

An Integrated Framework for Professional Ethical Thinking in Child
Clinical Psychology

by

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ABSTRACT

Practitioners face a number of unique challenges in child clinical psychology, particularly around areas such as competency, consent, confidentiality, and the balance of obligations towards the child or young person and their legal guardians. Resorting to ethical codes of practice to try and deal with these ethical dilemmas often fails to resolve the problem adequately, or leads to ‘moral blindness’ in which other ethical issues are ignored (Ward & Syversen, 2009). In order to provide a more complete ethical guideline for practitioners to consult when faced with ethical quandaries, I have created the Integrated Framework for Professional Ethical Thinking (IFPET) that is specifically tailored towards child and adolescent clinical psychology. The IFPET model provides a multi-faceted approach to ethical thinking that widens moral reasoning and awareness and promotes a more complete approach towards dealing with ethical issues in child and adolescent clinical psychology.

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Figure 1. Integrated Framework for Professional Ethical Thinking (IFPET).

Chapter One: Introduction

For practitioners and researchers working in the field of mental health today there are a range of ethical codes and principles that are available to guide practice from a moral perspective. These ethical codes range from outlining specific dos and don'ts to a more abstract guide detailing fundamental values such as justice, beneficence, and autonomy (Ward & Syversen, 2009). While these ethical codes provide valuable guidance to practitioners, they can fail to adequately address the issue at hand, or even provide conflicting advice, causing problems for professionals faced with an ethical quandary.

When this happens, practitioners who focus on the more concrete level of professional codes of conduct often fail to comprehend the full complexity of the relationship between foundational ethical concepts and the statement and understanding of the ethical problems that have arisen (Ward & Syversen, 2009). As such, professionals may adopt a more uni-dimensional approach to addressing the issue, or even fail to recognise an ethical conflict that has arisen (Prilleltensky & Walsh-Bowers, 1993). Because the majority of ethical codes are constituted by a set of explicit standards outlined on the basis of core values, practitioners may find they are grappling with an ethical issue not dealt with in the code they usually adhere to. In a functional sense, they suffer from “ethical blindness” and may simply overlook significant normative practice problems. When this happens, the natural judgements, personal biases, and preconceptions that all individuals hold may influence the practitioner's decision at the expense of the client (Donner, VandeCreek, Gonsiorek & Fisher, 2008).

It is therefore essential for good ethical practice to ground one's approach in a more overarching framework that functions as a basis for approaching ethical dilemmas or flashpoints. Moving from core, fundamental standards, and principles to a higher level of abstraction means that practitioners can analyse, reason, and produce decisions at a meta-ethical level, leading to more ethically defensible clinical practice (Donner et al., 2008). Having a comprehensive framework readily at hand is particularly important for practitioners who work with especially vulnerable populations such as offenders or children. It is the particular area of child and adolescent clinical practice that the current study will focus on with respect to creating this type of comprehensive ethical framework.

Thus the aim of the current study is to create an over-arching framework that can effectively respond to the ethical dilemmas that arise in everyday child clinical practice. This framework will be grounded in the fundamental concept of the inherent *dignity* that all human beings are entitled to. I argue that despite being owed the same acknowledgment of dignity as adults, children's rights are often subsumed by a paternalistic approach that places more value on the parent's wishes and decisions than the child's (Kipnis, 2004). The framework will therefore create an ethically defensible, theoretical approach for practitioners to be guided by that acknowledges and restores the intrinsic dignity children and adolescents are entitled to.

Chapter Two: The Current Ethical Codes

The current ethical codes and principles that function in psychological domains make a concerted effort to address moral and ethical dilemmas that arise in clinical practice (Knapp & VandeCreek, 2003). However there are a variety of these guidelines to choose from, and practitioners looking for an ethical guideline to practice by often have several state, country, or practice mandated codes they may use as a basis to work from (Brownlee, 1996). An analysis of several well-known codes, both New Zealand and international, indicates that there are a number of fundamental underlying principles that resonate across these moral mandates regardless of the country or state of origin. To examine more closely the current foundational concepts practitioners are guided by, a review will be undertaken of three influential codes for New Zealand practitioners: The American Psychological Association (APA) Code of Ethics, the New Zealand Code of Ethics and the United Nation's Universal Declaration of Human Rights (UNDHR).

The APA Code of Ethics

The APA developed a code of ethics with the principle goal of outlining a set of standards which psychologists could use to ethically guide their practice in order to safeguard individual safety and well-being (APA, 2002). As such, the APA developed five principles to function as foundational standards to support and influence ethical practice. These general principles of *Beneficence*, *Fidelity*, *Integrity*, *Justice*, and *Respect for People's Rights and Dignity* will be explored, and their influence on psychological practice discussed.

Principle A: Beneficence and Non-maleficence

The principle of *beneficence* was conceptualised by the APA as a means to promote the well-being of mental health clients, through encouraging practitioners to not only protect the physical and mental health of their clients, but to seek wherever possible to act in ways that are beneficial to them. Practices that cause harm, whether through breaking the confidentiality of a client unnecessarily or failing to make the choice that would be of the most benefit to the client are viewed as unethical. Practitioners are also encouraged to be aware of their own physical and mental well-being, and the possible influence that it may have on their capabilities and practices when working with clients.

Principle B: Fidelity and Responsibility

This principle stresses the importance of practitioners upholding their professional standards, duties and responsibilities both with their clients and within the wider society. Practitioners are expected to consult with other professionals where needed in order to maximise the client's well-being, and resolve conflicts in the most appropriate way. The principle of *fidelity and responsibility* also emphasises the idea of a duty of care, encouraging psychologists to be aware of the professional conduct and practice of other practitioners lest they cause unnecessary harm to individuals involved with them.

Furthermore, the importance of trust within the therapeutic relationship is raised, in order to engender a sense of security and safety for the client. This involves obtaining informed consent from the client where the nature, obligations and practices of the clinical psychologist are clearly outlined. The process of

accountability and ethical duties can help promote a sense of trust, respect and attitudes which are crucial within a therapeutic relationship.

Principle C: Integrity

The aim of the principle of *integrity* is to encourage a high level of personal and professional standards among practitioners in all areas of their professional work. Truth and honesty are highlighted as fundamental concepts in both research and practice, thus ensuring that deception is not undertaken unless it is ethically justifiable and enhances the overall goal of optimal beneficence. In this way, practitioners can ensure that clients are not only fully aware of all relevant outcomes and processes, but also further promote an understanding of partnership and equality within the therapeutic relationship (Ward & Syversen, 2009).

Principle D: Justice

The principle of *justice* concerns the entitlements of all individuals to be able to equally access mental health services. As such, it is expected that whether it is research or practice, the individual involved has the same right to an equal benefit as another individual. This frees persons from burdens resulting from biases, judgements or clinical decisions that may limit their experience of equal entitlement from mental health services in any way. This principle is particularly important in protecting individuals belonging to vulnerable populations such as children or offenders, who are at particularly at risk of being marginalised or having their needs subjugated.

Principle E: Respect for People's Rights and Dignity

Principle E holds that all individuals are entitled to the fundamental right of being treated with *respect*, with recognition of their *dignity* and worth. Those who are unable to autonomously make their own decisions must have choices made on their behalf that acknowledges the importance of their well-being interests, and dignity as human beings. Individual differences such as race, age, gender or cultural background should be respected, and factored in to the therapeutic relationship wherever required. This principle reminds practitioners of the importance of treating their clients with a high regard and appropriate deference, regardless of their deeds, position in society or other vulnerabilities. Crucial to such actions are the practitioners' ability to protect the client's right to confidentiality, autonomy, and the opportunity to make individually determined decisions (Ward & Syversen, 2009).

The New Zealand Code of Ethics

Adopted in 2002, similar to the APA's Code of Ethics, the New Zealand Code of Ethics is not legislated, and thus is not legally binding. However, it has been adopted by the New Zealand Psychologists Board and is viewed as a document that psychologists practising in New Zealand are expected to base their conduct on. The four key principles of this code are outlined below.

Principle 1: Respect for the Dignity of Persons and People

Similar to the APA's code of ethics, this principle espouses the intrinsic value of all individuals, and the need for practitioners to demonstrate awareness of the fundamental *dignity* and worth of all peoples. Individual differences should be treated with sensitivity where required, and no biases, judgements or discriminations

should occur based on these social diversities. The right for all individuals to have their confidentiality and privacy maintained and protected except in exceptional circumstances is also entailed. Particular mention is made of the relations between Maori and non-Maori individuals, advocating the importance of understanding the Treaty of Waitangi and its potential implications in practice and research. The issue of children and young person's welfare interests are also outlined in this section, with the recognition that such individuals are vulnerable members of society, and their best interests should be prioritised regardless of other considerations. It is this principle that highlights the need for children and young person's wishes, judgements and decisions to be respected and taken in to account wherever possible.

Principle 2: Responsible Caring

The principle of responsible caring is concerned with the promotion of the health, wellbeing, and safety of individuals by psychologists. All procedures, practices and research are expected to benefit individuals and the wider society, and to avoid harm at all costs. For those who are from vulnerable populations in particular, psychologists should not only recognise this harm, but take steps where necessary to minimise this and support the individual. This principle also details the importance of the veracity of the psychologist through maintaining a healthy therapeutic relationship, competent practices, and responsible actions

Principle 3: Integrity in Relationships

The principle of integrity recognises the importance of the relationships that a psychologist forms. It outlines the fundamental values such therapeutic relationships should display, such as respect, truthfulness, openness, and appropriateness. Within

these relationships, the Treaty of Waitangi provides a basis for building a respectful relationship between Maori and non-Maori.

Principle 4: Social Justice and Responsibility in Society

The responsibilities that psychologists have, both to their client and to the wider population, are recognised under the principle of *social justice and responsibility*. Psychologists are expected to acknowledge their potential influence on clients, and to work hard to address any unjustified effects so as not to cause an unequal relationship or role. Furthermore, they are expected to go beyond this and challenge any societal behaviours or implications that are considered unfair or disempowering for individuals.

United Nations Universal Declaration of Human Rights (UNDHR)

This cluster of ethical norms was developed and ratified by the United Nations in 1948 in order to protect the core needs and interests of human beings across the world. The document recognises the fundamental dignity and equality of all human beings, and the inviolable rights granted to each person regardless of country, political matters, or individual differences. The United Nations promotes the concept of human dignity, freedom, and well-being as the highest aspiration of all peoples, and the foundational concept for justice and peace throughout the world (United Nations, 1948).

