

Confidentiality in Child Psychiatry

ÇOCUK PSİKİYATRİSİNDE MAHREMİYET

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Summary

Confidentiality in child psychiatric presents some peculiar features linked to child competence to consent and to control the information flow that concerns him/her self.

In particular this paper addresses two main questions: i) How could child's privacy be defined? ii) Who is included in child's private sphere?

The paper concludes pointing out some basic rules that should be anyway respected.

Key Words: Confidentiality; Child Psychiatry; Medical Ethics

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Özet

Çocukların onam verme ve kendileri hakkında verilen bilgileri kontrol etme yetilerindeki sınırlılık gibi nedenlerden dolayı çocuk psikiyatrisi kendine özgü özelliklere sahiptir.

Bu makalede özellikle iki soruya cevap aranmaktadır. i) Çocuğun özel yaşamı nasıl tanımlanabilir? ii) Çocuğun özel yaşam alanına kimler girer?

Bu makalede ayrıca her durumda saygı duyulması gereken bazı temel kurallara işaret edilmektedir.

Anahtar Kelimeler. Çocuk psikiyatrisi; Mahremiyet; Tıp Etiği

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The idea of confidentiality is articulated in almost all codes of professional ethics. Confidentiality is "present when one person discloses information to another, whether through words or an examination, and the person to whom the information is disclosed pledges not to divulge that information to a third party without the confider's permission. In schematic terms, information I is confidential if and only if A discloses I to B, and B pledges to refrain from disclosing I to any other party C without A's consent. By definition, confidential information is both private and voluntarily imparted in confidence and trust". (1) Confidentiality therefore implies:

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i) the existence of two different domains, or spheres, or realms: the public (what is shared by citizens, or anyway by those who inhabit the *polis*, the village, the nation) and the private (what is shared by few individuals, by the family, or even by only one person, i.e. the subject);

ii) definition of boundaries between these two spheres;

iii) voluntary infringement of these boundaries according to some rules known and accepted by the actors of a contract.

The debate in child psychiatry has focused above all on the last point, i.e., voluntariness. It has been argued in fact that children are not competent enough to give their consent, or to establish a therapeutical contract, which may include some rules concerning confidentiality. However some previous problems should be solved before facing the issue of competence. In this paper I am going to deal with the definition of the child's private sphere. Ultimately my argument will be that there are dif-

ferent degrees of privacy in childhood and that we need to respect all of them though in different manners.

Public and Private

The private/public distinction comes from moral and political theory. Private conduct is that which it is no business of the law. The private realm is the realm of morality, where actions are not judged according to the law. Even if this distinction first appeared in the ancient Greece, liberal political theory made essential use of this category in assessing the permissible sphere of the law. In medicine we deal with information about patient's life, body, and state of health. In our societies this kind of information is supposed to be, largely, part of the private sphere (while, to say, information on one's education is public). Of course there many exceptions to be considered: say, information about the body of an athlete, such as his/her weight, and muscular conditions is in general public. It has been also argued that persons who are candidates to some highly responsible positions are not entitled any more to keep secret their medical records. However generally speaking medical information concerns a private domain. Doctors are therefore entitled to have access to this information under some rules involved in the medical contract. In particular doctors:

i) must use this information for the patient's benefit;

ii) must not cause any harm to the patient by means of the information obtained for therapeutic reasons (say, this the case of the so called "testimonial privilege", according to which a doctor cannot disclose any information in a judicial proceeding unless the patient gives his/her authorization);

iii) must not reveal to any third, or fourth party (even other members of the same family, who are inherently part of the patient's private sphere) any piece of medical information if it was not explicitly authorized by the patient.

However doctors are not expected to keep the secret with other medical doctors, namely medical information becomes part of the medical sphere; as a result medical information cannot be considered

any more private but it is in fact public even if only amongst doctors. This implies many interesting consequences. Actually it has been said that the medical secret is more the rite of a secret, the mark of an interdict, than a true secret. (1) Moreover exceptions to the patient's absolute right to confidentiality have always been recognized. These exceptions most often occur when the professional must also address society's right (or need) to know. In the current medical scenario information no longer is shared among providers and consumers. Third and fourth-party entities are more and more involved. As a consequence rather than speaking of confidentiality, it would be better speaking of the patient's right to control sources and flow of information. It means that the question that we should address is not: "Who, when, and why is entitled to breach confidentiality?" but "How can the patient control the information flow concerning his/her self?" (2)

In child psychiatry we face some complex problems. Third and fourth actors are very often present (parents and other relatives, legal guardians, judges, family associations, charitable institutions, police) and moreover the child's private sphere appears to be bad defined or even neglected. Nevertheless from an ethical point of view it is unquestionable that the principle of confidentiality should be a cornerstone also in child and adolescent psychiatry. Young patients are entitled with the same rights of adults and they should be sure that the information they have revealed to the doctors is not disclosed unless they give their consent

