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## Informed Consent with Children: Ethical and Practical Implications

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### ABSTRACT

This paper discusses ideas of informed consent as they apply to working with children. In general, counselling has accepted the view that each person has the right to control his/her own life; however, this right has traditionally been reserved for adults. This paper focuses on how counsellors can deal with issues of consent with children. Suggestions are made for improving the consent process with children in everyday practice.

### RÉSUMÉ

Cet article analyse les différentes idées sur le consentement éclairé tel qu'il s'applique au travail avec les enfants. En général, la psychologie a admis l'opinion que chaque individu possède le droit de contrôler sa propre vie. Ce droit était, cependant, réservé traditionnellement aux adultes. Cet article se concentre principalement sur les façons dont les psychologues peuvent traiter les questions de consentement telles qu'elles se présentent avec les enfants. Des suggestions sont offertes pour améliorer les procédures de consentement des enfants dans la pratique courante.

Informed consent of the client is an ongoing concern of counsellors, and one that is carefully considered in working with adults. As counselling moves toward an increasingly collaborative view in which counselling is a mutually respectful relationship with the client and counsellor working towards a shared goal, these concerns increase. Little attention has been paid, however, to addressing informed consent with children and adolescents. This paper will consider how informed consent issues have developed concerning children, and will provide some important considerations to heed in working with this population. The terms 'child' or 'children' will include both children and adolescents, unless adolescents are specified.

The relevant historical and philosophical underpinnings of informed consent will be briefly traced to enhance an understanding of views and practices surrounding informed consent. The current status of informed consent with children will be examined to highlight the complexity of the issue when applied to clinical practice. Based on our assessment of current thinking, recommendations for practice will be given.

Guidelines regarding the client-therapist relationship were generally developed from a paternalist medical model in which the physician decided what was in the

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patient/client's best interests to know (Faden & Beauchamp, 1986). This beneficence model allowed the balance of decision-making power to rest with the physician rather than the patient. Paternalism is shown in the following practices: (a) the client is provided with only the information that the practitioner deems necessary (Crowhurst & Dobson, 1993); (b) obtaining informed consent is considered a mundane duty to slog through before beginning the "real work" of therapy (Tymchuk, 1997); and (c) client knowledge and awareness of the treatment process will necessarily impede therapy (Sullivan, Martin, & Handelsman, 1993).

In general, counselling goals include increasing individual independence and lessening emotional distress (Crowhurst & Dobson, 1993). Thus, paternalistic attitudes have been replaced in ethical counselling practice by a more collaborative approach that is commensurate with fostering client independence. Obtaining informed consent is now viewed as an important mechanism for ensuring that individual autonomy is respected. As Morrissey, Hofmann, & Thrope (1986) note: "The doctrine of informed consent finds its roots in the most fundamental and basic rights of free people: the inviolability of the human body and the right of a person to exercise complete dominion over his or her own person" (p. 13). Informed consent is predicated on the belief that individual autonomy is a moral imperative and is respected and fostered in North American society (Gustafson, McNamara, & Jensen, 1994). While this paper maintains an individualist focus, it does not preclude consideration of familial, societal and cultural influences.

The acceptance of the principles underlying informed consent has significant ethical and practical implications for practitioners and clients. Of particular note is the aspect of informing for consent. Often decisions of a psychological nature require information that may not be readily available to all people. The responsibility placed on the counsellor shifts from making decisions for the client to a collaborative orientation in which the client is provided all necessary information to make an informed decision. Thus, the counsellor's role becomes one of responsibly enabling another to make a careful, considered decision.

The prevailing legal standard is the "reasonable practitioner" model in which the counsellor can be held accountable to what the courts decide a "reasonable" practitioner would do (Crowhurst & Dobson, 1993; Jensen, McNamara, & Gustafson, 1991). However, it is difficult to precisely spell out legal decisions made regarding informed consent as the meaning of truly informing for consent continues to evolve in its practical application. Common law, unwritten law based upon custom or court decision, strongly influences our understanding and application of informed consent issues as there is limited statutory law which legislate the process of obtaining informed consent. Each practitioner needs to determine the specific codes and doctrines relevant to his/her area of practice, both geographic and specialization. In addition to being familiar with appropriate provincial legislation, practitioners can refer to the following articles for further information in legal matters: Crowhurst & Dobson, 1993; Hesson, Bakal, & Dobson, 1993; *J. S. C. v. Wren*, 1987; Lawrence & Robinson Kurpius, 2000; Tymchuk, 1997.

