



Ethical and Legal Considerations When Counselling Children and Families*

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There are numerous unique legal and ethical concerns that clinicians should consider when counselling children, adolescents, and their families. These, however, are not generally emphasised in most ethics courses in graduate training programs. While ethical codes vary among professional organisations (e.g., marriage and family therapy, counselling, social work, psychology), this article addresses many subjects that are common across disciplines, such as (1) informed consent, (2) types of confidentiality, exceptions, and reporting issues, (3) sharing information revealed to the practitioner to parents, and (4) subpoenas. Other important topics are the importance of counselor competencies, multicultural considerations, and special topics including the use of touch and the role of the professional in divorce situations. Additionally, the role of computing and social media can enhance relationships for children, or be sources of stress or trauma. Lastly, laws, which typically supersede ethical codes often vary from state to state and nation to nation, and it is imperative that clinicians are cognisant of those in their jurisdiction.

Keywords: ethics, children, families, confidentiality, reporting issues, subpoenas, informed consent, touch, multicultural

Key Points

- 1 When working with children, issues of privacy, confidentiality, and legal privilege can be challenging due to competing interests of parents and children, as well as other stakeholders.
- 2 When records are subpoenaed, counsellors must be cognisant of legal and ethical threats to confidentiality, and respond appropriately in ways that are in the best interests of young clients.
- 3 There are numerous considerations which counsellors should consider before sharing information with parents, which could impact the course of therapy.
- 4 Family counsellors need to understand laws and ethical codes in getting informed consent to treat minors.
- 5 Special ethical issues in treating families with children include how to work with children of divorce, level of competency, multicultural considerations, and the use of touch.

The Intertwining of Ethical and Legal Issues with Child Counselling

There has been little guidance in mental health literature about ethical issues that may arise in counselling minors outside a school setting. Even popular ethics textbooks mention issues related to treating minors only briefly, with the exception of breaking confidentiality to report child abuse (Lawrence & Kurpius, 2000). Yet the potential legal and ethical issues when treating children in families are numerous. Common concerns relating to child treatment include the child's right to confiden-

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tiality, informed consent, children and divorce, the use of touch, counsellor competency, and multicultural issues.

Privacy, confidentiality, and privileged communication

Privacy. Privacy refers to clients' right to choose who has access to information about them (Thompson & Rudolph, 1996). Legally, parents of minors typically make all privacy-related decisions for them. This includes signing consent, releases of information, and access to medical and psychotherapy records. Decisions about protecting children's privacy and confidentiality in counselling must be examined from both legal and ethical lenses.

Confidentiality. The foundation on which counselling is built lies in the ethical obligation to keep information learned in counselling private from others. All codes of ethics in the mental health professions address confidentiality. Clinicians should not share any information with others without authorisation in the form of a written release signed by the client(s). What to include in releases is typically dictated by state mental health statutes. In addition, there are limitations to confidentiality dictated by state law, professional ethical codes, common law, and case law (Bartlett, 1996). However, laws are open to interpretation, so one must use careful judgment in making ethical decisions, especially about breaching confidentiality (Thompson & Rudolph, 1996). Access to an attorney familiar with mental health law is a wise investment.

Privilege. Privilege is the legal right owned by the client and protecting them from having their private therapy information divulged in judicial proceedings. Privilege is established by state statutes. Not all clients hold privilege; it depends upon the type of mental health discipline that is covered in state law. Some states allow privilege to adolescents at the age of 16 for specific issues (Reid, 1999). The legal right to privileged communication can only be waived by the client, although in the process of legal discovery (e.g., in child custody cases), attorneys often subpoena counsellors or their records. Unless the client (or potentially the client's parent or legal guardian) has waived privilege, the counsellor is obligated to appeal to the court to uphold state statute and keep the counselling information confidential.

There are legally prescribed conditions for which the counsellor is not subject to prosecution for withholding information needed by the court in litigation (Bartlett, 1996). State laws typically allow exceptions to privilege which may include client consent; treatment emergencies; duty to warn; duty to protect (see below); if the counsellor is sued for malpractice; mandatory report statutes (child abuse, elder abuse, disabled adult abuse); if a counsellor seeks a restraining order against a former client; or when a client's mental health status is in the legal forum (e.g., child custody cases, civil commitment hearings, competency to stand trial, or civil cases in which the plaintiff claims injury and a judge compels testimony).

Confidentiality When Working with Minor Children

One of the most confounding ethical issues that counsellors face when seeing children is what and how much information to share with parents (Lawrence & Kurpius, 2000; McCurdy & Murray, 2003; Thompson & Rudolph, 2000). For most counselling issues, parents have the legal right to know what occurs during their child's coun-

selling (Corey, Corey, & Callanan, 2002; Lawrence & Kurpius, 2000), though the degree of this right varies from state to state. Ethically, however, many believe minors should be guaranteed the same confidentiality as is promised to adults (Hendrix, 1991). The setting in which counselling occurs may also influence issues of confidentiality (Taylor & Adelman, 1989). For example, school counsellors may not have to disclose the content of individual sessions with minor children to parents, according to the Federal Education Rights and Privacy Act of 1994 (Corey et al., 2002). In states that allow mature minors to access treatment, counsellors still have an obligation to notify parents or guardians when it is in the best interests of the minor (Roberts & Dyer, 2004). In some situations, even though minors are legally able to access therapy for mental health treatment, they may not possess the right to authorise the release of information to third parties. In states where parents also have access to case records, in many situations providers can limit what is divulged to the parent if the information would be harmful to the child if disclosed (Roberts & Dyer, 2004).

