Sex, drugs, and rock n' roll (…and social media, self-harm, and high risk behavior): Ethical challenges while working with adolescents

Greg Snyder, Ph.D.
Supervising Psychologist, Research Director
Boys Town Center for Behavioral Health Outpatient Clinic
Assistant Clinical Professor, Creighton University SoM, Department of Psychiatry
May 17th, 2018

Disclosures

- None

Outline & Themes

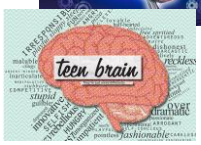
- Inform about my current training model
- Identify topical areas of interest and applicability to adolescent treatment
  - The examples are quite real, from my cases (disguised and anonymous)
- Provide guidance on decision making and invite participation
- Use professional and personal values to aid:
  - Identified actions
  - Evaluating effects
  - Navigate a chosen course

Decision Making

- Missing the forest for each individual tree (codes vs. spirit)
- What we face is often more challenging
  - Comparing relative ethicality
- Determining the type of Problem (Behnke, APA)
  - Ethical
  - Legal
  - Clinical
  - Risk Management

Unique Challenges: Adolescent Treatment

- Involvement of both children/adolescents and parents potential for conflicts
  - Treatment Consent & Treatment Goals
  - Confidentiality
    - Maximizing trust of the adolescent and adults/parents
    - Bad decisions (i.e., "Rationality in Absentia Disorder or RAD") vs. Imminent risk
    - Adolescent specific or family specific topics
    - Imminent risk of harm (self or others) and abuse
- When should you anticipate these issues?



Evaluation Relative Ethicality (Clinical)

- Exercise for trainees when confronted with problems
- How does our decision affect:
  - Autonomy of the adolescent
  - Integrity of the family unit/structure
  - Justice and uniform treatment across clients
  - Identifying and protecting from harm
  - Maintaining the integrity of the adolescent, family, and therapeutic relationship

	Likely Positive Outcomes	Likely Negative Outcomes
Option 1	1. 2. 3.	1. 2. 3.
Option 2	1. 2. 3.	1. 2. 3.

Treatment and Consent Challenges

The Unwilling Client

- A.R., a 13 year old European American female was referred to your care by a colleague who had previously worked with both parents (during couples counseling) and later individual therapy with one of the partners. Presenting issues include high conflict relationship with the father (who is the one that requested services). You talk with A.R.'s mother who provides consent and acknowledges the strain present in the father-child relationship, and reluctantly agrees to have the daughter work with you and the father. During the initial meeting, A.R. presents as generally resistant, and intentionally silent during conjoint portions of meetings, and after some cajoling and rapport building moves to two word responses and occasional smiles with the clinician. She reports tremendous dislike for her father, and also reports having no desire to be present in session, with or without her father. She is generally performing well in school, maintains good relationships with adults (besides father), interactive and engaged in outside activities.

Process

- What should I do?
- What are some alternatives that would be ethically appropriate?
- How do these affect the client, clinically?

Therapy and Consent

- Who is consenting, what are they consenting to
- Willingness to participate
  - What about the "unwilling client"?
- Willingness differences between client and family
  - Willingness weighted against current socioemotional wellbeing, strengths, and current functioning

	Likely Positive Outcomes	Likely Negative Outcomes
Option 1: **Discontinue treatment – encourage parent to work on relationship through individual therapy**	1. Increase power and establish sense of control 2. More likely to return if needed. 3. Sources of resilience and strength remain unchanged 4. Receive more credibility with other parent	1. No change in relationship. 2. Maintained or increased p-c conflict. 3. Hurt relationship with presenting parent
Option 2: **Continue scheduling – either individual or family sessions**	1. Potential (but unlikely) gain of rapport. 2. Identifying parent behavior that could improve motivation	1. Increase tx resistance 2. Make therapy punishing event 3. No change in parent-child conflict