Informed consent has developed from the view that people are competent to make decisions regarding their own person. It is important that the consent obtained is truly informed; however, it should be acknowledged that obtaining informed consent can at times be challenging. The struggle that occurs from fully respecting each individual's right to make decisions is highlighted in the complexity of engaging in consent practices with children.

Consent is understood as having three necessary components: a demonstrated competence for decision making, voluntariness, and understanding (Croxtton, Churchill, & Fellin, 1988; Tymchuk, 1997). Competence is defined as the *ability to decide* whether or not to participate in treatment, to withdraw or continue during the process of treatment, and to make these choices known in an understandable way. A voluntary decision must be made in the absence of coercion, either implied or actual. The final element, understanding, is the person's degree of discernment regarding the process and ramifications of the treatment being presented. Assessing another person's understanding can be difficult, as issues such as language, culture, and cognitive or emotional development are relevant.

For consent to be considered informed, Tymchuk (1997) indicates four additional criteria: an indication of choice, the reasonableness of the choice made within the circumstances, adequate understanding, and adherence to a decision-making process that minimally includes evaluation of risks and benefits of the treatment process. Similarly, Croxtton et al. (1988) indicate the need for knowledge defined as a "full explanation of the potential risks and benefits of the proposed procedures along with the exploration of alternative means of intervention" (p. 5). In order to ensure informed consent has been obtained, the counselor needs to be certain of two important factors: a) that the information regarding the proposed treatment and all viable alternatives has been fully presented and b) that the client has indeed understood this information. Ensuring that the consent obtained is truly informed can become a complex and lengthy assessment task.

### *Applicability to Children*

Traditionally, children have not been granted autonomy because it has been assumed that they are not competent to make decisions regarding their own person. While adults are presumed competent, children are required to prove competence as age is used as an arbitrary condition for consent (Levine, Anderson, Ferretti, & Steinberg, 1993). Specific questions have been raised about children's abilities to understand what they are agreeing to, including possible future consequences. It has been argued that children have limited cognitive understanding and a lack of experience (Powell & Vacha-Haase, 1994), both of which are necessary to make sound decisions. Granting rights of consent to children therefore becomes a developmental issue. Additionally, children are socialized to respect and obey adults. As many children have difficulty refusing or questioning a request made by an adult (Belter & Grisso, 1984; Gustafson & McNamara, 1987), the voluntary nature of informed consent becomes suspect. While these concerns are certainly understandable and have not been taken lightly in research to date

(Belter & Grisso, 1984; Dorn, Susman, & Fletcher, 1995; Melton, Koocher, & Saks, 1983), some researchers and new perspectives of counselling are beginning to question these assumptions.

Researchers have looked at children of various ages, examining processes of decision making in comparison to adults. Adelman, Lusk, Alvarez, & Acosta (1985) indicate that minors with learning and behaviour problems can understand, evaluate, communicate, and perform at a competent level regarding questions about possible interventions. Their results indicated that minors were interested in participating in decisions that affect them and felt satisfied with their contributions. As well, it was noted that a child's ability to make competent decisions may be enhanced through training, so a child's current measured ability level may not be his/her optimal ability level.

Kaser-Boyd, Adelman, & Taylor (1985) compared young persons' abilities to list potential risks and benefits of entering therapy. The results indicated a positive relationship between age and the ability to think about therapy in an abstract way. However, even young children were able to identify concerns that were practical, relevant, and appropriate to their situation. Belter & Grisso (1984) demonstrated that the capacity for an adolescent to comprehend and protect his/her rights was not significantly different between ages 15 and 21. This "suggests that by age 15, the average adolescent is fully capable of comprehending and exercising his or her rights" (p. 899). There is a growing body of research indicating that adolescents in particular are developmentally mature enough to make well-informed decisions about receiving counselling and that minors in general can effectively participate in treatment decisions (Gustafson & McNamara, 1987; Hesson, Bakal, & Dobson, 1993).

While children, especially adolescents, may be more competent than generally assumed, practitioners should not immediately consider all children to be capable of making treatment decisions. Through the work of persons like Piaget, Kohlberg, and Gilligan (Craig, 1996), an appreciation has been acquired for cognitive and moral developmental stages. However, each child is unique. It cannot be assumed that the child's developmental stage matches their particular age range (Group for the Advancement of Psychiatry, 1989), as there are too many variables in a child's life to make assumptions of this nature without appropriate assessment. Some children may be competent to make important decisions but are currently not permitted to do so.