While the 30 articles in this declaration are not grouped under a particular category, an outline of these articles will be subsumed within particular groups of fundamental rights to provide greater clarity.

Dignity

With regards to recognition of fundamental dignity, this document outlines the right of all human beings to life, liberty, and personal security, as well as freedom from servitude, degradation, torture or arbitrary detention. It also holds that no individuals should endure attacks or slander upon their personal honour and reputation, nor baseless interference into their personal or familial privacy. Should such fundamental rights be violated, then individuals have the right to seek asylum in other countries in order to escape persecution.

Legal rights

The UNDHR asserts that no individual should be detained, arrested or exiled without proper and fair grounds. Furthermore, those who are charged with impugning the law are granted the right to a full and fair trial by an independent and unbiased jury or juror, with the presumption of innocence until proven otherwise at said trial.

Freedom

The UDHR states that every individual is entitled to be able to move within their own country, and have the right to leave and return to their own country if desired. All individuals are permitted to own property, and retain this property without interference. Every individual is allowed the freedom of peaceful assembly

and association, as well the right to their own conscience, religion, beliefs, opinions and expression of such thoughts without interference or curtailment.

Equality

Regardless of race, gender, nationality or religion, all individuals are entitled to take part in the government of their nation, have equal access to all public services, and possess a right to equal pay in employment. Consenting individuals are also free to marry, with equal rights, whomever they wish, regardless of race, nationality or religion.

Well-being

All individuals are entitled under the declarations of this document to a standard of living through remuneration that provides for a dignified level of existence for themselves and their family, through access to goods such as adequate medical care, food, clothing and housing, and free education. Furthermore, all individuals' economic, social and cultural rights intrinsic to their fundamental dignity are socially secured and recognised. No individual should have to work without reasonable limitation of their working hours, or go without paid holidays. Individuals also have the right to pursue and participate in social and community settings, as well as share in all scientific benefits.

Problems with the current ethical codes

From the outline of the ethical codes above, one can see that they aim to cover a wide range of potential issues that may incur harm, distress or unethical practices. All three ethical codes or treaties offer a foundation for ethics that

practitioners can use as an abstract guidance tool when engaging in everyday practice. However, such codes cannot be regarded as providing a complete, ethically-safe approach for practitioners to base their work on. Firstly, a basic underlying assumption of these codes is that if clinicians follow their particular rules they will be able to resolve any moral or ethical dilemma encountered in the course of their clinical practice. However, given the complex and often emotionally fraught issues or problems that can arise within mental health services this is not always the case. Procedural difficulties, such as what constitutes the best or most ethical course to pursue in a given situation, are frequently not resolved by consulting such codes; indeed, at times such ethical codes can merely further complicate an issue by providing conflicting ethical standards that a practitioner must choose between (Koocher & Keith-Spiegel, 2008). Even worse, at times the principles can come into direct conflict with each other, leaving a quandary as to which principle should be followed. Jordan and Meara (1990) highlight this with an example researchers commonly face: whether beneficence, where the most people should receive the most benefit, should be prized over nonmaleficence, which argues that they should do no harm to their subjects (Jordan & Meara, 1990). Aiming to resolve problems such as these require practitioners and researchers to step outside the codes for a more fundamental ethical guideline, typically on their own initiative (Jordan & Meara, 1990). The final decision, therefore, may come down to a judgement that has been influenced by individual differences such as personality, values, and biases (Keith-Spiegel & Koocher, 1985).

Another problem with heavy reliance on ethical codes is *moral blindness*. This term, referred to by Ward and Syversen (2009), refers to the issue of ethical

particulars going unnoticed by practitioners because of their adherence to a code that restrains wider ethical thinking. Indeed, some argue that principle ethics forces too limited a restriction not just on practical ethical decision making, but also on true ethical discourse and engagement (Kilpatrick, 1986). As such, this means that practitioners who strictly follow current ethical codes as a guideline for practice may in fact unwittingly be guilty of unethical practices because they failed to recognise a moral issue outside of the normative codes purview (May, 1984; Ward & Syversen, 2009). Ward and Syversen (2009) give an example of this, arguing that offenders in prison who are not offered treatment because they are judged to be a lower risk of offending are victims of moral blindness, because while they may not respond to therapy as dramatically as high risk offenders, they are still deserving of treatment. A more child-centric example of this would be a research study which surveys parents having difficulties with children with anxiety, and offering access to a free parenting programme to only sufficiently high stress families in order to get the best research results. In both cases, the individuals who are still having difficulties miss out on possible referrals or treatment options because they are not considered to fall into a category necessary to receive allocated resources.

In essence, it can be argued that ethical codes highlight important values and concerns, but it is often up to the practitioner to decide what action is most appropriate to order to achieve the outlined values (Pope & Vasquez, 2010). As such, the utility of these codes is often more apparent for straightforward dilemmas, where practitioners may use them to provide a concrete level of justification for general practice (Ward & Syversen, 2009). Therefore, it is argued that these core principles need to be supplemented in order to provide a framework that allows for both

specific applications, as well as a more generalisable set of guiding principles. Hopefully a more comprehensive, and deeper, set of professional norms and concepts will make it less likely that practitioners will be confounded by ethical quandaries.

It is this key issue of the current codes' inability to be more applicable to complex or unique ethical predicaments that highlights the need for a framework with a metaethical level of abstraction. Since the focus of this framework is the human rights of children, a range of child and adolescent related ethical issues that cannot be adequately resolved with the application of current ethical codes will now be explored.

Chapter Three: Key Ethical Issues Arising from Child Clinical Practice

Chapter Three will discuss themes and issues evident in the current professional literature on ethical issues that arise when working with children, particularly focusing on the concepts of consent and confidentiality. When working with children and adolescents, practitioners have to deal with the challenge of determining the child's ability and understanding of consent, and actively assisting them to contribute to decisions affecting them, as well as balancing this with the parent's consent or refusal for them to participate. They also have a duty to protect the minor's best interests, which may involve maintaining the confidentiality owed to the client despite requests from the parents for more information (Ascherman & Rubin 2008). This balancing act of maintaining a minor's rights while protecting them from harm is further complicated by the obligations practitioners in professional practice face, with unique and separate sets of requirements owed towards the minor, the guardians, and the state (Kipnis, 2004).

Looking to resolve the quandary of such interwoven obligations, Ascherman and Rubin (2008) argue that practitioners should have the primary aspiration of doing no harm to the young person. Secondly, they should seek to provide for the best interests of the young person and thirdly to protect his or her privacy with regards to any divulgements and communications in therapy. Lastly, they argue that the practitioner should both demonstrate respect and understanding of the young person and the young person's guardians regardless of individual differences, and also make every effort to encourage and increase his or her development and autonomy (Ascherman & Rubin, 2008). These precepts offer at first glance, a sound

framework for engaging in ethical practice when working with minors. They do not, however, provide useful suggestions for a practitioner who is engaged in a situation where these ethical aspirations conflict.

When working in clinical practice, one of the fundamental initial actions in the therapeutic relationship is to provide clients with a complete understanding of the functions and obligations of a clinical psychologist. Armed with this knowledge, clients are then able to make informed decisions about whether it is in their best interest to proceed with the research or therapy in question. The practice of seeking consent is regarded as a pivotal ethical duty of a clinical psychologist largely in part because it is synonymous with recognising and enhancing clients' autonomy through respecting their ability to make their own life decisions (Ministry of Health, 1998). When it comes to working with minors however, this issue is complicated by ethical and legal mandates. In New Zealand, when a young person reaches the age of 16, they are regarded as an adult for the purposes of consent to medical and therapeutic engagements. However, simply using a concrete cut-off as an ethical guideline is not only overly simplistic, but can actually result in maleficent outcomes. The paternalistic assumption that those under the age of 16 are not competent to give consent is arguably an affront to their autonomy, self-sufficiency, and dignity as an individual.

The practice of consenting, or withdrawing consent on behalf of the young person for treatment, can affect the therapeutic relationship as well as the mental health of the individual him or herself. While laws in New Zealand protect young

people if their guardians refuse them medical treatment for serious health concerns, the law around psychological treatment is less clear (Ministry for Health, 1998). Parents may refuse to consent to therapy for their child if they do not have a diagnosable mental health disorder, which may have an adverse impact on the young person's short and long term mental health. The issue of consent can engender even more serious ethical issues internationally, owing to the rise of for-profit psychiatric hospitals or "speciality schools" such as those rapidly growing in the United States (Mohr, 2008). With parents able to commit their child, regardless of the child's consent, to such places full-time, the autonomy and agency of that individual is even more seriously threatened. The fact that the majority of these schools are not based on legitimate psychologically grounded theory-based practice, and may administer harsh discipline (Thomas, 2008), further promotes the urgent need for greater consideration of the issue of consent in children and adolescents.

The above discussion raises questions concerning the appropriate age at which children have the competency to give consent for themselves. Leikin (1983) argued that minors who are younger than 10 years old do not have the functional capacity to adequately weigh the costs and benefits before consenting, but that those who are older than 14 years can. This argument, however, not only introduces the idea of a cut-off age again, but leaves a grey area between the ages of 10 years and 14 years that practitioners must contend with. Kipnis (2004) proposed the application of a more developed theory of the "rule of sevens" – individuals who are younger than seven years old are considered to have a level of capacity low enough as to be considered incompetent when considering health related decisions in all cases. A duty to ascertain assent is considered ethical, but not required. When the

minor is between the ages of seven to 14, this presumptive incapacity can be reconsidered based both on the individual's maturation, and ability to understand and deliberate, as well as on the complexity and severity of the treatment sought. From the age of 14 onwards, in all cases the capacity to give informed consent is assumed, except, as with adults, in cases of severe mental or intellectual incapacitation (Kipnis, 2004).

While these age-related theories provide a reasonable argument based on the maturational capabilities of individuals' competencies, they use the hierarchical milestones of chronological age as opposed to a more holistic framework focused on the recognition of individuals as autonomous agents. The necessity of a holistic approach is important in New Zealand because it encompasses not only individual and personal issues, but also cultural and social considerations as well. Within New Zealand, the European sub-culture highly values individuality and independence. The Maori and Pacific island cultures, however, embrace a more collectivistic approach to the valuation of personhood (Ministry of Health, 2008). These cultural and social normative conceptions of personhood and independence may have more of an impact on a young person's grasp of autonomy and capacity issues than age. Other competency issues exist where there is a divide between wishes of the parents or legal guardians, and the wishes of the young person in question. In cases such as these, the practitioner is forced to consider whether the child or young person is of a level of competency that would justify overruling the family's decisions or his or her requests to respect their autonomy. The difficulty with this is that as the family have conflicting wishes, they may misrepresent the client's capacity. This issue is further complicated by a recognition of the fact that the right to autonomy 'involves not

merely the absences of involuntary treatment... [but also] the requirement that one should lead one's life according to convictions that are a product of one's rational reflection' (Clayton, 2006; p. 104). Thus, in order to respect this autonomy fully, the practitioner must deliberate as to whether the young person's wishes are indeed due to rational reflection and consideration, and the damage it could do to their autonomy should they be denied on a basis of competency.

