THE EFFECTS OF DIFFERENT CONFIDENTIALITY CONDITIONS ON
ADOLESCENT MINOR PATIENTS' SELF-REPORT OF
BEHAVIORAL AND EMOTIONAL PROBLEMS

DISSertation

Presented to the Graduate Council of the
University of North Texas in Partial
Fulfillment of the Requirements

For the Degree of

DOCTOR OF PHILOsoPHY

By

David Warren Drake, B.A., M.A.
Denton, Texas
May, 1992
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The primary purpose of the present study was to determine if information regarding potential parental or legal guardian access to mental health information would deleteriously impact male and female adolescent psychiatric patients' willingness to self-report personal problems and symptoms. Data collection was conducted at three Texas Department of Mental Health and Mental Retardation (TDMHMR) facilities. A total of 39 subjects (22 males; 17 females) comprised the final research sample, with participant ages ranging from 14 to 17 years.

Subjects were randomly assigned to one of three conditions (control; absolute confidentiality; limited confidentiality). Subjects in the absolute confidentiality condition (AC) were informed that only the experimenter would have access to their responses. Subjects in the limited confidentiality condition (LC) were provided this same information, but with the caveat that their parents or legal guardians retain the legal right to see their responses, and that they may do so upon request. The control group (CG) condition did not address the topic of confidentiality.
Due to significant correlations between the various primary personal problem and symptom self-report measures included in the study, separate 3 (confidentiality condition) x 2 (sex of subject) multivariate analyses of variance (MANOVAs) were computed. Contrary to predictions, all main and interaction effects were statistically nonsignificant.

Correlation coefficients based on results for the total sample yielded somewhat mixed results relative to predicted findings. As anticipated, evidence indicated inverse correlations between the four subject self-report measures and a short form of the Marlowe-Crowne Social Desirability Scale and the MMPI K scale. However, contrary to predictions, positive correlations were obtained between the four self-report measures and measures of approval motivation and public self-consciousness. Various possible explanations were discussed relative to all obtained findings, and recommendations for future research were suggested.
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CHAPTER I

INTRODUCTION

Confidentiality is fundamentally an ethical concept (Shah, 1969, 1970; Siegel, 1979), the function of which is to guard against the discussion and disclosure of client information by the professional (Keith-Spiegel & Koocher, 1985; Shah, 1969, 1970; Siegel, 1979). Generally, definitions of confidentiality have indicated that any disclosure by the professional of client information occur only with the consent of the client in question (Shaw, 1969; Siegel, 1979). However, despite such statements of recommended professional practice, there are situations in which the clinician may ethically disclose client data in the absence of such client consent (American Psychological Association, 1990). Indeed, in certain cases, such as child abuse (Butz, 1985) and potential client dangerousness (Knapp & Vandecreek, 1982), the failure to breach client confidentiality may be a violation of law.

In light of these and other potential limitations of confidentiality, numerous authors have recently recommended that psychologists in applied practice initiate discussion of confidentiality as an informed consent concern relative
to the client's decision to proceed with psychological services (e.g., Everstine, Everstine, Heymann, True, Frey, Johnson, & Seiden, 1980; Keith-Spiegel & Koocher, 1985; Woods & McNamara, 1980). Consistent with this view, Denkowski and Denkowski (1982) state that it is "imperative that counselors inform each client of the potential breaches that are likely to impinge on their relationship" (p. 374).

In addition to the increased call in the professional literature for such discussions, some data exists which indicates that the public may also want to be informed of confidentiality conditions associated with the therapeutic enterprise (Miller & Thelen, 1986). Further, evidence suggests that the majority of individuals expressing an interest in such information prefer to be notified of any attendant limits to confidentiality prior to the onset of therapy (Miller and Thelen, 1986).

As is the case with the concept of informed consent procedures generally, such information is seen as facilitating the client's evaluation of the risk-benefit ratio associated with a decision to pursue or forego such services (Keith-Spiegel & Koocher, 1985; Woods & McNamara, 1980). Consistent with this view, Haut and Muehleman (1986) suggested that such information could actually facilitate the work of therapy since "neither the client nor the therapist need waste time and effort worrying about the possible consequences
of certain statements" (p. 101). Further, as Everstine et al. (1980) indicated, prior warning of the limitations of confidentiality may protect the prospective client from unknowingly surrendering one's own right to privacy. Thus, for example, an individual may choose to either not seek treatment, or avoid discussing or reporting specific content not considered to be confidential.

Despite the apparent increased concern among professionals with providing clients with informed consent knowledge of potential limits to confidentiality in therapy, as well as evidence indicating possible public support for such a practice, there is no current consensus among professionals as to how to deal with the confidentiality issue (Baird & Rupert, 1987).

In an attempt to evaluate professional practice relative to this topic, Baird and Rupert (1987) surveyed psychologists in seven states. Results indicated that 71 percent of the respondents reported that they would be in favor of an ethical guideline which stated that "clients be informed in advance of the limits of confidentiality" (Baird & Rupert, 1987, p. 352). However, despite the preceding finding, approximately half of the respondents in the Baird and Rupert (1987) study indicated that they either do not discuss confidentiality at all at the beginning of therapy (39 percent of the total sample), or tell the client that everything discussed in
therapy will remain confidential (12 percent of the total sample). Of the remaining respondents, 9 percent indicated that they "allude to the existence of limits to confidentiality" (Baird & Rupert, 1987, p. 349), while 40 percent reportedly "list the limits of confidentiality in a specific manner" (Baird & Rupert, 1987, p. 349).

More recently, Beeman and Scott (1991) presented results from a nationwide survey of psychologists regarding the topic of informed consent with adolescent patients. Results indicated that a majority of the psychologists surveyed seek informed consent from their adolescent patients, and that the average age of such patients relative to the initiation of such procedures is 12.8 years (Beeman & Scott, 1991). Finally, Beeman and Scott (1991) reported that the topic of limits to confidentiality was rated as the most important information to provide regarding informed consent. The authors stated that their results "may be a reflection of a trend toward increased use of informed consent procedures by psychologists" (Beeman & Scott, 1991, p. 233).

A factor possibly related to the finding that some professionals do not routinely discuss the limits of confidentiality with clients (e.g., Baird & Rupert, 1987) is the concern that such information may have a deleterious impact on client self-report of personal data relevant to the therapeutic enterprise. For example, Haut and Muehleman
(1986) asked clinical psychologists to rate the effects of different levels of specificity regarding limitations to confidentiality on the disclosure of personal disciplinary practices by single mothers. Results indicated that the psychologists surveyed believed that the degree of client disclosure regarding such practices would be inversely related to the clarity and specificity of information regarding the limits to confidentiality (Haut & Muehleman, 1986). Consistent with this concern, Woods (1978) has noted that "legal and ethical decisions have been made on the assumption that without the promise of complete confidentiality, individuals will not reveal important matters to a therapist and may even be deterred from entering treatment" (p. 6186B). For psychologists in the state of Texas, several factors may make this issue particularly problematic relative to the mental health service needs of adolescents.

First, in Texas, the rights of minor youth are limited relative to independent access to mental health treatment. For example, according to the current Texas Family Code (Vernon's Texas Codes Annotated, Family Code §35.03, 1986), minor youth may seek counseling by psychologists for cases involving sexual abuse, physical abuse, or suicide prevention without obtaining parental consent. Similarly, § 22 of the Texas Mental Health Code (cited in Hays & Costello, 1985) permits adolescents 16 years of age and older to obtain
inpatient mental health treatment without parental consent. In all other instances, minor youth must obtain parental consent prior to receiving such services.

Second, under article 5561h of the Texas Mental Health Code (cited in Hays & Costello, 1985), parents retain legal access to the mental health information of their minor children. Further, even in those instances in which the minor youth has the legal right to independently seek treatment, § 35.03 of the Texas Family Code (Vernon's Texas Codes Annotated, 1986) indicated that the professional is still at liberty to discuss such treatment with the child's parents without the consent of the youth. Finally, in the case of suspected child abuse or neglect, § 34.01 and § 34.02 of the Texas Family Code (cited in Hays & Costello, 1985) indicate that suspected child abuse or neglect is to be reported to appropriate authorities. Thus, under current state statutes, both actual and potential limits to confidentiality pervade clinical and counseling relationships with minor-aged clients.

Third, evidence reported by Belter and Grisso (1984) suggests that adolescents 15 years of age and older have the ability to identify potential counseling rights violations, including violations of confidentiality, and to conceptualize appropriate actions necessary to protect such rights. Similarly, findings by Kaser-Boyd, Adelman,
and Taylor (1985) support the view that adolescents are capable of recognizing both risks and benefits of potential participation in psychotherapy. Indeed, the authors state:

The youngest participants in the study (ages 10 and 11) and those without previous therapy experience were able to identify aspects of entering psychotherapy that they would consider unpleasant and that were relevant to their situation, for example, anticipations of discomfort with self-disclosure, questions about the privacy of their communications, and so on (Kaser-Boyd et al., 1985, p. 416).

In light of these factors, the professional who works with this age group must confront the tension which exists between ethical obligations to inform such clients of applicable confidentiality limits, and concern that this information may have a deleterious impact on the adolescent client's willingness to self-report therapy relevant information.

To date, a limited research base exists relative to this specific topic. Thus, the present study reviewed the literature on the effects of degree of confidentiality on symptom admission, as well as on self-disclosure. While the self-disclosure literature does not directly address the self-reporting of psychopathology, such findings do provide some indirect evidence regarding the role of
confidentiality relative to obtaining client information. Finally, research findings which address the effects of subject sex relative to this topic were also reviewed.

On the basis of this literature review, the present study was designed to address the effects of different degrees of confidentiality on the self-report of behavioral and psychological problems among male and female adolescent youth. In addition, the present research also evaluated subject variables hypothesized to be related to predicted significant effects in order to both provide a conceptual framework for evaluating obtained results, and to suggest directions for future investigation.

Review of Literature

Effects of Confidentiality Limits

To date, research directly addressing the relationship between confidentiality limits and subject self-report and disclosure has yielded variable results. While the majority of research findings with adult subjects suggest that limited confidentiality has an inhibiting effect on such measures, there is a lack of empirical support for such a conclusion relative to an adolescent population.

In research with male and female undergraduate college students, results have indicated that subjects in nonconfidential conditions self-disclose less on standardized interviews (Woods & McNamara, 1980), report less socially
stigmatizing and illegal behaviors (Lane, 1979), and self-report less symptoms (El-Hage Boutros, 1986) than subjects given guarantees of confidentiality. Further, research by Meyer and Willage (1980) indicates that symptom self-report significantly decreases and socially desirable responding increases as a function of limitations to confidentiality. Unfortunately, Meyer and Willage (1980) do not provide specific information regarding the composition of their research sample. However, available evidence suggests that their sample was comprised of non-patient college students (Meyer & Willage, 1980).

Similar trends have been reported in research with nonstudent samples. Kaplan (1986), in an investigation of convicted child molesters, reported that "as perceived confidentiality increased, offenders were more willing to accurately report their past sexual crimes and continued interest in children" (p. 2812B).

In addition, results reported by Bennett (1982) indicated that self-disclosure was reduced for both client and nonclient subjects in the nonconfidential condition relative to subjects in the confidential condition. Interestingly, the Bennett (1982) study failed to find a significant interaction effect for subject status (i.e., client versus nonclient) and confidentiality condition. The lack of a significant interaction relative to these factors indicated that
confidentiality conditions did not differentially impact client versus nonclient scores on the relevant dependent measures (Bennett, 1982).

Finally, research conducted by Haut and Muehleman (1986) with single mothers indicated that subjects assured of anonymity disclosed significantly more regarding personal discipline practices than mothers in three separate limited confidentiality conditions. Of note, no significant differences in disclosure levels were noted between the three limited confidentiality condition subjects (Haut & Muehleman, 1986).

In contrast to the preceding findings, McGuire, Graves and Blau (1985) reported no significant differential effects of confidentiality conditions on undergraduate college student disclosure levels to interview questions. Similarly, while the Bennett (1982) research discussed above did report a significant finding on a measure of self disclosure, the same study failed to find significant differences on subject symptom admission related to different confidentiality conditions (Bennett, 1982).