Breaching confidentiality: Duty to protect, reporting issues of abuse and neglect

Counsellors often must breach confidentiality when mandated by law to act as an agent of social control. Confidentiality must be broken when there are threats of harm to oneself, threats of harm to another, or when it is learned (or in some states merely suspected) that a child or elder is a victim of abuse or neglect.

Harm to self. Any child or adolescent who may be at risk for depression should be interviewed to ascertain if they have any suicidal thoughts, have a plan to harm themselves, and have the means to carry out such a plan. The counsellor has a duty to inform parents of the child's suicidal thoughts or intent, and to work with them to take appropriate action. This may include having the child assessed at a hospital, having family members maintain a 24-hour suicide watch to ensure the safety of the child, or a referral to a psychiatrist for an evaluation for the possible use of medication. Care should be taken to document steps taken to protect the child, and clinicians are advised to consult with other professionals to be sure appropriate treatment is undertaken.

Harm to another. The landmark case of *Tarasoff v. Board of Regents of University of California* forever changed the landscape of counselling confidentiality. In 1968, the counsellor in this case notified the campus police at University of California that his client, Prosenjit Poddar, had threatened to kill another student, Tatiana Tarasoff. Although she was not named, she was 'readily identifiable.' The police warned Poddar to stay away from Tarasoff, and proceedings to have Poddar evaluated by a psychiatrist were initiated. Meanwhile, Tarasoff was given no warning regarding the danger to her life. Subsequently, Poddar stabbed and killed Tarasoff, and her parents filed suit against the university for not confining Poddar and for not warning Tarasoff of the threat against her life.

This case gave rise to what is commonly known today as a counsellor's *duty to warn* (sometimes also known as *duty to protect*). Duty to warn occurs when the following three conditions are met (*Tarasoff v. Board of Regents of University of California*, 1974, p. 346): (1) *Likelihood of harm.* The counsellor has established that there is likelihood that the client will cause physical harm, and believes the client is a threat. Some states have statutes requiring that a threat actually be communicated;

most do not. (2) *A 'special' relationship exists.* Generally a person does not have a duty to control the conduct of another, but counsellors have a special obligation due to the nature of their profession. (3) *There is a foreseeable victim.* (Some states have broadened this condition to include unknown victims.)

Counsellors must take reasonable steps to satisfy the duty to warn, which always includes warning the intended victim. Counsellors may also notify local law enforcement agencies, contact relatives or friends who can apprise the potential victim of danger at hand, or initiate voluntary or involuntary commitment. The failure to warn an individual of a potential threat against his or her life may result in an ethical violation (Thompson & Rudolph, 1996) and is legally actionable.

A more unique aspect of duty to warn arises with issues related to human immunodeficiency virus (HIV) (McCarthy & Sorenson, 1993). While the ethical codes of mental health professionals deal with duty to warn, HIV leads to a grey area in breaching confidentiality. Only the ethics code of the American Counseling Association (1995) directly addresses breaching confidentiality in regard to communicable, contagious, and fatal diseases. Even so, with the advanced pharmacology available today, one could argue HIV is no longer a fatal disease. Counsellors must analyse the ethical and legal aspects of duty to warn when seeing a seropositive client. While some believe that a HIV positive client who is having sex or IV drug use with an unsuspecting other meets the criteria for duty to warn, this is a complex issue, both legally and ethically. Schlossberger and Hecker (1996) argue that counsellors do not have the same fiduciary duties as physicians, therefore reporting mandates for physicians are not applicable to counsellors. Some states, however, do have laws regarding HIV transmission as a crime. So unless a state has a specific law mandating reporting of HIV, *or* if there is a state law making HIV transmission a crime, the counsellor is left to decide whether or not to breach confidentiality solely on ethical grounds.

Abuse. State laws require professionals to report any child abuse or neglect, and in most states failure to do so can result in criminal penalties (Kalichman, 1993; Lawrence & Kurpius, 2000; Thompson & Rudolph, 1996). Clinicians are mandated by law to immediately report child abuse or neglect; some state laws even require reporting of 'suspected' abuse or neglect. While there has been a significant increase in the number of cases of suspected child sexual or physical abuse, Kalichman reports that there are also a substantial number of professionals who fail to report. This contributes to child maltreatment being underestimated, according to Alvarez, Kenny, Donohue, and Carpin (2004).

Many clinicians may hesitate to report abuse because it can permanently damage the therapeutic alliance, both between counsellor and child, as well as between counsellor and parents. However, failing to report when a child is neglected or abused denies the child the right to be protected and to receive intervention services that may be crucially needed (Alvarez et al., 2004). These ethical decisions often place the counsellor in the difficult position of choosing to obey the letter of the law against the potential additional harm that may befall a child who may or may not have been abused.