Another common, ethically divisive issue in child clinical psychology is that of confidentiality. The American Psychological Society (APA) stated that "Confidentiality is essential to the psychotherapist-patient relationship because the effectiveness of psychotherapy depends on the client's willingness and ability to talk freely and candidly about his or her most intimate thoughts or feelings. The absence of confidentiality is likely to deter people from seeking therapy" (APA, 1995). This highlights the crucial role that confidentiality plays in a therapeutic relationship, engendering trust from clients that their confidences will not be betrayed. While confidentiality has limits, with most ethical codes acknowledging that in extreme circumstances such as risk to the client or a third party it is permissible to disclose information that the client wishes to be kept private (e.g. New Zealand Code of Ethics, APA Code of Ethics), these limits often become blurred in child clinical practice (Mannarino & Cohen, 2001).

Historically, a paternalistic approach was adopted by courts whereby parents were recognised as the guardians of their child, with complete control over his or her behaviours, choices, and future (Hesson, Bakal & Dobson, 1993). The rationale

behind this thinking was based upon the belief that parents are the most informed agent in the child's life and would thus make the optimal decisions for that child (Landau, 1986). This presumption of a lack of cognitive and emotional ability on the part of the child often meant that young people's autonomy was severely infringed, and lead to an eventual policy shift in the 1970s to giving more rights and control directly to young people (Hart, 1991). However, despite the recognition that parental impositions may negatively impact upon a young person's well-being or liberty, children and young people are still not afforded the same level of confidentiality that adults can expect in clinical practice. This is due to the fact that parents are still seen as legal guardians and advocates of their children who therefore have a right to be informed about practices the child partakes in with professionals (Ellis, 2009). The ethical and moral ramifications of these are evident when one explores particular issues such as the release of a young person's psychological records to court under the rationale of necessitating custodial evaluations, or placing a higher value on the parent's consent or refusal to consent than the child or young persons (Hesson, Bakal & Dobson, 1993). For example, Hesson et al (1993) point out that in Canada parents can legally argue that offering psychological treatment to a minor without parental consent is an offense as it is not in the child's best interests to undertake a process without parental support.

Compounding these issues of breaches to young peoples' autonomy and dignity is the concern that practitioners working in the field of child psychology do not have a comprehensive model to guide them towards making clinical judgements that are ethically defensible. This issue arises from an acknowledgement that all practitioners face ethically and morally complex issues during their practice that are

associated with unique individual and contextual factors. Consulting the current ethical codes, therefore, may not help to adequately resolve the quandary, leaving practitioners' with no choice but to resort to their own personal judgement. The obvious problem with relying primarily on one's own ethical judgement is that clinical decision-making is influenced by individual biases, conceptions, and perceptions that may influence an outcome; which may not result in outcomes that are of the utmost benefit to the client (Lehr & Sumarah, 2004).

In order to make this scenario more concrete, a range of ethically complex situations will be explored and analysed. An amalgamation of the principles of the APA Code of Ethics and the New Zealand Code of Ethics will be used as a framework for this analysis. Arguably, reliance on these principles represents customary practice. Individual case examples that are not able to be easily resolved by reliance on the principle alone will be outlined and the ethical complexity discussed.

Case example one: Beneficence

As previously outlined, the principle of beneficence revolves around the promotion of the client's health and well being, both physically and mentally. However, protecting the client's wellbeing can be ethically contentious, particularly when issues arise around whether or not to give treatment to a minor who has explicitly stated they do not want it.

Case example: a 15 year old girl who was diagnosed with Anorexia Nervosa died in hospital from malnourishment after refusing treatment. Right throughout her decline the girl continued to explicitly state that she did not want treatment, including both nourishment and psychological counselling. The individual's family disagreed, and requested under mental health legislation as a minor that she be placed in therapy, and be forcibly drip fed in spite of her protestations. The psychologist involved stated that she believed that the individual had a clear and rational understanding of her situation, and therefore recognised her right to refuse psychological treatment. The Director of Nursing similarly refused to overrule the girl's decision, and complied with the adolescent's request refusing all nourishment. After her death, the family sued the psychologist and the doctors involved in her care for failing to make the choice that would be of most benefit to the client.

Situations such as these, where it is unclear whether ignoring clients' express wishes is more beneficial than recognising their autonomy, are difficult ones for child practitioners to deal with. In the case example outlined above, the psychologist had to balance respecting the young person's autonomy and right to consent for treatment with the fact that if the young person did not receive therapy she would continue to deteriorate. Some individuals argue that forcing a non-compliant adolescent into therapy can cause just as much, if not more, damage to their mental

health than letting them continue their eating habits (Vandereycken, 1998). Indeed, individuals who experience dissonance between their goals and their lives are often left feeling powerless and devalued (Connelly & Ward, 2008). Thus, by this logic acting with beneficence would entail allowing the client make his or her own choice. However, with mental health disorders such as Anorexia Nervosa, where starvation can cause cognitive impairment (Katzman, Christensen, Young & Zipurskey, 2001), psychological intervention, even when it is not wanted, may be the more beneficial option for the young person.

The all or nothing approach that ethical codes arguably result in for this type of situation ignores the potential of using a richer set of ethical concepts such as that of scaffolding. Scaffolding, which focuses on the intensity and duration of the support required for each individual to achieve valued outcomes, aims to support the gap between the individual's goals and their lives (Connelly & Ward, 2008). In providing scaffolding for a young person, the practitioner would consider how to restructure her environment so that her goals may be achieved in a way that respects both her dignity, and also the rights of others (Connelly & Ward, 2008). By focusing on ethical codes alone to resolve this ethical dilemma, the practitioner is missing alternative options that help to build support for the individual that, regardless of the decision, will enable her to achieve a more dignified existence.

This case highlights not only that a principle of ethical codes can be applied in different ways with very different outcomes, but also provides an example of how ethical principles can collide. Abiding by the principle of beneficence would see the practitioners needing to do the most good for the most people – which in this case

could mean coercing the patient to accept treatment for the families' sake as well as the patient's. However, forcing someone to undergo treatment, both physical and psychological, is often argued to be against the principles of nonmaleficence as it could cause them psychological harm (Day, Drough & Davis, 1995; Vandereycken, 1998). As such, the principles of standard ethical codes alone fail to produce an acceptable ethical outcome when applied to this kind of situation.

Case example two: Non-Maleficence

Non-maleficence is concerned with protecting clients from harm, whether through acting to put safeguards in place to protect the client's well-being in the future, or through avoiding practices that may inflict harm such as breaking confidentiality unnecessarily. Non-maleficence is also concerned with the failure to make clinical choices that are of the most benefit to the client. However, in some situations, such as those of suspected child abuse or neglect, clinicians may find it difficult to identify which choice, whether reporting abuse or not, is actually the most beneficial choice for the client. Below is a case example adapted from an example given in an article by Bean, Softas and Mahoney (2011).

Case example: A 13-year old girl came in for family counselling with her mother in order to work on communication issues. The relationship had been strained by ongoing custody battles with the girl's father, and she had expressed a preference for living with her father as he

allowed her more freedom. The mother expressed concern that the girl was engaging in behaviour that had adverse long-term consequences, including dating a 19-year old male, and some experimentation with illegal drugs. The psychologist arranged for a private session with the girl after this initial assessment. During the next session, the girl confided to the counsellor that she had recently engaged in consensual sex with her 19-year old boyfriend. The girl stated that she did not want her mother to know about this. The psychologist was concerned about reporting the issue as the family relationship had already started showing signs of improving, and a good therapeutic alliance had been established. The psychologist eventually decided that since it fit the legal definition of sexual assault because the girl was less than 15-years old, and the boy was more than four years older than her, so she should report the incident. When she rang the girl and her mother to notify them of the report, the girl yelled and cried, and accused the counsellor of intentionally sabotaging her relationship. She also denied having been told about the limits of confidentiality, and said she would not return for family counselling again. (Bean, Softas-Nall, & Mahoney, 2011).

This example highlights the ethical conflicts psychologists can find themselves in when deciding whether or not to break confidentiality. While few

practitioners would find it ethically challenging when faced with clear evidence of child abuse, such as a child with a broken arm who reports that their father assaulted them, the situation is often less clear and the repercussions of harm to the client more complex. In some situations further harm may come to the client should the psychologist choose not to report abuse or neglect. Those who argue for reporting every instance of suspected abuse claim that psychologists are ethically bound to protect children as they are too disempowered, scared or confused about the situation to be able to adequately advocate for themselves (Allen, 2009). However, this consideration must be balanced with the damage that reporting could do to the therapeutic relationship, the client's feeling of trust being broken, and possible retribution or harm being directed towards the client by the other individual(s) involved in the situation (Allen, 2009). In fact, twenty-seven percent of clients reportedly drop out of therapy after the psychologist broke confidentiality to report situations of abuse or neglect (Steinberg, Levine & Doueck, 1997). Thus, psychologists must consider which action, whether reporting or not reporting, will cause the most harm to a client. Using non-maleficence as a guiding principle alone means that psychologists trying to make the most ethical choice have a relatively shallow basis to ground their decision on. This principle does not promote the need to extend consideration of the issue beyond the immediacy of physical or emotional harm to the child.

Case example three: Fidelity and Responsibility

The principles concerning fidelity and responsibility deal with the issues of trust, and the practitioners' relationship with the child. Child psychologists trying to

maintain ethical practices and adhere to the principle of fidelity and responsibility, are sometimes faced with the issue of whether their primary responsibility is to the child or the parent. The case example given below is taken from Koocher and Keith-Spiegel (1990).

