity, compliance, and reactance toward assessing the minor's capability of providing voluntary, informed consent.<sup>6, 10</sup> Studies that have examined the relationship between age and conforming to prescribed treatments have found that conformity reaches a peak in early adolescence and then declines as a function of adolescent maturity.<sup>5, 20-26</sup>

Scherer and Reppucci<sup>5</sup> point out that in most consent situations minors have neither the legal nor the psychological freedom to choose. Brehm<sup>25</sup> cites several studies that suggest free choice by minors is compromised because minors often respond to adult influence with compliance. However, as a minor moves through adolescent development, increased autonomy during adolescence heightens reactance to parental decisions.<sup>10</sup> Scherer and Reppucci<sup>5</sup> found

that in a sample of forty 14- and 15-year-old subjects, adolescents making treatment decisions were generally deferent to parental influence, although they might more likely resist influence of parents when the consequences of free choice and decision might have serious implications in hypothetical situations.

The literature on psychosocial development that explores the question of consent suggests that prior to adolescence, the psychosocial capacity of the minor to give voluntary consent is insufficient to formulate a valid, informed consent.<sup>10, 26</sup> However, for those adolescents who have reached the age of 13 years, the consensus in the literature reveals that these minors have the same cognitive capacities for providing consent that adults do, and therefore constitute a group of individuals who are able, yet often denied the legal right to give consent for treatment.<sup>5, 10, 26, 27</sup> Some states have reviewed this incongruence and have adjusted the legal age at which minors can consent for treatment. The law varies from state to state regarding the actual age at which minors can give their own consent, and clinicians should be reminded to review such laws in their own state.

### **The Law and Informed Consent**

Many legal statutes and professional standards have exhorted judges, legislators, policy makers, and clinicians to act in the best interest of children. The legal system in this country has long presumed that parents are free to determine what is "best" for their own child. The United States Supreme Court has pro-

mulgated the constitutional right of parental control and custody, which presumes that parents will make decisions and act in the best interests of the child.<sup>28</sup>

These determinations are largely based on the belief systems, preferences, and life-styles of the parents, with little consideration given to the rights of the minor.<sup>29</sup> However, with the ramifications of teenage pregnancy, child abuse, parental drug use, abortion, and child victims of satanic cults, the rights of the parents to decide what is best for their child may be called into question.

The last 20 years have seen the emerging movement of "children's rights," which advocates the philosophy that children have legal rights similar to those of adults. Plotkin suggests that this movement parallels increasing societal awareness that parents do not always act in the best interests of their children.<sup>27</sup> Consequently, a parent's decision to deny a child's access to appropriate treatment has created an inevitable collision between the rights of that child and the rights of that parent.<sup>27</sup> However, our clinical experience speaks to an increasing number of cases where the interests of one parent and child may differ significantly. The ramifications of authorizing consent in cases involving teenage pregnancy, abortion, child abuse, parental drug use, and when children are victims of satanic cults where the parent may be a cult member calls to question who is most appropriate to sanction consent for treatment. In such cases a child may be either forced to treatment that he or she does not want,

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or may be denied access to treatment that he or she desires and needs.

Although statutes vary from state to state, in the case of psychological services to minors, parental consent must be obtained except in the following cases: court ordered treatment, cases of child abuse, drug or alcohol counseling, or when a child is a risk to self or to others. Psychological services could be provided in some states in conjunction with a minor's right to seek birth control, drug treatment, or treatment for a sexually transmitted disease without parental notification or consent.

Plotkin<sup>27</sup> provides a useful review of those exceptions where parental consent need not be sought in the treatment of minors. The first such exception discussed by Plotkin<sup>27</sup> is that of the "mature minor." He points out that the Supreme Court<sup>30</sup> has noted, "Constitutional rights do not mature and come into being magically only when one attains the state defined age of majority." An increasing number of states have recognized this limitation on required consent and made allowances for the minor who is mature enough to understand the consequences of a chosen treatment.<sup>31</sup> In most states the minor's capacity to give consent is left to the discretion of the treating professional. While most professionals would prefer to avoid such a decision, "there are no reported cases [that] impose liability on a doctor or a hospital for failing to obtain parental consent when the consenting minor was over the age of 15 and the procedure was for his or her benefit."<sup>32</sup> However, while most such cases involved *medical*

*procedures* performed in a child's interest, the question of psychotherapy in the interest of the child, which is also against the will of the parents, is yet to be tested in court. Croxton *et al.*<sup>33</sup> report that despite the growth in youth counseling centers, hotlines, and crisis agencies, they have discovered no reported cases of mental health professionals being sued for child enticement or any behavior related to the counseling of minors without parental consent.