Finally, research by Kobocow, McGuire and Blau (1983) failed to find significant differences in subject self disclosure to questionnaire items as a function of degree of confidentiality for seventh and eighth grade students. The questionnaire items used in the Kobocow et al. (1983)
study were derived from psychological tests and a local county school district discipline code.

The results of the Kobocow et al. (1983) study are of particular relevance to the present investigation in that the findings are based on research with adolescent subjects. In discussing the failure to find significant disclosure differences between subject groups in their study, Kobocow et al. (1983) suggested two possible explanations for the obtained results. First, subjects significantly over-reported that responses would be kept confidential. This clearly constituted a major confound relative to the overall design of the study, making any conclusions regarding the effects of different confidentiality conditions on subject scores tentative at best.

A second potential explanation put forth by Kobocow et al. (1983) for their observed results was the viewpoint that "adolescents are very cautious about confidentiality and disclosure issues and are very self-protective regardless of the degree of assurance of privacy given by an adult" (pp. 440-441).

In addition to the tentative explanations proposed by Kobocow et al. (1983) relative to their nonsignificant findings with seventh and eighth grade subjects, a third possible explanation would appear to exist. As previously discussed, evidence cited by Belter and Grisso (1984) suggests
that adolescents aged 15 and older have the requisite competency necessary to recognize and appropriately respond to counseling related rights violations. For 11 to 14 year old adolescents, Grisso and Vierling (1978) state that "research suggests caution regarding any assumptions about these minors' abilities to consider intelligently the complexities of treatment alternatives, risks, and benefits, or to provide consent that is voluntary" (p. 423). Consistent with this view, Belter and Grisso (1984) suggested that 10 to 15 year old minor youth appear to be in a transitional period relative to the development of such abilities. Given the ages of the seventh and eighth grade subjects included in the Kobocow et al. (1983) study, it is possible that the failure to find significant effects related to different confidentiality conditions was due to the developmental status of the subjects studied.

However, it should be noted that the Belter and Grisso (1984) research compared three groups with reported mean ages of 9.08 years, 15.58 years, and 21.75 years. Thus, their conclusion regarding a transitional period between the ages of 10 and 15 in the development of the requisite abilities to recognize and respond to therapy-relevant rights concerns (Belter & Grisso, 1984) was apparently based on discontinuous age-related data. In light of this, it is possible that the Belter and Grisso (1984) study may not yield an accurate
assessment of the actual capabilities of 10 to 14 year olds relative to this topic.

Indeed, more recent findings reported by Kaser-Boyd et al. (1985) indicated that subjects as young as 10 were capable of identifying potential risks and benefits associated with psychotherapy. Of particular relevance to the present investigation, the Kaser-Boyd et al. (1985) results found that both self-disclosure and confidentiality breaches were identified by younger (10-13 years) and older (14-20 years) subjects as possible psychotherapy-related risks. While their research did not address the issue of what action subjects might take in response to perceived treatment risks (cf. Belter & Grisso, 1984), the Kaser-Boyd et al. (1985) findings suggest that even very young adolescents may profitably participate in informed consent discussions relative to psychotherapy risks.

The direct generalizability of the preceding research findings to the issue of the self-report of behavioral and emotional problems vis-a-vis therapy-relevant confidentiality limitations among 14 to 17 year old adolescent subjects is questionable for several reasons. First, the majority of the research conducted to date has studied adult subjects. Second, as already discussed, the existing research which did utilize adolescent subjects (Kobocow et al., 1983) was confounded, and utilized seventh and eighth grade non-patient
subjects. Thus, any conclusions drawn regarding the nonsignificant findings of Kobocow et al. (1983) relative to the case of older adolescent patient populations would be, at best, speculative. Finally, the confidentiality conditions empirically studied to date have not accurately reflected the nature or extent of the limitations which exist relative to the adolescent seeking psychological treatment.

For example, research has not assessed the impact of potential parental access to subject self-report and disclosure information on subjects' willingness to provide such data.

**Subject Sex**

Research to date suggests that when sex differences are found, females may be more guarded and more concerned with confidentiality issues than males relative to revealing personal information in therapy or therapy analogue settings. For example, in a study of self disclosure among college undergraduate students, McGuire et al. (1985) reported that females disclosed significantly less in response to interview questions than did their male counterparts.

Similarly, Kobocow et al. (1983) found that seventh and eighth grade female subjects disclosed less than male subjects during a private interview session. Further, they reported that post-testing revealed that female subjects "as a group placed a greater value on confidentiality than did males" (Kobocow et al., 1983, p. 442). The authors
concluded that the evidence "suggests that females are more cautious and have a higher level of self-protective needs than males" (Kobocow et al., 1983, p. 441). Consistent with this view, Rosen (1977) reported that when given an option, female clinic clients were significantly less likely to sign release of information forms than were male clients.

Finally, while Woods and McNamara (1980) reported generally equivalent disclosure levels for male and female undergraduate subjects under confidential interview conditions, they indicated that female subject disclosure levels were lower than those for males under nonconfidential conditions.

Measurement

Personal Problem and Symptom Self-Report. The present research will employ two measures in evaluating the potential impact of different confidentiality conditions on the willingness of adolescent patients to self-report behavioral and emotional problems.

First, the problem items section of Achenbach and Edelbrock's (1987) Youth Self-Report (YSR) was utilized. The YSR was developed for use with 11 to 18 year old individuals, and is suitable for self-administration by youth with at least a fifth grade reading level (Achenbach & Edelbrock, 1987). The problems section of the YSR is comprised of a maximum of 103 problem items scored on a 0 to 2 scale, with higher
scores reflecting admission of more personal difficulties (Achenbach & Edelbrock, 1987). Due to concerns regarding potential legal or ethical dilemmas, two items involving content addressing suicidal ideation or intent were deleted from the YSR forms utilized in the present study. Permission to delete these two items from the copyrighted forms was obtained from the senior author of the YSR (T. M. Achenbach, personal communication, September 21, 1989).

Three separate scores derived from the YSR were employed in the research, including the total problem score (YSRTOT), the internalizing scale score (YSRINT), and the externalizing scale score (YSREXT) (Achenbach & Edelbrock, 1987). The YSRTOT provides a summary score based on subject responses to all problem items, while the YSRINT and YSREXT are designed to assess so-called internalizing and externalizing problems, respectively (Achenbach & Edelbrock, 1987). As Achenbach and Edelbrock (1987) have indicated, the classification of problems as internalizing or externalizing denotes "a distinction between inhibited, overcontrolled behavior, and aggressive, antisocial, undercontrolled behavior" (p. 31).

Achenbach and Edelbrock (1987) indicate that sex differences exist, with females tending to score higher on the total problem measure. Additional sex differences are reflected in the item composition of the YSRINT and YSREXT scales, with variability in both the number and content of
the scales for males versus females (Achenbach & Edelbrock, 1987). In light of these differences, and as recommended by the authors (Achenbach & Edelbrock, 1987), YSR raw scores obtained in the research were converted to T scores to allow for more accurate comparisons between male and female subject self-reports on the three YSR measures.

It should be noted that the elimination of the two YSR items referring to suicidal ideation or intent differentially impacts male and female results on the YSR internalizing scale (Achenbach & Edelbrock, 1987). Both items load on the internalizing scale for females, while neither item does so for males (Achenbach & Edelbrock, 1987). Thus, it is likely that results obtained on the YSR internalizing scale for the female sample in the present study provide somewhat of an underestimate of actual internalizing problems.

The second major self-report measure utilized in the present study was the Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1982). The BSI is comprised of 53 items, and is "designed to reflect the psychological symptom patterns of psychiatric and medical patients as well as non-patient individuals" (Derogatis & Spencer, 1982). The measure is reportedly appropriate for use with individuals as young as 13 years of age (Derogatis & Spencer, 1982).

As with the YSR, concern existed regarding possible legal or ethical dilemmas associated with subject response
to item content addressing the issue of potential suicidal ideation. In light of this, permission was obtained from the publisher of the BSI to delete item number 9 from the measure (M. F. Derogatis, personal communication, September 25, 1989). Thus, the total number of BSI items was reduced from 53 to 52 in the present research.

BSI items are scored on a 0 to 4 scale, with higher scores reflecting greater symptom disturbance (Derogatis & Spencer, 1982). While several scores can be derived from subject responses to the BSI, "the GSI [General Severity Index] provides the most sensitive single indicator of the respondent's distress level, combining information on numbers of symptoms and intensity of distress" (Derogatis & Spencer, 1982, p. 30). The GSI is equal to the sum of all item responses divided by the total number of items answered by the subject (Derogatis & Spencer, 1982). Thus, for example, if a subject does not answer three items, the denominator for computing the GSI is reduced from 53 to 50. The resulting raw score number is then used in determining the appropriate T score value for the subject's age and sex (Derogatis & Spencer, 1982).

The present research utilized a score analogous to the GSI; however, in contrast to the GSI, computation of the BSI total score (BSITOT) employed in this study consisted simply of summing all item responses for each subject. The
decision to not divide this sum by the total number of items answered by the subject (i.e., GSI computation procedure) was based on two main considerations. First, the issue of missing data is theoretically and practically relevant to the current research project's investigation of the impact of different degrees of confidentiality on subjects' willingness to self-report personal information. For example, missing data could conceivably be interpreted as possibly reflecting avoidance or defensiveness on the part of the subject. In reality, of course, it is impossible to discern the actual reasons for missing data (e.g., defensiveness, carelessness, inability to understand a particular item, fatigue). However, the procedure for computing the GSI (Derogatis & Spencer, 1982), by reducing the denominator by the number of missing responses, effectively eliminates the possibility that any missing data may reflect subject defensiveness.

A second factor in the decision to not utilize the GSI in the present study is linked with a discussion of T score conversion tables provided for the various BSI scores (Derogatis & Spencer, 1982). Derogatis and Spencer (1982) cite the need for separate normative T scores for males and females "based on the consistent observation that females in our culture report significantly greater numbers of psychological symptoms than do males, and tend to do so with
increased levels of intensity" (p. 18). However, investigation of the appropriate adolescent norms provided for the BSI (Derogatis & Spencer, 1982) indicates the need to interpolate for raw scores not specifically listed in the normative tables. In light of this, it was decided to simply employ total raw score results in the analysis of the BSI, with any statistically significant differences between males and females discussed relative to interpretation of any observed main and interaction effects.

**Defensiveness.** The 30-item Minnesota Multiphasic Personality Inventory K scale (MMPI K) (Dahlstrom, Welsh, & Dahlsrom, 1972) was included in the present research, with all raw score results converted to T scores based on appropriate normative data for subject age and sex (Marks, Seeman, & Haller, 1974).

Interpretation of K scale results is typically modified according to such factors as subject socioeconomic and educational background (Graham, 1987), and subject psychopathology (Greene, 1980). As Greene (1980) has stated, "In a normal population high scores on the K scale do not indicate defensiveness; in a maladjusted population, however, high K scores do suggest defensiveness" (p. 41). Archer and Ball (1988) suggest that the interpretation of the K scale as a measure of defensiveness is appropriate for MMPI results for adolescents.
**Approval Motivation.** Social desirability, as conceptualized in the development of the original 33-item Marlowe-Crowne Social Desirability Scale (M-CSDS), was considered to reflect "the need of Ss to obtain approval by responding in a culturally appropriate and acceptable manner" (Crowne & Marlowe, 1960). Subsequent work by the authors (Crowne & Marlowe, 1964) expanded the need for approval (NA) construct to indicate that high NA individuals would also tend to be defensive and to exhibit a tenuous self-esteem. Thus, according to the Crowne and Marlowe (1964) revision, the need approval construct included approval seeking and disapproval avoidance motives.

Crowne and Marlowe (1964) have indicated that these opposing motives can, at times, create significant tension within the high NA individual. As an example of this, they cited the case of psychotherapy in which the high NA person is confronted with competing demands to either "give up his defensive self-conception or defy the therapist" (p. 157). Consequently, the approval motivated subject experiences an "avoidance-avoidance conflict" (Crowne & Marlowe, 1964, p. 157) which, in turn, is resolved by the individual's premature termination of therapy (Crowne & Marlowe, 1964).

