Master Therapists’ Decision Making Process Concerning Adolescent Confidentiality: A Grounded Theory Approach

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Ethical codes and laws provide counselors with guidelines for how to approach confidentiality, but there is gap in the literature surrounding counselors’ process of decision-making when managing confidentiality with adolescent clients. This study explored the decision-making process of master therapists concerning adolescent clients. I conducted semi-structured interviews with peer-identified master therapists (N = 10), all of whom were licensed professional counselors with 15 or more years of counseling experience and whose case loads contained 25% or more adolescent clients. Participants included seven females and three males; nine participants identified as Caucasian, and one participant identified as Hispanic. Participants’ ages ranged from 39-61. I analyzed the data, along with two research partners, according to Grounded Theory (GT) methodology. Through constant comparative analysis, a grounded theory emerged from the data in which participants converged understanding of client safety, relationships, and clinical intuition in a process of integrated experience and consultation. With the exception of mandated reporting and mortal danger, ethical guidelines and laws did not seem to factor into participants’ decision making. Implications for counseling practice, preparation, and research are provided.
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Emily Michero
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MASTER THERAPISTS’ DECISION MAKING PROCESS CONCERNING ADOLESCENT CONFIDENTIALITY: A GROUNDED THEORY APPROACH

Adolescence is a time of profound growth and development, and the adolescent brain is changing at the fastest rate since infancy (Siegel, 2013). The change is exciting and contributes to the abundant possibility of adolescence, yet also increases adolescent risk-taking behavior such as experimenting with alcohol and other drugs, reckless driving, unsafe sexual behavior, vandalism, shoplifting, and gang involvement (Collins & Steinburg, 2006; Geldard & Geldard, 2013; Sullivan et al., 2002). Adolescents are also at increased risk for mental health concerns including suicide, non-suicidal self-injury (NSSI), substance abuse, and eating disorders (Center for Disease Control [CDC], 2013; SAHMSA, 2014; Zetterqvist, Lundh, Dahlstrom, & Svedin, 2013). In any given year, 16% of adolescents consider suicide, 13% of adolescents create a suicide plan, and 8% of adolescents attempt suicide (CDC, 2013). Four of ten adolescents engaged in NSSI in the past year (Zetterqvist et al., 2013). Individuals are the most likely to develop substance abuse during adolescence; 70% of adolescents have consumed alcohol, and 50% have used an illegal substance by senior year of high school (SAHMSA, 2014). Eating disorders such as Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorder often emerge during adolescence are coupled with many, even lethal, health concerns (American Psychiatric Association, 2013). These examples are only a few examples of challenging mental health concerns that may bring adolescents to counseling.

Counselors must have thorough understanding of adolescent development and the developmental changes that impact decision-making skills, risk taking behavior, and common presenting concerns. Puberty, the process of sexual maturation, occurs at different times and rates for male and females (Berk, 2007), is the most outwardly visible change in adolescents, yet
only accounts for a fraction of changes during adolescence. Brain development in adolescence is
surpassed only by infancy, and adolescent brains experience a burst of neural production,
structural changes, and functional organization (Stiles & Jernigan, 2010). Connections between
the frontal lobes and other areas of the brain are not fully developed and impact adolescent
decision-making, particularly in time of stress or pressure (Siegel, 2013). Cognitive
development is also under construction, as adolescents shift from concrete operational thought to
a newfound capacity for abstract, formal operational thought (Piaget & Inhelder, 1969).

Physical, brain, and cognitive development impact adolescent decision-making. Some
research indicated adolescents’ decision-making capacity rivals that of adults (Grisso & Vierling,
1978) yet emotional and social variables may skew adolescents’ abilities to access newly-
acquired decision-making skills (Cauffman & Steinburg, 2012; Steinburg & Monahan, 2007). In
addition to potentially reduced decision-making skills, adolescents tend to place more emphasis
on immediate needs than long-term consequences, resulting in increased risk taking (Sullivan et
al., 2002). Adolescent risk taking may be a way to test limits of independent decision-making;
therefore, some level of risk taking is developmentally appropriate (Rae, Sullivan, Razo, George,
& Ramirez, 2002).

Adolescents often present to counseling for risk taking behaviors (Collins & Stienburg,
2006; Geldard & Geldard, 2013), and counselors must decide whether to notify parents or
guardians about potentially dangerous behavior. Unfortunately, this decision is not easily made
and can have a profound impact on the therapeutic relationship. In the following sections, I
present ethical codes, legal requirements, and scholarly literature addressing the unique
challenges of managing confidentiality with adolescent clients.

Ethical Codes and Legal Requirements
A unique aspect of working with minor clients is the balance of maintaining adolescent trust while recognizing parents’ ultimate responsibility for their children’s safety. When searching for guidance surrounding respecting adolescent client confidentiality while simultaneously respecting parental rights, counselors may struggle to rectify differences between ethical codes and laws.

“Confidentiality is the cornerstone of the counseling relationship” (ACA, 2014, p. 2). Both adult and child clients value confidentiality, and threats to confidentiality may negatively impact the counseling process (Gonzalez, 2003; Kobocow et al., 1983; McGuire, Graves, & Blau, 1985; Messanger & McGuire, 1981; Schmid et al, 1983). The ACA Code of Ethics highlights the importance of confidentiality for clients regardless of age. Counselors must inform clients of the limits of confidentiality explicitly (A.2.b). When clients are minors, counselors inform parents of the confidential nature of the counseling relationship consistent with current state laws and work collaboratively with parents to best serve clients (B.5.b). Taylor and Adelman (1989) suggested engaging parents in initial sessions to encourage collaboration and educate regarding the importance of confidentiality within the therapeutic relationship. However, the degree to which it is possible to protect client privacy varies greatly between clients and situations and is impacted by legal mandates.

The United States Supreme Court endorsed confidentiality in counseling noting that “the mere possibility of disclosure may impeded development of the confidential relationship necessary for successful treatment” (Jaffe v. Redmond, 1999, p. 10). Unfortunately, legal regulations for minors are not as clear with the exception of The Child Abuse Prevention and Treatment Act (1987) which requires counselors to report suspected child abuse to the authorities. The Health Insurance Portability and Accountability Act (HIPAA; 1996) identifies
parents as adolescents’ personal representatives, yet allows minors to act as their own representative when parents or guardians and providers have agreed to confidentiality.

State regulations also influence the degree to which counselors have a legal obligation to disclose elements of the counseling process to parents. For example, Texas Health and Safety Code 611 mandates the contents of a confidential record be made available to parents if the patient is a minor. Because parents hold the privilege of the files, parents may request access to their children’s files at any time. Although some states provide exceptions to parental consent for help seeking in certain circumstances (e.g., addiction or pregnancy treatment) parents tend to maintain the privilege of consent, confidentiality, and access to records.

The flexible nature of both ethical codes and laws may present unique challenges to counselors who work with adolescents who are engaging in risk-taking behaviors. To further complicate this dilemma, adolescents may be especially sensitive to issues surrounding confidentiality and, at times, expect greater levels of confidentiality than counselors are able to legally provide (Gonzalez, 2003; Kobocow et al., 1983; Messenger & McGuire, 1981). Given heightened concern about confidentiality, adolescents may be reluctant to enter into counseling out of concern for parental disclosure (Collins & Knowles, 1995; West & Kayser, 1991).

Scholarly Guidelines for Managing Confidentiality

To date, there is limited and often dated scholarly guidance regarding when and how physical and mental health professionals manage confidentiality with minors. In hypothetical vignette studies, both child psychologists (Rae et al., 2002) and school counselors (Moyer & Sullivan, 2008) indicated that they made decisions about parental disclosure based on severity and risk, with school counselors also indicating consideration of intensity of behaviors, duration...
of concern, and age of student. Similarly, mental health counselors indicated greater likelihood of parental disclosure for younger children compared to older adolescents (Isaac & Stone, 2001).

The medical community has also examined how adolescents’ beliefs regarding confidentiality impacted decisions to seek medical treatment. The Commonwealth Fund Survey of the Health of Adolescent Girls (Klein, Wilson, McNulty, Kapphahn, & Collins, 1999) discovered approximately one quarter (27%) of adolescents reported not seeking needed medical treatment for concerns, 35% of whom reported their primary reason was not wanting parents to know about treatment. Similarly, 18.7% of adolescents forwent healthcare in the previous year, many of whom reported fears regarding confidentiality as the primary reason for forgoing health care. Those foregoing healthcare had increased prevalence of depressive symptoms, suicidal ideation, and previous suicide attempts (Ford, Bearman, & Moody, 1999).

Adolescents’ perceptions of confidentiality and trust in the counseling relationship may impact level of disclosure in counseling (Geldard & Geldard, 2013; Welfel, 2012). Although research indicates adolescents value confidentiality, and scholars agree adolescents should be involved in the informed consent process (Gonzalez, 2003; McGuire, Parnell, Blau, & Abbott, 1994), it is unclear whether adolescents are capable of making independent treatment decisions. Some scholars believe adolescents’ decision-making skills rival adults (e.g., Moyer & Sullivan, 2008; Moyer et al., 2012; Rae et al., 2002; Weilhthorn & Campbell, 1982) while others assert adolescents’ decision-making is significantly impaired by stress and relational influence (e.g., Cauffman & Steinburg, 2012, Steinburg & Monahan, 2007). The research provides some insight into the unpredictable nature of adolescent decision-making skills and adds another layer of consideration when determining how to manage confidentiality with adolescents.
Adolescent development, decision-making skills, and the highly interpretive nature of existing codes and laws places makes decisions about confidentiality especially difficult. To date, much literature regarding breach of confidentiality with minors is general, hypothetical, and lacks concrete examples. Although these studies are successful in describing when mental health providers would hypothetically breach confidentiality, they do not account for uniqueness of each client’s situation, investigate actual counseling experiences, or provide understanding about how those decisions are, or should be, made in practice.