Another problematic issue for counsellors is the emotional abuse of a child. Although this type of abuse can severely damage a child, there are few legal resources to address it. While it can be reported, overwhelmed child protective agencies are unlikely to act on the report; some will even refuse to take such a report.

Subpoenas as a threat to confidentiality

When a counsellor receives a subpoena, *no* confidential information should be released to an attorney just for the asking. Here are a series of steps in responding to a subpoena: first, read the subpoena thoroughly. Is the attorney asking for specific information, for a case file, for testimony via court, or a deposition? Second, talk with the client (or the client's attorney with a written release) with regards to how he or she wants you to handle the subpoena. If the client is amenable to the information being made privy to the attorney, the counsellor may release the information *with written consent of the client*. If the client does not want the information revealed, let the attorney know that the information is confidential (and/or privileged), and that a signed court order is needed to reveal the information. Third, talk to both parents and the child regarding the dispensation of the information. If confidentiality has been promised to the child and he or she does not want to have this promise violated, the clinician has an ethical obligation to the child to ask the judge to protect the counselling information. If the child consents, the legal parent or guardian must sign the consent to release information. If any others were involved in counselling, do not release any information about them without their written consent. Fourth, a judge may order information to be revealed, in spite of the clinician's stated rationale for why the information should be kept private. Some courts may allow counsellors to share privileged information with the judge privately to determine if the information is necessary to the proceeding, or if public disclosure would be too hurtful to those involved, such as children (Bartlett, 1996). Finally, do not take case records to court unless they are specifically requested in the subpoena. Counsellors should inform clients why it is necessary to break confidentiality, explain what will be revealed, and invite them to participate in this process (Mappes, Robb, & Engels, 1985).

While most states have laws regarding privilege, Thompson and Rudolph (1996) caution that in states where clients do not hold privilege, the counsellor has 'no recourse except to reveal the information if subpoenaed' (p. 511). Finally, Bartlett (1996) states, 'Failure to observe confidentiality measures may result in a professional liability lawsuit. The counsellor must become aware of the myriad of threats to client confidentiality and implement appropriate safeguards' (p. 290). Counsellors can avoid misunderstandings if care is taken in the initial session to explain the process (Thompson & Rudolph, 1996).

HIPAA laws and minors

The Health Insurance Portability and Accountability Act (HIPAA) that many counsellors must abide by, depending on the nature of their practice, may affect minors. According to HIPAA regulations, parents have access to children's health information with the exception of 'psychotherapy notes', which the regulation specifically defines. Adolescents are treated the same as young children (Roberts & Dyer, 2004). However, if state law is more stringent than HIPAA regulation greater privacy protections, state statute should be followed instead of HIPAA (Chaikind et al., 2003).

Sharing information with parents

There is dissent among counselling professionals related to sharing information with parents of children who are seen in individual counselling, or seen individually within the context of family counselling. Because there may be contradictory expectations

between regulations and one's code of ethics, it is wise to get these permissions in the informed consent or in a special client–counsellor contract. Generally, information is shared with parents when it is in the *best interests of the child* (Roberts & Dyer, 2004). However, if state law is silent on the issue, determining the best interests of the child is left up to the discretion of the counsellor in consultation with the parents and child.

There are various options for managing confidentiality with minors. Hendrix (1991) describes four possible positions counsellors can take regarding this issue of sharing information with parents; we have added two additional positions to Hendrix's conceptualisation of confidentiality options. The first confidentiality alternative is to promise minors *complete confidentiality* (with the exception of what a professional is mandated by law to report, such as abuse, suicidality, or homicidality). The second is *limited confidentiality* which, according to Lawrence and Kurpius (2000), 'requires the minor to waive, in advance, the right to know what will be revealed to the parent or guardian' (p. 134). *Informed forced consent* is the third approach, which occurs when a child has no voice in what is disclosed, but is informed before the disclosure is made. This is a more moderate stance where counsellors inform children, teens, and parents up front that they will bring pertinent information back to parents.

The fourth is when *no guarantee of confidentiality* is made to a child. Secrets that are held by a counsellor can impede individual and family work. In using this approach it is vital that children and parents be told this at the onset of therapy, both verbally and in writing. This increases parents' trust that the counsellor respects their rights to know important facts about their child, while also educating them that the child does need privacy in order to talk about whatever concerns he or she has. The child can be assured that not everything talked about will be shared, and that if something does come up that the counsellor decides the parents should know, the counsellor will work with the child on how to share the information and to minimise any negative consequences that may result (Taylor & Adelman, 1989).

If this occurs, the counsellor could spend time discussing the child's fears in sharing the information, brainstorming, and role playing ways for the child to tell the parents, and discussing how to handle fallout after the disclosure. Lawrence and Kurpius (2000) recommend counsellors can motivate reluctant children to share information with parents that is deemed to be potentially helpful by explaining the probable benefits and the importance of disclosing. The success of these efforts often depends on the degree of trust and the quality of the professional relationship between counsellor and child.