Consistent with the theoretical model proposed by Crowne and Marlowe (1964), evidence does suggest that the M-CSDS taps both attribution of desirability and denial of
undesirability response dimensions (Millham, 1974; Ramanaiah, Schill, & Leung, 1977). Ramanaiah et al. (1977), in a study evaluating the validity of the two M-CSDS factor scores, stated that "results indicate that while approach behaviors are geared at enhancing self-esteem, the defensive behaviors represent a self-protective effort to avoid threats to self-esteem" (p. 257).

In contrast to the interpretation of the M-CSDS as reflecting both approval seeking and disapproval avoidance espoused by Crowne and Marlowe (1964), others have presented evidence indicating that high M-CSDS scores are more accurately interpreted mainly as indicative of defensive tendencies (Berger, Levin, Jacobson, & Millham, 1977; Millham, 1974). As stated by Millham (1974), the motives of high NA subjects "are primarily defensive and avoidant; the aim is to avoid censure and not to obtain approval" (p. 391). Further, he states that "behaviors previously shown to be related to approval motivation, as measured by the M-C, owe that relationship to the desire of evaluatively dependent subjects to avoid disapproval" (p. 392).

The Millham (1974) research also yields evidence of a possible sex-based difference relative to the need to avoid or defend against social disapproval, with female defensiveness linked with efforts to both present oneself positively and to defend against or deny negative self-related
data. Additional research evidence for such a view relative to females was reported by Evans (1979).

For male subjects, results from the Millham (1974) study suggest that high NA individuals' defensiveness is also manifested in efforts to deny negative self-related data. However, in contrast to females, male subjects do not attempt to present themselves in a favorable light as a defensive strategy. Evans (1979), distinguishing between motives of avoidance of social disapproval versus defending what Crowne and Marlowe (1964) have called a "vulnerable self-esteem" (p. 150), reports differential findings for elevated M-CSDS attribution and denial subscale scores for males. He suggests that male scores on the attribution subscale are consistent with an avoidance of disapproval interpretation, whereas males with elevated denial subscale results "will be less concerned with avoiding disapproval than with protecting vulnerable self-esteem" (Evans, 1979, p. 410).

Finally, relative to the topic of the validity of the approval motive construct as measured by the M-CSDS, Shulman and Silverman (1974) reported the results of a study in which they compared approval seeking versus disapproval avoidance behavior for high M-CSDS versus low M-CSDS scoring subjects. Findings from the study indicated that, contrary to the authors' prediction, high scoring subjects avoided contact with a psychologist after receiving feedback indicating
positive task performance, but sought such contact subsequent to perceived task failure. The observed findings were reversed for the low M-CSDS scoring group.

In discussing their study, Shulman and Silverman (1974) cite two alternative interpretations of results from the M-CSDS. First, they suggest the possibility that the instrument is a measure of self-esteem (Shulman & Silverman, 1974). As the authors state, "The inference of this explanation is that high MCSD subjects do actually believe the positive appraisals they make of themselves and are not merely responding in a socially approved way" (Shulman & Silverman, 1974, p. 30).

In support of this hypothesis, Shulman and Silverman noted that "MCSD scores were found to relate positively with self-esteem and negatively with anxiety" (Shulman & Silverman, 1974, p. 31). Consistent with the Shulman and Silverman (1974) self-esteem findings, Martin (1984) also reported positive correlations between the M-CSDS and different measures of self-esteem. In addition to the above correlational data, Shulman and Silverman (1974) also noted that subjects in their research who scored high on the M-CSDS evaluated personal achievement on the experimental tasks more favorably than low M-CSDS scoring subjects (Shulman & Silverman, 1974).

A second alternative view of the M-CSDS proposed by Shulman and Silverman (1974) is that it is low scores which
are associated with tendencies to seek approval or to avoid disapproval. They state that individuals taking the M-CSDS "may readily conceive that it is designed to measure their honesty and willingness to admit to common human fallabilities [sic]. On this premise, it is the person who scores low who is actually more concerned with the experimenter's impression of him" (Shulman & Silverman, 1974, p. 31).

While the Shulman and Silverman (1974) alternative hypotheses regarding the M-CSDS merit consideration, it is possible to interpret the above findings in terms of the approval seeking, disapproval avoidance, or combined approval-avoidance models previously discussed (i.e., Berger et al., 1977; Crowne & Marlowe, 1964; Evans, 1979; Millham, 1974; Ramanaiah et al., 1977).

For example, results reported by Berger et al. (1977) and Millham (1974) would suggest that the avoidance of disapproval is the primary motive evident among subjects scoring high on the M-CSDS. Unfortunately, Shulman and Silverman's (1974) study did not assess the actual intent of subjects either seeking or avoiding contact with the psychologist, thus precluding any definitive interpretation of their research results. However, consistent with the view of Berger et al. (1977) and Millham (1974), it could be concluded that the failure of the high M-CSDS group to seek approval from the psychologist in the Shulman and
Silverman (1974) study simply reflects a lack of need or motive on the part of such individuals for such contact. Similarly, efforts by such subjects subsequent to perceived failure may be interpreted as reflecting an increased need or motive to defend one's poor performance.

In light of the preceding discussion, the present study included a 20 item version of the M-CSDS (Strahan & Gerbasi, 1972) to assess the possible impact of approval motivation on subject's willingness to self-report personal problems and psychiatric symptoms. Prior research results with undergraduate subjects indicated a significant relationship between subject responses on the M-CSDS and a measure of symptom report (El-Hage Boutros, 1986). While the direction of the relationship reported by El-Hage Boutros (1986) was not explicitly stated, it was assumed that it was inverse. Consistent with this, it was anticipated that high NA individuals, as measured by the M-CSDS, would report less problems or symptoms than their low NA counterparts.

Also of relevance to the present investigation, two previous studies evaluating subject responses on the M-CSDS as a function of different confidentiality conditions have yielded nonsignificant findings (Bennett, 1982; Meyer & Willage, 1980). However, results reported by Meyer and Willage (1980) indicated that M-CSDS scores were close to statistical
significance (p<.062), with the highest M-CSDS scores obtained by the nonconfidentiality condition group.

Finally, in light of evidence suggesting that the M-CSDS is best interpreted as a measure of defensiveness or denial tendencies intended to avoid disapproval, the present study also included a 20-item revision of the Martin-Larsen Approval Motivation scale (M-LAM) (Corcoran & Fischer, 1987; Martin, 1984). Martin (1984) has indicated that "the MLAM is more of a behavioral self-description of reactions to approval/disapproval in social settings" (p. 509). Thus, the M-LAM is considered to tap both the need to obtain social approval, and the desire to avert social disapproval.

In conceptualizing the need for social approval, Larsen, Martin, Ettinger, and Nelson (1976) noted that the actual behavior of high need for social approval subjects will vary as a function of the relative status or importance of the other individual with whom the subject is interacting.

This consideration is relevant to the present study in that the limited confidentiality condition indicated that parents or legal guardians may potentially access subject data. In contrast, subjects in the absolute confidentiality condition were informed that only the experimenter had access to their responses. At a hypothetical level, variations in the significance or importance of the individuals (e.g.,
experimenter versus parent or legal guardian) with real or potential access to subjects' personal responses could be seen as potentially impacting the degree of subject self-report.

**Self-Consciousness.** On theoretical and empirical grounds, the constructs of public and private self-consciousness (Fenigstein, Scheier, & Buss, 1975) both appear to have implications relative to the present topic. As noted by Scheier (1980), public self-consciousness is concerned with "overt and observable aspects of self" (p. 520), while private self-consciousness is related to "more covert, personal and unshared aspects of self" (p. 520).

The present study used a revision (Corcoran & Fischer, 1987; Scheier & Carver, 1985) of the original Self-Consciousness Scale (SCS) developed by Fenigstein et al. (1975). The revised form is comprised of a total of 22 items, and is considered to be more suitable for use with individuals lacking a college education (Corcoran & Fischer, 1987; Scheier & Carver, 1985).

As with the original scale (Fenigstein et al., 1975), the SCS revision yields three separate scores, including measures of Private Self-Consciousness (PRISC), Public Self-Consciousness (PUBSC), and Social Anxiety (Scheier & Carver, 1985).
Findings from the original SCS (Fenigstein et al., 1975) failed to indicate major sex of subject differences on the private self-consciousness, public self-consciousness, or social anxiety scales. However, for the revised version, evidence did reveal one significant sex-related difference, with female scores on the private self-consciousness scale being significantly higher than those reported for males (Scheier & Carver, 1985).

While the entire SCS was administered to subjects participating in the present project, the primary scores of interest were the private self-consciousness and public self-consciousness results. Evidence exists indicating that private self-consciousness may have an impact on self-report data. Factor analyses of the Fenigstein et al. (1975) private self-consciousness scale have indicated that the scale is composed of two factors which have been labeled self-reflectiveness, and internal state awareness (Burnkrant & Page, 1984; Mittal & Balasubramanian, 1987). Research findings by Scheier, Buss, and Buss (1978) suggest that high private self-consciousness may result in greater accuracy relative to self-report data. However, not all research has supported such a conclusion. Turner and Peterson (1977) reported mixed results relative to a predicted relationship between high self-consciousness and the accuracy of self-reported emotional behavior.
In research designed to assess the correlation between subjects' private and public attitudes statements, Scheier (1980) provided evidence that suggested that both private and public self-consciousness impact the accuracy of self-report data. Scheier (1980) analyzed subject data according to a fourfold typology based on combinations of high versus low private and public self-consciousness scores. Results revealed that accuracy of self-report data was associated with low public-high private self-consciousness scores. In all of the three remaining types, correlations between subject private versus public attitude statements were nonsignificant.

Such evidence would appear to suggest that high private self-consciousness is a necessary condition for accurate self-report, but that subjects with high public self-consciousness scores may modify responses for public consumption (Scheier, 1980). Consistent with such an interpretation of the Scheier (1980) data, research by Tunnell (1984) revealed significant correlations between high public self-consciousness scores and measures of anxiety, conformity, and value orthodoxy.

Rationale and Hypotheses

In light of the preceding literature review, the present research studied the effects of different confidentiality conditions and sex of subject on 14 to 17 year old adolescent
psychiatric patients' self-report of behavioral and psychological problems.

Specifically, three confidentiality conditions were experimentally investigated. The conditions included a control group in which the issue of confidentiality was not addressed, an absolute confidentiality condition, and a limited confidentiality condition. The limited confidentiality condition included information regarding possible parental access to the adolescent subject's responses.

Predictions relative to anticipated control group results were considered to be contingent upon the information provided to subjects regarding confidentiality by the treatment facilities in which data were collected. Consistent with information regarding patient's rights within the Texas Department of Mental Health and Mental Retardation (TDMHMR) system (Texas Department of Mental Health and Mental Retardation, 1985; Waco Center for Youth, n.d.) obtained after the completion of data collection, it was predicted that control group responses would be most similar to those of the limited confidentiality condition group.

A three (confidentiality condition) by two (sex of subject) design was employed in order to test three main research hypotheses. First, a significant main effect for confidentiality condition was predicted, with subjects in the limited confidentiality and control group conditions
expected to self-report significantly less behavioral and emotional problems than subjects in the absolute confidentiality condition.

Second, the present study also tested for a main effect for the sex of subject factor. In light of evidence that females may be more concerned than males with confidentiality issues, it was predicted that significant sex differences would be observed on the self-report measures of behavioral and psychological problems, with females reporting significantly less difficulties than male subjects.

Third, a significant confidentiality condition by sex of subject interaction was also predicted. It was anticipated that simple main effects analyses would reveal that females reported significantly less behavioral and psychological problems than males in the limited confidentiality and control group conditions. No significant sex of subject simple main effect was predicted for the absolute condition.

Stated in null terms, the following research hypotheses were tested:

\( H_{0I} \): There will be no significant main effect of confidentiality condition on self-reported behavioral or psychological problems.

\( H_{0II} \): There will be no significant main effect of subject sex on self-reported behavioral or psychological problems.
There will be no significant confidentiality condition by subject sex interaction on self-reported behavioral or psychological problems.