The purpose of this study was to develop a grounded theory that explained master therapists’ decision-making process concerning adolescent confidentiality. Specifically, (1) what strategies do counselors use to resolve ethical dilemmas about confidentiality, (2) what conditions influence decision-making about confidentiality, and (3) what are the consequences of chosen decisions?

Method

I utilized the constant comparative method to identify a grounded theory that emerged from participants’ experiences (Charmaz, 2006). In the following section I describe participants, research team, participant selection, data collection, data analysis, and trustworthiness of this study.

Participants

All participants (N = 10) met the following criteria: identification as a master therapists by colleagues, minimum of fifteen years counseling experience, 25% of counseling practiced dedicated to adolescents, and current licensure as Licensed Professional Counselor in the state Texas. Six participants identified as Caucasian females, one participant identified as a Latino female, and three participants identified as Caucasian males. Nine participants worked in private
practice, and one participant worked in a school system as well as in private practice. Six participants held masters degrees, and four participants held doctoral degrees. Additional demographic information, including practice details and theoretical orientation, is provided in Table 1.

Research Team

The research team consisted of three doctoral students and a supervising researcher. The primary researcher was a White female in her mid-thirties who was a Licensed Professional Counselor-Supervisor (LPC-S), operated a private practice, and had extensive counseling experience with adolescents. In grounded theory, researchers accept and acknowledge the impossibility of approaching data with a “clean slate” (Charmez, 2006; Creswell, 2012), thus the primary researcher considered how clinical focus and life experiences impact interpretation of the data. The remaining coding team members were doctoral students who had training in qualitative methodology, and intentionally did not possess significant clinical experience with adolescents in order to reduce bias. A faculty member experienced in research methodology served as a consultant and peer reviewer throughout the process.

Procedures

Participant selection. Following Institutional Review Board approval, I utilized purposeful and snowball sampling initially, followed by theoretical sampling to select participants (Creswell, 2009; Glaser & Strauss, 1967; Morse, 2007) who may add richness to a developing theory or who may contradict a developing theory (Morse, 2007). Through purposeful sampling, I identified the initial two master therapist participants due to their excellent reputation in the community and experience with adolescents. Remaining participants were nominated by participants or esteemed counselors in the field. I contacted nominated
participants to inform them about the study and assess their eligibility for participation. Interested individuals received informed consent documentation and completed a demographic survey regarding gender, age, ethnicity, years of experience, percentage of adolescent clients, degrees, practice location, and theoretical orientation.

Data collection. The primary means of data collection was semi-structured interviews and also included informed consent paperwork and a demographic form. I developed the interview based on recommendations by Heppner et al. (2008) and used six types of questions to gain understanding of participant’s experiences: background, behavioral, opinion or belief, feelings, knowledge, and experience. The interview protocol included the following questions:

- What is your background working with adolescents?
- What do you usually do when confidentiality becomes an issue with adolescent clients?
- What is your belief about the best way to handle confidentiality with adolescents?
- How do you feel when a situation arises that may warrant parental notification?
- Describe your experience(s) of handling adolescent confidentiality?

The interview protocol also included potential prompts for further exploration. In later stages of data collection, I adapted questions to confirm or disconfirm the developing theory (Corbin & Strauss, 2008). Interviews lasted an average of 60 minutes and were conducted in person, audio-recorded, de-identified, transcribed verbatim, and checked prior to analysis.

Data analysis. The research tea utilized the constant comparative method with attention to open, focused, and theoretical waves of coding (Charmaz, 2006; Corbin & Strauss, 2008). The coding team began by reading through each transcript in order to gain an overall sense of the interview. Next team members engaged in line-by-line coding noting themes, key terms, and
emerging categories. The coding team compared new and existing codes throughout the constant comparative process, meeting weekly to discuss and compare codes for each interview. Within the identified categories, we looked for potential subcategories encompassed by a larger category (Corbin & Strauss, 2008). In the focused coding phase, the coding team drew categories together paying attention to causal conditions that prompted decision making, strategies and actions that were used in the decision making process, intervening conditions that influenced decisions made, and consequences of decisions (Bryant & Charmaz, 2012).

Selective or theoretical coding occurred after the research team identified potential core categories (Bryant & Charmaz, 2012). After the seventh interview analysis, the coding team identified four potential core categories. From that point on, coding and data gathering were purposeful and relevant to the emerging conceptual framework (Corbin & Strauss, 2008). In the following interviews, the primary researcher asked participants about these four categories in order to elicit confirmatory or non-confirmatory information. The four core categories were confirmed through the three additional interviews and developed into a theory about the decision-making process of master therapists and adolescent confidentiality. As recommended by Francis (2010), data saturation was evaluated at intervals, in this study after the fourth, seventh, and tenth interviews. After the tenth interview, it was clear saturation had been reached given no new data had emerged since the seventh interview. All members of the research team agreed upon the final analysis. Finally, all participants were presented with the theory and eight confirmed the accuracy of the findings.

Trustworthiness

Corbin and Strauss (2011) recommended researchers stay vigilant during interviews and analysis, maintaining connection with respondents while maintaining enough distance to think
analytically and be aware of their own internal processes. In order to reduce the research teams
bias’ we discussed how our experiences might impact analysis prior to data collection and again
throughout the coding process. I intentionally used participants’ rich descriptions to illuminate
the theory rather than relying on my subjective interpretation (Creswell, 2011). I also utilized a
coding team to enhance trustworthiness, as well as consultation with a supervising faculty
member which adds to the reliability of coding (Saldana, 2009). Rigor was further enhanced by
triangulation of the data through member checks (Creswell, 2011). Consistent with grounded
theory recommendations, I kept memos and an audit trail throughout the process (Birks & Mills,
2012; Charmaz, 2006; Creswell, 2008; Corbin & Strauss, 2008).

Results

Through constant comparative analysis, a grounded theory emerged from the data in
which participants converged understanding of client safety, relationships, and clinical intuition
in a process of integrated experience and consultation. With the exception of mandated reporting
and mortal danger, rules, ethical guidelines, and laws did not seem to factor into participants’
decision making. Rather than adhering to a formal ethical decision making model, participants
described integrated knowledge and consultation as guiding the process in their decisions. The
resulting model can be found in Figure 1. Figure 1 illustrates the core component of mortal
safety encircled by the counselor as a person and the complex relationships involved. Ethical
codes, legal regulations, and informed consent practices sit below as the foundation for the
decision-making process. Participants began interviews by introducing their informed consent
process as the foundation for decision-making about confidentiality. I also begin with
participants’ informed consent procedures in attempt to lay groundwork for the remainder of
their process.
Early in the interviews, participants talked about the importance of clearly explaining confidentiality to parents and adolescents prior to engaging in counseling. Although the informed consent process did not seem to factor into participants’ decision-making process during ethical dilemmas, the initial education and agreement was the foundation for participants’ decisions. Faith said, “It’s really important to me that everybody knows what the ground rules are.” Betsy further explained, “The benefit of so much being said ahead of time so the informed consent really being, ‘You need to know this.’” In all, participants described the importance of informed consent early and rarely referenced it again, but it was apparent they felt the process was essential for future decision-making.
Similarly, participants mentioned ethical codes and laws early in the interviews, or almost in passing later, indicating an integration of those codes and laws that inform their decision-making in a foundational manner. In the words of Tom, “Always adhere to your baseline code of ethics.” Participants also referenced relevant laws, particularly in regard to mandated reporting, as a foundation piece of their decision-making. In general participants moved onto safety after they described informed consent and ethical/legal foundations.

Safety

Counselors most clearly agreed upon one area surrounding adolescent confidentiality: safety. All 10 counselors identified life or death danger as a clear-cut factor that influenced their decision-making with regard to informing parents. When asked about when participants breach confidentiality they responded with answers about safety, such as;

*The 3... Injury to self, injury to others, and somebody hurting them.* (Trish)

*In a situation where I really do believe that it is life in danger, not quality of life, not protecting some future I want to be a doctor thing, but are you going to die...bleeding on the carpet.* (Tom)

Their responses clearly indicated mortal safety concerns would result in a breach of confidentiality. As Faith stated, “safety trumps everything.”

Although participants focused the most on mortal safety, they also discussed the process of decision-making surrounding non-lethal behavior. Participants described the tension or discomfort of knowing their adolescent clients could be engaging in potentially dangerous behavior without their parents’ knowledge, and several participants gauged the severity of the behavior based on their ability to sleep that night knowing the behavior may occur. In Nancy’s words, “Am I going to be able to sleep at night if something really does happen?”
Although participants had nuanced differences in their interpretation of harm, they all discussed the difference between mortal safety and potentially dangerous behavior. Generally, participants discussed mortal safety within the first few minutes of interviews, as if ethical decision-making began after an assurance of client safety. In making decisions concerning types of behavior including NSSI, substance use, and sexual activity, participants described consideration of how severe the behavior was (severity), how often the behavior happened (intensity), and how long the behavior had been going on (duration). Individual interpretations of severity, intensity, and duration varied, but the each participant talked about these factors in their decision-making.