Case example: An eleven-year old girl was brought to therapy by her exasperated parents who claimed that she was so disruptive and uncooperative at home that they were “at their wit’s end”. The girl made it clear that she did not want to “be shrunk” and vigorously protested any attempts to sway her to a more cooperative attitude. The parents urged the therapist to give it a try anyway, and they accompanied the girl to every session, waiting for her in the reception area. During the initial session, the girl sat straight and rigid in her chair, did not utter a single word, and made no eye contact or other response to the therapist’s best efforts to interact or communicate. Despite this, the psychologist gave in to the parent’s wishes, and saw the girl for two more sessions. During the following sessions the girl reiterated her desire not to be there, and said little else. The parents remained convinced that the girl would “break down soon” and requested that the therapist continue scheduling sessions and trying to get through to her (Koocher & Keith-Spiegel, 1990).

This example highlights the choices child psychologists need to make when considering whether to continue therapy with a child. As an adult, clients have the right to terminate therapy at any point and make it known what they would like to get out of therapy. Minors however are often subjected to their parent's wants, and practitioners wishing to demonstrate the ethical principle of integrity must consider whether the child has been consulted about their personal wishes, and whether the therapy is for the benefit of the child, or for the parent. In order to honour a child's right to equal opportunities and benefits from therapy, the goals of therapy need to be defined independently with the child, rather than with the parents (Koocher & Keith-Spiegel, 1990). In this particular case example, there is also danger of pathologising the child's behaviours rather than recognising that such actions may be the only avenue through which she has to show her objections.

Should psychologists rely on the ethical principle of fidelity and responsibility to help resolve this issue, they may find it difficult to know whether or not to terminate the therapy. Because this principle emphasises the importance of developing a trusting, caring relationship, the practitioner may find it difficult to know whether the most ethical option is to continue to try and develop a good relationship with this client, or to terminate therapy as per her wishes.

Case example four: Justice

Psychologists abiding by the ethical principle of justice in their practice are aware of the responsibility to make sure their clients are given equal consideration in all issues that affect them. When this is related to children, it involves making sure they are properly consulted about their wishes, what they expect or aim to get out of treatment, and consideration given to the way they would like things to therapeutically proceed. Furthermore, practitioners ought to be aware that minors are entitled to all benefits from their participation in research or practice, and may need to advocate on their behalf to receive this. While adult client's wishes regarding therapy are given consideration, and their choices around whether or not they wish to participate in research projects are respected, children are not always given the same respect for their choices. The following is a case example by Koocher and Keith-Spiegel (1990).

Case example: Normal, healthy toddlers were solicited from lower socio-economic neighbourhoods to serve as a control group in a longitudinal study of the mental health of children with a serious allergy. Although the control toddlers were not given any experimental medical procedures, they were hospitalised on several occasions to undergo a series of tests, some of which were uncomfortable, invasive, and painful. Parents were paid

several hundred dollars for their cooperation (Koocher & Keith-Spiegel, 1990).

This example highlights what can happen when research practices fail to follow the principle of social justice. The children in this research were subjected to discomfort and pain for a study that was going to be of no benefit to them. While it can be argued that individuals who participate in research that does not directly benefit them do so because they value the opportunity to contribute towards science, this is not likely to be the case for children (Koocher & Keith-Spiegel, 1990). Researchers and psychologists who involve children in their research need to be conscious of the fact that children deserve to get a benefit that is equal to their participation. While it could be argued that the attention, and value of feeling special and singled out can be enjoyable for some children (Koocher & Keith-Spiegel, 1990), practitioners must make sure that the research costs involved for the child are not outweighed by such benefits.

In this case example, the researchers financially compensated the parents, which means they could claim they are abiding by the principle of justice. However, there were no efforts made to ensure that money would specifically benefit the children in any way. Furthermore, targeting parents in a lower socioeconomic group means they may have been more ready to accept the money due to financial difficulties, rather than out of a wish to participate in a medical experiment. In addition to this, even if the researchers made sure the children participating received a benefit that equalled their participation, following this principle of social justice

directly conflicts with the principle of nonmaleficence. If researchers continued to pursue this research, they may learn important information about child mental health which can help many children; however, the children in this study are being harmed, by virtue of their experiencing painful medical procedures. The researchers in this example, therefore, may be more likely to choose the principle of social justice over the principle of nonmaleficence simply because that principle benefits them and their research more. However, it does not mean that this necessarily the most ethical decision.

Case example five: Integrity

Psychologists who wish to demonstrate the principle of integrity when working with young people need to make sure that their clients completely understand not only the limits that exist during therapy, but also make sure that they are aware of all the outcomes and processes that may arise from their therapeutic relationship (Ward & Syversen, 2009). Adolescents who are unaware that their psychological records may be shared for a number of reasons can feel betrayed, upset, and angry if they have not been fully informed of when and why such actions may be taken. Furthermore, psychologists wishing to act with integrity must ensure that any action taken on their part is for the optimal benefit of the client, rather than any other party. Below is a case example by Ellis (2009) which has been shortened for the purposes of this section.

Case example: A father sought treatment for a 14-year old boy per court order that was issued at the end of a bitter, protracted child custody dispute in State X. Allegedly, the case was awaiting trial when the mother physically assaulted the boy. In an emergency hearing, the judge awarded the father custody of the boy, and he moved to State Y to live with his father. The mother continued to have joint legal custody, and the boy was ordered to have ongoing visitation with her. On initiating treatment with the boy, the mother contacted the psychotherapist and demanded to be included by phone in the boy's psychotherapy sessions. The psychotherapist declined and instead scheduled an appointment by phone with the mother, which she did not turn up for. Six months later, the mother's attorney demanded the records from the boy's treatment sessions. The father reported that his son did not want his mother to see his records because he feared retaliation, both physical and emotional. The father stated further that the previous psychotherapist had, on the mother's demand, turned over the boy's records to the mother, who allegedly then used the notes to verbally berate and harass the son. Seeking to protect the boy, but also to provide information to the mother, the psychologist offered three compromises to the mother's attorney: (a) allow the boy to redact the record so as to shield those parts of the

notes he did not want his mother to see, (b) provide a written summary of treatment to the mother, or (c) let a guardian ad litem appointed by the court review the case. The mother declined all three options. The mother then filed a complaint against the psychologist with the state licensing board. (Ellis, 2009).

This case example illustrates the ethical dilemma faced by psychologists when trying to balance the rights of the young person versus the rights of the guardians. While the APA (2000) advocates that the psychologist must always seek to minimize harm to the client, it also states that confidentiality must be maintained. In the case of children however, the privilege of confidentiality can be extended to the parents (Ellis, 2009). These ethical obligations can mean that the rights of the minor can often be subsumed, with practitioners choosing to include parents for fear of repercussion (Ellis, 2009). However, research has suggested that adolescents feel that trust and a guarantee of confidentiality being kept are the fundamental basis for a relationship between a client and a psychologist (Tatar, 2001). Such a paternalistic approach, therefore, can clearly affect the therapeutic relationship and can leave the minor feeling disempowered and wary. With each case being unique, it is an ongoing issue for practitioners to find an ethical way to approach the situation while balancing unique responsibilities to both the parents, and to the client, without causing harm or violating fidelity.

In cases such as the one outlined above, the difficulties of implementing the APA ethical code to resolve the issue are clearly highlighted. Because of the nature of the problem, some ethical principles clash – namely the principle of integrity clashes with the principle of responsibility. For practitioners confronted with this issue, if they want to give an honest, un-edited account to the parent requesting it, they are then breaking the relationship of trust that has been built with the young person in question. Furthermore, the current codes of ethics offers no clear guidelines around whether the psychologist should prioritise the mother's requests, the fathers requests or the young persons' requests, and what factors may influence each of these decisions.

Chapter Four: Dignity and Human Rights

With the current arguments surrounding the difficulty of maintaining ethical practice when codes of ethics fail to resolve the quandary, I suggest that it is may be helpful to introduce the concepts of dignity and human rights as a fundamental basis for guiding practice.

Dignity is an age-old concept that has gradually changed over the centuries through a process of societal evolution. Initially dignity was associated with high social status, such as the nobility, and not considered for those low on the social hierarchy. However, revolutions of modern liberal thought has lead to dignity evolving from being reserved only for high status individuals to a more decentralised conception where dignity is seen as a fundamental feature of every human being (Ward, 2011). As such, the concept of dignity is now regarded as a seminal construct denoting the inherent worth and value of all human beings (Ward & Syversen, 2008). This denotation of dignity being inherent in all human beings therefore assumes that human beings' moral statuses are similarly egalitarian, and thus every individual should be granted the expectation of consideration for their wants and needs (Ward, 2011). For children, the concept of dignity therefore recognises their right to have their own wishes and desires taken into account in clinical practice. This is because dignity is owed to every individual regardless of age, gender or race, and as a dignified being they should be accorded the respect that any other individual would claim. Furthermore, the concept of dignity functions to protect children from maleficence, as actions that would infringe upon their human dignity are effectively

removing them from the equal status granted to all human beings, and therefore must be rectified.

While this conceptualisation of dignity as a construct of human worth is largely accepted, promulgations around the more specific aspects of it appear to diverge (Beyleveld & Brownsword, 2001). Definitions of what constitutes a dignified life include: (a) the notion that dignity is a minimum level of basic living standards for human beings, such as housing, nutrition, and security; (b) autonomy, whereby individuals has the right to enact their own decisions and life goals, and embody lifestyles of their choice; (c) the ability to live as an accepted member of their community through the enactment of social norms and conventions; and (d) the liberty to be able to function in a chosen lifestyle without undue coercion or interference into their actions (Ward, 2011; Ward & Syversen, 2008). With all these diverse, disseminated conceptualisations of dignity being propounded, it seems prudential to venture forward a more compact, overarching definition of what dignity is for human beings. Beyleveld and Brownsword (2001) unified the concept of dignity through proposing just two distinct categories that amalgamated the various definitions. The first category, *empowerment*, highlights autonomy and freedom as being the crucial factors for human dignity, allowing humans to live without coercion or unnecessary interference. The other category is *constraint*, which focuses on the importance of human beings having their basic life needs such as nutrition, shelter, free education and medical access met (Beyleveld & Brownsword, 2001). Ward (2011) went a step further and subsumed these two categories into the fundamental foundations of freedom and well-being, with the empowerment category argued to fall into the freedom component, and the constraint category is

assimilated into the well-being component. In summary therefore, it is argued that the notion of dignity for human beings refers to their having fundamental needs met and being able to live their lives according to personally endorsed beliefs and values.