Consent and Co-parenting

- You receive a telephone call from a father to initiate services for his teenage son. Primary issues were reported during the phone call include his emotional adjustment in coping with his parents' divorce. During the phone conversation, the father expresses concern about his son's current therapist, as well as his ex-wife's behavior. He reports that his son has been working with a therapist for 3 years at the request of his mother, and indicates that the therapist is going to be testifying in court in an upcoming custody dispute. The father reports to you that he is felt uncomfortable with the current treating therapist, and reports that his son has also voiced similar concerns with him, but has yet to share this concern with his mother. Father reports being largely uninvolved in the care or treatment that the son is currently receiving from the current therapist. He is requesting you to do an initial evaluation and establish care. He reported that the current custody arrangement provides for the father being the primary physical custodian, and he and his ex-wife share legal custody of both the son and his younger brother.

Confidentiality

Confidentiality in treatment with adolescents

- Who is the patient
  - HIPPA
  - Legal guardians/parents
- Know your state laws and regulations
  - Reporting requirements
  - Statutory definitions
- Be consistent (Justice)
  - Mandatory, morally, or legally shared information
  - Rehearse and feedback

Confidentiality and Co-parenting

- Parent who maintains legal custody
- Any/either parent can initiate services – BUT…..
- Suggestions at intake
  - Having office clarify married/divorced
  - If divorced, have copy of parenting plan at intake
  - Obtaining numbers and contact information for both parents
  - Requiring both parents to be present at the initial intake
  - Discussion of confidentiality, privacy and communication with the adolescent and family
  - Clarify and obtain explicit consent from both about non-parent involvement

Confidentiality & Adolescent Decision Making

Social Media

Confidentiality and Social Media

- You are working with a 13-year-old female with presenting concerns that involve depressed mood, and somatic complaints/sympathetic arousal that appear to be preceded (partially) by social interaction in close friendships and romantic relationships (also - generalized worry, social anxiety & panic). For her 13th birthday, parents reportedly give her a brand-new iPhone 7 as a way for her to keep in contact with parents during their work hours (as their family doesn't have a landline) and as a recognition for her good grades. She is in the 7th grade, and many of her friends are using social media including Snapchat, Instagram, and most recently Kik. She maintains positive relationships with her family, though parents report that their daughter has been increasingly isolated in a room and spends a majority of each evening alone in a room with her phone and computer, and when asked about this, she reports often using YouTube to watch videos and surf the web. She presents at the session a bit more distressed than what is typically seen. During this interaction, she reports that she had been dating a young man in her class and the two had recently broken up. She also reported feeling increasingly nervous and anxious about what her ex-boyfriend will do, given that the relationship had ended because he discovered that she had been "cheating" on him with another boy at a nearby school. When asked about this, she reported that both she and the young man have sent multiple explicit pictures to each other that include nudity. She also acknowledges that the two were sexually active and she is unsure whether he had any photographs of their sexual activity outside of the pictures that she voluntarily took and sent to him during the overnight hours.

- Type(s) of problem?
- What should you do?
- How do these affect the client, clinically?

- For the professionals
  - Who has Facebook, Instagram, LinkedIn, Twitter, Tumblr, Snapchat (or ….)?
  - Who emails or texts?
  - Ethical risks
    - Parents, clients, other peripheral or collateral contacts

Confidentiality & Adolescent Decision Making

Suicidal behavior and Self-injurious behavior

Confidentiality and Risk to Others

- D. 14-year-old European-American male presenting with frequent disruptive and aggressive behavior in the home, poor academic performance, and impaired social functioning. Clinical interview information as well as past history is consistent with diagnoses of ADHD, ASD (Asperger's/High Functioning Autism), and ODD. Early in treatment, you worked with the family during a conflict D. had with peers on social media that escalated after his girlfriend publicly ended their relationship. During your session, he made specific, actionable physical threats to harm his ex-girlfriend by sneaking out of the house and at night (which he had done previously during their relationship to "hook up"), and "slit her throat". During his discussion with you, he talked in detail about how and when he would leave the home and how he would access his girlfriend's home/room. He has made multiple threats before – generally online through social media, and he has been suspended before following physical altercations with peers at school, typically after reactively responding to verbal harassment from peers. Parents have generally been inconsistent (at best) with implementation of any behavioral interventions in the home due to his tendency to get verbally combative.