A second common exception to mandated parental consent is the "emancipated minor." Emancipation occurs when a child is married, joins the armed forces, declares emancipation and is subsequently granted a court declaration while living independently and economically self-sufficiently.<sup>34</sup> In such cases, the family unit no longer exerts a governing jurisdiction over a minor. The emancipated minor is authorized to consent for his or her own treatment, and the treating professional has neither an obligation under the law to notify parents, nor the right to hold the parents financially liable for services rendered.<sup>27</sup>

The "emergency treatment" exception to mandated parental consent is viewed more relevant to the medical profession where the threat to life or limb is immediate if such consent is not authorized. In these cases the law assumes that a reasonable and responsible parent would consent to the provision of treatment.<sup>31</sup> Similarly, the provision of "emergency treatment" in the mental health profession suggests that in cases of involuntary hospitalization where the minor is assessed to be a danger to him

or herself or to others, or if he or she is gravely disabled, mandatory consent from parents should be waived as occurs with "medical" emergencies. Fortunately, a Massachusetts statute boldly addresses this problem where unauthorized treatment must be provided where delay in such treatment would "endanger . . . the mental well-being of the patient."<sup>35</sup>

Finally, court-ordered treatment for a minor without parental consent does occur. We have observed that those parents who refuse medical treatment in the face of their minor's life-threatening illness would be culpable of felonious child neglect. Our experiences suggest that with regard to the provision for treatment without parental consent, the courts appear more comfortable authorizing such treatment that is more clearly medical in nature as opposed to treatment that is psychological.

Plotkin<sup>27</sup> concludes from his discussion of exceptions to parental consent that:

A practical alternative to the parental consent rule would be to lower the age of consent for treatment significantly. This age should not be determined by tradition, history, or whim, but rather by reliance upon existing child development data. This research demonstrates the substantial development in cognitive abilities of adolescents, including the ability to consider propositions not connected to immediately observable events (36).

Plotkin suggests that the ability of a minor to provide consent for treatment should be anchored in specific developmental criteria. We would argue that because of the intensive training in child developmental psychometrics, that the

clinical psychologist may be the most knowledgeable professional to determine the minor's ability to consent for the provision of any emergency treatment. We would not assume expertise in explaining difficult medical procedures, yet would assume expertise in determining the minor's ability to understand an explanation given by a competently trained professional. However, the criteria used by clinical psychologists and carefully examined by Weithorn and Campbell<sup>26</sup> remain "soft" in their application to cases of multiple trauma, cult coercion, severe environmental stress, and youth gang violence. These criteria are inadequate in guaranteeing the minor and the psychologist the freedom to have an appropriate professional relationship without parental consent and without fear of recrimination from the legal guardian.

Of critical importance is consideration of the position of the court on the question of treatment of adolescents and parental consent. While a case of providing a minor with psychological treatment without parental consent has never gone before the Supreme Court, cases regarding abortion and parental notice have been reviewed by the court. Such cases are useful in this discussion because they illustrate the current status of the court's position on issues of consent and adolescents.

In a recent Supreme Court decision,<sup>37</sup> the Court affirmed a Minnesota statute that requires a minor's physician or an agent thereof to give written notice to both of the minor's parents at least 48 hours before such an abortion would



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take place. The court decided that such a statute without "judicial bypass" (court order) would be unconstitutional, but that the statute with a bypass clause was constitutional. The bypass provision states that:

If a court were to enjoin the enforcement of the parental notice requirement, the requirement would be enforced with the proviso that any judge of a court of competent jurisdiction would authorize the abortion if the judge determined that (1) the minor was mature and capable of giving informed consent, or (2) an abortion without parental notification would be in the minor's best interest.<sup>37</sup>

An exception to mandatory parental notification in the Minnesota statute is in the instance of the pregnant woman being "a victim of parental abuse or neglect, in which event notice of her declaration must be given to proper authorities." While there is a similar exception to mandatory consent in the case of providing psychotherapy to minors, notification to authorities can create a substantial risk that the confidentiality of the minor's decision (to have an abortion or undergo psychotherapy) will be lost. Justice O'Connor points out that the Minnesota exception to notification for minors who are victims of abuse or neglect is, in reality, a means of notifying the parents. In such cases notification of investigative authorities is mandated, and such investigators must notify parents of such investigations.