Child's Private Sphere

Childhood is not a fact: it is a theory, namely a social theory. While infancy is a physiological period of life in which the young individual cannot survive if not feeded and cared by an adult (literally infancy refers to the pre-linguistic period, an infant is any human before learning his/he native language), childhood is rather a social role than a mere physiological state; one is child when, and only till the moment when, the society decides that he/she is a child, namely that he/she has different rights and obligations from an adult. Some human societies have not had children at all, namely they have not

had a specific social role for children; in these societies persons used to pass directly from infancy to adulthood, sometimes through a very short adolescence which was the period of "passage", namely the period of apprenticeship to adult's life. It was, say, the case of many European societies (e.g., rural communities) in the modern era till the end of nineteenth century. (3)

The existence of the childhood implies the definition of its boundaries. It is obviously matter of temporal boundaries (When does childhood start? When does it end?) but, less obvious, it is also matter of its social boundaries (Which are child's rights and duties? What is a child expected to do and not to do in order to accomplish his/her social role?). As a consequence, social boundaries imply the distinction between private and public, namely the fact that some actions are ruled by the law (and they are public) while others do not regard the law (and therefore they are private). As far as the distinction private/public in childhood is concerned, we face two very different perspectives.

From the first perspective, only adults possess a public sphere (or, better, have access to the public sphere) since only adults are truly subjected to the law. According to this view there is no point trying to define a child's space of privacy; children are "part" of an adult's private sphere but they have no right to privacy, namely their privacy is held by an adult. Say, in any medical context child's feeling of modesty are not respected and the child is visited by the doctor before his/her parents. Child's naked body exposed to a third party (the parents) during a medical physical examination is a typical example of infringement of child's privacy that is based on the assumption that there is no a true privacy to defend since the child's body is actually "part of" parents' private sphere.

From the second perspective any human, as a human, possesses his/her privacy, no matter of his/her age. The distinction between public and private concerns children not because they are possessed by an adult, but because they possess both a private and a public sphere. In fact in modern Western societies children as well as adults are subjected to the law; they have some public obligations (e.g., to attend to school, to undergo to some medical preventive measures such as vaccinations), and

they are entitled with some civil rights (e.g., they cannot be batted, their modesty must be respected, they are requested to express their wishes in case of parents' divorce). The mere fact that these obligations and rights are very often guaranteed by an adult (parent, guardian, judge or anybody else) does not imply that they are no more "children's" obligations and rights, namely that it is matter of public rules that the community (the *polis*) apply to its citizens. In this paper we will assume this perspective.

Considering confidentiality in the particular field of child psychiatry, two main questions should be addressed; they both regard the definition of child's private sphere. The first concerns the information that has to be disclosed and protected: namely the nature of the medical secret. The second regards those persons who should be included in the child's private sphere. Overturning the view according to which children are part of an adult's privacy, the question that might be posed is: "which adults can be considered part of a child's privacy?"

Medical information and child's secrets

In child psychiatry we must deal with several secrets. The first one is the very secret of the childhood. The child in itself is something of mysterious for adults. In Western culture - since Dionysus to the child Jesus - people have felt that an inner, sacred, secret is kept in the first ages of the life. (4) The image of the "divine child" has always been taken as a symbol of a time renewal, of a cyclic regeneration (it is just to mention that Christmas coincides with an old pagan feast devoted to the Sun). Nevertheless this image also possesses some perturbing aspects, as it is clearly revealed by the myth of the child Dionysus torn up by Titans while he was playing with his toys (and many books have been written around the symbolism of these toys, a mirror, a circle, and a top).

Undoubtedly there are some features of child's mental life that can be felt as *unheimliche* by adults: e.g. the use of different kind of logic, the refusal of a linear time. (5) Moreover psychoanalysis suspects that the secret of childhood concerns child sexual and aggressive drives. There are no doubts that what we perceive as perturbing in childhood is somehow linked to the instinctual life but yet we

should avoid the risk of oversimplifying. The secret of childhood is perhaps more a poetic secret than a scientific one; there is a sort of a hidden core in childhood that should be preserved. Perhaps it is the capacity to feel a naive and joyful astonishment before the world, as stated by an Italian poet, Giovanni Pascoli. It is very important that the doctor does not disclose this secret, namely that he/she does not face child's internal world with the aim to turn it into a "normal" adult mental world. Child psychiatrists should pay a great deal of attention not to confuse child's use of multiple and non-Aristotelian logic, child's fantasies and dreams, with psychological symptoms. In particular a good psychotherapy should get the child more available to confront his/her mental contents with the reality without impairing the richness of child's mental life.

A second group of secrets that we have to face in child psychiatry concerns family secrets. It has been said that any family has been built around some secrets. It is likely to be true, at least in the sense that any family has some constitutive secrets that shape its inner structure. These secrets should be - at least in part - unveiled during a psychotherapy since they are very often an important causal agent of child's disturbs. From a therapeutic perspective family secrets are those secrets that a child should learn to understand. Say, a child might need to understand that his/her father feels a sense of inadequacy toward his wife and for this reason tends to react aggressively to certain remarks. As a consequence some paternal behaviours will become less incomprehensible for the child and he/she could learn to cope with them.