_I just say, "Well, let's look at it. Your grades are dropping. Your face is breaking out a lot. I'm concerned about what drug you're using, how often you're using it." I'll look at that intensity, duration, and severity...We look at that all, the client and I, "Okay, let's look at this. How often is it happening?" It depends I guess on how severe it is._ (Nancy)

_If we use the cutter as our example...in their actions that they really are cutting deeper, cutting longer, that kind of a thing. That would be one of my criteria._ (Tom)

After discussing mortal safety, severity, intensity, and duration of behavior, participants turned attention to complex relationships. Participants spoke less of the following factors if mortal safety was in jeopardy, and it appeared relationships involved had greater impact on decisions not related to imminent harm.

Parent, Adolescent, and Parent Relationships

Participants’ decision-making process included consideration of the impact of maintaining confidentiality or sharing information on all relationships. There appeared to be a relationship triad that impacted counselor decision-making: the client-counselor relationship,
counselor-parent relationship, and the adolescent-parent relationship. These three relationships were interwoven throughout interviews and impacted decisions about confidentiality in a multitude of ways. Ethan succinctly described the balance of the relationships involved, “the balance between maintaining trust with adolescent and providing parents with just enough to stay off my back and let me work with their kid; and to provide parents with enough information to make their own changes for their own benefit.” Other participants described their desire to include parents in the counseling process:

"On the other hand, the way that child is being parented is a very close second to how that child's functioning and healing that family communication. Parents can do the therapy if they're responding in a way that's helpful. Sometimes that's part of what brings a teenager in, is just the disconnect that's happening at home. That's where I guess it gets blurry is because the parents have to be part of the healing process." (Olivia)

"I always want to include them, the level of inclusion is really determined by the level of trust that the client had in me in branching out, and the level of capabilities that the parents have." (Tom)

Although counselors highly advocated for parental involvement in the counseling process, they also talked about the difficulty of protecting the client/counselor relationship while holding potentially risking information from parents.

"I also know that if I do that (inform parents) I am risking losing the client or the losing the relationship, and if I lose the client, then ethically what have I done to this family and this child?" (Olivia)

"If I called every single parent on every single child that told me they smoked weed, I wouldn't have any kids talking to me. It's very important to me to work with the child on
making better choices before I just run to them...I can't work with them, they're not going to work for me, trying to work through and make better choices about drugs. (Trish)

Notably, participants reported assessing the impact of parental notification based on parents’ ability to use the information in a helpful manner:

I've got to take a look at the quality of my parent and figure out for myself, what's that line? ‘You can't handle the truth.’ (Tom)

If a parent can be trusted with information ... There's a kid that I work with and the mom was always very volatile and reactive and so I was very careful what I told her, very careful. (Stephen)

Only one participant reported parental fitness did not impact her decisions about parental disclosure. She was the only participant bound by a school policy and expressed regret in being bound by those rules:

A lot of these parents aren't necessarily going to handle it the way I want them to.

Because sometimes it is worse calling the parents. But it doesn't change. It's in the back of my head... but it doesn't change what I have to do. (Trish)

Above all relationships, participants clearly valued the client/counselor relationship, “The relationship is the healing component” (Olivia). As illustrated in the above excerpts, counselors considered the impact of breach of confidentiality on the client/counselor relationship and, in turn, the effectiveness of counseling. Several participants described a breach of confidentiality in cases of safety as positive modeling for the client/counselor relationship. Olivia described the core messages as “I'm saying that as a human being. I'm an adult in your life and I care about your safety.” Although participants generally referred to the relationship as essential, several reported their willingness to risk the relationship for the safety of the adolescent. For example,
Even if she was pissed off and alive and didn't ever want to see me again. That was better than the possibility of her being dead. (Terri)

Counselors described the importance of all parties involved trusting one another. Through this trust and enhanced communication with parents, adolescents had less fear of the counselors “ratting me out” (Tom). It appeared ideally a level of trust was established in which adolescents trusted their counselor to inform parents of information if truly in their best interest.

Intuition

The phenomenon of intuition arose when participants were asked about how they determined when adolescent clients were in danger and warranted parental notification. As included in the following excerpts, several counselors included a spiritual element in decision-making and included that influence when talking about feeling, intuition, or knowing. These discussions included an ineffable component; often participants’ speech slowed and they appeared to be searching for the right word. Several clients pointed to their chest or abdomen when describing a feeling, knowing, or gut reaction.

Gut... Do I believe the person, do I trust them?... 'I'm sorry I care about you too much to let you go. I know you're saying you're okay, but there's something inside of me that's saying 'Don't let you go.’” (Betsy)

So much is happening that I don't know how to put words to it but that perception, if I was given enough time I could tell you exactly how I came to that conclusion. You look at them and you just get something’s not right here ... It is sort of clinical intuition but there are markers that you see.... A lot of life is lived on intuition” (Stephen)

I asked Betsy if her use of intuition was related to her experience; in response, she spoke to how she learned to trust her intuition:
I think what I've noticed, at least in my beginning counselors is a lot of times they'll see the exact same thing I saw, they just don't trust themselves to either act on it, or that it's there, or they don't know how to say it, but they already see it. I can't teach somebody to see it, I can only teach somebody on how to deliver it. Helping them trust what is innately in there, maybe in all of us. (Betsy)

Integrated Decision-Making

I included the question, “Do you follow an ethical decision making model?” in the interview protocol due to the prevalence of ethical decision-making models in academic recommendations. Not one participant reported following a formal ethical decision making model. Although participants appeared taken aback by questions about decision-making models, their responses included important information about their decision-making processes. Participants used words such as “integrated,” “ingrained,” and “intrinsic” to describe their decision-making process,

I think they become almost intrinsic, just like your skill set. (Betsy)

I think it's just ingrained in the way that I think, because ethically we're suppose to protect our clients. By extensions the client’s family is like our client as well, but we have our primary client. Everything is about protecting the client. All the decisions are about protecting the client. Protecting and assisting. (Terri)

Many participants talked about the importance of consultation in their decision-making process. Focus on consultation generally occurred directly after I asked participants about adherence to a decision-making mode.
I think consultation has been my best bet... That's not a formal model, but consultation... So what I did was, again, great deal of thought, consulting, called my mentor from graduate school. (Faith)

I mean, quite often my model is that, okay, an ethical dilemma comes up, and I'm not totally for sure. I will call a colleague first. We'll discuss it. If they don't know for sure, there are times I actually will call CPS and say, "Don't have a clue on this one."

(Stephanie)

It really is about client care, it really is about let me consult somebody who knows more than I do so that I can give the best. (Terri)

Through the interviews and the development of the preceding core categories, a theory about the decision-making process of master therapists emerged. The master therapists have convergent process of integrated experience and consultation involving consideration of client safety, examination of relationships involved, and use of clinical intuition and experiences.

Discussion

In the following I explore how the grounded theory of master therapists decision-making surrounding adolescent confidentiality supports, challenges, or expands the current literature. I consider limitations of the present study, and I conclude with implications for clinical practice, training, teaching, and research.

Consistent with previous literature that identifies mortal risk as the most cohesive deciding factor for counselors’ confidentiality decisions (e.g., Moyer & Sullivan, 2008; Moyer, Sullivan, & Growcock, 2012; Rae et al., 2002), participants identified suicidal ideation as the most common reason for breaching confidentiality with adolescents. Like previous scholars (Rae et al., 2001), participants noted that adolescents often take risks and some degree of risk taking is
developmentally appropriate, presenting a need to determine when an adolescent’s risk taking behavior has become dangerous and in need of parental notification. Many of the counselors described weighing severity, intensity, and duration of behavior when considering level of harm with adolescents, and several referenced participant age as factoring into assessment of these elements. Authors of previous research identified similar considerations for when counselors would breach confidentiality (Isaac & Stone, 2001; Moyer & Sullivan, 2008; Moyer et al., 2012; Rae et al., 2002); however, participants in this study went well beyond considering these behavioral elements. These participants include a complex, rational process that has not been discussed in the research.

Participants discussed the importance of parental involvement in the adolescent counseling process and how parental involvement enhanced their decision-making process. Consistent with ethical guidelines and existing literature, participants stressed the importance of a clear informed consent process to educate all parties about the limits of confidentiality (ACA, 2004; Taylor & Adelman, 1989). Unique to this study is the clear inclusion of parental-adolescent-counselor relationships directly impacting decisions about confidentiality. Participants weighed complex factors when deciding whether or how to disclose risk-taking behaviors to parents, often using intuition to predict potential consequences of their decisions.

Although the *ACA Code of Ethics* (2014) encourages the use of ethical decision-making models, participating counselors not did not follow ethical decision-making models, and several were not familiar with such models. Rather, they described an integrated process of decision-making based on a culmination of experience and pattern recognition. These descriptions included consideration of ethical codes, laws, and literature perhaps in a way that led them to feel as if they did not need to consult the codes formally. Interestingly, participants’ responses
included many, if not all, of the components of highly regarded decision-making models (ACA, 2014, Welfel, 2011). These models encourage the use of consultation, and participants spoke with passion and humility about the importance of consultation in their decision-making practice, often gathering multiple perspectives before making decisions.

Generally participants talked about a sense of knowing that included a felt sense along with an integrated sense of knowledge. Some scholars have described intuition in counseling as the synthesis of clinical data, theoretical knowledge, and practical experience (Eisengart & Faiver, 1996, p. 41), and experienced counselors have shown the ability to act intuitively more often than novices, perhaps due to accumulated experience and increased ability to recognize familiar patterns (Benner, 1982; Prietula & Simon, 1989). Participants described the ambiguity and complexity of confidentiality that required them to trust themselves and their clinical knowledge. These descriptions of clinical intuition fit with Jennings and Skovholt’s (1999) descriptions of master therapists who value cognitive complexity and ambiguity and draw heavily on accumulated experiences. The use of intuition to guide decision-making is not a new finding, but the use of intuition in regard to adolescent confidentiality enhances the literature.