Justice Marshall notes that "although the court considers the burdens that the two-parent notification requirement imposed on a minor woman's right to privacy . . . it fails to recognize that forced notification of only one parent also sig-

nificantly burdens a young woman's right to have an abortion." He also notes the emotional consequences of such forced notification: "A notification requirement can have severe [physical] and psychological effects on a young woman . . . forced notification can be extremely traumatic for a young woman, depending on the nature of her relationship with her parents."<sup>37</sup> The court also cites conclusions that "forced notification in dysfunctional families is likely to sever communication patterns and increase the risk of violence." Justice Marshall concludes, "Parental notification in the less-than-ideal family, therefore, would not lead to an informed decision by the minor."

The bypass provision while providing an avenue for minors to circumvent parental notification in limited circumstances, poses other significant burdens. Justice Marshall sites the shortcomings of that procedure and its impact on the adolescent: "Some mature minors and some minors in whose interests it is to proceed without notifying their parents are so daunted by the judicial proceeding that they forego the bypass option." Similarly, he sites that of the judges who adjudicated over 90 percent of the bypass petitions between 1981 and 1986, none could identify any positive effects of the bypass procedure. This argument suggests that even though there is an avenue for adolescents to decide independently of their parents, the current state of the law sets up obstacles that make such independence sufficiently aversive that it is more likely to be avoided. Because psychotherapy, unlike

an abortion, is an ongoing event, the adolescent does not have the option of engaging in such ongoing treatment without parental notification, despite some very circumscribed exceptions.

*Prince v. Massachusetts* (1944)<sup>38</sup> is a dated case, but one that reflects a view that is the contemporary position of the courts. This case stated, "This history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition."<sup>38</sup> In a more recent case, *Parham v. J. R.* (1979), this position was taken a step further.

As with so many other legal presumptions, experience and reality may rebut what the law accepts as a starting point; the incidence of child neglect and abuse cases attest to this. That some parents may at times be acting against the best interests of their children . . . creates a basis for caution, but is hardly a reason to discard wholesale those pages of the human experience that teach that parents generally do act in the child's best interests.<sup>28</sup>

And in the case under consideration here (*Hodgson v. Minnesota*, 1990), Justice Kennedy writes:

But the Court errs in serious degree when it commands its own solution to the cruel consequences of individual misconduct, parental failure, and social ills. The legislative authority is entitled to attempt to meet these wrongs by taking responsible measures to recognize and promote the primacy of the family tie, a concept which this Court now seems intent on declaring a constitutional irrelevance.<sup>37</sup>

Justice Kennedy's concern over the prospect of the Court considering the "primacy of the family tie" a "constitu-

tional irrelevance" comes from its action in deeming mandatory consent without bypass unconstitutional, while upholding it with bypass provisions. What is most unfortunate is the position that holds the primacy of the family and the presumption that parents will always act in the interest of their children, and consequently sets Supreme Court precedents that can restrict competent, mature adolescents from procuring treatment in their own interest. There may be thousands of adolescents who are victims of both the court system as well as their parents being unable to exercise decisions on their behalf or in their interest. These adolescents are in a sense discriminated against when court rulings consider them the exception. Legal precedents should be nondiscriminatory and take into consideration the needs of this growing group of minors. Unfortunately, the position of the highest court in this land, or at least some of its members, is as Justice Kennedy writes, "the Court erring in serious degree" when it commands solution to individual misconduct and parental failure.

### **The Ethics of Psychotherapy and Informed Consent**

The first line of the preamble of the American Psychological Association's "Ethical Principles of Psychologists" reads, "Psychologists respect the dignity of and worth of the individual and strive for the preservation and protection of fundamental human rights."<sup>7</sup> While the language of this passage is not specific, it implies that the clinician practice in such a way that upholds the fundamen-

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tal rights of the patient and honors the worth of this individual.