$H_{0_{III}}$: There will be no significant confidentiality condition by subject sex interaction on self-reported behavioral or psychological problems.
Subjects

Subsequent to a meeting with staff members at one of the data collection sites (i.e., Terrell State Hospital) held prior to the onset of the data collection phase of the research, a decision was made to ascertain the reading level of each prospective participant. This information was obtained either from patient charts, or was provided by treatment facility personnel.

In an effort to increase the probability of obtaining valid research results, a sixth-grade reading level was established as the minimum criterion for subject participation. While various authors have reported somewhat different reading level criteria for the MMPI (e.g., Graham, 1987, Greene, 1980; Meyer, 1983), the sixth-grade criterion was determined to be basically adequate for completion of the MMPI K scale employed in the present investigation. The established criterion exceeded the fifth-grade level required for completion of the Youth Self Report form (Achenbach & Edelbrock, 1987).

Subjects for the study were 14 to 17 year old adolescent
male and female patients drawn from three Texas Department of Mental Health and Mental Retardation (TDMHMR) treatment facilities. Specific data collection sites included Terrell State Hospital (TSH; n = 11), Waco Center for Youth (WCFY; n = 23), and Wichita Falls State Hospital (WFSH; n = 10). A total of 44 patients participated in the research. Due to factors to be discussed below, 5 of these individuals were eliminated from the study. Thus, a total N of 39 subjects comprised the research sample on which data analyses were computed.

It should be noted that the original research proposal indicated that subjects included in the study would be in the 15 to 17 year age range. However, checks on subject ages indicated that two 14 year-olds were erroneously allowed to complete the data collection phase of the study. In light of difficulties encountered in securing sufficient numbers of research participants for the present study, and given previously discussed evidence that youths as young as 10 years of age are capable of identifying potential risks associated with psychotherapy (Kaser-Boyd et al., 1985), a decision was made to include these subjects in the sample. Of note relative to this issue, an assessment of the validity check item indicated that both 14 year-old participants accurately identified the confidentiality condition to which they had been assigned.
Subsequent checks on subject reading ability indicated that 4 individuals with less than a sixth-grade level were incorrectly allowed to take part in the study. Of these, three were eliminated on the basis of reading levels considered well below the established sixth-grade minimum (i.e., grade levels of 2.7, 4.0 and 4.2). However, the fourth subject, whose reading grade level was 5.7, was included in the final research sample. As previously discussed, some variation exists relative to the requisite reading skills necessary to adequately complete the MMPI, with levels discussed ranging from the fifth to the sixth or seventh grade (cf. Graham, 1987; Greene, 1980; Meyer, 1983). Further, as Greene (1980) notes, even subjects with deficient reading skills may still be able to complete the MMPI if more difficult items are explained. On the basis of these considerations, a decision was made to include the subject with the 5.7 reading grade level in the final research sample.

Two additional subjects (1 male; 1 female) were eliminated from the absolute confidentiality condition due to incorrect responses to the validity check item at the end of the research questionnaire. Of note, these were the only two invalid responses from the two experimental conditions (i.e., absolute confidentiality; limited confidentiality), with both subjects erroneously marking the limited confidentiality condition validity check item.
In contrast to the high valid response rate observed among subjects in the absolute and limited confidentiality conditions (93%), only 5 of 12 subjects (42%) in the control condition accurately identified the research condition to which they had been assigned. Of the 7 invalid control group responses, 5 incorrectly indicated that they had been assigned to the limited confidentiality condition, while 2 marked the absolute confidentiality validity check item. It should be noted that all control condition subjects were included in the final data analysis regardless of validity check response given the theoretical importance of evaluating patient self-report responses in the absence of specific information regarding real or potential limits to confidentiality.

A 3 (confidentiality condition) by 2 (sex of subject) research design was employed, yielding a total of 6 experimental cells. Random assignment procedures (Downie & Heath, 1974; Rand Corporation, 1955; Snedecor & Cochran, 1980) were utilized to generate separate lists for assigning males and females at each of the three data collection sites to one of three confidentiality conditions. A minimum of 5 subjects were randomly assigned to each of the 6 cells.

**Procedure**

Prior to taking part in the data collection phase of the study, each prospective research participant and a parent
or legal guardian were given a cover letter (Appendix A) and were required to sign an informed consent form (Appendix B) which provided a brief description of the research. All patients participated on a volunteer basis. Each subject who agreed to take part in the study was paid five dollars at the time of his or her actual research participation.

The data collection phase of the study consisted of the completion of a two-part research questionnaire. The first part included a second consent form, the Youth Self Report form (YSR), the Brief Symptom Inventory (BSI), and the MMPI K scale. The content of this second consent form was read over with each subject, and varied according to the confidentiality condition to which the subject had been randomly assigned.

The initial portion of the questionnaire consent form was identical for all subjects, and provided the following brief rationale regarding the completion of the attached questionnaires: "I understand that on the following pages I will be asked to provide personal information regarding a number of topics. I understand that this information is used to assess problem areas for which people my age often seek professional psychological counseling. Further, while I understand that my responses will not be used for treatment purposes here at (name of facility), I also understand that I am to complete the attached forms as if they will be used
for personal assessment and treatment information. In addition, I understand that I am to read the directions for each separate measure carefully before proceeding, and that I should answer every item."

In addition to the preceding information included in the control group condition consent form, the cover page for subjects in the absolute and limited confidentiality conditions included information regarding the degree of assured confidentiality relative to subject responses.

In the absolute confidentiality condition, the cover page also stated: "Finally, I understand that my responses will be kept confidential, with only Mr. Drake having access to my answers." It is of considerable relevance to note that this statement provides the subject with assurance of confidentiality, but not anonymity (cf. Meyer & Willage, 1980). The distinction is one of import, in that some prior research in the area has apparently confused the two concepts (e.g., Haut & Muehleman, 1986).

Subjects in the limited confidentiality condition read the following: "Finally, I understand that my responses will be kept confidential, with only Mr. Drake having access to my answers. However, I also understand that my parents (or legal guardians) retain the legal right to see my responses, and they may do so upon request." Examples of the control group, absolute confidentiality, and limited
confidentiality questionnaire cover pages are presented in Appendices C, D, and E, respectively.

Due to experimenter error, 3 subjects included in the final research sample of 39 were administered questionnaires with cover pages indicating the wrong data collection site. For each of these cover pages, the incorrect facility name was crossed out, and the correct name written in. It should be noted that subsequent evaluations of the validity check item indicated that each of these 3 subjects correctly identified the confidentiality condition to which he or she had been assigned.

After signing the appropriate consent form, subjects then completed the specific measures included in the first part of the research questionnaire (i.e., YSR, BSI, and MMPI K scale). Upon returning this part of the questionnaire, the experimenter quickly scanned the completed form in order to detect any missing data. Subjects were then asked to provide answers for any omitted or unanswered items. Despite this experimenter effort, subsequent coding of all research data indicated that some missing responses escaped detection.

The second part of the research questionnaire was then given to the subject to complete. This part consisted of a second brief instructional cover page (Appendix F), the Martin-Larsen Approval Motivation (M-LAM) scale, the Marlowe-Crowne Social Desirability Scale (M-CSDS), the Self-
Consciousness Scale (SCS), and a validity check item designed to assess subject knowledge of the confidentiality condition to which he or she was assigned. Separate administration of the validity check item as part of the ancillary measures was intended to minimize the possibility of confounding due to subject awareness of the main purpose of the study when completing the primary measures of interest, i.e., the YSR, BSI, and MMPI K scale.

Again, prior to beginning work on the second part of the research questionnaire, the experimenter read over the brief instructional cover page with the participant, and informed the subject that he would attempt to answer any questions during completion of the form.

After completing the data collection phase of the study, subjects were thanked and were paid five dollars in return for their participation. Finally, subjects were informed that they would later receive a debriefing letter providing additional information regarding the study, were again thanked for their participation, and dismissed. This completed the data collection phase of the study for each participant.

In order to insure the anonymity of all research data subsequent to completion of the data collection phase, questionnaires were coded and all identifying information was removed.
Prior to conducting the data analysis phase of the study, all raw data were transferred to code sheets. Several points merit discussion relative to this process. First, a decision was made to code all missing data as a response of zero.

Second, in contrast to Achenbach and Edelbrock's (1987) recommendation regarding the scoring of YSR items with two answers marked as 1, the present study coded all such items marked with two answers as zero. While it could be argued that a score of 1 would be more appropriate in cases where, for example, the subject marked a 1 and a 2, this procedure obviated the need for the experimenter to try and surmise the actual scoring intent of the subject across all such items (e.g., if a subject marked a 2 and 0). It should be noted that this procedure was employed across all subjects and across all dependent measures.

A third and final consideration regarding the scoring or coding of raw data relates specifically to the YSR. A total of 17 items on the YSR request that the subject provide a written description of the problem addressed to allow for subsequent evaluation of the scoring of those particular problems (Achenbach & Edelbrock, 1987). All subject responses were reviewed and scored according to scoring criteria provided by Achenbach and Edelbrock (1987). However, two points regarding this process are noteworthy. First, in all cases in which no written elaboration was provided by the
subject, the number circled by the subject for the item in question was accepted as valid and was coded accordingly. In this regard, it should be noted that one or two subjects may have been erroneously informed by the experimenter that they need not complete the written descriptions for the items in question. Second, in instances in which a subject did provide a written response for such items, but did not mark a specific number, it was again decided to code such items as zero (cf. Achenbach & Edelbrock, 1987).

Finally, subjects and parents or legal guardians who had provided informed consent were sent letters providing a debriefing regarding the research (Appendices G and H, respectively). The main purpose of the debriefing letter was to provide notification that all identifying information had been removed from each subjects' questionnaire, thus rendering all subject data anonymous and strictly confidential. In addition, the debriefing letter provided participants and their parents or guardians information regarding how to contact the experimenter to obtain a summary of the research findings or answers to any questions not specifically addressed in the debriefing letter.
PEARSON correlation coefficients were computed (SPSS User's Guide, 1983) for all measures included in the study (see Table 1). Table 2 presents means and standard deviations for the YSRTOT, YSRINT, YSREXT, BSITOT, and MMPI K. Table 3 presents means and standard deviations for the M-LAM, M-CSDS, PUBSC, and PRISC.

Results of the correlation matrix indicated that all four primary self-report problem or symptom measures (i.e., YSRTOT, YSRINT, YSREXT, and BSITOT) were significantly correlated with each other ($p < .01$). The MMPI K scale, as expected, was inversely correlated with each of the problem measures; however, only the correlations with the YSRINT and BSITOT reached statistically significant levels ($p < .05$).