However it is to note that not all family secrets are purely emotional, i.e. concerning the relationship within the family. Sometimes there are true secrets (previous divorces, abortions, cases of abuse, petty offences or even crimes committed by one or the two members of the parental couple). Sometimes these secrets directly regard the child (e.g., the child was conceived for economical reasons, or the child was not wanted and the mother tried to abort him/her, or child's name is the same name of a previous dead sibling). In all these cases it might happen that the therapist comes to know

the secret through the parents or one of the parents. Since the information is confidential, is the doctor entitled to disclose it to the child? Perhaps a so posed question is disguising. In fact it is very rare that the alternative is so sharp. Usually psychotherapists can manoeuvre in way that the child may arrive to understand the secret (or that part of the secret that really matters for the treatment) without explicitly breaking parents confidentiality.

A third group of secrets directly concerns the child. Any child has his/her inner mental, emotional, and private life. Even if any family can be considered as a system, any child is also an individual with his/her secrets, namely information that he/she needs to communicate to the doctor but he/she does not want to be known by others. Here the matter is rather simple, since it does not differ from the general medical practice. To respect child privacy is an ethical commitment for any therapist. In particular there are no clinical reason to disclose information to parents without the child's informed consent, as it has been stated also by the *Principles of Practice of Child Psychiatry* adopted by the American Academy of Child Psychiatry Code of Ethics*. Anyway, when the disclosure of the information is needed with the aim to make the cure effective (say, the child pretends to take medications but actually he/she throws them away) the doctor should try to negotiate him/her consent, also using rewards and soft coercion, but substantially respecting child's will. I mean that when the therapist believes that some child's secrets should be communicate to a third party, he/she should try to negotiate the child's (informed) consent before any disclosure. A puzzling issue is obviously that of abused and neglected children. Very often to breach child's confidence is required by law or by the need to preserve the child or other children by later injuries. These are typical ethical dilemmas that cannot be solved theoretically but need to be discussed case by case.

* A child or adolescent and the family may expect the Child Psychiatrist to [...] protect specific confidences of the child or adolescent and the parents or guardians and other involved, unless this course would involve untenable risks or jeopardise care-taking responsibility (Am. Academ. Child. Psych. May 16, 1982)

A fourth group of secrets concerns the child-therapist relationship, namely they are the secrets of the treatment, things that happen and are told during the psychotherapy. Very often parents feel envy towards these secrets and try to unravel them. Since it is matter of secrets shared by both the child and the therapist, they should decide together whether and when disclose them to child's parents or other third entities. It is important to emphasize that the mental disturbed child often comes from an intrusive family, where he/she has not his/her own privacy. One of the therapy goals should be that of creating a child's private sphere. In that case the therapy in itself should become part of child privacy and the psychiatrist should defend the therapy from any external intrusion.

Who makes part of the child's private sphere?

Eventually, one last point should be considered. When we speak about families, we are not speaking only of the traditional family but, more and more, of new kind of families: step-families, reconstructed families, mononuclear families, families made by homosexual couples. This poses new ethical questions since the system children/family has changed. For instance one can pose the question about the step-parent's right to participate to child's life, or whether a child with a single parent is entitled to know the reason why his/her father/mother divorced or never married.

Generally speaking questions posed by new family structures imply the need to define the persons who are part of child's private sphere. In the past, private and family used to coincide but it is no longer possible to believe that persons have a deeper relationship since they simply belong to a same family. Perhaps, in an era of social changes such as the present, we need to give an operational definition of "private relationships" avoiding any legal and bureaucratic definition based on formal family structures.

Conclusion

Even if it is clear that further discussion is needed to clarify the issue of confidentiality in child psychiatry, some conclusion can be drawn all the same.

First of all, it is unquestionable that a child is a patient carrying the same rights of an adult. As a consequence those guarantees given by most ethical and medical codes on confidentiality in the doctor/patient relationship are thoroughly in force also in childhood. In particular in child psychiatry, doctors and all care givers should be kept to a strict respect of confidentiality in accordance to general rules affirmed by the main international ethical and medical codes. In no case children can be less protected than adults in epidemiological studies and anonymity should be kept in publishing clinical cases as far as possible.

Second, in child psychiatry the relationship with child's family is critical: parents and relatives are not always the more adequate subjects to be informed about what the child confidentially told to the therapist. Moreover a serious problem arises when one tries to define boundaries of child's private sphere. Even if the child is definitely entitled with the same right to privacy than an adult, it is more difficult to understand the complex nature of child's privacy. It implies that we cannot be sure about what is felt by the child as belonging to his/her privacy and what not. The need to respect child's feeling of modesty, even if it appears to be different from that of an adult, is a good example of this point.

Third, beyond any juridical formalism, it is recommendable always to search child's consent before any disclosure of information and to respect his/her will to keep confidential his/her communications, except in case of very relevant clinical or legal reasons. Even in these cases doctor should always try to negotiate children's consent before any breach of confidentiality.

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