The discussion of consent to psychological treatment must include consideration of involvement of parents/guardians. Parents bear responsibility for their child's well-being and it is presumed that they will act in the best interests of their child (Walsh-Sukys & Krug, 1997; Hesson et al., 1993). Assuming this responsibility, there has not been reason to question the parent's right to consent for the child. Obtaining informed consent from the parent/guardian is usually a requirement before beginning treatment with a child. This assumption of proxy consent speaks to the value that society places on the family (Gaylin & Macklin, 1982). However, when the parent does not appear to be acting in the child's best interest

or the parent and child disagree about the best course of action, the counsellor is faced with a dilemma about how to proceed.

Surprisingly, in Canada, there is no specific legislation denying children the right to consent; however under the age of 15, they are generally not assumed to be competent to do so (Crowhurst & Dobson, 1993). Although various ethical codes have implicit assumptions that children are not capable of providing informed consent (Canadian Psychological Association, 1992; Canadian Counselling Association, 1999), it appears that common law does not necessarily support this assumption (*J. S. C. v. Wren*, 1987). Crowhurst and Dobson (1993) refer to an 'age of discretion' in which the child is permitted to make his/her own decisions when they are deemed to have sufficient reasoning and understanding. Whether the child has sufficient understanding and reasoning skills is determined in a case-by-case assessment. Additionally, there appears to be little recourse for a child if the parent authorizes a treatment in which the child does not wish to participate (Melton, Koocher, & Saks, 1983).

Four areas in Canadian law recognize a general exception to the requirement of parental consent. The first is the "mature minor" doctrine which permits a minor to consent to treatment independently if he or she is of sufficient maturity or intelligence to understand the nature and consequences of treatment (Morrissey et al., 1986; Gustafson & McNamara, 1987). This exception requires the child to prove competence. The second, the "emancipated minor" doctrine, refers to minors who are legally entitled to rights and duties of adulthood as outlined in legislation (for example, a married minor). Emergency treatment is the third exception as parental consent is assumed due to the urgency of the situation. Treatment ordered by the court is the final exception in which both the minor's ability to consent and the ability of his or her parent to consent is overridden (Gustafson & McNamara, 1987). Of these four exceptions, two give the right of consent to the child, and two remove the right of consent from both parent/guardian and child. Seemingly minors have been granted the right to make decisions in some areas but are still considered incompetent overall.

### *Canadian Codes of Ethics*

Johnson, Cournoyer, & Bond (1995) point out that ethical codes work to provide normative standards for practice by allowing or encouraging some behaviours and disallowing others. As a normative guide it is important that the philosophical underpinnings that guide ethical code development are in harmony with the goals of counselling and current societal beliefs.

In 1999, the Canadian Counselling Association published an updated code of ethics that serves as a guide for many counsellors working within Canada. Within this code there is a brief discussion regarding informed consent which indicates that clients are to be informed of the "purposes, goals, techniques, procedures, limitations, potential risks and benefits of services performed and other such pertinent information" (p. 5). The code further specifies that counsellors need to ensure clients understand the various ramifications of counselling.

As well, there is a further section in reference specifically to children and persons with diminished capacity. This section states:

Counsellors conduct the informed consent process with those legally appropriate to give consent when counselling, assessing, and having as research subjects children and / or persons with diminished capacity. These clients also give consent to such services or involvement commensurate with their capacity to do so (p. 5-6).

This statement, while addressing issues of children, is in fact vaguely worded and possibly misleading. While this code does not cite a specific age that defines children, there is an implication that up to the age of adulthood the parent or legal guardian is required to give the formal consent. Provincial statutory law typically defines an adult as 18 or 19 years old, meaning that persons at this age are competent and have the right of self-determination. Confusion creeps in because common or case law decisions typically demonstrate a realization that persons much younger can also provide competent consent (Bersoff, 1982; Hesson et al., 1993; *J. S. C. v. Wren*, 1987). Therefore, strict adherence to statutory law limitations in our ethical codes is not only counter to common law decisions, but can result in disallowing a youthful client the respect and autonomy that is potentially deserved. The final statement in the code that indicates that the client can give assent to treatment alongside their guardian's consent in fact does little to ensure the young client is treated respectfully and appropriately. Finally, the code is rather unclear in directing counsellors in the implementation of the process of gaining informed consent.