In the service of the Preamble, which acknowledges the value, self-worth, and legal rights of the "individual," the therapist can assume that the minor possesses sufficient competency and is mature enough to request psychological treatment without parental consent. Review of the literature<sup>26</sup> and empirical research<sup>5, 10, 27, 36</sup> concludes that indeed adolescents have the competency to consent for psychotherapy as do adults. Thus, to maintain that adolescents are unable to act independently in requesting psychological care on the basis that they lack competency is neither empirically supported nor, more importantly, embraced by the fundamental tenant of the A.P.A. code of ethics.

The preamble also calls for the "preservation and protection of fundamental human rights." One such right afforded adolescents is the Right to Privacy as it extends to minors. The Right to Privacy has been defined as the right to be left alone, and is thought to be "the most comprehensive of rights and the right most valued by civilized men."<sup>39</sup> This right was first described by Warren and Brandeis in 1890,<sup>40</sup> but was not applied by the Supreme Court proceedings until the case of *Griswold v. Connecticut*.<sup>41</sup> It was another decade before the Right to Privacy was extended to minors in the case of *Planned Parenthood v. Danforth*.<sup>30</sup> In their review of legal cases, Croxton *et al.* note that the right to privacy is applied differentially to minors.<sup>33</sup> It appears that minors have some legitimate reasons to request privacy but

the extent of what this privacy protects is limited. Moreover, they note that the courts have a long history of supporting the conservative position of leaving the "determination of the limits of privacy" to parents. In difficult cases, such as those presented, where the rights of the minor to claim a right of privacy in securing psychological treatment would be considered beyond the acceptable limit in the mind of the guardian and the law, the clinician confronts a delicate dilemma: to respect the ethical charge that validates the "individual's" (in this case a minor) rights and proceed without consent of a guardian, or to be sued by an irate parent who feels the clinician has gone beyond this vaguely defined limit. Indeed, this matter is exacerbated where treatment of the minor reveals illegal conduct by the guardian or where the lives of the minor and/or guardian are at risk.

Despite the fact that the courts have stated that parents have "an important guiding role"<sup>42</sup> in the rearing of their children, these authors are treating an increasing number of cases where parents seem to have abandoned their role; especially in the case of inner city adolescents where the constant pressures of poverty and violence have ripped apart the minor-guardian bond. Consider the case of the competent adolescent who voluntarily seeks treatment and who wants his or her treatment to be initiated without parental consent. Further, suppose this minor is neither at-risk to him or herself or to others, nor gravely disabled, nor the victim of child abuse. The only obstacle to treatment is that the

legal guardian is absent or has a vested interest in their minor not being seen in treatment. If the clinician chooses to proceed, thereby honoring the ethical responsibility to respect the rights of the individual, the clinician will collide with the legal demand that authorizes consent by the legal guardian before treatment can proceed. This scenario becomes increasingly complex for the clinician if the minor is a victim of a cult, violent street gang, or has parents who are engaged in illegal activities. How does the clinician feel protected when choosing a course of action that may bring retribution on behalf of the minor (for failing to treat) or by the guardian (for choosing to treat)?

Can this difficulty be resolved if other ethical principles are employed to justify necessary treatment without consent from the legal guardian? The fifth section of the American Psychological Association's "Ethical Principles of Psychologists" addresses "confidentiality," and makes a specific reference to the treatment of minors.<sup>7</sup> Section 5d reads, "When working with minors or other persons who are not able to give voluntary, informed consent, psychologists take special care to protect these persons' best interests." If a liberal interpretation is applied here, the clinician could argue for treatment being in the "best interest" of the minor. However, the clinician would have to carefully document the clinical reasons for such action which would include justifying the competency for a minor to participate (or not participate) intelligently in the therapeutic process. Developmental research does

not provide a neat, uniform, applicable set of standards for determining such competency. Thus, competency for participating in therapy would be determined on a case-by-case basis. We would argue that the clinician deciding for the "best interests of the individual" without fear of legal intimidation from the legal guardian in many cases seems most appropriate. This then puts the treating psychologist in a position to decide on the "best interest" of his or her patient.