Limitations

Although Corbin and Strauss (2011) proposed that GT is abstractly generalizable, this research is not generalizable. Participants were seasoned clinicians, a distinction that enhanced yet also limited the theory. I believe master therapists provide an enhanced level of insight and experience, yet this theory may not represent all counselors’ decision-making processes. Most participants practiced in a historically conservative area of the country, religiously and politically, which may impact the abstract generalizability of the study. Also, the majority of participants were independent private practice counselors who did not accept third party
reimbursement and who reported high levels of parental involvement. Although one participant was a school counselor who had a small private practice and another participant had a long history of working for outpatient mental health programs, their collective experience may vary from counselors who work in public mental health settings. Despite efforts to recruit a diverse participant pool and success identifying participants who were diverse in theoretical orientation, the study lacked ethnic diversity; nine participants identified as Caucasian and one participant identified as Hispanic. In all, the counselors interviewed generally served primarily middle to upper class, conservative clients with involved parents.

An unavoidable limitation of this study was my bias as a counselor who primarily works with adolescent clients. I knew four of the participants professionally prior to the interviews, which may have impacted the interviews. I did not perceive those participants to be more or less open yet I cannot know how they may have responded to a more anonymous researcher. I strove to reduce bias by recruiting coding team members who do not primarily see adolescent clients. I discussed my potential bias with the coding team weekly and addressed bias in my memos but it is impossible to erase my experiences and beliefs from the process. I acknowledge the bias I am unable to completely remove.

Implications

Findings regarding master therapists’ consideration of risk elements, complex relationships, intuition, and integrated decision-making may be used to support counselor preparation, practice, and research.

Counselor preparation. Counselor preparation programs teach students to balance legal mandates along with what is best clinically and ethically. Although beginning counselors may benefit from the structure of an ethical decision-making model, it appears advanced counselors
are less likely to use or be familiar with decision-making models. Still, participants’ rich
descriptions of decision-making process’ included several aspects of ethical decision-making
models through an integrated mode of responding. Counselor educators may wish to consider
how to create meaningful, personalized experiences when teaching ethical decision-making
models that can develop with the counselors in training.

Several participants reflected on how supervisors enhanced their ability to make ethical
decisions and trust their decisions and the positive impact excellent supervisors had on their
decision-making abilities at length. Specifically participants talked about the impact of
supervisors encouraging and trusting independent decision-making. This finding highlights the
impact of returning responsibility to the supervisee rather than providing concrete advice.

Counseling practice. Participants’ experiences can serve as model for counselors faced
with dilemmas about adolescent confidentiality. Counselors can be encouraged by these master
therapists to consider level of safety along with impact on relationships. Counselors may also be
inspired to consult their intuition along with peers and supervisors. Although qualitative findings
are inherently not generalizable, these master therapists’ experiences may serve as an
aspirational model for practice.

I doubt many are surprised by the counselors’ emphasis on client safety and the impact of
mortal safety on their decision-making. Regardless, I believe the distinction between adolescent
risk taking and mortal safety is often blurry. The participants interviewed felt strongly about
suicidal clients but were not able to provide definitive markers for danger to self with other
behaviors. Their acceptance of the ambiguity with so many situations and a willingness to take
each decision as a case by case may serve as a model for counselors who look for a “right” way
to handle a given scenario. The participants described a multitude of variables that influences each decision, and the need to weigh each variable for each case.

The master therapists’ use of self and intuition was a prominent similarity among participants and highlights the importance of counselors’ use of self and trust of self in decision-making. Supervisors and counselor preparation programs are encouraged to enhance trainees’ trust in self and use of intuition by increased focus on the internal experience of the counselor. Emphasis on personal growth and clinical judgment may encourage counselors in training to notice and trust their intuition.

Although participants were selected based on distinction and expert status in the counseling profession, consultation was one of the most salient factors for their decision-making. This finding can encourage a sense of humility for all counselors to seek out consultation when presented with ethical dilemmas. Counselors may be well served to foster and maintain relationships with other counselors in order to access the clearly invaluable tool of consultation.

Research. It is possible that master therapists make decisions regarding risk and confidentiality differently than beginning counselors. Future research could include comparisons of master therapists and beginning counselors’ decision making or explore how counselor development impacts ethical decision-making process. Additionally, a further look into the decision-making of counselors in various settings such as schools, outpatient clinics, or hospitals would enhance the literature. Existing literature encourages the use of decision-making models yet ten advanced counselors, many who supervisee and teach, are not familiar with decision-making models. Future research on the functionality or presentation of ethical decision-making models is warranted.

Conclusion
The limitations described are important but do not detract from the importance of this study and the implications for future research, counselor preparation, and practice. Many aspects of participants’ experiences and decision-making processes align with the existing literature. Counselors described an informed consent process that follows the recommendations of many authors. Counselors assessed safety and made decisions based on the level of lethal risk as well as the severity, intensity, and duration of behaviors. Counselors valued all relationships involved and the relationships impacted decision-making in a variety of ways. I believe these participants can serve as a model for current and future counselors. In particular, each of these participants holds a bank of knowledge and experiences and models the ability to trust intuition and the humility to ask for help. Ethical dilemmas are often unclear, yet the participants provide guidance on navigating these dilemmas with integrity and intention.

Table 1

*Participant Demographics*

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<th>Name</th>
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<th>Degree</th>
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References


APPENDIX A:

INTRODUCTION
Adolescence is a time of profound growth and development, and the adolescent brain is changing at the fastest rate since infancy (Siegel, 2013). The change is exciting and contributes to the abundant possibility of adolescence, yet also increases adolescent risk-taking behavior such as experimenting with alcohol and other drugs, reckless driving, unsafe sexual behavior, vandalism, shoplifting, and gang involvement (Collins & Steinburg, 2006; Geldard & Geldard, 2013; Sullivan et al., 2002). Although, some level of risk-taking is developmentally appropriate for adolescents (Rae, Sullivan, Razo, George, & Ramirez, 2002), clinicians may struggle to determine when normative risk taking has escalated to dangerous risk.

Adolescents are also at increased risk for mental health concerns including suicide, non-suicidal self-injury (NSSI), substance abuse, and eating disorders (ED). Suicide is the third leading cause of death for young people, behind homicide and automobile accidents, resulting in approximately 4,600 adolescent deaths per year (Center for Disease Control [CDC], 2013). In any given year, 16% of adolescents consider suicide, 13% of adolescents create a suicide plan, and 8% of adolescents attempt suicide (CDC, 2013). In two separate studies, 39% of adolescents engaged in NSSI in the past year (Lloyd, 1998; Zetterqvist, Lundh, Dahlstrom, & Svedin, 2013). Individuals are the most likely to develop substance abuse during adolescence; 70% of adolescents have consumed alcohol, and 50% have used an illegal substance by senior year of high school (SAHMSA, 2014). Eating disorders such as Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorder are coupled with many, even lethal, health concerns (Sullivan, & Joyce, 1999). Suicide, NSSI, substance abuse, and eating disorders are only a few examples of challenging mental health concerns that may bring adolescents to counseling.

Counselors are aware of the normative aspect of adolescent risk taking yet are faced with the complicated process of determining when an adolescent’s risk has transcended into imminent
harm. Perhaps the crux of the confidentiality dilemma is whether or not the adolescents’ risk-taking warrants parental notification. Suicidal ideation is the most agreed upon reason to breach confidentiality with parents (Isaacs & Stone, 2001; Moyer et al., 2012; Moyer & Sullivan, 2008; Rae et al., 2002), and adolescents appear to understand the necessity of breach in regard to suicidal behavior (Collins & Knowles, 1995; Gonzalez, 2003). Unfortunately, there are a myriad of instances that are not as easily rectified.

In helping professions, codes of ethics exist to provide standards of ethical conduct for practitioners and to provide a system of professional accountability that serves to protect the public. The American Counseling Association (ACA) Code of Ethics guides ethical practice, stresses importance and value of confidentiality, and emphasizes the lengths to which counselors must go to protect client privacy (ACA, 2014). The Code of Ethics (ACA, 2014) is less clear on how confidentiality applies to minors, and federal and state law often identify parents or guardians as the personal representative of the adolescent client.

Counselors who work with adolescents must balance maintaining trust, protecting client well being, preserving parents’ legal rights, and honoring the therapeutic alliance when making decisions about confidentiality (Welfel, 2012). When faced with ethical dilemmas, counselors seek out relevant ethics literature to guide their decision-making (Welfel, 2012), yet there is a startling lack of attention to confidentiality in adolescent counseling textbooks. After a review of three prominent counseling adolescents textbooks (i.e., Carlson & Lewis, 2002; Geldard & Geldard, 2003; Vernon, 2004), I found just six out of over 2,000 pages of text dedicated to confidentiality.

The empirical literature is similarly sparse. It appears as if client age and severity of behavior influence mental health professionals’ decisions about confidentiality. The younger the
client and the more severe the behaviors, the more likely counselor were to inform parents (Collins & Knowles, 1995; Gonzalez, 2003; Isaacs & Stone, 2001; Moyer et al., 2012; Moyer & Sullivan, 2008; Rae et al., 2002).