In the current Canadian Code of Ethics for Psychologists (Canadian Psychological Association [CPA], 1992), informed consent falls under the rubric of the first and most important ethical principle, Respect for the Dignity of Persons. Within this principle, nine sections deal directly with informed consent, with a further section specific to vulnerable clients in which children are included.

The counsellor's duty to "avoid or refuse to participate in practices disrespectful of the legal, civil, or moral rights of others" and to "not practice, condone, facilitate, or collaborate with any form of unjust discrimination" (CPA, 1992, p. 29) highlights the responsibility to respect the autonomy of each client. If the child is indeed competent to consent to treatment, to discriminate against the child based on age is a questionable practice. However, Principle I, section 29 states that if a person is not legally responsible, informed consent should be sought from the legally appointed guardian. Additionally, Principle I, section 30 indicates that informed consent is to be sought of those of "diminished capacity" (which would include most children by current standards), and if assent is not given, the treatment can only proceed if it will be of direct benefit to the person. Crowhurst & Dobson (1993) question the standard practice of directly linking diminished capacity to age. Overall, the code indicates that decision makers need to be very careful in their assessment of the child's capacity and their assessment of what will be beneficial to the child.

The practitioner has a clear responsibility to assess the child's ability to give an informed consent to treatment (Arambula, DeKraai, & Sales, 1993). If they fail to assess the child and incorrectly assume a lack of competence, that child is not

being respected. If the counsellor accepts an informed consent from a child not competent to give it without involvement from parents/guardians, they are not acting in the best interests of the child. Legally, the practitioner can be held accountable for allowing a child to consent to treatment, if the child does not actually have the capacity to do so (Hesson et al., 1993). Thus, it is apparent that there is a clear need for careful assessment of the child's competence. Although informed consent in general is given significant attention in the Canadian Code of Ethics for Psychologists (1992), it has been criticized as "somewhat vague with respect to standards regarding children, parents and consent" (Hesson et al., 1993, p. 325). These criticisms could also be applied to the CCA code of ethics (1999). The suggestion made by Hesson et al. (1993) is that the Code be revised to recognize the specific conditions under which children should be "granted full rights of self-determination" (p. 326). If the codes were clarified in this manner, the duty of practitioners would be more straightforward. As well, children would have a greater assurance of being treated in a similar manner regardless of where they are receiving treatment. As Hesson et al. (1993) state: "If we are to respect our minor clients' basic rights, ethical guidelines must be developed that reflect their potential for autonomy" (p. 326).

### *Implications for Practice*

The preceding information regarding informed consent stimulates curiosity about how current procedures with children can be improved. Just as counsellors encourage their clients to change, grow, and try new ways of being, so too should therapists be open to change and growth. As understanding of child processes increases, standards of practice need to consistently reflect this knowledge.

It has been argued that informed consent based on principles encouraged in counselling may be helpful to therapy (Crowhurst & Dobson, 1993), or at a minimum will not harm or impede good therapy (Sullivan et al., 1993). When adolescents are involved in planning and evaluating their treatment, they seem to have a more positive response (Janzen & Love, 1977 as cited in Gustafson & McNamara, 1987). If a child is involved in and assents to the treatment plan, it is reasonable to expect that the child will be more motivated to participate in treatment and more likely to have a positive outcome (Fennell, 1996). Levine et al. (1993) suggest that while it is currently unclear what therapists actually tell children, those who are prepared for therapy are less likely to terminate prematurely and are rated by therapists as less "disturbed." As well, informed consent encourages open and honest communication that may enhance the therapeutic relationship. As the relationship has been shown to be crucial to outcome (Bordin, 1994), the consent process becomes an important component of the therapeutic treatment.

### *Assessment*

Assessing a child's ability to give informed consent is a complex task that must be completed at the onset of the therapeutic process. The assessment needs to occur on a case-by-case basis, in which the practitioner is flexible and responsive to the indi-

vidual child. While a lengthy, complex, and formal assessment is not appropriate, there are steps the practitioner can take to ensure that a careful, thorough assessment is conducted while remaining mindful of the basic aspects of informed consent: competence for decision making, voluntariness, and understanding. The purpose of the assessment is to determine whether or not the child has the capacity to engage in an informed consent process. The assessment can be accomplished through an extended discussion in which the process of and intent of counselling are considered and to which both client and counsellor contribute.