The importance of this concept of dignity for child practitioners is particularly apparent when one considers the practical aspects of the inherent dignity that all individuals are entitled to. Once an individual has accepted that freedom and well-being are necessary rights as they enable individuals to achieve their unique goals and life plans, he or she must then acknowledge (at the risk of inconsistency) that every other individual also has the same rights. Thus, any action taken which interferes with another's dignity is therefore violating the principle that all individuals have equal worth in this sense; thereby nullifying the concept that you yourself are entitled to dignity (Gewirth, 1996). It is the ethical equivalent of the Schrodinger's Cat theory – the outcome (inherent dignity), cannot exist without being observed (or respected, by others). Child practitioners, therefore, ought to be aware of this moral agency requirement, as the dignity entitled to them - allowing their claim to basic rights- also highlights their obligations towards their child client in maintaining their dignity.

The concept of human dignity and its function as an ethical mandate to mediate human interactions and coordinate competing interests is recognised not just in academic theories, but also in major human rights treaties such as the UDHR (Ward, 2011). The preamble for this doctrine goes beyond legal conceptions of dignity, and instead promotes it as a fundamental moral value which acts as a

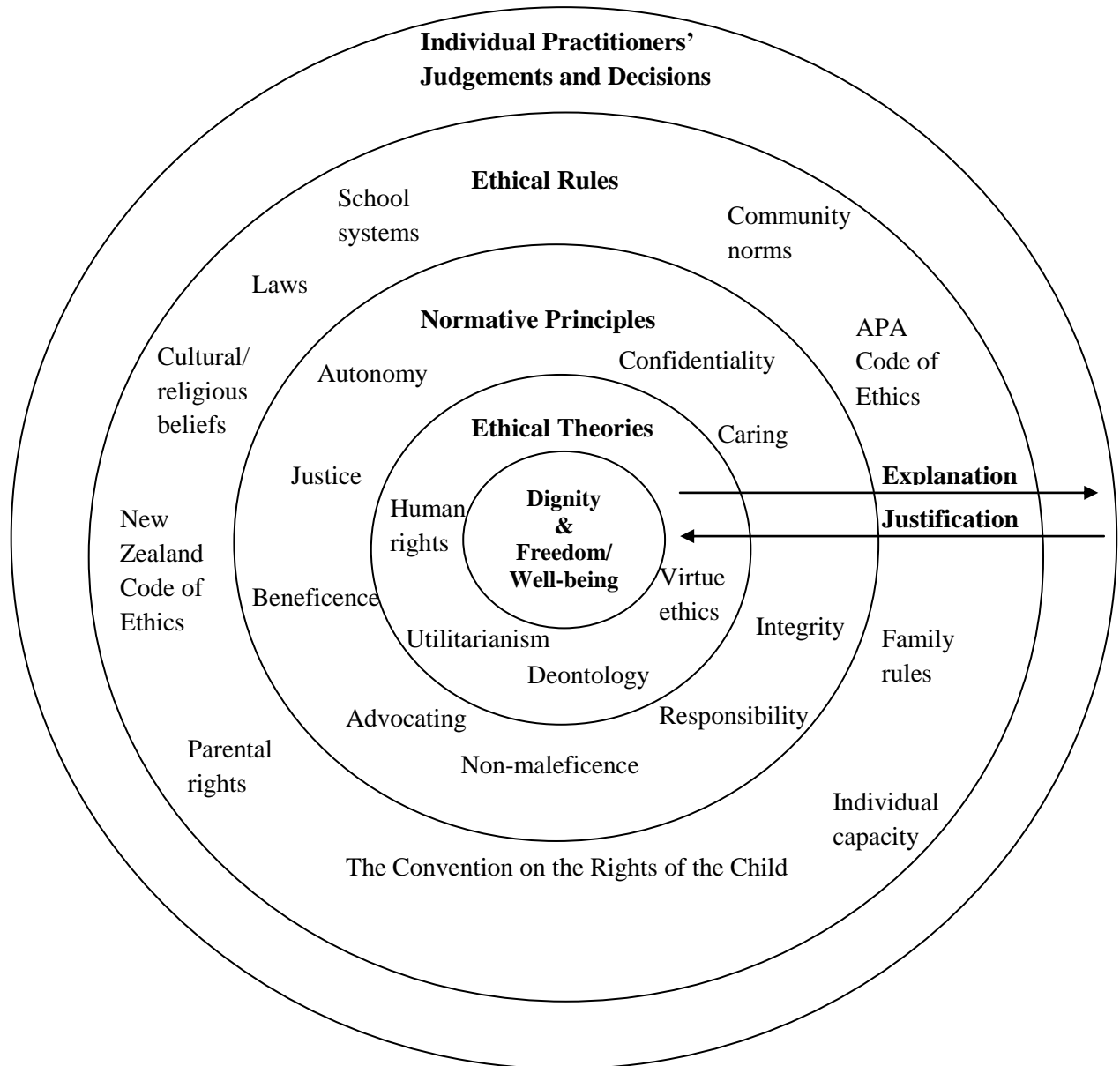
foundational focus for laws that are created to further serve human rights and needs (Churchill, 2006). Like dignity, the human rights outlined in the UDHR are also respected as a universally mandated entitlement for all individuals regardless of race, social status or country (Ishay, 2004). To outline these rights succinctly, the categories conceived by Orend (2002) will be employed, where the 30 articles of human rights contained the UDHR are collapsed into the five categories of personal freedom, material subsistence, personal security, elemental equality, and social recognition. The expectation of what is owed, by right, to any individual therefore means that curtailment of any of these five categories is a breach of an individual's human rights, unless the curtailment is a temporary for such individuals as for offenders, because the individual violated another's rights (Connolly & Ward, 2008). The fact that dignity has a close link with human rights, and is often referenced in treaties, books and various human rights documents (Churchill, 2006), means that norms embodying human rights could be viewed constituting ethically sound guidelines to base practice and decision-making on (Ward, 2011). However, with individuals and services in the mental health sector often choosing to embrace these rights with a more legalistic, rather than ethical focus, it can mean that the benefits of a rights-based analysis of ethically complex issues can be subsumed in favour of a more black and white approach (Ward, 2008). Thus, it is instead proposed that the valuable role human rights play can be recognised within an overarching framework that is based on dignity and its core components of well-being and autonomy (Freedon, 1991; Ward, 2008). It is important to note here that by respecting an individual's rights, one is not promising them a satisfying and fulfilled life; rather, one is guaranteeing that they instead are given the autonomy and freedom to work toward their own goals, values and plans necessary for a dignified life (Connolly &

Ward, 2008). In other words, rights function as protective mechanisms to preserve the conditions individuals require to live lives characterised by dignity; reflecting the worth owed to them as human beings (Freedon, 1991).

Chapter Five: An Integrated Framework for Professional Ethical Thinking in Child and Adolescent Psychology

With the concept of dignity and its components of freedom and well-being arguably at the centre of ethical practice, it is thereby asserted that these values should function as the fundamental guiding principles for all child practitioners. As such, in order to construct a model which will function as a complete guide for therapists wishing to practice ethically, a framework based on the work of Ward and Syversen (2009) will be used, with these core values at the centre. The Integrated Framework for Professional Ethical Thinking (IFPET) is outlined in figure 1.

Figure 1. Integrated Framework for Professional Ethical Thinking (IFPET).



While based on Ward and Syversen's (2009) framework, this model has been modified to function more specifically as a child-centric ethical model to guide practitioners when working in child psychology. The step-wise progression of the model is based on the arguments by Cooper (2004) who outlined the progression of ethical justification that practitioners follow in decision-making. Practitioners struggling with an ethical dilemma or problem should initially resort to the standard ethics code applicable in their country. If further justification is needed after applying these standard principles, practitioners may then invoke ethical beliefs or theories such as the belief that the greater good is justified (Cooper, 2004; Ward & Syversen, 2009). This progression from concrete practices and rules to a more metaethical level of abstraction is seen as justificatory in that it outlines for practitioners a moral defence of decision-making at ground level (Cooper, 2004). Extending on this inwards step-wise justification, Ward and Syversen (2009) propose an outward movement through their model as an explanatory progression, whereby practitioners can explain their decisions through highlighting abstract values first, and then moving through the layers of the model towards more grounded and concrete explanations for their judgements. Therefore, it is argued that such a progression allows a rational explanation of practitioner's particular judgement calls and decisions and illustrates how they came to this outcome (Ward & Syversen, 2009). For the purposes of the current model, both Ward and Syversen's (2009) outward explanation and Cooper's (2004) inward justification will be used in order to provide a complete and comprehensive model that is able to be practically used in child psychology. Now I shall move to a more complete description of each individual layer of this model.

With dignity and freedom/well-being at the core, this model highlights the need for those fundamental factors to be placed at the centre of an individual's ethical framework before further ethical reasoning can continue. This is because, as mentioned earlier, these values function as protective factors for the basic necessities that human beings need as part of a good life (Ward & Syversen, 2009). The importance of the well-being value is that progressive therapy is unable to be achieved without the client's personal well-being attended to. Without these necessities of food, water, medical care, personal safety and education the child cannot be expected to derive the maximum benefit from therapy, and further ethical abstraction is arguably pointless. Furthermore, the rights of freedom and well-being help protect and encourage individuals to 'develop the range of skills and competencies essential to effective functioning' (Ward & Syversen, 2009; p. 96). Therefore, the inclusion of these rights function not only to protect the clients' basic well-being, but also to promote the pursuit of their own life-goals. In addition to this, it has also been argued that familial relationships are one of the goods that are crucial to a child's well-being (Connelly & Ward, 2008). This idea emerged from the proposal of tandem development, whereby family members reciprocally influence each other as they develop and grow (Germaine & Bloom, 1999). In recognition of this, practitioners should therefore be aware that in order to promote and maintain a child's well-being, the family relationships should be considered, and efforts made to continue to promote healthy, nurturing relationships between the client and their family. These values of freedom and well-being help promote a recognition of the dignity of the client, which encourages practitioners to respect their child clients as equal members of a moral community who have autonomy entitlements that should

not be infringed upon without very good reasons. As such, practitioners looking to base their practice on ethical grounds should attempt to provide their child clients with freedom in their treatment choices, and ability to give consent wherever possible. In doing so, they will be respecting the child's right to confidentiality as an equal member of the community, rather seeing them as a sub-member with lesser rights. In this way practitioners will be able to maintain and empower child clients and their place as part of the moral community without compromising their dignity and autonomy. It should be recognised that by maintaining their freedom and empowering young people, practitioners are not only respecting their dignity, but also enabling them to recognise both their own personal values and the importance of respecting the values, rights and dignity of others (Connelly & Ward, 2008). As such, practitioners must make sure the fundamental, core part of the model is ensured, and the child's rights of dignity and freedom/well-being are respected.