Adolescents’ perceptions of confidentiality and trust in the counseling relationship may impact level of disclosure in counseling (ACA, 2014; Geldard & Geldard, 2013; Welfel, 2012). Although research indicates adolescents value confidentiality and scholars agree adolescents should be involved in the informed consent process (Gonzalez, 2003; McGuire, Parnell, Blau, & Abbott, 1994), it is unclear whether adolescents are capable of making independent treatment decisions. Some studies indicate adolescents’ decision-making skills rival adults (e.g., Moyer & Sullivan, 2008; Moyer et al., 2012; Rae et al., 2002; Weilhthorn & Campbell, 1982) while others assert adolescents’ decision-making is significantly impaired by stress and relational influence (e.g., Cauffman & Steinburg, 2012, Steinburg & Monahan, 2007). The research provides some insight into the unpredictable nature of adolescent decision-making skills and adds another layer of consideration when determining how to manage confidentiality with adolescents.

Statement of the Problem

Adolescent development, decision-making skills, and the highly interpretive nature of existing codes and laws places makes decisions about confidentiality especially difficult. To date, much literature regarding breach of confidentiality with minors is general, hypothetical, and lacks concrete examples. The majority of recent studies conducted focus on when counselors would breach confidentiality (Isaacs & Stone, 2001; Moyer, 2012; Moyer & Sullivan, 2008; Rae et al., 2002) rather than how counselors make decisions about confidentiality. Counselors continue to lack guidance or information about how to make decisions about adolescent confidentiality. Prior research does not account for the uniqueness of each client’s situation and
family. In addition, quantitative analysis of hypothetical scenarios cannot capture an essential component of counseling, the client-counselor relationship.

Purpose of the Study

The purpose of this study was to develop a grounded theory to answer the following question: what is the theory that explains the decision making process of managing confidentiality of adolescents for master therapists? Specifically, (1) what strategies do counselors use to resolve ethical dilemmas about confidentiality, (2) what conditions influence decision-making about confidentiality, and (3) what are the consequences of chosen decisions?

Significance of the Study

Study findings may provide counselors with insight into master counselors’ process of navigating adolescent confidentiality and provide examples of the poorly defined process, perhaps providing a foundation for best practice guidelines for practicing professional counselors and supervisors. This exploratory study may create additional research questions and inspire research surrounding the important topic of adolescent confidentiality. Above all, I hope the research will personalize adolescent confidentiality and highlight the multiple factors that impact counselor decision-making.

Definition of Terms

Many of the terms in this study lack concrete definitions. Below are my interpretations of three important constructs; adolescence, confidentiality, and master therapists.

- Adolescents - Adolescence has been defined as 12 year-olds to 24 year-olds (Siegel, 2013) while others define adolescence as the period between puberty and adult identity (Pediatrics & Child Health, 2003). For the purpose of this study, adolescents are individuals who are 12 to 17 years of age; I decided to limit the definition of adolescents...
to individuals under age 18 because 18-year-old clients are legally able to consent for treatment as adults.

- Confidentiality - Confidentiality is the ethical duty of counselors to keep client information private. Confidentiality has also been described as the “cornerstone of the counseling relationship” (ACA, 2014, p. 2).

- Master Therapists - Master therapists are well-regarded mental health professionals who are nominated by their colleagues as the best and most knowledgeable counselors in regard to adolescent counseling. Jennings and Skovholt (1999) identified master therapists by asking respected practitioners to identify therapists who fit the following three criteria; 1) considered to be “master therapist,” 2) frequently considered when referring family member of close friend, and 3) one would considering seeing the therapist for personal counseling (Jennings & Skovholt, 1999). In this study, master therapists were individuals identified by peers whose caseload consisted of at least 25% adolescent clients and who had a minimum of 15 years experience counseling adolescents.

Conclusion

In Appendix B I present an extended literature review of adolescent development, legal and ethical principles that impact adolescent confidentiality decisions, and existing research on confidentiality in adolescent confidentiality. I hope to highlight the need for greater understanding of how master counselors make decisions about confidentiality with adolescents. In Appendix C I describe a grounded theory methodology for exploring counselors’ decisions about adolescent confidentiality. I will apply GT methodology to the proposed study although while remaining true to GT I will let the data direct the research therefore changes may occur
during the research process. In appendix D I present the results of this grounded theory study complete with excerpts from participants to bring the theory to life. Appendix E contains a discussion of the results, implications for practice, training, and research, and limitations of the study. The informed consent, phone script, and interview schedule are located in Appendix F.
APPENDIX B:

EXPANDED LITERATURE REVIEW
Adolescence is a unique developmental period characterized by profound changes. These changes often occur across several domains of an adolescent’s experience including emotional, cognitive, neurological, physical, and relational development. Adolescents are also presented with a multitude of stressors in their academic, social, and familial lives. The changes experienced during adolescence are often accompanied by emotional distress and risk taking behavior (Collins & Stienburg, 2006).

Adolescents often present to counseling for risk taking behaviors, such as experimentation with drugs and alcohol or sexualized behaviors (Geldard & Geldard, 2013). Although counselors who work with adolescents are aware risk taking is a normal part of the process of seeking independence, some risks are potentially dangerous to adolescents. When counselors encounter adolescent clients who are engaged in potentially dangerous risk taking behavior, they must make decisions about whether or not to notify parents or guardians about the potentially dangerous behavior.

Unfortunately, this decision is not easily made and can have a profound impact on the therapeutic relationship. Literature guiding counselors who work with adolescence is limited, particularly surrounding ethical decisions. In order to make informed decisions about when to inform parents about adolescents’ behavior, counselors must possess knowledge about adolescent development, normative adolescent risk taking behavior, and the impact of disclosure on the therapeutic relationship.

In this literature review, I briefly review adolescent development and normative risk taking in order to provide a context for understanding unique challenges associated with confidentiality and adolescents. I then present current legal mandates and ethical codes that pertain to confidentiality and minor clients and the implications for the therapeutic relationship.
In summary, I review recommendations for counselors on how to best proceed with ethical decision-making and confidentiality. The literature review will provide the reader with the framework for the proposed study and the need for such study based on the unique developmental phase of adolescence and the subjective ethical codes.

Adolescent Development

In order to make informed treatment decisions, clinicians must have a thorough understanding of adolescent development. There is not a universally adopted definition for adolescence, and the myriad of physical, social, cognitive, and emotional changes that characterize adolescence are difficult to measure objectively. The Merriam-Webster dictionary (2014), defined adolescence as “(1) the state or process of growing up; (2) the period of life from puberty to maturity terminating legally at the age of maturity; (3) a stage of development (as a language or culture) prior to maturity.” According to this definition, adolescence would begin at various times and end at the age of 18 in the United States. In *Brainstorm*, Siegel (2013) expanded the range to include ages 12-24 based on the profound neurological changes that occur from 12-24 years of age. Developmental changes during adolescence impacts decision-making skills, risk taking behavior, and common presenting issues for counseling. I address the primary developmental changes that occur during adolescence in the following pages.

Physical Development

Puberty, the process through which females and males mature sexually, is often used to identify the beginning of adolescence (Berk, 2007). Adolescents experience a growth spurt along with puberty, although sexual maturation begins before outward physical symptoms are visible. The changes that occur during puberty are experienced differently for females and male.
Females typically begin to experience the physical changes congruent with puberty earlier than their male counterparts. For females, growth spurts begin around 10 to 12 years of age, reaching adult height between 17 and 19 years of age (Hoffman & Greydanus, 1997). Hormonal changes during puberty also initiate physical changes. An increase in estrogen released by females’ ovaries during puberty begins breast development, menstruation, and developed underarm and pubic hair. In the United States, the mean age of menstruation is 12.4 years (Chumlea, 2003); however, there is great variance in the rate of adolescent females pubertal development. During this time, females also begin to accumulate fat, which can cause distress for many females (Berk, 2007). Research indicates a link between early pubertal development and depression in girls (Stice, Presnell & Bearman, 2001). The surge of hormones, along with possible unwanted sexual attention, and increased body fat, may create feelings of confusion and shame for adolescent females (Stice et al, 2001).

Adolescent males also experience a wide range of range pubertal development. Males begin their growth spurts a few years later than females, between the ages of 12 and 14, reaching their adult height closer to age 20 (Hoffman & Greydanus, 1997). The beginning of puberty for males begins with enlargement of the testes (Berk, 2007) and also includes increased growth in penis and scrotum and downy hair on base of penis (Berk, 2007). Underarm and facial hair may also begin to appear. The larynx begins to enlarge, causing a change in voice and potential cracking sound many males find embarrassing. While most girls are approximately half way through pubertal development by early adolescence, most males are only beginning their pubertal development (Berk, 2007).

Physical development is the most outwardly visible change in adolescence and only accounts for a fraction of the changes experienced during adolescence. As adolescents’ bodies
are transforming from those of children to those of adults, their brains are also under construction. An understanding of the neurological changes in adolescents’ brain provides a framework for understanding cognitive development.