Possible questions that can be used to encourage discussion include: What do you expect to have happen here? How do you understand the issue that brought you here? What do you hope to gain from counselling? What do your parents know about this issue? Do your parents know that you are here? If no, why not? Is there a way that your parents can be helpful or involved in solving this problem? What are the benefits of being here? What are the drawbacks? Was counselling your idea, or did somebody suggest it to you? How did you decide that counselling might be helpful with this issue? These kinds of questions will enable the child to begin to inform the practitioner about his/her capacity to understand and make reasonable decisions regarding engagement in the counselling process. In addition, through discussion and exploration of the child's answers, the counsellor is able to provide accurate information concerning goals and tasks achievable in counselling. Clearly, rather than lecturing a child, this discussion needs to include a give and take of information in which the child demonstrates their understanding of the information using their own words.

Throughout this discussion, it is the counsellor's task to be assessing the child. The purpose of the discussion is twofold: to provide information and to assess the child's ability to give informed consent. Guidelines suggest that the conditions for assessment have been satisfied when the practitioner is confident that the child has been given and understood all necessary information, including the reasonable benefits and risks of the proposed treatment (Wuester & Wuester Milne, 1998). To this end, it is imperative to maintain detailed and comprehensive case notes regarding these discussions. By keeping in mind the three keys of consent the counsellor can demonstrate that his/her assessment of the child has been thorough and meets the standard for reasonable practice. Once a decision has been made regarding the child's capacity to give informed consent, the therapist needs to ensure that the child is fully informed and provides consent. It seems clear that children fare better when they are approached in an honest, understandable, and clear manner.

A typical informed consent presentation consists of "discussion of goals, methods, and concomitant benefits and risks of psychotherapy, as well as possible alternatives to proposed treatment" (Jensen et al., 1991, p. 161). Although the counsellor is likely to have already covered much of this information in their prior assessment, it needs to be clearly spelled out to the child. While practitioners have an ethical responsibility to develop and use informed consent procedures (CPA, 1992; CCA, 1999), guidelines regarding required content of informed consent discussions are less clear (Jensen et al., 1991). Obtaining informed con-



sent is usually demonstrated by having the client sign an informed consent form. Often the readability is poor, which can interfere with understanding (Somberg, Stone, & Claiborn, 1993), and there is no accommodation made for personal variables. In general, it appears that current practices surrounding informed consent are often of the rubber stamp variety, and are clearly adult-oriented.

While some children may be able to fulfill the requirements of informed consent, not all will be able to do so. Advocating that informed consent be sought from all children without regard to concerns of parents/guardians would not be beneficial for the children or the parents, particularly since therapy with children is often more effective if the parents are supportive (Weisz, Huey, & Weersing, 1998). Due to those concerns, an alternative often preferred when working with children is the concept of 'assent.' To assent to treatment indicates that the child is provided with as much information as he/she is judged to be capable of absorbing (Towbin, 1995). The parent/guardian is still required to give the legally binding consent but the goal of assent is to involve the child as much as possible in the treatment process (Walsh-Sukys & Krug, 1997). This way of working with children who are evaluated as not able to give informed consent maintains a respectful stance toward the child. Just as informed consent implies the right to withdraw at any time (Goldberg, 1997), so assent implies the right to dissent. However, this right to dissent is often complicated in the counselling setting where the child may be mandated by the court or forced by parents/guardians to attend counselling. Just as children are not always able to refuse treatment, so too can the child's right to dissent be negated.

Within the discussion of consent and assent, there are a number of approaches that can easily be incorporated into standard practice with children. One idea of merit that suggests a positive way in which child, parent/guardian, and therapist can work in a cooperative manner is the signed service agreement discussed by Gustafson & McNamara (1987). The counsellor meets with the parents/guardians along with the individual child prior to beginning treatment in order to discuss confidentiality and treatment conditions. Upon reaching an understanding and agreement from all involved parties, a professional services agreement is drawn up, signed, and placed in the file. In this way parental involvement is encouraged and a shared understanding can be reached in a positive, collaborative manner. There is much discussion surrounding ways to increase parental consent, both in therapy and research; however, as this is beyond the scope of this paper, the reader is referred to Ellickson & Hawes (1989), Gustafson et al. (1994), Iverson & Cook (1994), and Johnson et al. (1995).

Towbin (1995) suggests that time be made during each visit for the child to ask questions or voice concerns regarding the process of treatment. The counsellor needs to be patient and open in order for the child to feel comfortable with asking questions. This is a type of ongoing assent, in which the child can continually "check in" to clarify any outstanding issues the child may have. Similar to this is the idea proposed by Hesson et al. (1993) in which consent is gained from the child in as many areas as the child is competent to consent to which is a respectful position toward the child.