Correlations obtained between the various ancillary measures and the primary problem scales revealed mixed findings relative to anticipated results. Contrary to hypothesized findings, the Martin-Larsen Approval Motivation (M-LAM) scale was positively correlated with all four problem measures, with correlations with the YSRTOT ($p < .05$), YSRINT
**Table 1**

**Pearson Correlation Coefficients for All Measures**

<table>
<thead>
<tr>
<th></th>
<th>YSRINT</th>
<th>YSREXT</th>
<th>BSITOT</th>
<th>MMPI K</th>
<th>M-LAM</th>
<th>M-CSDS</th>
<th>PUBSC</th>
<th>PRISC</th>
</tr>
</thead>
<tbody>
<tr>
<td>YSRINT</td>
<td>.89**</td>
<td>.57**</td>
<td>-.32*</td>
<td>-.30</td>
<td>-.29</td>
<td>-.33*</td>
<td>.59**</td>
<td>---</td>
</tr>
<tr>
<td>YSREXT</td>
<td></td>
<td>.79**</td>
<td>-.27</td>
<td>.33*</td>
<td>.23</td>
<td>-.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BSITOT</td>
<td></td>
<td></td>
<td>.41**</td>
<td>-.25</td>
<td>.11</td>
<td>.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMPI K</td>
<td></td>
<td></td>
<td></td>
<td>.33*</td>
<td>.11</td>
<td>.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M-LAM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M-CSDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PUBSC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.05</td>
<td>.01</td>
</tr>
</tbody>
</table>

*p < .05  **p < .01
Table 2

Means and Standard Deviations for the YSRTOT, YSRINT, YSREXT, BSITOT, and MMPI K

<table>
<thead>
<tr>
<th>Confidentiality Condition</th>
<th>Control</th>
<th>Absolute</th>
<th>Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
</tr>
<tr>
<td></td>
<td>(n = 5)</td>
<td>(n = 7)</td>
<td>(n = 12)</td>
</tr>
<tr>
<td>YSRTOT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>54.60</td>
<td>65.28</td>
<td>61.00</td>
</tr>
<tr>
<td>SD</td>
<td>12.17</td>
<td>10.84</td>
<td>7.75</td>
</tr>
<tr>
<td>YSRINT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>53.80</td>
<td>58.85</td>
<td>58.16</td>
</tr>
<tr>
<td>SD</td>
<td>10.23</td>
<td>8.74</td>
<td>6.93</td>
</tr>
<tr>
<td>YSREXT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>57.20</td>
<td>70.57</td>
<td>63.33</td>
</tr>
<tr>
<td>SD</td>
<td>11.75</td>
<td>12.25</td>
<td>10.67</td>
</tr>
<tr>
<td>BSITOT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>35.80</td>
<td>53.71</td>
<td>37.66</td>
</tr>
<tr>
<td>SD</td>
<td>32.49</td>
<td>28.86</td>
<td>22.03</td>
</tr>
<tr>
<td>MMPI K</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>44.80</td>
<td>45.00</td>
<td>47.08</td>
</tr>
<tr>
<td>SD</td>
<td>13.75</td>
<td>7.50</td>
<td>11.53</td>
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</tbody>
</table>
Table 3

Means and Standard Deviations for the M-LAM, M-CSDS, PUBSC, and PRISC

<table>
<thead>
<tr>
<th>Confidentiality Condition</th>
<th>Control</th>
<th>Absolute</th>
<th>Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
</tr>
<tr>
<td></td>
<td>(n = 5)</td>
<td>(n = 7)</td>
<td>(n = 12)</td>
</tr>
<tr>
<td>M-LAM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>52.80</td>
<td>57.14</td>
<td>53.66</td>
</tr>
<tr>
<td>SD</td>
<td>10.77</td>
<td>18.88</td>
<td>7.19</td>
</tr>
<tr>
<td>M-CSDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>11.20</td>
<td>7.00</td>
<td>8.66</td>
</tr>
<tr>
<td>SD</td>
<td>2.94</td>
<td>3.26</td>
<td>3.60</td>
</tr>
<tr>
<td>PUBSC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>12.60</td>
<td>11.57</td>
<td>13.08</td>
</tr>
<tr>
<td>SD</td>
<td>6.69</td>
<td>5.38</td>
<td>4.92</td>
</tr>
<tr>
<td>PRISC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>16.20</td>
<td>9.57</td>
<td>13.91</td>
</tr>
<tr>
<td>SD</td>
<td>5.58</td>
<td>3.86</td>
<td>5.28</td>
</tr>
</tbody>
</table>
(p ≤ .05), and the BSITOT (p ≤ .01) all statistically significant. Consistent with predictions, the 20 item short version of the Marlowe-Crowne Social Desirability Scale (M-CSDS) was significantly correlated inversely with the primary self-report problem scales (p ≤ .01). Results also indicated a significant positive correlation between the M-CSDS and the MMPI K (p ≤ .05). Results of correlations between the Public Self-Consciousness Scale (PUBSC) and the primary symptom and problem measures yielded one significant positive correlation with the YSRINT (p ≤ .05). Finally, all correlations between the Private Self-Consciousness Scale (PRISC) and the various personal problem self-report measures were nonsignificant.

In view of the aforementioned findings, multivariate analysis of variance (MANOVA) procedures were utilized where appropriate in order to account for significant relationships between dependent measures (Norusis, 1985). Due to concerns regarding statistical power and variance-covariance homogeneity (Tabachnick & Fidell, 1983), the number of dependent variables included in each multivariate analysis was limited so that the number of subjects in each experimental cell was greater than the number of dependent variables per analysis (Tabachnik & Fidell, 1983). As Tabachnik and Fidell (1983) have noted, the probability of violating the assumption of homogeneity of variance-covariance
matrices is greater when experimental cells have only one or two subjects more than the number of dependent variables in the MANOVA. In view of this, all MANOVA results reported in the present study utilized the more robust Pillais' Trace multivariate test of statistical significance (Norusis, 1985).

Several 3 (confidentiality condition) by 2 (sex of subject) MANOVAs were computed. Separate analyses included different dependent variables grouped according to whether the measures were from the first or second part of the questionnaire, and according to correlations between those specific measures. Results of the MANOVA of the four self-report symptom and personal problem measures of primary importance to the present study (YSRTOT, YSRINT, YSREXT, and BSITOT) are presented in Table 4. As previously discussed, all YSR results are based on T score conversions (Achenbach & Edelbrock, 1987), while BSITOT data are based on raw score results (Derogatis & Spencer, 1982). As indicated, all main and interaction effects were nonsignificant.

Tables 5, 6 and 7 present univariate F test results for each separate dependent measure based on main effects analyses for confidentiality condition and for sex of subject, as well as for the confidentiality by sex interaction, respectively. While not interpretable given the failure to find multivariate significance, inspection of Table 6 indicates that univariate F tests for the YSRTOT ($p = .072$)
Table 4

(Confidentiality Condition) x 2 (Sex of Subject)

MANOVA Results for the YSRTOT, YSRINT, YSREXT, and BSITOT Dependent Variables

<table>
<thead>
<tr>
<th>Effect</th>
<th>DF</th>
<th>F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidentiality</td>
<td>8,62</td>
<td>.34742</td>
<td>.944</td>
</tr>
<tr>
<td>Sex</td>
<td>4,30</td>
<td>1.35099</td>
<td>.274</td>
</tr>
<tr>
<td>Confidentiality x Sex</td>
<td>8,62</td>
<td>1.06750</td>
<td>.397</td>
</tr>
</tbody>
</table>

Table 5

Univariate F Tests for the YSRTOT, YSRINT, YSREXT, and BSITOT: Results of Main Effects Analysis for the Confidentiality Factor

<table>
<thead>
<tr>
<th>Measure</th>
<th>F*</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>YSRTOT</td>
<td>.69614</td>
<td>.506</td>
</tr>
<tr>
<td>YSRINT</td>
<td>1.13115</td>
<td>.335</td>
</tr>
<tr>
<td>YSREXT</td>
<td>.08634</td>
<td>.917</td>
</tr>
<tr>
<td>BSITOT</td>
<td>.54522</td>
<td>.585</td>
</tr>
</tbody>
</table>

*df = (2,33)
Table 6
Univariate F Tests for the YSRTOT, YSRINT, YSREXT, and BSITOT: Results of Main Effects Analysis for the Sex of Subject Factor

<table>
<thead>
<tr>
<th>Measure</th>
<th>F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>YSRTOT</td>
<td>3.45616</td>
<td>.072</td>
</tr>
<tr>
<td>YSRINT</td>
<td>1.33567</td>
<td>.256</td>
</tr>
<tr>
<td>YSREXT</td>
<td>2.25724</td>
<td>.143</td>
</tr>
<tr>
<td>BSITOT</td>
<td>3.36206</td>
<td>.076</td>
</tr>
</tbody>
</table>

*df = (1, 33)

Table 7
Univariate F Tests for the YSRTOT, YSRINT, YSREXT, and BSITOT: Results of the Confidentiality Condition by Sex of Subject Interaction Analysis

<table>
<thead>
<tr>
<th>Measure</th>
<th>F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>YSRTOT</td>
<td>.65682</td>
<td>.525</td>
</tr>
<tr>
<td>YSRINT</td>
<td>.44880</td>
<td>.642</td>
</tr>
<tr>
<td>YSREXT</td>
<td>1.43874</td>
<td>.252</td>
</tr>
<tr>
<td>BSITOT</td>
<td>1.17987</td>
<td>.320</td>
</tr>
</tbody>
</table>

*df = (2, 33)
and BSITOT (p = 0.076) results were close to statistically significant levels, with females reporting more problems and symptoms than their male counterparts (YSRTOT: Female M = 65.58, Male M = 60.04; BSITOT: Female M = 60.70, Male M = 40.90).

Results of the 3 (confidentiality condition) x 2 (sex of subject) MANOVA of the MMPI K scale (MMPI K), the YSRINT, and the BSITOT are presented in Table 8. Main and interaction effects were all nonsignificant. Tables 9, 10, and 11 present results of univariate F tests for the MMPI K, YSRINT, and BSITOT dependent measures for the confidentiality condition main effect, sex of subject main effect, and the confidentiality x sex of subject interaction, respectively. Univariate F tests were nonsignificant across all main and interaction effect analyses.

Nonsignificant results (Table 12) were also obtained for a 3 x 2 MANOVA of the 20 item form of the Marlowe-Crowne Social Desirability Scale (M-CSDS), the Public Self-Consciousness Scale (PUBSC), and the Private Self-Consciousness Scale (PRISC). Univariate F test results for the individual dependent measures are presented in Table 13 (confidentiality condition main effect), Table 14 (sex of subject main effect), and Table 15 (confidentiality x sex of subject interaction). Again, while uninterpretable given nonsignificant multivariate results, findings presented
Table 8

3 (Confidentiality Condition) x 2 (Sex of Subject)

MANOVA Results for the MMPI K Scale, YSRINT and BSITOT Dependent Variables

<table>
<thead>
<tr>
<th>Effect</th>
<th>DF</th>
<th>F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidentiality</td>
<td>6,64</td>
<td>.77628</td>
<td>.592</td>
</tr>
<tr>
<td>Sex</td>
<td>3,31</td>
<td>1.45122</td>
<td>.247</td>
</tr>
<tr>
<td>Confidentiality x Sex</td>
<td>6,64</td>
<td>.51207</td>
<td>.797</td>
</tr>
</tbody>
</table>

Table 9

Univariate F Tests for the MMPI K Scale, YSRINT, and BSITOT: Results of the Main Effects Analysis for the Confidentiality Factor

<table>
<thead>
<tr>
<th>Measure</th>
<th>F*</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMPI K</td>
<td>.34550</td>
<td>.710</td>
</tr>
<tr>
<td>YSRINT</td>
<td>1.13115</td>
<td>.335</td>
</tr>
<tr>
<td>BSITOT</td>
<td>.54522</td>
<td>.585</td>
</tr>
</tbody>
</table>

*df = (2,33)
Table 10

Univariate F Tests for the MMPI K Scale, YSRINT, and BSITOT: Results of Main Effects Analysis for the Sex of Subject Factor

<table>
<thead>
<tr>
<th>Measure</th>
<th>F*</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMPI-K</td>
<td>.08899</td>
<td>.767</td>
</tr>
<tr>
<td>YSRINT</td>
<td>1.33567</td>
<td>.256</td>
</tr>
<tr>
<td>BSITOT</td>
<td>3.36206</td>
<td>.076</td>
</tr>
</tbody>
</table>

*df = (1,33)

Table 11

Univariate F Tests for the MMPI K Scale, YSRINT, and BSITOT: Results of the Confidentiality Condition by Sex of Subject Interaction Analysis

<table>
<thead>
<tr>
<th>Measure</th>
<th>F*</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMPI-K</td>
<td>.01463</td>
<td>.985</td>
</tr>
<tr>
<td>YSRINT</td>
<td>.44880</td>
<td>.642</td>
</tr>
<tr>
<td>BSITOT</td>
<td>1.17987</td>
<td>.320</td>
</tr>
</tbody>
</table>

*df = (2,33)
Table 12

3 (Confidentiality Condition) x 2 (Sex of Subject)

MANOVA Results for the M-CSDS, PUBSC, and PRISC

Dependent Variables

<table>
<thead>
<tr>
<th>Effect</th>
<th>DF</th>
<th>F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidentiality</td>
<td>6,64</td>
<td>.43640</td>
<td>.852</td>
</tr>
<tr>
<td>Sex</td>
<td>3,31</td>
<td>1.00622</td>
<td>.403</td>
</tr>
<tr>
<td>Confidentiality x Sex</td>
<td>6,64</td>
<td>1.51205</td>
<td>.189</td>
</tr>
</tbody>
</table>

Table 13

Univariate F Tests for the M-CSDS, PUBSC, and PRISC:

Results of Main Effects Analysis for the Confidentiality Factor

<table>
<thead>
<tr>
<th>Measure</th>
<th>F*</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>M-CSDS</td>
<td>.53063</td>
<td>.593</td>
</tr>
<tr>
<td>PUBSC</td>
<td>.61106</td>
<td>.549</td>
</tr>
<tr>
<td>PRISC</td>
<td>.39691</td>
<td>.676</td>
</tr>
</tbody>
</table>

*df = (2,33)
Table 14

Univariate F Tests for the M-CSDS, PUBSC, and PRISC:

Results of Main Effects Analysis for the Sex of Subject Factor

<table>
<thead>
<tr>
<th>Measure</th>
<th>F*</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>M-CSDS</td>
<td>2.07543</td>
<td>.159</td>
</tr>
<tr>
<td>PUBSC</td>
<td>.07652</td>
<td>.784</td>
</tr>
<tr>
<td>PRISC</td>
<td>.59244</td>
<td>.447</td>
</tr>
</tbody>
</table>

*df = (1,33)

Table 15

Univariate F Tests for the M-CSDS, PUBSC, and PRISC:

Results of the Confidentiality Condition by Sex of Subject Interaction Analysis

<table>
<thead>
<tr>
<th>Measure</th>
<th>F*</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>M-CSDS</td>
<td>.91176</td>
<td>.412</td>
</tr>
<tr>
<td>PUBSC</td>
<td>.38247</td>
<td>.685</td>
</tr>
<tr>
<td>PRISC</td>
<td>3.19334</td>
<td>.054</td>
</tr>
</tbody>
</table>

*df = (2,33)
in Table 15 indicate that the confidentiality x sex of subject interaction univariate F for the PRISC measure was close to statistically significant levels (p = .054). Inspection of cell means for the PRISC (see Table 3) suggests that this finding is due to differences between male and female subjects in the control condition.

A 3 (confidentiality condition) x 2 (sex of subject) analysis of variance (ANOVA) was computed for results on the Martin-Larsen Approval Motivation (M-LAM) scale. Again, all main and interaction effects were nonsignificant (Table 16).

In view of the absence of any significant main or interaction effects from any of the previous analyses, separate MANOVAs were computed in which data were collapses across the subject sex factor for the confidentiality analysis, and collapsed for the confidentiality factor for the sex of subject analysis. Collapsing across the sex of subject factor raised the minimum number of subjects per experimental cell to 10 for the confidentiality condition analysis. Collapsing across the confidentiality condition factor raised the minimum number of subjects per experimental cell to 17 for the sex of subject analysis. While such a strategy eliminates the possibility of analysis of a confidentiality condition by sex of subject interaction effect, the increase in the number of subjects per
Table 16

3 (Confidentiality Condition) x 2 (Sex of Subject)

Analysis of Variance for the M-LAM Dependent Variable

<table>
<thead>
<tr>
<th>Effect</th>
<th>DF</th>
<th>F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition</td>
<td>2,33</td>
<td>.00</td>
<td>.997</td>
</tr>
<tr>
<td>Sex</td>
<td>1,33</td>
<td>.23</td>
<td>.631</td>
</tr>
<tr>
<td>Condition x Sex</td>
<td>2,33</td>
<td>.13</td>
<td>.876</td>
</tr>
</tbody>
</table>
experimental cell allows for evaluation of possible main effects under conditions of increased statistical power (Winer, 1971).

Table 17 presents nonsignificant ($p > .05$) results of the MANOVA of all dependent measures for the confidentiality factor, with the sex of subject factor collapsed. Table 18 lists nonsignificant univariate $F$ test results for all 9 dependent measures included in the confidentiality condition multivariate analysis.

Results of the MANOVA of all dependent measures for the sex of subject factor, with collapsing across the confidentiality condition factor, are presented in Table 19. Again, multivariate results were nonsignificant ($p > .05$). Table 20 presents univariate $F$ test results for the 9 dependent measures included in the sex of subject MANOVA. In light of the increased statistical power of the sex of subject analysis subsequent to collapsing across the confidentiality condition, univariate $F$ test results for the four main symptom and personal problem dependent measures (i.e., YSRTOT, YSRINT, YSREXT, and BSITOT) were inspected to compare the present results with those obtained from the previous univariate analyses of the same measures (Table 6). This comparison indicated that the statistical probability of accepting the null hypothesis increased for two of the four measures (i.e., YSRTOT, and YSRINT), while decreasing
Table 17
MANOVA of All Experimental Measures for Confidentiality Condition

<table>
<thead>
<tr>
<th>Effect</th>
<th>DF</th>
<th>F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidentiality</td>
<td>18,58</td>
<td>.36336</td>
<td>.990</td>
</tr>
</tbody>
</table>

Table 18
Univariate F Tests for All Experimental Measures:
Results of the Confidentiality MANOVA

<table>
<thead>
<tr>
<th>Measure</th>
<th>F*</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>YSRTOT</td>
<td>.26600</td>
<td>.768</td>
</tr>
<tr>
<td>YSRINT</td>
<td>.72807</td>
<td>.490</td>
</tr>
<tr>
<td>YSREXT</td>
<td>.05664</td>
<td>.945</td>
</tr>
<tr>
<td>BSITOT</td>
<td>.15575</td>
<td>.856</td>
</tr>
<tr>
<td>MMPI K</td>
<td>.35567</td>
<td>.703</td>
</tr>
<tr>
<td>M-LAM</td>
<td>.03090</td>
<td>.970</td>
</tr>
<tr>
<td>M-CSDS</td>
<td>.15796</td>
<td>.854</td>
</tr>
<tr>
<td>PUBSC</td>
<td>.45052</td>
<td>.641</td>
</tr>
<tr>
<td>PRISC</td>
<td>.67092</td>
<td>.518</td>
</tr>
</tbody>
</table>

*df = (2,36)
Table 19

MANOVA of All Experimental Measures for
Sex of Subject

<table>
<thead>
<tr>
<th>Effect</th>
<th>DF</th>
<th>F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex of Subject</td>
<td>9,29</td>
<td>.89755</td>
<td>.540</td>
</tr>
</tbody>
</table>

Table 20

Univariate F Tests for All Experimental Measures:
Results of the Sex of Subject MANOVA

<table>
<thead>
<tr>
<th>Measure</th>
<th>F*</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>YSRTOT</td>
<td>3.33049</td>
<td>.076</td>
</tr>
<tr>
<td>YSRINT</td>
<td>1.18677</td>
<td>.283</td>
</tr>
<tr>
<td>YSREXT</td>
<td>2.55944</td>
<td>.118</td>
</tr>
<tr>
<td>BSI</td>
<td>4.00108</td>
<td>.053</td>
</tr>
<tr>
<td>MMPI K</td>
<td>.02884</td>
<td>.866</td>
</tr>
<tr>
<td>M-LAM</td>
<td>.35425</td>
<td>.555</td>
</tr>
<tr>
<td>M-CSDS</td>
<td>2.04172</td>
<td>.161</td>
</tr>
<tr>
<td>PUBSC</td>
<td>.01575</td>
<td>.901</td>
</tr>
<tr>
<td>PRISC</td>
<td>.88836</td>
<td>.352</td>
</tr>
</tbody>
</table>

*df = (1,37)
for the YSREXT and BSITOT results. Of particular relevance to the present discussion, none of the four primary self-report measures reached statistically significant levels for the sex of subject factor despite collapsing across the confidentiality factor. Consistent with results of the previously discussed 3 x 2 MANOVA of the YSRTOT, YSRINT, YSREXT, and BSITOT, the univariate F tests for the YSRTOT ($p = .076$) and BSITOT ($p = .053$) were close to statistically significant levels, with females self-reporting more problems than males.
CHAPTER IV

DISCUSSION

In light of legal limits to confidentiality in the Texas Mental Health Code (cited in Hays & Costello, 1985) allowing potential parental or legal guardian access to the mental health information of minor youth, the primary focus of the present study was to evaluate the impact of different levels of assured confidentiality on adolescent psychiatric patients' willingness to self-report personal problems and psychiatric symptoms. Specifically, it was anticipated that subjects informed of the possibility of such a limit to their confidentiality would self-report significantly less problems and psychiatric symptoms than their absolute confidentiality condition counterparts.

In addition, in view of information indicating that patients involved in the present study were informed of their rights under the Texas Mental Health Code (Texas Department of Mental Health and Mental Retardation, 1985), it was predicted that subjects not receiving any information regarding confidentiality in the present study (i.e., control group) would respond according to their preconceived (and legally accurate) beliefs regarding confidentiality limits,
and would also self-report significantly less problems than subjects in the absolute confidentiality condition.

As previously indicated, results obtained failed to support the prediction that limited confidentiality would have a deleterious impact on adolescent patients' personal problem and symptom self-report relative to patients given a guarantee of absolute confidentiality. The present failure to find such an effect is consistent with previous nonsignificant self-disclosure findings reported by Kobocow et al. (1983), and McGuire et al. (1985). In addition, while Bennett (1982) did report differences in self-disclosure as a function of different confidentiality conditions, no significant differences were observed on a measure of symptom self-report.

It should be noted that the failure to find significant confidentiality related differences in both the Kobocow et al. (1983) and Bennett (1982) studies may have been due to confounding effects. For example, Kobocow et al. (1983) indicated that their sample over-reported being given guarantees of confidentiality, while Bennett (1982) reported a higher refusal rate for subjects in the nonconfidential condition than for those in the group in which confidentiality was not addressed. While no significant refusal rate differences were reported between confidential versus nonconfidential condition subjects in the Bennett (1982)
Research, the possibility exists that the refusal rate factor accounted for the failure to find significant differences in symptom report as a function of different confidentiality levels.

In view of prior evidence indicating some degree of adolescent awareness of confidentiality as a potential risk factor relative to treatment (Kaser-Boyd et al., 1985), and other research supporting the view that self-report and self-disclosure are inversely related to limitations on confidentiality (Bennett, 1982; El-Hage Boutros, 1986; Kaplan, 1986; Lane, 1979; Meyer & Willage, 1980; Woods & McNamara, 1980), the present nonsignificant findings suggest several possible explanations.

First, it is conceivable that the potential for parental or legal guardian access to personal mental health information does not constitute a substantial concern for the patient population studied. Consistent with the Larsen et al. (1976) discussion of the need for social approval, the status or importance of the other person is likely to have an impact on the relative risk associated with the possible breach of confidentiality. Thus, for example, in families in which parent-child relationships are strained, distant, or virtually nonexistent, the prospect of the potential involvement of the parent or guardian in the adolescent's personal problems may be considered, at best, remote.
Further, even in situations in which such parental or guardian involvement does exist, a lack of respect or a devaluing of the parent(s) by the teen-ager would similarly seem to reduce the importance of the parent as a significant other. In turn, the relative risk of the parent-legal guardian limit to minors' mental health information confidentiality would also seem to be diminished.

Conversely, while the above discussion is based on the assumption that low significance of the parent or guardian to the adolescent may account for the current null results, it could be hypothesized that high parental or guardian significance could also lead to such findings. For example, in the case of very positive, healthy parent-child relationships, adolescents may not be threatened by possible parental or guardian access to data based on the belief that subsequent parental or guardian responses would be supportive and constructive.

Consistent with the preceding discussion, it is suggested that future work in this area evaluate the quantity and quality of the parent-child relationship as independent variables. For example, it might reasonably be predicted that the possibility of parental or guardian involvement in the teen-ager's mental health concerns would pose little perceived risk in cases of low parental involvement, or in cases of high but supportive parental involvement. Conversely,
in cases of high involvement, but non-supportive or critical parent-child relationships, the prospect of limited confidentiality with respect to parents or guardians may be associated with a greater sense of risk, and thus be linked with increased adolescent defensiveness.

A second factor possibly associated with the present failure to obtain significant confidentiality condition differences in patient self-report is subject trust (cf. Kobocow et al., 1983). Kobocow et al. (1983) stated that "adolescents are very cautious about confidentiality and disclosure issues and are very self-protective regardless of the degree of assurance of privacy given by an adult" (pp. 440-441). Consistent with the Kobocow et al. (1983) discussion of this issue, a possible interpretation of the obtained confidentiality condition null results is that trust in the evaluative context of the study was a more salient factor for participants than the possibility of future parental access of subject responses.