In addition to these, a fifth position is that the counsellor may work with the parents and child to come to a *mutual agreement regarding confidentiality* as to what will be disclosed to parents and what will not. For example, some parents will want to know about an adolescent's sexual activity, others will not. Use of alcohol may not need to be disclosed, but what if the counsellor learns that the adolescent client is drinking and driving? If the parents and adolescents cannot agree, the parental rights typically prevail, unless state law is contrary to this position. Written contracts can be used to solidify agreements, and help protect the therapeutic relationship by transparency in potential actions that may need to be taken by the counsellor.

Finally, some counsellors will set up a 'best interests' *agreement* with the child and parents. The limits to confidentiality in this agreement are set up by the counsellor

him or herself, and the children and parents leave the decision to share information solely with her. It is agreed that confidentiality will be maintained unless the counsellor believes that the child's best interests are not being served in relation to his or her health, welfare, or significant relationships. If any of these areas are seriously impaired the counsellor uses his/her judgment to decide if confidentiality should be breached. Again, a written agreement can solidify the contract between all stakeholders.

There are advantages and disadvantages to each type of agreement. The more broad the disclosure policy is with regard to what the counsellor shares with others, the less likely the child or adolescent will reveal important information in therapy. The more narrow the disclosure policy, the more the counsellor risks becoming therapeutically immobile if there is important information that parents should know. If a child or adolescent has been promised complete confidentiality, the counsellor may be unsure of the ethics of proceeding in therapy with information that may upset parents if they learned of it. Examples may include pregnancy, sexual activity, risky sexual activity, or other risky behaviours, especially if the minor client insists that the counsellor not tell her parents.

Isaacs and Stone (1999, 2001) suggest that there are two factors that counsellors should consider in deciding whether to breach confidentiality: the age of the child and how serious the behaviour is in which the minor child is engaging. Less serious behaviours might include smoking or breaking curfew. According to Roberts and Dyer (2004, p. 124), potential high risk behaviours might include substance abuse, sexual activity, truancy, gang involvement, irresponsible driving behaviour, extreme religious practices, unorthodox dieting procedures, fascination with guns or other weapons, or illegal behaviour. Roberts and Dyer advocate for a clear description by the counsellor as to what constitutes dangerous behaviour. Agreements reached should be clearly detailed to avoid undermining trust in the therapeutic relationship between the counsellor, parents, and child.

When the counsellor has to force disclosure, children can be allowed to decide if they want to tell their parents, if they want the counsellor to tell in their presence, or if they want to wait in the hallway while parents are told. Children can also be reassured that the counsellor will be available to help the child and parents work through the problem. It is important to prepare parents, reminding them that no one should be punished for anything said in counselling, and to point out that in telling them the child shows courage and trust in the parents.

Group confidentiality

Although confidentiality is vital in establishing trust among participants in group counselling, there are inherent problems, especially in children's groups (Thompson & Rudolph, 1996). Complete confidentiality in group counselling is harder to attain (McCarthy & Sorenson, 1993). Time and care must be taken to explain the concept of confidentiality, and to be certain that each child understands the concept, as well as to explore how children might be harmed if participants discuss what is talked about outside the group. Children should be encouraged to consider the potential limits of confidentiality before disclosing very personal information during group counselling. Salo and Shumate (1993) also advise counsellors to explain to group members that privileged communication may not apply to discussions that take place in a group format. Cant (2002) notes confidentiality limitations need to be clarified

when working with children in a residential setting, where many staff have access to children's records.

Informed Consent to Treat Minors

Informed consent 'is the formal permission given by a client that signals the beginning of the legal, contractual agreement that allows treatment to be initiated' (Lawrence & Kurpius, 2000, p. 133). Clients need to give informed consent freely, after being appraised of the risks and benefits of treatment. (See Jensen, McNamara, & Gustafson, 1991 for the results of a study on what to include when discussing informed consent with parents.) Minors may contract for professional counselling either by having parental consent, involuntarily (at the insistence of a parent), or involuntarily through a court order. Informed consent in all of these cases can alleviate any misunderstandings and decrease counsellor angst and potential liability issues.

Twenty states allow mature minors (see later) to provide consent to access mental health treatment (Roberts & Dyer, 2004). In addition, in some jurisdictions, minors are allowed to consent to treatment without parental knowledge, often when they are facing situations for which they would not access treatment if parental consent was required. Some states may not require parental consent to treat minors for issues such as drug abuse, pregnancy, or birth control counselling, sexually transmitted diseases, or following a sexual assault on a minor 12 or older (Lawrence & Kurpius, 2000).

Exceptions to parental consent typically include the mature minor exception, emancipated minors (see below), and for emergency treatment. Court-ordered treatment also is an exception (Gustafson & McNamara, 1999; Plotkin, 1981).

Emancipated minors typically have the rights and obligations granted to adults. Emancipation may occur in several ways, depending upon state law. Typical emancipating actions include: by parental permission, by court order, when the minor marries, has a child, is able to support oneself and live independently, or enlists in the armed forces (Dickson, 1998). Emancipated minors are over the age of 14 or 15 (but under 18). Differences exist by state statute. Emancipated minors are treated as adults with regard to confidentiality and typically privilege, as well. They do not need parental consent for treatment (Bartlett, 1996; Lawrence & Kurpius, 2000).