In discussing the concept of informing *for* consent, Tymchuk (1997) has a number of helpful suggestions for the counsellor interested in encouraging autonomy in children. Suggestions are provided for a wide variety of strategies that can be employed to assess understanding and decision-making skills. Often informed consent forms are written using small fonts and complex words that are difficult for children to understand. Rewording using terms that are clear and understandable as well as presenting information in a variety of ways such as illustrations or video tape role plays facilitates the child's understanding. As well, the discussion of informed consent can be enhanced by teaching decision-making skills (Adelman et al., 1985). Tymchuk's (1997) informing for consent model is predicated on the idea that the informed consent procedure should be individualized. A standard informed consent procedure, while perhaps appearing to ease the therapist's work load, may not address the developmentally appropriate issues of the child. Therapeutic progress may be diminished as young clients who are not informed effectively may not respond as well to therapy.

Along with these valuable guidelines for practice from the literature, the following examples present alternative ways of informing children about counselling.

### *Respecting Children In Counselling*

Children are allowed to: (a) ask any questions about what is happening in therapy, at anytime, (b) know what their counsellor is planning to do, (c) have opinions, (d) speak up when decisions are being made, (e) disagree with their counsellor (and not feel bad about it), (f) refuse to do something if they think it might hurt them, (g) make mistakes, (h) have feelings, (i)\_\_\_\_\_.

The suggestions to enhance respect for children in counselling can be presented to each child upon initiation of therapy. Leaving a few blank lines enables the child to participate with the counsellor in the development of respectful guidelines. The "Respecting Children in Counselling" list can be complimented by providing a "Rules for Counsellors" list, which can be used to enhance feelings of empowerment and control within the child.

### *Rules for Counsellors*

Counsellors must: (a) ask for the child's ideas, especially concerning important decisions, (b) listen closely, (c) treat each child like he/she is smart, (d) inform of all possible choices, (e) play fair, (f) be honest when asked questions, (g)\_\_\_\_\_.

Counsellors must NOT: (a) ignore the child, (b) make decisions for the child without talking to them first, (c) tell lies, (d)\_\_\_\_\_.

Again, space can be left for further rules that may be developed with the child's input. These forms should be presented in a child-friendly manner and may be stylistically altered. Using the two forms together can show the child that not only will they be respected, but it is also reasonable for them to expect certain things from their counsellor. Using these two forms develops a context in which

the working relationship of counselling can be discussed in a detailed, meaningful way. This allows the counsellor to fulfill his/her mandate to provide information and stimulate discussion about informed consent or assent in a way that also stimulates the child's interest and curiosity. Returning to these lists throughout the course of therapy can allow these issues to be revisited and reviewed whenever necessary. Simply incorporating them into standard practice will help ensure that understanding is sought and obtained throughout the process of counselling.

As well, every practitioner, particularly those who work with children or adolescents, has a clear duty to develop an assessment model. It is clear that the ability to consent rests on the "discernment" of the client, regardless of the client's age. Therefore, each client needs to be assessed to ensure that the criteria for informed consent are met. The client needs to be able to understand the ramifications of their decision and possess the ability to understand and make a sound decision. This requires the counsellor to have in place a clear model for assessment that is not overly cumbersome but is efficient and effective. While Tymchuk (1997) develops a fully laid out assessment model, it appears to be somewhat unwieldy and inefficient. Utilizing lists like the ones suggested earlier, while requiring a certain degree of judgement on the part of the counsellor, may help streamline the process while maintaining a respectful stance toward each client.

#### CONCLUSION

In summary, a growing body of research indicates that children, and adolescents in particular, are often competent in making decisions regarding psychological treatment. However, the current ethical codes are not clear on the issue of allowing younger children to make autonomous treatment decisions. Hesson et al. (1993) clearly call for further treatment of and clarity in ethical codes regarding informed consent with children. Perhaps as knowledge about processes of development increases, a greater respect for the abilities children possess will emerge. The model of granting autonomy within competence without discrimination regarding age is a fine one for counselling. This model extends the current respect given to adults in counselling to include children and adolescents.

Informed consent needs to be considered an integral part of therapy, rather than a step to hurry through prior to beginning the "real" therapy. Obtaining informed consent from children may be difficult in the real world of therapy and perhaps it will always need to be obtained in conjunction with consent from caregivers. However, obtaining assent is not difficult and should be incorporated into standard practice. Treating each child as an individual deserving of dignity and respect is certainly within the realm of ethical practice.

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