### Conclusion

The above cases serve to illustrate several ethical dilemmas in the treatment of adolescent patients. Common in both cases is the issue of the problem in obtaining parental consent for treatment. In both the case of Kate and the case of Jamie, an issue is present that disrupts a therapeutic process that is both indicated and desired by the adolescent. In both instances, pursuing parental consent would have led to the end of the therapy and possibly to the endangerment of both Kate and Jamie. Such practice could not have been in good conscience. Given that in each of these cases there is no rationale within the law that would permit continuing psychotherapy without parental consent, the authors were left in a quandary about how to proceed. It became quickly apparent that these cases represented a collision between the law and the ethics of psychology, and that there were few if any ways to continue and at the same time practice both legally and ethically.

A review of the literature finds only a few studies of agency policies and prac-

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tices of agencies that provide services to adolescents without parental consent for treatment. Two such studies of mental health agencies who counsel adolescents without parental consent are from an agency in Massachusetts<sup>43</sup> and Virginia.<sup>44</sup> These studies found that treatment often had stipulations attached, such as duration of treatment allowed, and that the agencies were often operating without knowledge of pertinent state law.

Despite the fact that review of the legal issues suggests that the mental health practitioner has relatively little to fear from the law in counseling minors without parental consent, most agencies and professional practitioners continue to follow cautious, conservative policies that err on the side of the law and the decision-making power of the parents, and perhaps against the best interest of the adolescent patient. This is likely due to clinicians not feeling protected by the law when confronted with difficult cases. Moreover, ambiguities in the law leave judges, practitioners, minors, and parents in a state of uncertainty on the issue of consent. For these reasons among others, Croxton *et al.*<sup>33</sup> accurately point out that the legal parameters of the privacy rights of minors in seeking psychotherapy must be clarified.

Given that both research and experience suggest that some adolescents have similar capacity as adults to make informed decisions, we are left with little doubt about the competency of adolescents to give informed consent for treatment. Moreover, there are increasing numbers of cases like those presented

here that will continue to leave the professional in a struggle with the law and ethics of the practice of psychotherapy.

The arguments presented here are not made to suggest that parents should not be involved in treatment. On the contrary, parents should be involved in treatment decisions regarding their adolescents in some instances. The participation of parents should be encouraged and promoted, but not to the exclusion of the privacy rights of adolescents. Given that some modifications need to be made in the law regarding consent for treatment of adolescents, and because research finds little in the way of legal threats to professional care providers, we, as do Croxton *et al.*,<sup>33</sup> recommend the following policy as stated in the legal code of the state of Alabama:

Any minor who is 14 years of age or older may give effective consent for any legally authorized medical or mental health services for himself or herself and the consent of no other person shall be necessary. Providers of such services shall encourage the minor to inform and gain the cooperation of his or her parents in treatment, but notification prior to the provision of service shall not be required.<sup>45</sup>

Croxton *et al.*<sup>33</sup> give four excellent arguments as to why the rights of minors need to be expanded: (1) the reality of today's society is that for many adolescents the protective function of the family is failing; (2) some parents refuse to acknowledge that the problems of minors are real or important and that they have psychological consequences; (3) that for some parents there is such conflict between them and their children that parental knowledge of the counsel-

ing relationship could only serve to exacerbate differences and jeopardize the minor both physically and psychologically; and (4) that parents may refuse to consent for treatment for their minor because of their own fears.

To this list we would add that there is a significant need for expanding the rights of minors because of an increasing number of cases that clinicians will encounter that will pose a collision between legal and ethical statutes. In the treatment of adolescents, we encourage practitioners to be mindful of the adolescent patient's "right to privacy," and the issue of the "mature minor," which can be used in order to justify the treatment of an adolescent without parental consent, and within the limits of the law. One should be cautious, however, to use these constructs only in the best interest of the adolescent, and at the same time be sensitive to the adolescent's vulnerability to the influence of the therapist. The cases presented here have embedded within them both the legal-ethical collision, and all of those points made by Croxton et al.<sup>33</sup> that warrant careful review of the present practice of psychotherapy with adolescents and the issues involved in parental consent for treatment.

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