- What would you do?
- Type(s) of problem
- How could you

Confidentiality & Adolescent Risk

- 16 y.o. male, referred initially regarding his parents' divorce with a history of ADHD. "High conflict divorce, parents prominent members of the community. Periodically suffered from increased depressive symptoms and was self-described as "an emotionally sensitive guy". Preforming adequately academically in a highly competitive college preparatory environment. Very intelligent and "legalistic", appearing to be between concrete and formal operations in appreciating abstraction. He always presented as pleasant, verbally sophisticated and very opinionated. This was similarly reported by parents and outside collateral reports. His "opinionated" side would get him into trouble on occasion at school during disagreements with teachers (not angry, but passionate, well articulated disagreements, but often didn't know when to stop). I had not seen for approximately 6 months, when his mother contacted me to schedule an appointment during the beginning of his sophomore year.

- Upon the meeting, reported to be acclimating well, even joining the school's lacrosse team. He reported a number of friendships, many of whom were carried over from his prior school (stability in friends, increased time socializing). He acknowledged struggling with his parents' divorce (1 year post decree), but had improved relationships with both parents. In January, he reported feeling a bit more depressed, but denied any suicidal ideation (as he had endorsed this in the past) and acknowledged some recent use of marijuana (after passing his yearly "random" drug test at school (requirement). In February, he presented to a session very angry about a recent disciplinary issue that erupted at school following a "tweet" he posted about a class retreat. We reviewed a plan to address his actions (similar to prior sessions) and he agreed to follow up with me the following week. I received a call one week later from his mother prior, indicating J.K. had another disciplinary incident occurred during a school assembly (involving pt and three friends, all of whom were caught vaping), following which he stormed out of school (uncharacteristic) and was unable to be found. His body was discovered outside of his old home (prior to the divorce) with his father's shotgun.

- You have been working with a 17-year-old male for issues related to his depressed mood and suicidality. He has a history of hospitalization on 2 separate occasions during the last 3 years. While he has no history of any suicidal attempts, he does report a history of self-injurious behavior (cutting). He has made improvements with you during the three months that you have worked together. He currently denies any active suicidal ideation, hopelessness, isolation, or change in activity. You review safety plans at each session and ensure that he continues to remain committed to follow through with these if suicidal ideation becomes more serious. He and his mother have a brief talk (per recommendation) each day to review mood, acknowledgement, and briefly assess suicidal ideation. He presents to you at a session and you notice him wearing long sleeves which is generally uncharacteristic of him especially during the summer months. When you ask further, he raises his sleeve to expose numerous new cuts in various stages of the healing process, some of which appear deep and serious.

- What would you do?
- Type of problem?
- How do you balance autonomy with risk of harm to your adolescent clients?
- Would client resistance change your answer?

- Differentiating between NSSI and suicide
- Growing connection between facets of NSSI and suicidal behavior
  - Females more than males
  - Not frequency, but variety/number of different forms with suicidal behavior
- Discussion of suicidal ideation, and suicide
- Navigated with family at the outset of treatment

Confidentiality and Abuse

- A.M. is a with a 15 year old male, who splits time (week on/week off) with mom/dad respectively. Presenting issues included depressed mood, defiance, poor academic achievement, in addition to frequent and intense family conflict (with both parents). While his father attended the initial meeting, he has been unavailable/refused to attend most follow-up treatment sessions. Family treatment sessions aimed at improving communication, problem solving and limit setting to address conflict and escalating pattern of parental coercive escalation. While conflict and physical aggression have decreased during time that A.M., he presents to an individual session quite distressed and reports that he and his father were physical with each other the day prior to your session. During the conversation, you learn that the two had become angry over the style/completeness of a chore (toilet bowl), and the resulting conflict resulted in both A. and his father becoming physical. He reported that his father threw him down to the floor after A. charged in anger toward his father. His father reacted by shoving A. against the wall, pinning A. to the floor, and holding onto his arms, while yelling back at his son. He subsequently contacted his mother to pick him up to leave his father's home. His mother also requested assistance to help figure out a plan to help the two while A. has parenting time with his father. You contact the father and request that he attend the upcoming therapy session.