The next layer of the model focuses on meta-ethical theories, which function to provide a deeper level of justification for clinical decision making, and the protection of dignity, in child clinical psychology. Despite the fact that most of the literature surrounding normative ethical theories fails to integrate them into a cohesive framework due to the vast number and differences in ethical perspectives (Ward & Syversen, 2009), some of the more important ones have been included in the current framework. Utilitarianism, a consequence focused theory, is based on the idea that happiness is enmeshed with well-being, and therefore prescribes actions which contribute towards to maximum amount of happiness for the maximum amount of people (Brülde & Bykvist, 2010). As such, psychologists adopting this theory must make sure their decisions and practice judgements result in the greatest

amount of well-being for their child client and the client's family. The theory of virtue ethics is also included in the current model. Virtue ethics revolve around the theory that an individual wishing to practice ethical decision-making should consider what a virtuous person would do in that particular situation. Virtues are complex psychologically and include emotions, behaviours, and thoughts that, when suitably integrated, combine to produce a justified ethical action (Louden, 1986). As such, its relevance in the current model lies in the perception that practitioners who appeal to this will use their experience, judgement and knowledge to consider what the most virtuous child psychologist would wish to do in such a circumstance, and aim to replicate such behaviour. A positive feature of this model is its emphasis on conducting all decision-making behaviour in the most virtuous and morally focused way possible. The last normative theory that has been included in the current model is deontology, a backward looking theory that focuses less on the outcomes and more on the guiding principles of behaviour that caused them (Ward & Syversen, 2009). This theory assumes that principles are derived by moral agents from reflection and analysis, and thus those who choose to be guided by such principles are being guided by rational thinking and moral agency. The theory of deontology also functions as a protection for dignity in that it holds that individuals should be given the autonomy to pursue their life goals and plans, so long as they do not commit actions which cause a curtailment or violation of other's human rights (Connelly & Ward, 2008). Therefore, practitioners using the IFPET model should consider whether both their own actions would cause an unnecessary curtailment of the young person's rights, and also if the client's stated actions would cause a violation of another's human rights and dignity. Also included in this layer of the model are human rights. This is because, as noted earlier, human rights function to

protect the core components of dignity (Ward, 2008). Without these rights of personal freedom, material subsistence, physical security, elemental equality and social recognition (Orend, 2002), one cannot expect to live a dignified existence. As such, human rights in this layer serve to protect both legally and ethically the freedom and well-being of young people, and to remind the practitioner that curtailment of any of these rights would be to violate the young person's inherent value as a person. The necessity of having a multitude of normative theories contained within this layer of the model is that they serve to highlight that utilising a single theory alone may not be the most useful approach. For example, relying on utilitarianism alone may mean that the autonomy of a young person is subjugated in favour of the family's wishes because it may produce the greater good for the family. As such, the theories in this layer are included to promote higher ethical reasoning, multiple avenues of exploration and a deeper level of consideration. Furthermore, although normative theories provide a level of ethical reasoning that can help analyse and guide practice, they are too abstract to be used to ground ethically complex decisions in alone.

For practitioners looking for further steps of ethical practice, we now move to the next layer of the model. This layer contains the normative *principles* that comprise ethical codes and standards. An amalgamation of the principles from the New Zealand Code of Ethics, the APA Code of Ethics and the UNDHR, which were outlined above, were collated into this layer of the model to provide a formulative guide of core ethical principles. Practitioners looking to be guided by these normative principles are able to follow the overarching rules and values encapsulated by them, to use them as a moral compass. The reason these principles are included as

a layer of this model, rather than viewed as a fully functional stand-alone ethical guideline is that the principles are intended as a general guideline without requiring specific behaviour, actions or responsibilities (Ward & Syversen, 2009). As evidenced above, when attempting to apply these principles to ethical quandaries, they do not always have the ability to identify a specific action that is ethically optimal. Therefore, it is proposed that these particular principles function within the current model by elaborating or enhancing the core component of dignity.

The next layer of the model introduces a grounded, concrete guide to enable clinicians to deal with ethical quandaries that occur in every-day practice. This layer employs the legal, social and ethical rules that guide moral practice at the “ground” level. The codes of ethics included in this layer provide the standards that elaborate, and are underpinned by, the more abstract principles outlined above. Although, as argued earlier, these standards can be restrictive, they function as a useful addition within this framework. Because the standards provide relatively specific rules of conduct, practitioners may find them useful to consult to guide their practice. However, as stated above, if practitioners consult these standards they need to be aware of their limited scope as a stand-alone set of ethical resources, and instead, employ the whole framework when seeking to determine how best to arrive at, and justify, a specific action. Based on the arguments provided earlier, I suggest following this line of ethical reasoning for every set of rules included in this layer of the model, from legal rules to community norms. Practitioners who are guiding their practice by laws or social norms therefore must continue to maintain an awareness of the inherent dignity of all members of society, and continue to uphold that dignity. One of the benefits of the model is that it provides a more concrete layer - such as

this one of particular ethical rules - which enables practitioners to organise their thinking after contemplating the more abstract and meta-ethical aspects of professional practice. Furthermore, it helps practitioners to resolve conflicts between differing ethical stances or responsibilities. For example, incorporating a family's particular rules and beliefs may create dissonance when trying to also incorporate the child's individual interests. When conflicts such as these arise, and there is no clear resolution found from consulting the standards of an ethical code, practitioners can move to the next layer of the model and consult a higher level of moral concepts and theories, to arrive at a decision. This layer also functions to highlight and promote the individuality of each young person and situation. By including rules from different social practices such as culture, religion and education as ethical considerations, the IFPET model recognises the influence that a host of different factors can play in the young person's life. Therefore, practitioners engaging in an ethical decision-making process with the young person should include a consideration of all these individual factors and how they may function to serve the outcome.

Chapter Six: Application of the IFPET Model

In order to demonstrate the versatility and usefulness of the IFPET model, I shall apply it to the five examples of child related ethical problems outlined earlier. The earlier analysis of the five cases of moral conflict indicated that simply following a code of ethics is sometimes not sufficient to arrive at an ethically justifiable decision. They will now be revisited using the new model, and hopefully more nuanced and ethically justifiable decisions will be provided.

Case example one: Beneficence

Case example: a 15 year old girl who was diagnosed with Anorexia Nervosa died in hospital from malnourishment after refusing treatment. Right throughout her decline the girl continued to explicitly state that she did not want treatment, including both nourishment and psychological counselling. The individual's family disagreed, and requested under mental health legislation as a minor that she be placed in therapy, and be forcibly drip fed in spite of her protestations. The psychologist involved stated that she believed that the individual had a clear and rational understanding of her situation, and therefore recognised her right to refuse psychological treatment. The Director of Nursing similarly refused to overrule the girl's decision, and complied with the adolescent's request refusing all nourishment. After her death, the family sued the psychologist and the doctors involved in

her care for failing to make the choice that would be of most benefit to the client.

In this case example given above, a young person exercised her right to refuse treatment against the wishes of her family. The family argued that the doctors and psychologist had failed to make the choice that would be of utmost benefit to the client, as abiding by her choice to refuse food eventually lead to her death. To consider this case using the new model, the individuals involved in her care should have first considered the fundamental dignity of the client involved. As Ward and Syversen (2008) argue, this means that her position as an agent and fellow being within the moral society should be respected, and her ability to function as a moral agent should be strongly considered. As such, the family should not gain the right automatically to be able to make decisions on her behalf simply because she is under age or choosing a treatment option which is undesirable to them. Furthermore, should any decision be made on her behalf, every effort should be made to maximise her freedom and choices wherever possible.

The next step in deciding on the most ethical decision for this case would be to consult the second layer of the model and think through their implications for this client. Practitioners should think about which decision is most likely to align with her overall net happiness, and whether their decision will ultimately result in the greater good for the well-being of the client. For the individual in this example therefore, they must ascertain whether she would physically and mentally benefit, and gain the most happiness from receiving unwanted treatment and living, or

exercising her right to continue to starve herself. In doing so they must look to the future as well as the present situation for this client – for example, whether they think that the client would feel the same, or better or worse in two years time. Should the practitioners decide to override her wishes, they must remain mindful of the fact that such a decision represents a (temporary) curtailment of her human right to autonomy, rather than a complete forfeiture.

The next step is where those involved in her care consider the specific set normative of principles outlined in codes to help them come to a sound decision. For this case, it means that the practitioners should maintain those principles of beneficence, advocating, caring and integrity regardless of their decision. As such, the decision should maximise her well-being, and reflect the practitioner's commitment to caring for her.

The last layer to be considered when making the clinical judgement as to whether to intervene against the client's wishes looks at factors such as parental rights. Therefore, the practitioners should very carefully consider both morally and legally what rights the parents have in this decision, and whether this entitles them to have their claim overridden by their daughter's preferences. This layer also encourages practitioners to consider the individual's capacity. Therefore, practitioners should consider all the factors in her case, such as the potential effect of a lack of food on her cognitive functioning, the reasons behind her decisions, and the reasons behind the family's wishes. Practitioners should be fully aware of the client's premorbid functioning, personality, and behaviours otherwise they would be

attempting to make a decision that is not fully informed. This means that they may under or over estimate the effect of starvation on her cognitions and behaviour, and may judge incorrectly what outcome may bring her the most happiness, and over-all well-being and benefit. Any cultural or religious beliefs should also be considered – for example, if the client has a religion that has negative views towards suicide or self-harm this should be discussed with her, and what it means to her.

Finally, with all these factors being weighed up and considered, the decision that upholds these ethical requirements to the utmost standard should be made. Regardless of this decision, the client's dignity should be respected. This means that should the practitioners choose to abide by the family's wishes and treat the client without her consent, then every effort should be made to maintain her dignity during this process, and she should be fully informed of what will happen. Furthermore, choosing to override her decision to refuse treatment does not mean that every other decision concerning her should be made by the parents – wherever possible the young person's dignity as a moral agent with autonomous desires should be respected. Should the practitioners decide to abide by the client's wish, then every effort should be made to provide her with support and respect. The family should also have this decision explained to them with the moral, legal, ethical and cultural decisions that factored in to this choice all being clearly outlined, and the practitioners should continue to include them in the therapeutic process. In doing these actions, the practitioner is providing an ethical scaffold for the client and her family, so that she is supported in any way necessary, and her dignity is maintained at every stage.