Combining the previous discussion of the role of significant others in evaluating the need for social approval (Larsen et al., 1976) with the Kobocow et al. (1983) concern with adolescents' trust of adults leads to the rather interesting speculation that any subject concerns regarding parental access to information would be effectively masked by even greater immediate approval and trust concerns.
vis-a-vis the experimenter. Congruent with this, correlational data (see Table 1) suggest that both defensiveness and avoidance of disapproval motives (cf. Crowne & Marlowe, 1964; Greene, 1980) were associated with subject responses to the various problem and psychiatric symptom self-report measures.

A third variable of relevance to the present discussion of nonsignificant confidentiality effects is the possibility that subjects who volunteered to participate in the study were less concerned with disclosure or self-report issues than individuals who refused such participation (cf. Taube & Elwork, 1990). Consistent with this possibility, the previously discussed Bennett (1982) finding of differential subject refusal rates for subjects in a nonconfidentiality condition compared to a group in which confidentiality was not mentioned is considered noteworthy. As previously indicated, the Bennett (1982) study did not report significant refusal rate differences between the confidential versus nonconfidential groups.

Specific data were not collected regarding the number of prospective subjects who refused to participate in this study, or the reasons for such refusals; thus, the possibility of a similar factor impacting the present findings cannot be completely ruled out. Anecdotal data indicate that at least one male prospect refused to sign the original informed consent form after asking about the issue of confidentiality.
In order to adequately evaluate this area in future research, it is recommended that the experimenter consider utilizing two separate initial informed consent forms for subjects and for parents or legal guardians. The content of the separate consent form for the prospective subjects would then be varied according to the confidentiality condition to which the participant had been randomly assigned (e.g., control; absolute; limited). Consistent with the Bennett (1982) study, subject rates of refusal to participate as a function of confidentiality condition could then be employed as a dependent measure.

A fourth possible factor in the failure to obtain significant confidentiality findings is related to the issue of the degree of risk associated with the disclosure or report of certain content. For example, research results reported by Taube and Elwork (1990) indicated that different degrees of information regarding confidentiality limitations differentially impacted the admission rate of specific problem areas (e.g., sexual behavior, child neglect, ideation regarding self-harm).

Meyer and Willage (1980), on the basis of research showing differential confidentiality condition effects on subject responses, state that "the more private the information asked and the greater the ability of the subjects to give socially acceptable answers, the stronger the effect
of degree of confidentiality" (p. 243). Unfortunately, Meyer and Willage (1980) failed to specify whether their sample was drawn from a client or nonclient population, with available evidence suggesting that their findings were based on a nonpatient sample. Further, their conclusion regarding differential response effects as a function of the privacy of the content involved was based on comparisons of measures addressing symptom admission, social desirability, and locus of control (Meyer & Willage, 1980).

One implication of the Meyer and Willage (1980) and Taube and Elwork (1990) research is that evaluating item content relative to privacy-related risks may be an important consideration in the evaluation of self-report under various confidentiality conditions. For example, it is possible that the global nature of the self-report measures employed in the present study may have masked possible differential effects which potentially exist relative to more sensitive self-report content. Further, this possibility is considered more likely in the case of the present study in which a patient population was studied, and for whom a certain degree of parental or legal guardian awareness of treatment-related problems pre-existed.

Consistent with this issue, Kobocow et al. (1983) had mental health experts and school teachers rate items utilized in their study of seventh and eighth grade nonpatients
according to the degree of sensitivity associated with disclosure of such content. While results from the Kobocow et al. (1983) study failed to find a significant confidentiality-related effect for the most sensitive items, it is nevertheless recommended that future research evaluate the real or perceived risks of reporting specific content among adolescents (cf. Kobocow et al., 1983). However, in contrast to the Kobocow et al. (1983) strategy of using adults in rating items, it is recommended that the risk of disclosure or self-report for specific content be determined by adolescents themselves. Such an approach would allow a specific test of the hypothesis that subjects would self-report significantly less high-risk content under conditions of limited confidentiality (cf. Meyer & Willage, 1980).

In addition to predictions regarding confidentiality, the present study also predicted sex of subject main and interaction effects. Specifically, in view of evidence suggesting that females may tend to be more concerned and guarded relative to confidentiality and disclosure issues (cf. Kobocow et al., 1983; McGuire et al., 1985; Rosen, 1977; Woods & McNamara, 1980), it was predicted that female patients in the present investigation would self-report significantly less personal problems and psychiatric symptoms than their male patient counterparts. In addition, a confidentiality
condition by sex of subject interaction was also predicted, with subsequent simple main effects analyses indicating that females self-reported significantly less than males in both the limited confidentiality and control group conditions.

Again, results of the present study failed to support these predictions, with all multivariate analyses computed for the various dependent measures indicating nonsignificant differences. Indeed, while basically uninterpretable given the failure to find multivariate significance, it should be noted that the only two problem or symptom self-report measures to come close to statistically significant levels (i.e., YSRTOT and BSITOT) were based on the sex of subject main effects analysis, with results indicating that females actually reported more problems than males as measured by the YSRTOT and BSITOT.

Relative to the discussion of the sex of subject self-report data, one additional point merits consideration. As Derogatis and Spencer (1982) have noted, "females in our culture report significantly greater numbers of psychological symptoms than do males, and tend to do so with increased levels of intensity" (p.18). Thus, it would be possible to argue that the current nonsignificant findings are due to the reduction of female self-report to levels roughly equivalent to those of male subjects based on female concerns
regarding disclosure. However, two major factors would preclude such a possibility.

First, consistent with the recommendation of Achenbach and Edelbrock (1987), all YSR raw scores (i.e., YSRTOT, YSRINT, and YSREXT) were converted to normalized T scores based on appropriate sex of subject normative data. Second, even in the absence of such a conversion from raw scores to T scores for the present BSI results, a significant confidentiality condition by sex of subject interaction effect would still be detected. However, in contrast to the significant simple main effects analyses results predicted above, it would be predicted that such an effect would be observed for the absolute confidentiality condition, with female subjects reporting significantly more than their male counterparts for this level of the confidentiality factor.

A final possible explanation of the obtained null results for both the confidentiality and sex of subject factors is that the reduction in the number of research subjects from the original proposal of a minimum of 10 subjects per experimental cell to a minimum of 5 per cell substantially reduced the statistical power of the study, thereby increasing the likelihood that real differences between groups existed but were not detected (i.e., type 2 error) (Winer, 1971).

As a partial check of this possibility, two additional MANOVAs were computed including all 9 dependent measures
in which results were collapsed across either the confidentiality or the sex of subject factor. The resulting confidentiality condition MANOVA was thus based on a minimum of 10 subjects per cell, while the sex of subject MANOVA had a minimum of 17 subjects per cell. Results of both MANOVAs were nonsignificant (see Tables 17 and 19).

Further, inspection of univariate F test results from the collapsed MANOVA for the confidentiality factor (see Table 18) indicates nonsignificant results for all four of the primary self-report measures. Indeed, the probability of rejecting the null hypothesis actually decreased for three of the four main self-report instruments (i.e., YSRTOT, YSRINT, and YSREXT). Similarly, results of the sex of subject univariate F tests for the primary self-report measures (see Table 20) indicated that all four remained nonsignificant, with both the YSRTOT ($p = .076$) and BSITOT ($p = .053$) again close to reaching statistically significant levels.

While the preceding results cannot, of course, be used to evaluate a confidentiality by sex of subject interaction, they nonetheless provide useful information relative to the topic of statistical power in the separate evaluation of obtained confidentiality and sex of subject factor results. Specifically, the increased number of subjects per experimental cell for the separate confidentiality (minimum $n = 10$) and sex of subject (minimum $n = 17$) MANOVAs (in which
data are collapsed across the other experimental factor) should have resulted in increased statistical power (Winer, 1971). In light of this, the consistency of these results with the nonsignificant findings from the full factorial confidentiality and sex of subject main effects analyses is considered particularly noteworthy.

Finally, in order to provide a theoretical framework for any observed significant confidentiality condition, sex of subject, or confidentiality by sex of subject interaction effects, the present study also evaluated the relationship of several different variables to measures of subject self-report. In view of the failure to obtain significant main or interaction effects from the various relevant multivariate analyses, the following discussion of correlational findings is based on data for the total sample.

First, consistent with the interpretation of the MMPI K scale as a measure of defensiveness (Greene, 1980), it was predicted that significant inverse correlations would be found between the K scale and each of the four problem and symptom self-report measures. As indicated in Table 1, all observed correlations were in the predicted inverse direction. However, only the MMPI K correlations with the YSRINT (p < .05) and the BSITOT (p < .05) reached statistically significant levels.
The present research yielded mixed results relative to predictions regarding the proposed relationship between self-report and subject approval needs. As anticipated, significant inverse correlations ($p < .01$) were found between the M-CSDS and the four primary problem and symptom self-report measures. These findings appear to support the view of the M-CSDS as reflecting defensive tendencies designed to avoid disapproval (Berger et al., 1977; Millham, 1974).

In contrast to the M-CSDS data, however, correlational results between the M-LAM (Martin, 1984) and the four main self-report measures for the total sample were contrary to predictions, with all correlations indicating a positive relationship between the M-LAM and increased problem and symptom admission. Further, correlations between the M-LAM and YSRTOT ($p < .05$), YSRINT ($p < .05$), and BSITOT ($p < .01$) reached statistically significant levels.

It was originally anticipated that, as a measure of the need for social approval (Martin, 1984), higher M-LAM scores would result in attempts to present oneself in a positive light. Thus, it was predicted that an inverse relationship would exist between the M-LAM and the self-reporting of personal problems and symptoms. In view of the obtained contradictory findings, two alternative explanations of the present results are proposed.
First, Martin (1984) has indicated that "high NSA individuals attend to their own behavior as well as actively monitor the social environment for cues concerning appropriate conduct" (p. 517). Given the stated focus of the present research on adolescent self-report, it is possible that the observed positive correlations between the M-LAM and the various personal problem measures reflect a kind of compliance factor.

A second possible explanation is based on the premise put forth by Larsen et al. (1976) that the high need for social approval individual is competitive. The authors suggest that one method "to obtain the approval of significant others is to rank high or higher than other members of society on important social dimensions" (Larsen et al., 1976, p. 4). While at first glance this may seem unrelated to the present discussion, it is suggested that within a treatment setting context it would be possible for individuals to, in essence, compete for attention by actually reporting a greater number of problems or psychiatric symptoms relative to their peers.

While it is not possible to determine the validity of either of these alternative interpretations of the M-LAM correlational findings based on the present investigation, both are considered to be consistent with the data and with the Larsen et al. (1976) and Martin (1984) conceptualization of the need for social approval construct.
Finally, based on evidence that the Fenigstein et al. (1975) private self-consciousness scale is composed of two factors labeled self-reflectiveness and internal state awareness (Burnkrant & Page, 1984; Mittal & Balasubramanian, 1987), it was expected that private self-consciousness scores would be positively correlated with subject self-report on the internalizing scale of the Achenbach and Edelbrock (1987) Youth Self-Report. Further, given evidence that high public self-consciousness subjects may modify responses for public consumption (Scheier, 1980), and that high public self-consciousness subjects scored higher than low public self-consciousness subjects on measures of anxiety and conformity (Tunnell, 1984), an inverse relationship was anticipated between public self-consciousness and subject self-report. This predicted inverse relationship between public self-consciousness and self-report was expected to serve a kind of suppressor variable function, thus accounting for anticipated differences in YSR internalizing scale self-report as a function of different confidentiality conditions.

These predictions were not supported by the obtained findings, with results failing to indicate any significant differences on YSRINT scores across the three confidentiality conditions included in the study (i.e., control group, limited confidentiality group, and absolute confidentiality group).
Further, relative to specific correlational findings, while reference to Table 1 does reveal that the correlation obtained between private self-consciousness scores and the YSR internalizing scale results was in the predicted direction, the results were weak and statistically nonsignificant. In contrast, correlational results for the public self-consciousness measure and the YSRINT scale were statistically significant ($p < .05$). However, contrary to prediction, the observed relationship indicated that higher public self-consciousness scores were associated with greater self-report of internalizing scale problems. Indeed, while the three other correlations obtained between public self-consciousness and problem self-report were statistically nonsignificant, all were positive in direction.