- What should you do?
- What are the legal standards for child abuse in your state?
- What are your state's guidelines for reporting?
- How would reporting affect treatment?

Drug Use

A 17-year-old male presents to you following the pediatrician referral due to concerns surrounding his anxiety and depressed mood. He attends 2 sessions during which you initiate treatment to address coping and management of his anxiety and depressed mood. He fails to show for the two additional sessions that you had scheduled and fails to call to reschedule these appointments. Approximately 6 months later, the young man contacts you again, scheduling an appointment and reports escalating impairment associated with panic symptoms. During this meeting, as your conducting an interval history, you discover that during the 8 months prior to that appointment, and prior to your initial diagnostic interview, he reportedly began using stimulants that were given to him by a friend to help improve his basketball performance. Per his report, he indicated that as the use of stimulants increased, he noticed concurrent escalation in his physiological arousal and anxiety. He then sought out benzodiazepines from friends, in the form of Xanax, to begin coping with the side effects associated with his inappropriate stimulant use. He acknowledges that he is had difficulty stopping use of benzodiazepines, despite having stopped in total his use of stimulants. His pediatrician, with whom you work quite closely, is unaware of this, and believes that the young man is suffering from depression. He reported that his mother is unaware of the history that he has just reported to you.

Drug Use and Teens

- Primary vs. secondary substance use disorder diagnoses important
  - CFR Standards
- Use during adolescence is quite common
- Parents often unaware of any use
  - Use can often be a factor in creating impairment

	8th Graders	10th Grade	12th Grade
	2017	2017	2017
Alcohol (lifetime)	23.1	42.2	61.5
Alcohol (Past Year)	18.2	37.7	55.7
Alcohol (Past Month)	8	19.7	33.2
Cigarettes (Lifetime)	9.4	15.9	26.6
Cigarettes (Past month)	[1.90]	5	9.7
Illicit Drugs (Lifetime)	18.2	34.3	48.9
Illicit Drugs (Past Year)	12.9	27.8	39.9
Illicit Drugs (Past Month)	7	17.2	24.9

** Data from the Monitoring the future (National Institute of Drug Abuse National Longitudinal Survey, 2017)

- What would you do?
- Legal, ethical, clinical or risk management?
- What would be the steps you would take during/after the session?
- What are the aspirational principles at odds?

You are working as a primary supervisor. During supervision sessions, your trainee has voiced concern about a parent's functional status and possible intoxication during the recent two sessions that they have had together with the family. He reports to you that the mother has arrived at the last two sessions smelling strongly of marijuana, and has often required him to repeat or restate things during session because she is off task or was unable to grasp what was being said. Her son, who is placed in a residential group home, has a prior history of drug use and problematic behavior at home. You are concerned about the safety of his mother, as she travels over 75 miles in order to be present at sessions, and she arrives at the most recent session again smelling strongly of marijuana. Your trainee has on at least one occasion discussed the issue of being sober at sessions, and has made it a requirement for both the adolescent and the mother to be sober and present at family therapy.

- What should you do as a supervisor?
- Legal, ethical, clinical or risk management?
- What would be the steps you would take during/after the session?

Parental Drug/Alcohol Use

- Setting limits during therapy and throughout treatment
- Sober, safe and engaged
- Concerns and how to address it
  - Ending family therapy sessions
  - Transportation
  - Police involvement

Conclusions

- Therapeutic intervention inherently more challenging when working with adolescent conduct
- Up front work, however tedious, is incredibly valuable
- Ethical practice needs to consider and weigh
  - Adolescent autonomy
  - Safety (Nonmalfesience)
  - Justice
    - And circumstances can radically shift importance
- Know the law and reporting standards in your state