Brain Development

Brain development forms the foundation for cognitive functioning, emotional development, and relational development in adolescents. Adolescence is the second most active period for brain development, second only to infancy (Siegel, 2013). During this time, brain development includes a rapid and widespread burst of neural production that leads to structural changes in both grey and white matter and changes in functional organization (Badenoch, 2008; Stiles & Jernigan, 2010). All of these changes drastically impact behavior and learning. This period of neural production, known as exuberance, creates a potential for billions of new connections and results in a period of rapid experience-based learning and neuroplasticity. As the frontal lobes develop, many aspects of intelligence, including judgment, rationality, mental organization, diligence, forethought, working memory, and impulse control, are enriched through a process of differentiation, or specialization of different parts of the brain (Diamond & Hopson, 1998; Sowell, 1999). For most adolescents, connections between the frontal lobes and other areas of the brain are not fully developed (Sabbagh, 2006). Because the frontal lobes are the areas of the brain involved with questioning given actions and evaluating the consequences of those actions, their function is crucial in the process of decision-making (Siegel, 2013). While adolescent brains are active with development, there is a normative lack of integration, or connection, among the parts of the brain. As a result, adolescents often process information at much slower rates than adults (Siegel, 2013). Thus, adolescents’ impulsive decision-making does not fully represent their reasoning abilities; impulsivity may actually be a result of an
inability to fully access frontal lobe functioning at a rapid rate. Lack of integration in the middle prefrontal cortex may also explain why adolescents may struggle to appreciate and empathize with the struggle of others or incorrectly read social cues. These symptoms are heightened during times of stress (Badencoh, 2008). In order to experience excitement, adolescents’ limbic systems requires more stimulation than those of adults; some hypothesize this difference is related to increased risk taking in adolescence (Spear, 2000). Brain development is a critical factor in cognitive development in adolescents and directly impacts judgment, rationality, mental organization, diligence, forethought, working memory, and impulse control.

Cognitive Development

During early adolescence, most individuals develop the ability to think abstractly and develop what Piaget and Inhelder (1969) described as formal operational thought. Beginning at around age 11 but not fully reached until ages 15-20 (Piaget & Inhelder, 1969), formal operational thought includes the ability for abstract thoughts, deductive reasoning, and systematic planning (Piaget & Inhelder, 1969). During this time, adolescents may develop a new interest in the future, becoming less confined to the here-and-now, and more able to focus on possibilities and goals. Adolescents operating from formal operations can draw conclusions through hypo-deductive thought and assimilate reality through imagined or deduced events (Piaget & Inhelder, 1969). The adolescent may overuse their newfound ability to anticipate the reaction of others and perspective taking leading to what Elkind (1967) described as the imaginary audience and personal fable. The imaginary audience refers to adolescents’ belief that all others are as preoccupied with their appearance and behavior as they are, leading to heightened self-consciousness (Elkind, 1967). The personal fable refers to adolescents’ belief they are special, unique, and their feelings are more intense than others. Elkind (1967)
hypothesized the personal fable of adolescence creates a feeling of invulnerability within adolescents and increases risk taking.

Although younger adolescents may begin to have access to formal operations, it most likely is not their primary mode of thought. Early adolescents may struggle fully linking events, feelings, and situations. Although they are beginning to have the capacity to create links better seemingly unrelated objects or events, they still may miss important factors. As with all areas of development, adolescents’ cognitive development is not linear, and newfound formal operational thought may not apply to all concepts. During times of distress, adolescents may regress in their newly acquired skills. The inconsistency of cognitive development impacts decision-making skills particularly during times of stress.

**Adolescent decision-making.** Cognitive changes that occur during adolescence impact adolescents’ decision-making skills. Decision-making is the intellectual process through which an individual chooses a response to a circumstance through examination of alternatives (Nelson, 1984). Adolescents’ decision-making skills often rival those of adults, yet adolescents lack the ability to make advanced decisions during stressful situations (Grisso & Verrling, 1978; Modeki, 2008; Weithorn & Campbell, 1982). Much of the research surrounding adolescent decision-making has been prompted by questions surrounding treatment of adolescents in the legal system.

Weiththorn and Campbell (1982) contributed to the understanding of adolescent decision-making skills through an examination of the differences in decision-making processes of between 14, 18, and 21 year-old participants. The researchers designed scenarios intended to reproduce standards of competency for individuals to make treatment decisions in counseling. Weiththorn and Campbell (1982) included scales that measured evidence of choice,
understanding, rational reasoning, and reasonable outcome and found no statistically significant
differences between decision-making skills of 14 year-olds and 21 year-olds. They concluded
adolescents’ aged 14 and older were fully capable of making autonomous decisions about
treatment. Similarly, Grisso and Vierling (1978) found 15 year olds were as competent in
making decisions as adults. Further, Belter and Grisso (1984) found no statistically significant
difference between 15 and 21 year-olds’ comprehension of rights and ability to exercise their
rights in counseling. Although these studies seem to support adolescent decision-making rivals
adult decision-making in regard to counseling treatment, not all research supports this
hypothesis.

Along with others (e.g., Reppucci, 1999; Steinberg and Cauffman, 1996), Modecki
postulated adolescents may not possess the judgmental maturity to make decisions due to
psychosocial factors. Modecki (2008) compared the maturity of judgment by adolescents to the
judgment of college students, young adults, and adults. Maturity of judgment referred to
individuals’ levels of responsibility, perspective, and temperance. Responsibility referred to the
ability to be self-sufficient. Temperance was the ability to evaluate a situation before taking
action. Perspective was the ability to consider multiple positions and viewpoints before taking
action or making decisions. Adolescents in the study had less developed traits of maturity of
judgment compared to college students, young adults, and adults. Modecki (2008) posited
although at times adolescents can make comparable reasoning choices, adolescents show reduced
maturity of judgment as compared to adults. Although responsibility and perspective appeared
to be consistent from age 18, temperance continued to improve into mid-twenties. Modecki’s
findings have implications for the level of autonomy adolescents are granted in counseling.
Most research supporting the assertion that adolescents are as capable of making decisions as adults is based on hypothetical, vignette-style studies, rather than the process of decision-making in context of psychosocial stressors (Moyer & Sullivan, 2008; Moyer, Sullivan, & Growcock, 2012; Rae, Sullivan, Razo, George, & Ramirez, 2002; Weilhthorn & Campbell, 1982). Although adolescents and adults may possess similar abilities for thoughtful reasoning, emotional and social variables skew adolescents’ abilities to access newly-acquired decision-making skills (Cauffman & Steinburg, 2012). Social risk and peer perception weigh heavily on adolescent decision-making. Adolescents are also significantly more susceptible to peer influence than adults (Steinburg & Monahan, 2007). Adolescents’ focus on peer relations may enhance the focus on social acceptance, over potential risk. Exposure to peer pressure and increased impulsivity further complicate the ability for adolescents to make decisions in real time under external pressures (Cauffman & Steinburg, 2012). In short, adolescent psychosocial development maturity trails behind cognitive development, making adolescents vulnerable to poor decision-making (Cauffman & Steinburg, 2012).

Because adolescents are less future-oriented than adults (Steinburg & Monahan, 2007), they are less likely to consider future consequences or future planning. Another contributing factor to adolescents’ risk taking behavior may be a heightened sensitivity for reward and lessened sensitivity for punishment. Adolescents may weigh rewards and rewarding sensations higher than adults (Steniburg & Monahan, 2007). The reward seeking bias may impact adolescent decision-making by increasing their motivation for dangerous activities, while decreasing motivation to avoid negative consequences.

Adolescent risk-taking. Adolescents tend to place more emphasis on immediate needs than long-term consequences, resulting in risk-taking behavior such as experimenting with
alcohol and other drugs and reckless driving (Sullivan et al., 2002). Adolescents may engage in risks as a way to test limits of independent decision-making; therefore, some level of risk taking is developmentally appropriate for adolescents (Rae et al., 2001). Some believe adolescent risk taking is biologically driven (Steinberg, 2004). Adolescents’ decision-making skills impact risk-taking behaviors and can be the difference between normative and dangerous risk-taking. For example, Elkind (1967) linked the invulnerability of adolescents’ personal fable to risk-taking behavior. He and colleagues (Alberts, Elkind, & Ginsberg, 2007) later found males scored higher on invulnerability than females, indicating males were more likely to feel invincible than females.

Clinicians who possess broad knowledge of adolescent behavior are more likely to make ethical decisions about adolescents’ level of danger and need for parental disclosure (Sullivan et al., 2002). The profound changes that occur during adolescence, coupled with a lack of clarity in ethical codes, complicate the issue of confidentiality when counseling adolescents. An understanding of the unique period of adolescence provides a foundation for navigating ethical decisions with adolescents. In the following section, I will review some of the most common presenting concerns for adolescent clients and potential threats to confidentiality.

Common Presenting Concerns

A healthy and well-adjusted adolescent may struggle with affect regulation and emotional control, making it hard to determine what is “normal” and what warrants outside assistance from counseling professionals (Sommers-Flannagan et al., 2011). Adolescents may often experience overwhelming emotions, which have the potential to lead to more severe distress. The developing ego increases adolescents’ sensitivity in peer and family relationships, and internal and external pressures may cause intense worry about performance, acceptance, and appearance
(Steinburg & Monahan, 2007). As a result, a variety of internalizing (depression, anxiety, eating disorders), externalizing (acting out, violence), and addictive (drugs, alcohol) behaviors first emerge during adolescence (Sommers-Flannagan et al., 2010). Each of these presenting concerns is accompanied by considerations for confidentiality within the therapeutic relationship. In this section, I attend to presenting concerns including depression, substance abuse, non-suicidal self harm, suicidal ideation, and eating disorders.

**Depression**

According to a national survey, 11% of adolescents reported experiencing a depressive disorder by age 18 (National Comorbidity Survey-Adolescent Supplement [NCS-A], 2013). Despite this, it is difficult to truly understand how many adolescents across the country struggle with depression and depressive symptoms. Depressive symptoms may be masked by adolescents’ mood swings and increasing autonomy from parents, increasing difficulty of diagnosis and identification. According to The Youth Risk Behavior Surveillance Survey Report (Eaton et al., 2011), 29.9% of students across the nation felt so hopeless or helpless in the past year they disengaged from some of their usual activities. Girls exhibited higher levels of depression in early adolescence than boys, perhaps because there may be a link between early pubertal development and depression among preadolescent girls (Conger & Elder, 2001). Adolescents who struggle with depression are higher risk for substance abuse, self-harm, and suicide (Shafer & Greenberg, 2002).