Two possible explanations are proposed to explain these unexpected findings. First, consistent with the prior discussion of the M-LAM results, higher scores on the public self-consciousness scale may reflect a kind of compliance factor, with such individuals' self-report scores increasing as a function of the perceived self-report focus of the study. Such a conclusion is consistent with the findings reported by Tunnell (1984) indicating that high public self-consciousness subjects scored significantly higher than low public self-consciousness subjects on a measure of conformity.
Alternatively, it is possible that the observed positive correlation between public self-consciousness and internalizing problems reflects overlap in the constructs measured. For example, items regarding anxiety, self-consciousness, and deficient energy load on the YSR internalizing scale for both females and males (Achenbach & Edelbrock, 1987). In addition to the previously discussed higher anxiety and conformity scores, Tunnell (1984) found that high public self-consciousness subjects also scored significantly lower on a measure of energy level than their low public self-consciousness counterparts.

Further, findings previously reported by Fenigstein et al. (1975) and by Scheier and Carver (1985) indicated a significant positive correlation between the public self-consciousness and social anxiety subscales of the Self-Consciousness Scale (SCS). Consistent with the Fenigstein et al. (1975) and Scheier and Carver (1985) results, findings from the present study also indicated that public self-consciousness results were significantly correlated with the social anxiety subscale of the revised version of the SCS (Scheier & Carver, 1985) utilized in this investigation ($r = .38, p < .05$). Consistent with the hypothesis that the YSRINT and PUBSC measure somewhat overlapping constructs, the present findings also indicated
a significant correlation between the YSRINT and the social anxiety subscale of the SCS ($r = .53, p < .01$).

As was the case in discussing the M-LAM results, it is not possible to determine which of these competing hypotheses most accurately explain the observed unexpected findings. Indeed, it is considered possible that a combination of the compliance and overlap in construct hypotheses most fully account for the obtained results.

In summary, as Taube and Elwork (1990) have stated relative to discussing contradictory confidentiality-related research findings, "Privacy may matter only to some types of patients and under some types of circumstances" (p. 72). The authors suggested that future research needs to consider two separate factors which may be related to the topic of disclosure in psychological treatment settings as a function of confidentiality (Taube & Elwork, 1990). As stated by Taube and Elwork (1990), these factors are "(a) the extent to which the law is understood by a patient and (b) the extent to which the law is relevant and consequential to a patient" (p. 72). Consistent with this, the present research focus on the impact of specific legal confidentiality limits of direct relevance to adolescent psychiatric patients on personal problem and symptom self-report is considered a step in the right direction.
Finally, while the generalizability of the present findings to other adolescent populations is admittedly limited, the present findings provide some preliminary evidence to suggest that potential parental or guardian access to mental health information may not have a significant global deleterious impact on minor-aged psychiatric patients' willingness to self-report treatment-relevant information.

Given concerns of the potential adverse impact of such information on patient self-report or disclosure (e.g., Haut & Muehleman, 1986; Woods, 1978), such findings would appear to support the view of Muehleman, Pickens, and Robinson (1985) that professionals "need not necessarily fear frightening clients with our disclosures" (p. 396). Congruent with this, Denkowski and Denkowski (1982) have stated that "counseling and psychotherapy seem to proceed adequately without the security of absolute confidentiality" (p. 374).

However, despite such optimism, additional research in this area is considered necessary. As Taube and Elwork (1990) stated, "The extent to which patients are informed about the law and the extent to which the law is consequential for them are two of the factors that determine whether limitations to privacy will affect patients' self-disclosures" (p. 74). The present study addressed the first of these factors. Research directed at more specific features of the second clearly needs to be pursued.
APPENDIX A

INFORMED CONSENT FORM COVER LETTER
Dear Patient and Parent (or Legal Guardian):

Attached you will find a copy of an informed consent form which explains research being conducted at this facility involving 15 to 17 year old patients. Participation in the research is voluntary, and will not interfere with any phase of an individual's ongoing treatment. Those individuals who do volunteer and take part in the research will be paid five (5) dollars at the time of their participation in the study. It should be noted that a decision to volunteer does not guarantee that an individual will be included as an actual research participant.

Prior to participating, each volunteer and his or her parent (or legal guardian) must first read and sign page two (2) of the attached form providing written consent for such participation. All volunteers and their parents or legal guardians retain the right to withdraw consent for participating in the study at any time. Those who choose to not participate should indicate this decision by signing page three (3) of the attached form. After the consent form has been signed by the subject and his or her parent or legal guardian, it should be returned to Mr. David W. Drake in care of the following:

(Insert name and address here)

If any questions remain unanswered by the information provided in the attached consent form, you may contact me for clarification of any concerns by calling (817) 382-8724, collect.

Thank you for your consideration of this matter.

Sincerely,

David W. Drake, M.A.
APPENDIX B

INFORMED CONSENT FORM
INFORMED CONSENT
TEEN-AGER SELF-REPORT STUDY

The primary purpose of the present study is to evaluate teen-agers' self-reporting of information of potential interest to the assessment process in treatment settings. Participation in the research is voluntary, and subjects may withdraw from the study at any time. A decision to not participate will in no way interfere with a patient's ongoing treatment program. Those individuals who do choose to volunteer for the study will be paid five (5) dollars at the time of their actual participation.

Participation in the study will pose no physiological risks to subjects. Psychological and social risks of participation are considered to be no greater than risks incurred in the course of typical assessment or treatment programs.

Participation will involve the completion of a two part research questionnaire which will consist of various individual measures of interest. Subjects will complete the two part research questionnaire in a single session. It is anticipated that approximately one hour of subject time will be required to complete the questionnaire.

Participation in the present study will not yield any direct benefits relative to individual subjects' ongoing treatment program. However, results from the study may have implications for the assessment process for similar patients in the future.

Individuals interested in receiving additional information regarding the study may contact Mr. David W. Drake at (817) 382-8724.

You may consult with a member of the IRB at any time concerning your treatment and welfare by calling the IRB chairman, (name of facility), at (telephone number).

You may consult with a member of the Public Responsibility Committee at any time concerning your treatment and welfare by writing to: Public Responsibility Committee, (address). The Public Responsibility Committee is a group of volunteers who work to protect the rights and interest of patients.

There is no special provision for compensation and medical treatment for research subjects who are physically injured as a result of participating in a research project. Compensation and medical treatment are available to research subjects on the same basis that compensation and medical treatment are
available to other patients.

A. Certification of Person Giving Consent:
I understand each of the above items relating to the participation of ____________ in the research of Teen-ager Self-Report under the care of David Drake, and I hereby consent to his/her participation in the research project.

__________________________
Signature of Parent or Legal Guardian

__________________________
Relation to Subject (Parent or Legal Guardian)


B. Certification of Assent by Proposed Subject:
I understand each of the above items relating to the participation of ____________ in the research of Teen-ager Self-Report under the care of David Drake, and I hereby agree to my participation in the research project. Finally, I understand that I will be paid five (5) dollars, to be paid in cash, at the time of my actual participation in the study.

__________________________
Signature of Patient

__________________________
Date

__________________________
Witness

__________________________
Date

__________________________
Witness

__________________________
Date
I have decided not to participate in the above-named research project.

_________________________________________  __________________________
Signature of Patient                      Date

_________________________________________  __________________________
Witness                                Date

_________________________________________  __________________________
Witness                                Date
APPENDIX C

CONTROL GROUP QUESTIONNAIRE

CONSENT FORM
I understand that on the following pages I will be asked to provide personal information regarding a number of topics. I understand that this information is used to assess problem areas for which people my age often seek professional psychological counseling. Further, while I understand that my responses will not be used for treatment purposes here at (insert name of facility), I also understand that I am to complete the attached forms as if they will be used for personal assessment and treatment information. In addition, I understand that I am to read the directions for each separate measure carefully before proceeding, and that I should answer every item.

__________________________________________
Signature of Patient

__________________________________________
Date
APPENDIX D

ABSOLUTE CONFIDENTIALITY QUESTIONNAIRE

CONSENT FORM
QUESTIONNAIRE-PART I

I understand that on the following pages I will be asked to provide personal information regarding a number of topics. I understand that this information is used to assess problem areas for which people my age often seek professional psychological counseling. Further, while I understand that my responses will not be used for treatment purposes here at (insert name of facility), I also understand that I am to complete the attached forms as if they will be used for personal assessment and treatment information. In addition, I understand that I am to read the directions for each separate measure carefully before proceeding, and that I should answer every item. Finally, I understand that my responses will be kept confidential, with only Mr. Drake having access to my answers.

Signature of Patient    Date
APPENDIX E

LIMITED CONFIDENTIALITY QUESTIONNAIRE

CONSENT FORM
I understand that on the following pages I will be asked to provide personal information regarding a number of topics. I understand that this information is used to assess problem areas for which people my age often seek professional psychological counseling. Further, while I understand that my responses will not be used for treatment purposes here at (insert name of facility), I also understand that I am to complete the attached forms as if they will be used for personal assessment and treatment information. In addition, I understand that I am to read the directions for each separate measure carefully before proceeding, and that I should answer every item. Finally, I understand that my responses will be kept confidential, with only Mr. Drake having access to my answers. However, I also understand that my parents (or legal guardians) retain the legal right to see my responses, and they may do so upon request.

__________________________________________
Signature of Patient

__________________________________________
Date
APPENDIX F

QUESTIONNAIRE PART TWO

COVER PAGE
(Do not write in this space)

QUESTIONNAIRE-PART II

Attached are additional pages for you to complete. Again, please be sure to read the instructions for each separate measure carefully before proceeding, and be sure to respond to every item.
APPENDIX G

PARTICIPANT DEBRIEFING LETTER
Dear Research Participant:

I am writing to provide additional information regarding the research in which you participated at (insert facility name here). The primary purpose of the study was to evaluate the impact of different statements about confidentiality on teenagers' willingness to self-report information of interest in professional counseling settings.

In order to adequately research this issue, each participant was asked to read and sign a form immediately prior to completing the various research measures. This form either made no reference to confidentiality, indicated that all information would be kept absolutely confidential, or stated that parents or legal guardians could see responses upon request.

Subsequent to completing the data collection phase of the study, any identifying information was removed from all subjects' questionnaires. I wanted to take this opportunity to reassure you that your research form is now totally anonymous, thus insuring the complete confidentiality of all of your responses.

If you are interested in receiving an additional letter providing a summary of the conclusions from the research, or if you have additional questions regarding the study, please write to me, prior to June 1, 1992, at the following address:

Mr. David W. Drake  
UNT Box 9514  
Denton, Texas 76203

Your participation has been an important part of this research effort. Allow me to offer my thanks for your cooperation in this matter.

Sincerely,

David W. Drake, M.A.
APPENDIX H

PARENT OR LEGAL GUARDIAN

DEBRIEFING LETTER
Dear Parent or Legal Guardian:

I am writing to provide additional information regarding the research in which your son, daughter, or legal ward participated at (insert facility name here). The primary purpose of the study was to evaluate the impact of different statements about confidentiality on teenagers' willingness to self-report information of interest in professional counseling settings.

In order to adequately research this issue, each participant was asked to read and sign a form immediately prior to completing the various research measures. This form either made no reference to confidentiality, indicated that all information would be kept absolutely confidential, or stated that parents or legal guardians could see responses upon request.

Subsequent to completing the data collection phase of the study, any identifying information was removed from all subjects' questionnaires. As a result, all research forms are now totally anonymous, thus insuring the complete confidentiality of all subject responses.

If you are interested in receiving an additional letter providing a summary of the conclusions from the research, or if you have additional questions regarding the study, please write to me, prior to July 1, 1992, at the following address:

Mr. David W. Drake  
UNT Box 9514  
Denton, Texas 76203

Your son, daughter, or legal ward has been an important part of this research effort. Allow me to offer my thanks for granting permission allowing his or her participation.

Sincerely,

David W. Drake, M.A.
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