One important criterion to consider regarding the need for parental consent is the age of the minor child. Bartlett (1996) describes a *mature minor* as one who is thought to be capable of making informed decisions as well as adults. Mature minors may give informed consent for treatment, and may authorise the release of confidential information (see Morrissey, Hofman, & Thrope, 1986). Mature minors are generally children over the age of 16 (Lawrence & Kurpius, 2000), but the age may vary as this status is defined by state statute.

Young minors are usually those under 14 years old, and for these children 'the parent or guardian is the legal decision-maker and can legally obtain information about the diagnosis, prognosis, therapy, and so on' (Bartlett, 1996, p. 280). Although some states allow young minors to grant their own informed consent in the case of an emergency when their health or life appears to be endangered, parental consent should still be procured as quickly as possible (Lawrence & Kurpius, 2000).

While there is no general rule that explicitly requires counsellors to obtain written permission from parents for children to receive counselling, 'obtaining parental consent is good practice for counsellors unless potential danger to the minor exists. ...

The law generally supports parents who forbid counselling of their minor children unless there are extenuating circumstances' (Thompson & Rudolph, 1996, p. 509). It is wise to prevent problems by communicating early with parents, and parents should be made aware their child has sought counselling and be asked to provide informed consent at the onset of treatment. An exception to this may be schools that have policies that allow a child to see a school counsellor for a few sessions before parents are informed and asked to give consent.

Obtaining consent to treat a minor

Counsellors should ask parents to sign an informed consent form giving their permission to treat the minor children at the first session where children are seen. At this time, release forms allowing communication with other professionals involved in the treatment of the child (e.g., physicians, school counsellors) also may be obtained. Counsellors always must obtain signed permission from the parent who has legal (not physical) custody of the children, and should insist on being given written proof as to who retains legal custody of the children (Thompson & Rudolph, 1996). It is wise to know state law regarding the rights of noncustodial parents. According to Bartlett (1996), 'Only a custodial parent can authorize treatment or release of confidential information' (p. 280). Divorced parents can be polarised on the issue of counselling, with one parent advocating for individual or family counselling, and the other demanding the right to be informed and/or give consent.

Obtaining informed consent can become a contentious issue if the parents are recently separated and custody of the children has not yet been decided (Bartlett, p. 280). There is typically a provisional order outlining temporary custody. Barring a specific court order to the contrary, both parents have the right to consent to treatment for their child. Clinicians should ask for a copy of this provisional order, as well as a copy once a final divorce decree has been issued. If there is joint legal custody and one parent is against treatment, this parent would be hard pressed to explain their rationale to the judge to have a court order barring treatment. While this might take care of the legal issue involved in this dilemma, the clinical issues abound. Involvement of the noncustodial parent, as well as loyalty issues for the child about treatment will be difficult.

Special Ethical Issues When Working with Children

Psychotherapy with children raises numerous ethical issues that are specific to working with this population. The remainder of this chapter discusses several of these issues that warrant special consideration.

Role of the psychotherapist in working with children of divorce

One area in which counsellors are most vulnerable to charges of ethical misconduct is when working with children and families of divorce. Often parents are locked in ongoing bitter legal battles over child custody, visitation, support payments, and myriad other postdecree issues. Divorce and postdivorce situations are often emotionally charged, and pull children into destructive loyalty conflicts. In addition, lawyers work within an adversarial system, and counsellors work in a collaborative system. These differing systems can lead to misunderstandings and frustrations for both professions.

Counsellors can play many potential roles in custody cases. Due to the potential litigation that surrounds custody evaluations, it is wise for counsellors to clearly define their roles when working with the child and his or her family. These roles as outlined by Woody (2000, p. 74) include: (1) the *treating counsellor* for the child, parents or family (this could occur before, during, or after the divorce); (2) the *evaluator* in the custody dispute, evaluating the psychological characteristics of the relevant adults; (3) the *guardian ad litem* for the child or children; (4) the *mediator* to resolve the disputes between the parents; or (5) the *expert critic*, who evaluates the validity of the testimony given by other mental health professionals.

Bartlett (1996) has several suggestions for counsellors working with children of divorce. First, it is vital to clarify your role with the child and the parents. Identify who the real client is, and specify if your role is to provide individual or family treatment, to do a custody evaluation, be a guardian ad litem, or perform mediation with the parents. For example, *if your role is to do family counselling you should not offer an opinion in court regarding the custody of the children*. Make this clear to the family or you risk family members 'positioning' to look good, rather than focusing on keeping the children's interests primary to therapy. Second, emphasise to parents the importance of focusing on the child's welfare, and clarify who you will communicate with and how. Explain that you will not take sides, and that harm is done when a child is caught in the middle of parental conflict (also see Hecker & Sori, 2003). Third, establish ground rules and, if doing an evaluation, discuss to whom it will be sent. If permitted in your state, Bartlett suggests asking parents to sign a waiver of the right to subpoena your records. We suggest doing this whenever families with children are seen, as any couple could decide to divorce at some future date and attempt to subpoena records of past counselling. Such a waiver discourages parents from attempting to negate a child's confidentiality in the throes of a legal battle, though such waivers are not legally binding.