Case example two: Nonmaleficence

Case example: A 13-year old girl came in for family counselling with her mother in order to work on communication issues. The relationship had been strained by ongoing custody battles with the girl's father, and she had expressed a preference for living with her father as he allowed her more freedom. The mother expressed concern that the girl was engaging in behaviour that had long-term consequences, including dating an 18-year old male, and some experimentation with illegal drugs. The psychologist arranged for a private session with the girl after this initial assessment. During the next session, the girl confided to the counsellor that she had recently engaged in consensual sex with her 18-year old boyfriend. The girl stated that she did not want her mother to know about this. The psychologist was concerned about reporting the issue as the family relationship had already started showing signs of improving, and a good therapeutic alliance had been established. The psychologist eventually decided that since it fit the legal definition of sexual assault as the girl was less than 15-years old, and the boy was more than four years older than her, she should report the incident. When she rang the girl and her mother to notify them of the report, the girl yelled and cried, and accused the counsellor of intentionally sabotaging

her relationship. She also denied having been told about the limits of confidentiality, and said she would not return for family counselling again. (Bean, Softas-Nall, & Mahoney, 2011).

This case example highlights the difficulties of attempting to solve an ethical issue by following the APA principle of non-maleficence. In this example, the client, who engaged in a consensual sexual relationship with her adult partner felt betrayed by the therapist. For the therapist, the decision focused on making the clinical choice that did not cause harm to their client. Using the principle of non-maleficence as an ethical guide therefore means that the practitioner must decide whether telling the minor's parent about her relationship, and thus losing the client's trust, is the harmful decision, or whether keeping it confidential and thus allowing the relationship to continue is harmful. Not only is this an ethically un-productive way of attempting to problem solve, it also means that the practitioner is offered very little guidance beyond 'not causing harm' as to what decision to come to.

Approaching this situation using the IFPET model means it is possible to provide a more ethically complex, and justified approach. Applying the core basis of the model, that of dignity, immediately focuses the issue. By recognising the client's inherent dignity, the practitioner avoids adopting paternalism as a guiding force. Paternalistic choices occur when an individual's decisions or preferences are ignored or deemed irrelevant by another person. This person then justifies their overriding or disregarding such interests by saying that doing so will reduce the likelihood of

further harm to the individual concerned (Beauchamp and Childress, 2009). An obvious problem is that this type of claim directly violates an individual's dignity as an autonomous agent (Ward, 2011). In this situation, the psychologist should acknowledge the client's dignity and autonomy as important ethical elements rather than resorting to paternalism through a justification of non-maleficent practice.

Having done this first step, the practitioner can then move to a consideration of the meta-ethical theories and guidance they provide. Considering which outcome for this client is for her greater good and well-being, is consistent with her human rights to safety and security, and additionally, the action a virtuous individual would choose may also provide a further layer of consideration.

The next layer, encapsulating normative principles, serves to guide practitioners toward their decision with a recognition of the many facets of ethical practice. Confidentiality, encapsulated in this layer, is regarded as an almost sacred principle of clinical practice (Donner et al., 2008). The breaking of confidentiality is typically only judged to be ethically permissible by ethical codes when there are good reasons for thinking he or she is in serious danger of doing harm to themselves or others (e.g. APA code of principles, New Zealand code of ethics). Thus, the practitioner in this case should consider whether having consensual sexual relations with a partner does indeed a serious risk of harm to their client. Other principles within this layer also provide further guidance, such as the principle of responsibility. As a child clinical psychologist, the practitioner should be aware of his or her duty to advocate for the child; in this situation that may mean advocating

for the client's right to continue the relationship, regardless of which decision they choose.

In the next layer, the more concrete societal and legal rules function as an interconnected set of rules to guide practice. In this case example, the practitioner should be aware of the laws concerning sexual relationships between minors and adults. They may need to consult a lawyer to arrive at an adequate understanding of the laws surrounding this matter. The question of individuals' capacity is also salient and the psychologist should conduct a thorough assessment of the client and her thoughts, feelings and justifications for her relationship. In doing so the psychologist may find that the client has the capacity to understand her actions and their outcomes, which may influence the ethical judgment concerning the appropriate course of action. Other rules contained in this layer, such as family rules, also need to be considered. While family rules (for example not being allowed to date), may not influence the clinical decision to break confidentiality, they should be factored in to the psychologist's interactions and discussions with the client. In this instance, the psychologist may arrange a meeting with the mother and daughter, to work through and discuss what is and is not acceptable within the family.

Case example three: Fidelity and Responsibility

Case example: An eleven-year old girl was brought to therapy by her exasperated parents who claimed that she was so disruptive and uncooperative at home that they were "at their

wit's end". The girl made it clear that she did not want to "be shrunk" and vigorously protested any attempts to sway her to a more cooperative attitude. The parents urged the therapist to give it a try anyway, and they accompanied the girl to every session, waiting for her in the reception area. During the initial session, the girl sat straight and rigid in her chair, did not utter a single word, and made no eye contact or other response to the therapist's best efforts to interact or communicate. Despite this, the psychologist gave in to the parent's wishes, and saw the girl for two more sessions. During the following sessions the girl reiterated her desire not to be there, and said little else. The parents remained convinced that the girl would "break down soon" and requested that the therapist continue scheduling sessions and trying to get through to her (Koocher & Keith-Spiegel, 1990).

The next case example highlights the difficulty of using the APA principle of fidelity and integrity as a stand-alone ethical guideline. In this situation, the issue of responsibility as an ethical mandate becomes unclear when the practitioner must decide if their primary responsibility is to the child or the parent.

Considering this decision using the model, the practitioner should immediately be reminded that with the child as their client, they should focus on her as an individual. As with the other case examples, by recognising the client's dignity

and holding that as the basis for further decision making, the practitioner is able to realise that the client's needs and wishes are separate and distinct, and no less relevant, than her parents. Furthermore, it has been argued that one of the fundamental aspects of well-being is having fulfilling familial relationships (Connelly & Ward, 2008). As such, the practitioner should be aware of the value that the family relationship plays in this girl's life as she grows up, and the importance therefore of maintaining this relationship in the best way possible.

The next step would be for the practitioner to consider ethical theories and how different approaches could be used to maintain the client's dignity. Here, the practitioner, if they consider consequential aspects of the decision, should formulate ideas around what the potential outcomes could be of continuing therapy versus terminating it. This would require the practitioner to reflect on the psychological, emotional, behavioural and social outcomes of their decision, and whether the outcome of each of these components for the client cognizant of her dignity and realtldly, freedom and well-being.

The normative principles function in this case example to consider the ethical stance of treating a client against their will. The principle of autonomy would not be embraced by refusing to recognise the child's decision, nor is advocacy. To make an ethical decision the practitioner needs to remember that they should be advocating on the client's behalf – and in this case, advocating for the client's wishes.

Finally, when making this decision, if the practitioner moves to the next layer of the model, they will need to reflect on the importance of parental rights, family rules, and individual capacity and the impact these may have on the final decision. This is important as the psychologist needs to be aware if the child can make an informed decision for herself, and understand the meaning and consequences of it. Furthermore, the family rules may be functioning to influence the therapy, and the psychologist may need to explore whether the family is realistic in their expectations of their child's behaviour and the pathology of it.

Case example four: Social Justice

Case example: Normal, healthy toddlers were solicited from lower socio-economic neighbourhoods to serve as a control group in a longitudinal study of the mental health of children with a serious allergy. Although the control toddlers were not given any experimental medical procedures, they were hospitalised on several occasions to undergo a series of tests, some of which were uncomfortable, invasive, and painful. Parents were paid several hundred dollars for their cooperation (Koocher & Keith-Spiegel, 1990).

This example highlighted the issue of social justice, and the necessity of being aware of children's vulnerability. The researcher felt that the procedure was

ethically justifiable because of the financial compensation; however it appears that further efforts were not taken to ensure whether the children benefitted in equal proportion to what they had to endure.

Should the practitioners in this case have wished to consider a more ethical approach the IFPET model would have guided them to first reflect on the fact that dignity is a right accorded to all human beings regardless of age, and therefore their research participants should be respected as dignified beings. This means that actions that would harm their dignity, such as endangering their personal safety or security are unethical. If the researchers consider the children's well-being as a foremost factor in their considerations, they should then consider how the children's well-being will be affected by their research, and what, if any, steps can be taken to protect this. Because of the nature of the research being undertaken in the case study, and the fact that the children's well-being will be compromised by having to undergo painful tests, the researchers should reflect on whether including these children will provide for their well-being in the future, or how they can replicate the experiment so that it does not cause a threat to it.

Secondly, the researchers should consider the ethical theories and how they factor in to the decision making process. Would the research in question have the most benefit for the most people? It may be that this research only benefits a small amount of individuals, or is unnecessary outside of academia. The researchers should also consider the outcomes of this research and how that may affect their decision. For example, if a potential outcome is a null result for the research, will the

consequences of the research on the children still be ethically justifiable? Even if the research produces a result which indicates a significant effect, they must consider whether that will be beneficial enough to justify the research requirements.

Then the researchers should explore ethical principles and whether their research is in line with these. Because the research appears to be in line with the ethical guidelines under the principles of justice and non-maleficence, they must consider how they can conduct the experiment so that it adheres to these principles. It may be that the children in the control group do not undergo any painful medical tests, and that they receive compensation that is earmarked specifically for the children, as the participants, rather than giving it to the parents. This may help reduce any participants whose parents consented for their own financial gain.

The last layer of consideration for the researcher's helps to guide the researchers to consider concrete factors such as individual capacity – in this case, despite the parents continued consent, if the child says no, or wants to leave, is this withdrawal of assent enough to stop the child's participation? They should also consider the community when considering where to draw their sample; if they chose to select children from a more affluent community, then they may get consent from parents who are willing to let their child participate for reasons other than financial ones. It may also mean that the parents are not as beholden to the research, as the money is not as important to them.

By using the IFPET model, the researchers in this case example may be led to a more ethically justifiable decision than by relying on the principle of social justice alone.