In 2012, the Substance Abuse and Mental Health Service Administration (SAMSHA) found just 37%-41% of adolescents’ aged 12-17 with a Major Depressive Episode sought treatment; 63%-59% of adolescents experiencing a Major Depressive Episode did not seek treatment. Improper treatment of depression places adolescents in danger of developing negative
coping skills, which, in turn, may lead to increased severity with age. Depression is not an adolescent risk-taking behavior, yet places adolescents at risk for further harm at risk of harm to self or others, especially when youth wish to hide their depression from parents. Counselors must decide whether to withhold adolescents’ depressive episodes from parents.

Non-suicidal Self Injury

Non-suicidal self-injury (NSSI) is a complex group of behaviors that involve deliberate harm to the body without suicidal intent (Stone & Sias, 2003). NSSI can include self-cutting, self-scratching, self-burning, and other self-destructive behavior is absent of a desire to die (Weirich & Nock, 2008). Self-harm is often an outward sign of internal pain and a warning sign of distress in adolescents; scholars have conceptualized NSSI as a temporary relief due to an inability to regulate overwhelming emotions (Chapman, Gratz, & Brown, 2006).

A survey of 143 high-school students found 39% had engaged in self-harm behaviors in their lifetime (Lloyd, 1998). More recently, a survey of 3,060 adolescents indicated that 39.6% of adolescents reported self-harm within the past year (Zetterqvist, Lundh, Dahlstrom, & Svedin, 2013). Despite the high occurrence of self-harm behaviors during adolescence, self-harm does not necessary indicate suicidal thoughts (Nock, Prinstein, & Sterba, 2009). Counselors must decide whether to inform parents about NSSI. NSSI is clearly self-harm yet counselors may interpret ethical codes differently in cases involving NSSI.

Suicidal Ideation

Suicidal ideation is cause for concern, regardless of age. Suicide ranks behind homicide and automobile accidents as the third leading cause of death for young people, and it results in approximately 4,600 adolescent deaths per year (Center for Disease Control [CDC], 2013). According to a national survey conducted by the CDC (2013), 16% of teens have considered
suicide, 13% have created a plan, and 8% have attempted suicide in the year preceding the survey. The CDC (2013) also estimated females attempt suicide three times more than males, indicating males are more lethal in their attempts while females are more frequent. Risk factors for suicidal ideations among preadolescents and adolescents include depression, exposure to suicide by friends or family, social isolation, substance abuse, and access to guns in the home (Bearman & Moody, 2004).

Although suicidal ideations place adolescents in danger, suicidal ideations with a plan place adolescents in imminent danger. When faced with adolescents considering suicide, counselors may be less conflicted about whether to inform parents or guardians of the concerns. When inquired, counselors reported being most likely to break confidentiality and inform parents if an adolescent is presenting as suicidal (Moyer & Sullivan, 2008; Moyer, Sullivan, & Growcock, 2012; Rae, Sullivan, Razo, Geroge, & Ramirez, 2002). While working with a client who is suicidal may be emotionally intense, it may be one of the most clearly defined circumstances when deciding whether to inform parents of adolescents’ disclosures.

Body Image and Eating Disorders

Body image and eating disorders are also identified as concerns for adolescents presenting to counseling. Puberty brings about body changes for both males and females, which often include weight gain (Berk, 2008). In a culture that places value on body size, weight accrued during adolescence may encourage disordered eating in some adolescents (Archibald, Graber & Brooks-Gunn, 1999; Striegel-Moore & Cachelin, 1999). Between 0.5% to 3% of females in the United States may be diagnosed with anorexia nervosa or bulimia nervosa, and as many as 20% engage in unhealthy dieting (Dounchis, Hayden & Wilfley, 2001). Low self esteem, lack of coping skills, early childhood abuse, early sexual maturation, and perfectionism
increase one’s risk of developing anorexia or bulimia (Stice et al., 2001). Restriction of food intake, skipping meals, significant weight loss, preoccupation with calories, vomiting after meals, and obsessive exercise are warning signs of an eating disorder.

In addition to the multitude of significant health concerns (e.g., heart failure, heart attack, blood pressure irregularities), individuals with eating disorders also have elevated risk of suicide (Apter et al., 1995; Bulik, Sullivan, & Joyce, 1999; Pompili, Manccinelli, Girardi, Ruberto, & Taterelli, 2004). According to Sullivan (1995), the second most common cause of death in anorexia nervosa sufferers was completed suicide. Counselors must consider potential health concerns along with elevated risk of suicide associated with eating disorders when considering confidentiality. Counselors are not equipped to assess clients’ health risks and may find it difficult to determine when the client is inflicting harm to self.

Drug or Alcohol Use

Given the unique state of their brain development, adolescents are especially vulnerable to substance abuse. The same neuroplasticity that allows for the surge of development during adolescence leaves adolescents’ brains susceptible to substance dependence (Sigel, 2013). According to SAMHSA (2014), individuals are the most likely to begin abusing drugs and alcohol during adolescence. In an annual survey on youth drug use, 70% of high school seniors reported trying alcohol, 50% reported trying an illegal drug such as marijuana, and 40% reported smoking cigarettes in their lifetime (SAMHSA, 2013). The Youth Risk Behavior Surveillance Survey (CDC, 2013) found 18.6% of adolescents tried alcohol before the age of 13. The survey revealed 34.9% of adolescents drank alcohol in the past month, 20.8% of adolescents reported having five or more alcoholic drinks in a row in the past month, and 6.1% reported taking ten or more alcoholic drinks in the past month. The same survey reported on illicit drug use: marijuana
(40.7%), prescription drugs without a prescription (17.8%), inhalants (8.8%), hallucinogenic
drugs (7.1%), ecstasy (6.6%), cocaine (5.5%), methamphetamines (3.2%), and heroin (2.2%).

Given high rates of use, it is common for counselors working with adolescents to
encounter substance use and abuse. While many adolescents will walk away from alcohol or
drug experimentation relatively unscathed, some will experience significant consequences from
their use.

A unique aspect of working with minor clients is the balance of maintaining adolescent
trust while respecting parents’ ultimate responsibility for their children’s’ safety. In the
following sections I will explore ethical and legal guidelines that influence counselors’ actions. I
will begin by addressing confidentiality in counseling. I will then summarize the ethical
principles upon which the ACA Code of Ethics (2014) is founded. An understanding of the
foundational principles will provide context to the codes and laws I review next. Finally, I will
delve into the complicated task of applying the ethical principles, codes, and laws to work with
adolescent clients.

Confidentiality

When considering confidentiality, counselors must understand the differences between
ethical and legal standards. The Merriam-Webster Dictionary (2014) defines ethics as “the code
of good conduct for an individual or group”. Legal standards are defined as “based on the law”
(Merriam-Webster.com, 2014). Laws are minimally-required acceptable behaviors, not
aspirational behavior. Professional ethics and legal mandates are developed to aid individuals in
decision-making. According to Kitchener (1984), counseling ethics include both behavioral and
attitudinal components. The American Counseling Association Codes of Ethics (2014) guides
counselors’ behaviors while ethical principles encourage an ethical and moral attitude. Ethical
decision-making requires counselors to simultaneously utilize cognitive abilities, personal
character, and decision-making skills (Welfel, 2012).

“Confidentiality is the cornerstone of the counseling relationship “ (ACA, 2104, p.2). Confidentiality refers to an “ethical duty to keep client identity and disclosures secret and a legal
duty to honor the fiduciary relationship with the client” (Welfel, 2012, p. 116). Throughout the
literature, the terms privacy, confidentiality, and privilege are used seemingly interchangeably. Although privacy, confidential, confidentiality, and privilege share common themes, they are
three distinct concepts. In counseling, privacy refers to the client’s right to keep personal
information from others (Luepker, 2012), and the term confidential refers to information kept
between the client and the counselor. Confidentiality is the trust between client and counselor
that information will not be shared unlawfully (Luepker, 2012). Privileged communication
refers to the client’s right to determine whether information is shared in a court of law. Privilege
protects the client’s information from being shared without consent (Luepker, 2012). Although
these terms are similar, understanding of the nuances that separate them is essential for
counselors to accurately protect their clients’ rights.

Researchers have supported the belief both adult and child clients value confidentiality, and threats to confidentiality may negatively impact the counseling process (Gonzalez, 2003; Kobocow et al., 1983; McGuire, Graves, & Blau, 1985; Messanger & McGuire, 1981; Schmid et
al, 1983). In most circumstances, clients have the right to decide to whom and when counselors
disclose information. When the client is a minor, his or her parents or guardians hold the rights
to these decisions. The ACA Code of Ethics (2014) also mandates that clients have access to
their personal records. For minors, the parent or guardian is the party who is able to request
records from the counselor.
Counseling Ethics

Kitchener (1984) identified five moral principles that are generally viewed as the foundation for the ethical guidelines of the ACA *Code of Ethics* (2014). These principles of autonomy, nonmaleficence, beneficence, justice, and fidelity are considered to be of equal importance, although some would argue nonmaleficence; do no harm, takes priority (Kitchner, 1984; Miller & Davis, 1996). ACA (2014) added veracity as a fundamental principle that guides ethical behavior. When fundamental principles are in conflict, counselors must consider each principle and weigh potential outcomes (Herlihy & Corey, 2006; Welfel, 2012). The ethical value of confidentiality has roots in all six of the moral principles, and each has a significant impact on the counseling process. When counselors consider a breach in confidentiality, they must particularly consider three of the fundamental principles; autonomy, beneficence, and nonmaleficence. In the following section I will review the six moral principles and the way in which each principle connects with confidentiality.