Competencies

All mental health professional codes of ethics prohibit professionals from practicing outside their area of competence (Thompson & Rudolph, 1996). Counsellors need to be well trained and follow what is legally referred to as an *appropriate standard of care* (Hecker, 2003), in which a counsellor acts in ways that most counsellors would treat a case under similar circumstances. Practicing outside one's area of competence is one of the most common types of malpractice claims (Stromberg & Dellinger, 1993).

Special skills and techniques are necessary to work with children individually or in a family setting (Sori, 2006; Sori & Sprenkle, 2004). Lawrence and Kurpius (2000) point out that a counsellor who is skilled and effective in working with adults may not have the same level of effectiveness when treating children or adolescents, which requires 'areas of knowledge and skills that are unique to working with children' (p. 132). Certain disorders, such as separation anxiety disorder, reactive detachment disorder, oppositional defiant disorder, enuresis, encopresis, ADHD, and trichotillomania, for which parents often seek professional help, mostly affect children. As Lawrence and Kurpius point out, one cannot apply an understanding of adult issues to children's problems. 'Because minors are a special, diverse client population, ethical practice mandates distinct education, training, and supervised practice before commencing independent practice that includes minors' (Lawrence & Kurpius, 2000, p. 133). (See Sori for an in-depth discussion of the training necessary to prepare coun-

sellors to work with children and families.) Therefore, counsellors who have not had adequate training to treat children are not meeting an appropriate standard of care.

Use of touch

There is little in the literature regarding ethical considerations about the occurrence of nonerotic touch in therapy. McNeil-Haber (2004) contends that it is difficult to counsell young children without some form of touch. Touch is natural and developmentally appropriate for young children, and is a major component in children's play. When touch is initiated by a child in counselling, it presents an opportunity to discuss personal boundaries and differences in how people feel about being touched. However, care must be taken when discussing child-initiated touch that children don't feel shamed or rejected when the counsellor is setting appropriate boundaries.

McNeil-Haber (2004) offers the following guidelines in making case by case ethical decisions (p. 128):

- What are the possible benefits of touch? Touch can be reinforcing and calming.
- How might this child perceive the touch? It could enhance self-esteem or make the child feel powerless to comment on it.
- What considerations are related to the counsellor? Whose needs are being met? Is touch genuine?
- What safety issues are related to the child? Is it harmful to the child? Does this child have a history of abuse? If so, touch could be alarming. (Abused children have trouble separating fact from fantasy.)
- What in this child's family background might be an issue?
- What are some practical considerations? Culture should be considered, as people from different cultural backgrounds have different attitudes toward using touch as a means of emotional expression, or in socialising children.

At the onset of therapy, counsellors should discuss touch with children, inform parents about the use of touch, and ask permission to use touch when appropriate. Parents should be informed as to how touch might be used (e.g., a hug at the end of a session, to prevent a child from harm, or for encouragement). In addition, because a child may act out during session to the degree that the counsellor needs to intervene to prevent harm from the child, self, or property, parents should be consulted before individual treatment to explore their wishes with regard to in-session discipline.

Multicultural considerations when seeing children in families

When seeing children and their families, the context of culture should be assessed before making therapeutic judgments and interventions. Cheung and Hong (2004) note several value differences that may occur when seeing families from other cultures. First, most family therapy models emphasise individualistic orientation, helping members to achieve independence, individuation, identity and self esteem. Other non-European-American cultures are collectivistic and 'value mutuality and collective welfare, the closeness between parent and children, dependence of children on their parents, and a firm family hierarchy' (Cheung & Hong, 2004, p. 14). In addition, dissimilar cultures may embrace different familial values, norms and roles, calling for understanding counsellors who have a willingness to examine the constructs of our established theories (Cheung & Hong, 2004, p. 15) and to be sensitive to the values of each culture.

Conclusion

There is much to consider in avoiding the numerous potential pitfalls that could inadvertently result in legal and ethical problems. Of note is the difference between parental and children's rights in treatment. Children have few rights, except those bestowed by state statute, and counsellors must work to protect the sanctity of the counselling relationship. Counsellors should remain cognisant of the vulnerability of children and adolescents, have a broad repertoire of developmental and topical information regarding children, work with the larger systems within which children are embedded (e.g., families, agencies, and schools) and seek education, consultation, and advice (Roberts & Dyer, 2004).

It is important for counsellors to review their professional code of ethics regularly, and to refresh their ethical skills and knowledge by gaining continuing education in ethics and legal issues. This training can keep clinicians abreast of new federal laws, state statutes, and case laws. Many professional organisations offer such training at conferences or via home study, and some liability insurance companies provide reduced rates to those who take advantage of additional ethics training. Although client welfare and risk management must be carefully balanced when counselling children, numerous benefits to working with this population can be seen in the child, his family, and, ultimately, the future of our society.

Author Commentary and Update

This article was originally published as a book chapter in Sori and Hecker (2006). The issues facing counsellors working with children and their families remain the same, though families and issues continue to evolve as society changes. We are now seeing more developmental fallout from children from prolonged divorce conflict, especially when dealing with child alienation issues (see Hecker & Murphy, this issue). Children benefit when family counsellors are willing to wade into this conflict, and examine individual, relational, and systemic issues involved, which includes the courts as part of the family's larger system. Divorce mediation may be a legal option to reduce child-centered parental conflict and its deleterious effects on children. Counsellors who are not trained in potential iterations of divorce dynamics and parental alienation, risk mis-stepping in therapy with potentially disastrous consequences. Too many counsellors have made a pronouncement about the wellbeing of a child while being ill-informed concerning individual or systemic dynamics at play. Additionally, remarried parents continue to create step-families, and step-roles are gradually becoming commonplace; every counsellor must learn to manage ambiguity about family roles in stepfamilies as they form and evolve.