Case example five: Integrity

Case example: A father sought treatment for a 14-year old boy per court order that was issued at the end of a bitter, protracted child custody dispute in State X. Allegedly, the case was awaiting trial when the mother physically assaulted the boy. In an emergency hearing, the judge awarded the father custody of the boy, and he moved to State Y to live with his father. The mother continued to have joint legal custody, and the boy was ordered to have ongoing visitation with her. On initiating treatment with the boy, the mother contacted the psychotherapist and demanded to be included by phone in the boy's psychotherapy sessions. The psychotherapist declined and instead scheduled an appointment by phone with the mother, which she did not turn up for. Six months later, the mother's attorney demanded the records from the boy's treatment sessions. The father reported that his son did not want his mother to see his records because he feared retaliation, both physical and emotional. The father stated further that the previous psychotherapist had, on the mother's demand, turned over the

boy's records to the mother, who allegedly then used the notes to verbally berate and harass the son. Seeking to protect the boy, but also to provide information to the mother, the psychologist offered three compromises to the mother's attorney: (a) allow the boy to redact the record so as to shield those parts of the notes he did not want his mother to see, (b) provide a written summary of treatment to the mother, or (c) let a guardian ad litem appointed by the court review the case. The mother declined all three options. The mother then filed a complaint against the psychologist with the state licensing board. (Ellis, 2009).

This case example highlights the difficulties that practitioners can face when trying maintain open, honest and trustworthy relationships with their clients while also completing ethical responsibilities towards the parents. For this situation, it is clear that there is an active conflict of wishes, and the practitioner needs to clearly consider what the most ethical decision should be for this situation.

Applying the IFPET model for this example means starting off, as with the other examples, with the recognition of the young person's dignity. In this situation, that means recognising the boy's right to security, safety and autonomy. As such, the practitioner should consider whether their decision may affect these critical factors. In addition to this, this recognition of dignity means that the young person, as an equal member of the moral community, should have their right to confidentiality respected as much as possible. Actions that may subjugate the young person in any

way are denying this equality and lack the proper dignity that should be accorded to him.

Moving to the second layer of the model, the practitioner can assess the underlying moral tenants of ethical theories and how they may influence the decision in this case. For this case the practitioner may consider how the different potential outcomes may influence the ethics of the decision; for example, the boy's mother may use the psychological records to manipulate him, which would infringe on his dignity. In doing so, the practitioner can then consider what decision to make that would be least likely to cause a less than beneficial outcome for the young person. The practitioner may also adopt a utilitarian viewpoint, and review what outcome would lead to the greater overall good – for example, would the mother's knowledge of her son's therapy records help improve their relationship, and is that in turn worth jeopardising the young person's trust in therapists?

In the next layer of the model the practitioner can consult the normative principles and consider their influence in the decision-making progress. In this case, the practitioner must consider the principles of beneficence, non-maleficence, confidentiality and integrity in particular, and consider what influence they have on the decision. This is because for this situation, the mother has allegedly caused harm to the boy after previously receiving his psychological records, in which case the principles of beneficence and non-maleficence would be violated. For the principle of confidentiality, it is an important consideration as the young person has not indicated any risk of imminent harm to himself or to others, and breaking confidentiality for reasons other than those is considered unethical. The principle of

integrity is also considered important here for the practitioner to review, because the therapeutic relationship could be violated by any actions that are not truthful, honest and open. The practitioner must therefore consider what was discussed with the client around confidentiality and its limitations, and whether their actions would go beyond this discussion.

In the next stage of reviewing the most ethical approach, the practitioner must contemplate what ethical rules factor in to the current situation. For example, what are the parental rights in this case? Does the mother have an ethical or legal right to receive her son's psychological records for a custody case? The practitioner should also reflect on the family's own rules, such as whether the parents decided to keep each other fully informed about their son's behaviours or wishes. Importantly, the practitioner should also consider the young person's individual capacity, and whether he understood what informed consent was, and whether he has the capacity to make his own judgement calls about the confidentiality of his psychological records. The practitioner may also explore whether the current code of ethics in their country have particular standards that are relevant to their case which may help inform their decision. Furthermore, the practitioner should be aware of cultural or religious beliefs that the family or individual parents hold, and what part they may play in this situation. For example, some Asian cultures hold beliefs that health decisions are a communal consideration made by the whole family, whereas most Western cultures prefer individual autonomy in their health decisions (Searight & Gafford, 2005). As such, the practitioner may therefore need to consider how the family normally makes the decision, whether in an individual or joint capacity, and how this consideration might affect their overall decision.

By being aware of this multitude of influences, rules, principles and theories, the practitioner can therefore ideally be guided towards a more well-thought out decision that is not restricted to the more narrow confines of a single ethical code.

Chapter Seven: Conclusion

This thesis has explored some of the most well-regarded contemporary ethical codes and treaties that are in place for psychologists today. Their principles, standards and ethical reasoning's were explored, outlining what guidance practitioners can expect through following such codes. While these ethical codes provide sound ethical reasoning and moral aspirations that psychologists should indeed seek to follow, they appear to fall short when considered as a complete ethical guideline. Providing such a complete ethical guideline that will unfailingly produce the most ethical outcome or decision possible is not a straightforward or easy (or indeed, arguably even possible) conceptualisation. However, the IFPET model created in this thesis attempts to resolve this issue, and to provide an ethically reliable, structured approach that helps to ensure that the decision that has been made by a practitioner has been thought through.

The inherently complex, multi-faceted issues that arrive when working with children and young people are the reason that this model has been specifically tailored towards resolving ethical conundrums in child psychology alone. A more generic model focussed on dealing with all ethical issues that practitioners come across in psychology would risk excluding some of the important areas that occur only in child psychology. For example, a more generic model may fail to address the importance of family cultures, parental rules and parent and child relationship dynamics. The IFPET model therefore confronts and deals with some of the criticism of the current ethical codes for child clinical psychology.

In order to look at the advantages of this model over the current existing ethical guidelines, it is worth addressing some of the common critiques of the ethical codes in practice today. One of the most commonly cited critiques of the APA code of ethics is its inability to cover the entire range of ethical issues that practitioners can come across (Ward & Syversen, 2008). This means that should practitioners come across an ethically complex situation not dealt with by the APA, they must then resort to their own judgement, which may be strongly influenced by their own biases, assumptions and values. Even worse, this may lead them to not even notice that an unethical situation may exist because they have not encountered it in the past and it is not explicitly mentioned in their professional ethical code. Thus moral blindness means that practitioners may be engaging in unethical behaviour while completely unaware of doing so (Ward & Syversen, 2008). The advantage of the IFPET model is that by encouraging practitioners to consider the inherent dignity of the individuals they are involved with, it increases the scope of the ethical awareness. Practitioners who are focused on providing and protecting the dignity of their clients must therefore consider their freedom and well-being in a wide variety of ways. In addition to this, by assisting practitioners to move to a more abstract, higher level of ethical reasoning this model can help to identify and highlight issues that may have been overlooked. As such, individuals who may have been disregarded are given increased attention and their interests and concerns highlighted by use of the IFPET model.

Another criticism of the current ethical codes is that they prescribe a more rigid, mechanical approach to ethical practice, which is no substitute for explicit well-reasoned ethical thinking, especially in certain contexts (Pope & Vasquez, 2010). With every ethical situation being influenced by a variety of individual factors and considerations, the current codes act merely as a guide to divert practitioners from what is *unethical* (Pope & Vasquez, 2010). Indeed, the rigid inflexibility of these ethical codes may “operate as blunt instruments... that function to restrict and control the actions of practitioners” (Connolly & Ward, 2006, p.179). By way of contrast, the IFPET model functions instead to promote more active, individually-focused ethical reasoning that highlights the different contexts and values that may occur in varying situations. Rather than having simply prescribed, generic standards and principles that may not apply to a particular cases, the IFPET model takes into account a variety of internal and external factors that affect both the current situation, and the decision-making process. For example, the differences that culture, family rules, and parental dynamics make on an individual situation can be hugely influential, and deserve serious consideration in the decision-making process. It is the inclusion of such factors, combined with the foundational considerations of dignity and well-being, that give the IFPET model the unique ability to adapt to each situation and provide a well-thought out reasoning process, without excluding important areas. In addition to this, this combination of individual factors and more foundational concepts such as dignity helps to promote awareness of the moral equality, agency and value of all individuals involved. The IFPET model achieves this through firstly highlighting the inherent dignity of all human beings, and their role as active moral agents in the community regardless of status, gender, race or age. Then, by detecting individual factors which are influential in

young people's lives such as parenting rules, the model seeks to emphasise the unique individuality of each person and the importance this individuality should play in clinical practice.

Another issue with the current ethical codes is the emphasis on the practitioner being in charge, and having primary responsibility to make choices on behalf of the client. For example, the APA notes that exceptions for waiving confidentiality are "permitted by law for a valid purpose" (APA, 2002; 5.05). This denotation firmly places the burden of responsibility on the practitioner to decide what is valid and what is not. Instead, a more ethical approach would be to ensure that the right to confidentiality belongs to the person unless in circumstances of extreme harm (Satcher, 1999). The advantage of the IFPET model is that it actively encourages the recognition of this autonomy through encouraging practitioners to focus on the young person's inherent dignity before considering any further steps. In doing so, the practitioner is therefore recognising that their client is an equal, and an autonomous being with the right to be included and consulted in every phase of treatment. This recognition also helps to negate the arguably still commonly held practices in child psychology that function from an "adult point of view, with little reference to childhood cultures and the need for children to be involved in the processes that concern them" (Connelly, Crichton-Hill & Ward, 2006; p. 60). By bringing the focus back to the young person, and actively promoting the need to engage them in the therapeutic processes, the IFPET model helps practitioners to move beyond an overly paternalistic view-point.

It is hoped that the advantages of the IFPET model encourages practitioners working in the field of child and adolescent psychology to widen their ethical reasoning beyond the current prescribed codes of ethics. Although ethical quandaries will continue to appear in this domain of psychology, practitioners and researchers are encouraged to adopt the tenants of this model, and continue to evaluate and build upon their current ethical processes in order to allow for more morally complex and well-reasoned practice. The approach of ethical scaffolding that this model undertook, guiding practitioners through the multiple layers of ethical reasoning, is also one that would benefit other areas of clinical practice. As such, it is hoped that this approach is adopted and tailored to apply to other areas of clinical research and practice so that populations such as the intellectual disability population or elderly population receive a scaffolded approach beyond the rigidity of ethical codes alone. Because it allows multiple ethical principles and theories to work together to provide an interconnected process the IFPET model combats reductive ethical thinking and instead aims to expand ethical awareness beyond a simple reliance on rules and standards.

Good ethical practice has its roots in knowledge and perception, and an appreciation that the complex nature of social encounters will often exceed our capacity to encode them within a set of concrete norms. However if we approach clinical work with a recognition of the inestimable worth of every human being, and appreciate the need to create and maintain the conditions that underpin their dignity, we are more likely to do what is right and good for our clients.

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