The role of computing and social media can enhance relationships for children, or be sources of stress or trauma. While social media can help bridge the 'generation gap' between counsellors and minors, additional concerns may arise regarding clinicians' decisions to share any concerns gleaned online with parents.

People are marrying less often, and we are seeing more serial monogamy, where children in a family may have just one common biological parent. Counsellors need to be cognisant of how this affects children in terms of roles, multiple losses, and ability to trust the stability of relationships. Special efforts should be made to procure consent to treat minors from all biological parents and, when appropriate, involve

them in treatment. The ethically responsible practitioner also is aware of cultural beliefs and practices, and uses this knowledge to avoid pathologising families from non-majority backgrounds. There has also been recent attention to the unique needs and concerns of military families both during and after deployment. Counsellors who elect to treat members of the armed forces for PTSD should have additional training and supervision, especially due to the high suicide rate among returning servicemen and women.

In the US, there has been an alarming increase in the suicide rate and suicidal ideation among children and adolescents (Cash & Bridge, 2009). Suicide is the third leading cause of death in youth aged 10–19 years. Counsellors must be aware of risk factors that include mood disorders (especially depression), substance abuse, family factors (parental psychopathology, family history of suicidal behaviour, parental loss due to death or divorce, family conflict, poor parent–child relationships), sexual and physical abuse, frequent moves, and same-sex orientation. Bullying, including cyber bullying, is prevalent and has led to well-publicised incidents of adolescent suicide. Also, there are hundreds of Internet sites that provide information on how to commit suicide (Cash & Bridge, 2009). We have found that adolescents are more forthcoming in revealing suicidal ideation in individual sessions with a caring and trustworthy counsellor, and then subsequently become amenable to sharing this information with parents and psychiatrists. Managing suicide ideation or intent can be an ethical minefield, and requires special training and counsellors who stay current on this topic (see Sori, Hecker, & Bachenberg, 2015 for treating the above issues).

As a field, we need to continue to evolve to support all types of families in our global society, and nurture a move away from heteronormative ideas about marriage in order to best support children from myriad backgrounds. Ethical treatment of children means respecting and supporting the structure of their families, that is, parents.

References

- Alvarez, K.M., Kenny, M.C., Donohue, B., & Carpin, K.M. (2004). Why are professionals failing to initiate mandated reports of child maltreatment, and are there any empirically based training programs to assist professionals in reporting process? *Aggression and Violent Behavior, 9*, 563–578.
- American Counseling Association. (1995). *American Counseling Association, Code of Ethics and Standards of Practice*. Alexandria, VA: American Counseling Association.
- Bartlett, E.E. (1996). Protecting the confidentiality of children and adolescents, in J. Lonsdale, S. Powell, & L. Soloman (Eds.), *The Hatherleigh Guide to Child and Adolescent Therapy* (pp. 275–290). New York: Hatherleigh Press.
- Cant, D. (2002). Joined-up psychotherapy: The place of individual psychotherapy in residential therapeutic provision for children. *Journal of Child Psychotherapy, 28*(3), 267–281.
- Cash, S.J., & Bridge, J.A. (2009). Epidemiology of youth suicide and suicidal behavior. *Current Opinion in Pediatrics, 21*(5), 613–619. doi:10.1097/MOP.0b013e3283306el.
- Chaikind, H.R., Hearne, J., Lyke, B., Redhead, S., Stone, J., Franco, C. et al. (2003). *Health Insurance Portability and Accountability Act (HIPAA): Overview and Analysis*. Hauppauge, NY: Novinka Books.
- Cheung, S., & Hong, G.K. (2004). Family therapy with children: Sociocultural considerations. *The Family Psychologist, 20*(3), 14–16.

- Corey, G., Corey, M., & Callanan, P. (2002). *Issues and Ethics in the Helping Professions* (6th edn). Belmont, CA: Wadsworth-Brooks/Cole.
- Dickson, D.T. (1998). *Confidentiality and Privacy in Social Work*. New York, NY: The Free Press.
- Gustafson, K.E., & McNamara, J.R. (1999). Confidentiality with minor clients: Issues and guidelines for therapists, in D.N. Bersoff (Ed.), *Ethical Conflicts in Psychology* (2nd edn, pp. 200–204). Washington, DC: American Psychological Association.
- Hecker, L.L. (2003). Ethical, legal, and professional issues in marriage and family therapy, in L.L. Hecker & J.L. Wetchler (Eds.), *An Introduction to Marriage and Family Therapy* (pp. 493–537). Binghamton, NY: Haworth Press.
- Hecker, L., & Murphy, M. (this issue). Contemporary and emerging ethical issues in family therapy. *Australian and New Zealand Journal of Family Therapy*.
- Hecker, L.L., & Sori, C.F. (2003). The parent's guide to good divorce behavior, in C.F. Sori, & L.L. Hecker & Associates (Eds.), *The Therapist's Notebook for Children and Adolescents: Homework, Handouts, and Activities for Use in Psychotherapy* (pp. 323–329). Binghamton, NY: Haworth Press.
- Hendrix, D.H. (1991). Ethics and intrafamily confidentiality in counseling with children. *Journal of Mental Health Counseling*, 13(3), 323–333.
- Isaacs, M.L., & Stone, C. (1999). School counselors and confidentiality: Factors affecting professional choices. *Professional School Counseling*, 2, 258–266.
- Isaacs, M.L., & Stone, C. (2001). Confidentiality with minors: Mental health counselors' attitudes toward breaching or preserving confidentiality. *Journal of Mental Health Counseling*, 23, 342–356.
- Jensen, J.A., McNamara, R.J., & Gustafson, K.E. (1991). Parents' and clinicians' attitudes toward the risks and benefits of child psychotherapy: A study of informed-consent content. *Professional Psychology: Research and Practice*, 22(2), 151–170.
- Kalichman, S.C. (1993). *Mandated Reporting of Suspected Child Abuse: Ethics, Law, and Policy*. Washington, DC: American Psychological Association.
- Lawrence, G., & Kurpius, S.E.R. (2000). Legal and ethical issues involved when counseling minors in nonschool settings. *Journal of Counseling & Development*, 78, 130–136.
- Mappes, D., Robb, G., & Engels, D. (1985). Conflicts between ethics and law in counseling and psychotherapy. *Journal of Counseling and Development*, 64, 246–252.
- McCarthy, M.M., & Sorenson, G.P. (1993). School counselors and consultants: Legal duties and liabilities. *Journal of Counseling and Development*, 72, 159–167.
- McCurdy, K.G., & Murray, K.C. (2003). Confidentiality issues when minor children disclose family secrets in family counseling. *The Family Journal: Counseling and Therapy for Couples and Families*, 22(4), 393–398.
- McNeil-Haber, F.M. (2004). Ethical considerations in the use of nonerotic touch in psychotherapy with children. *Ethics & Behavior*, 14(2), 123–140.
- Morrissey, J.M., Hofman, A.D., & Thrope, J.C. (1986). *Consent and Confidentiality in the Health Care of Children and Adolescents*. New York, NY: The Free Press.
- Plotkin, R. (1981). When rights collide: Parents, children and consent to treatment. *Journal of Pediatric Psychology*, 6, 121–130.
- Reid, W.H. (1999). *A Clinician's Guide to Legal Issues in Psychotherapy: Or Proceed with Caution*. Phoenix, AZ: Zeig, Tucker & Co., Inc.
- Roberts, L.W., & Dyer, A.R. (2004). *Ethics in Mental Health Care*. Washington, DC: American Psychiatric Publishing Inc.
- Salo, M.M., & Shumate, S.G. (1993). *The ACA legal series: Counseling minor clients*, Vol. 4. Alexandria, VA: American Counseling Association.

- Schlossberger, E., & Hecker, L. (1996). HIV and duty to warn: A legal and ethical analysis. *Journal of Marital and Family Therapy*, 22(1), 27–40.
- Sori, C.F. (2006). On counseling children and families: Advice from the experts, in C.F. Sori & Associates (Eds.), *Counseling Children and Families*. (pp. 3–20). New York, NY: Routledge.
- Sori, C.F., & Hecker, L.L. (2006). Ethical and legal considerations when counseling children and families, in C.F. Sori (Ed.), *Engaging Children in Family Therapy: Creative Approaches to Integrating Theory and Research in Clinical Practice* (pp. 159–174). New York, NY: Routledge.
- Sori, C.F., & Sprenkle, D.H. (2004). Training family therapists to work with children and families: A modified Delphi study. *Journal of Marital and Family Therapy*, 30(4), 479–495.
- Sori, C.F., Hecker, L.L., & Bachenberg, M.E. (Eds.) (2015). *The Therapist's Notebook for Children and Adolescents: Homework, Handouts, and Activities for Use in Psychotherapy* (2nd edn). New York, NY: Routledge.
- Stromberg, C., & Dellinger, A. (1993). A legal update on malpractice and other professional liability. *The Psychologist's Legal Update*, 3, 3–15.
- Tarasoff v. Regents of University of California. (1974). 13c. D177; 529 p. 2D553; 118 California Reporter, 129.
- Taylor, L., & Adelman, H.S. (1989). Reframing the confidentiality dilemma to work in children's best interests. *Professional Psychology: Research and Practice*, 29(2), 79–83.
- Thompson, C.L., & Rudolph, L.B. (1996). *Counseling Children* (4th edn). Belmont, CA: Wadsworth-Brooks/Cole.
- Thompson, C.L., & Rudolph, L.B. (2000). *Counseling Children* (5th edn). Belmont, CA: Wadsworth-Brooks/Cole.
- Woody, R.H. (2000). *Child Custody: Practice Standards, Ethical Issues, and Legal Safeguards for Mental Health Professionals*. Sarasota, FL: Professional Resource Press.