Autonomy is the ethical principle associated with an individual’s right to independence and self-determination (Kitchener, 1984). Autonomy refers to a client’s freedom to make self-directed choices without interference from others, including the counselor. Counselors can promote autonomy by encouraging client self-reliance, refraining from judgment, and avoiding imposing goals on clients (Welfel, 2012). The ethical principle of autonomy has a significant impact on the importance of confidentiality; clients have the right to decide who has access to their private information.

Beneficence is the ethical principle associated with the responsibility of counselors to do good in order to promote and safeguard the welfare of their clients (Kitchener, 1984). Counselors are duty-bound to encourage mental health, wellness, and growth of the client.
When considering confidentiality, the counselor must consider if sharing information with the parent is in the best interest of the client. Counselors should consider how parents may react and what purpose sharing the information serves. If parents are apt to react in anger and potentially harm the adolescent, counselors may consider the potential consequences of disclosing information. Conversely, if parents are likely to accept the information with appropriate levels of fear or concern, counselors may feel more confident sharing information is the most ethical decision.

Nonmaleficence is the ethical principle associated with doing no harm (Kitchener, 1984). Counselors must avoid directly harming clients and avoid engaging in actions that may cause harm. Nonmaleficence is especially important when considering confidentiality and adolescent risk-taking behavior. Although counselors may encounter situations where not divulging information may inherently cause harm, there are also situations in which sharing information with parents may cause harm. Similar to beneficence, in circumstances where parents may react negatively towards the adolescent client, counselor may violate nonmaleficence through disclosure. Under certain circumstances, a breach of confidentiality may cause an adolescent to lose confidence in the counseling process, therefore significantly reducing or destroying effectiveness of counseling. If clients have lost faith in the counseling process, they cannot benefit from counseling (Welfel, 2012). At the same time, withholding information from parents when adolescents are engaging in life-threatening behavior would violate the ethical principle of nonmaleficence.

Justice is based on the principle that people are equals (Kitchener, 1984). Counselors are expected to be fair and promote equal treatment for all individuals, regardless of differences, including age. The ethical principle of justice obliges counselors to have accessible and non-
discriminatory services. In regard to adolescent clients, justice implies treating them with
dignity and respect, regardless of their minor status.

Finally, fidelity is associated with faithfulness and trust (Kitchener, 1984). Counselors
are ethically bound to keep promises, including promises about confidentiality. Counselors
implicitly and explicitly promise to keep private information confidential. Furthermore,
counselors must be reliable in order to build trust with clients (Welfel, 2012). In regard to
adolescent confidentiality, clients must trust their counselors’ word and vow to keep information
private whenever possible.

Veracity in counseling is defined as “dealing truthfully with individuals whom counselors
come into professional contact” (ACA, 2014, p.3). Educating clients of confidentiality
limitations during informed consent and assent can promote veracity by truthfully describing
limitation up front and adhering to the limitations described. The *ACA codes of Ethics* (2014)
are founded on these six ethical principles and in the following section I will review the specific
*ACA Codes of Ethics* (2014) codes that impact adolescent confidentiality.

**Ethical Guidelines**

In helping professions, codes of ethics exist to provide standards of ethical conduct for
practitioners and to provide a system of professional accountability that serves to protect the
public. For counselors, the *ACA Code of Ethics* guides ethical practice and stresses importance
and value of confidentiality (ACA, 2014). The code also emphasizes the lengths to which
counselors must go to protect client privacy. The *ACA Code of Ethics* is less clear regarding
how confidentiality applies to minors and their parents, and it does not provide guidance
regarding how counselors should make decisions on parental disclosure. In this section, I review
the ACA codes that apply to confidentiality (Table 1) and discuss how these codes may be
applied to counseling minors.

Table 1

<table>
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<th>A.2. Informed Consent in the Counseling Relationship</th>
<th><strong>A.2.b. Types of Information Needed</strong></th>
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<td>Counselors explicitly explain to clients the nature of all services provided. They inform clients about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the counselor’s qualifications, credentials, relevant experience, and approach to counseling; continuation of services upon the incapacitation or death of the counselor; the role of technology; and other pertinent information. Counselors take steps to ensure that clients understand the implications of diagnosis and the intended use of tests and reports. Additionally, counselors inform clients about fees and billing arrangements, including procedures for nonpayment of fees. Clients have the right to confidentiality and to be provided with an explanation of its limits (including how supervisors and/or treatment or interdisciplinary team professionals are involved), to obtain clear information about their records, to participate in the ongoing counseling plans, and to refuse any services or modality changes and to be advised of the consequences of such refusal.</td>
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<tr>
<th>B.1.b. Respect for Privacy</th>
<th><strong>Counselors respect the privacy of prospective and current clients.</strong></th>
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<tbody>
<tr>
<td>Counselors request private information from clients only when it is</td>
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beneficial to the counseling process.

| B.1.c. Respect for Confidentiality | Counselors protect the confidential information of prospective and current clients. Counselors disclose information only with appropriate consent or with sound legal or ethical justification. |
| B.1.d. Explanation of Limitations | At initiation and throughout the counseling process, counselors inform clients of the limitations of confidentiality and seek to identify situations in which confidentiality must be breached. |
| B.2. Exceptions | The general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception. Additional considerations apply when addressing end-of-life issues. |
| B.2.e. Minimal Disclosure | To the extent possible, clients are informed before confidential information is disclosed and are involved in the disclosure decision-making process. When circumstances require the disclosure of confidential information, only essential information is revealed. |
| B.4.b. Couples and Family Counseling | In couples and family counseling, counselors clearly define who is considered “the client” and discuss expectations and limitations of confidentiality. Counselors seek agreement and document in writing such agreement among all involved parties regarding the confidentiality of information. In the absence of an agreement to the |
contrary, the couple or family is considered to be the client.

B.5. Clients Lacking Capacity to Give Informed Consent

B.5.a. Responsibility to Clients

When counseling minor clients or adult clients who lack the capacity to give voluntary, informed consent, counselors protect the confidentiality of information received—in any medium—in the counseling relationship as specified by federal and state laws, written policies, and applicable ethical standards.

B.5.b. Responsibility to Parents and Legal Guardians

Counselors inform parents and legal guardians about the role of counselors and the confidential nature of the counseling relationship, consistent with current legal and custodial arrangements. Counselors are sensitive to the cultural diversity of families and respect the inherent rights and responsibilities of parents/guardians regarding the welfare of their children/charges according to law. Counselors work to establish, as appropriate, collaborative relationships with parents/guardians to best serve clients.

B.5.c. Release of Confidential Information

When counseling minor clients or adult clients who lack the capacity to give voluntary consent to release confidential information, counselors seek permission from an appropriate third party to disclose information. In such instances, counselors inform clients consistent with their level of understanding and take appropriate measures to safeguard client confidentiality.
The ACA *Code of Ethics* highlights the importance of confidentiality for clients regardless of age. Section A.2.b. mandates counselors explicitly inform clients of the limits of confidentiality. When clients are minors, according to B.5.b. counselors inform parents of the confidential nature of the counseling relationship consistent with current state laws. B.5.b also states counselors work collaboratively with parents to best serve clients. These codes imply counselors are to inform parents of confidentiality, collaborate with parents through the counseling process, and protect the privacy of the adolescent when possible. How possible it is to protect the client’s privacy varies greatly between clients and situations. The codes do not provide counselors with concrete guidance of when or how to protect adolescent privacy while respecting parents’ lawful rights to information about their child.

The *ACA Codes of Ethics* (2014), along with other professional ethical codes, cannot guide counselor behavior. Rather, the codes provide a framework for ethical decision-making. As will all ethical decisions, counselors must use their subjective interpretation of the ethical codes and principles, coupled with relevant laws to make the best decisions for their client. The ethical codes are aspiration in nature, providing counselors with guidance how to best proceed with ethical decisions. In contrast, legal guidelines provide counselors with guidelines for minimally accepted behavior. In the following section I review legal guidelines pertinent to confidentiality and minor clients.

**Legal Guidelines**

Federal, state, and case law all impact confidentiality. The laws influence each other but remain separate statues. In this section I will begin by reviewing federal law, followed by state law, and finish with case law.

Federal Law
There are four circumstances where parental consent for counseling can be waived; a mature minor, an emancipated minor, an emergency, and court ordered (Gustafson & McNamara, 1987). The first circumstance is the mature minor, a minor whose level of maturity and understanding allows him or her to consent to treatment. The second circumstance is the emancipated minor, a minor who has been legally emancipated from his or her parents and has full legal independence. The third circumstance is in the case of an emergency where immediate treatment is needed. The last circumstance is when the court that allows the minor to consent to treatment has waived parental consent. Per federal law, minors are also able to consent to alcohol and drug treatment without parent or guardian consent (Welfel, 2012). In minor maturity and emergency circumstances, counselors utilize clinical judgment and knowledge of adolescent development to make decision about appropriate care.

Under certain circumstances, counselors must breach confidentiality without the client’s consent. The Federal Prevention and Treatment Act (1987), demands counselors report child abuse to the authorities, and all states have enacted mandatory reporting laws. In cases of child abuse or neglect, counselors do not need parental/guardian consent. Another time when counselors must breach confidentiality without client consent is if the client is in imminent harm to self. If a client is actively suicidal, a counselor may break confidentiality against the client’s will in order to protect the client’s safety.

The Health Insurance Portability and Accountability Act (HIPAA; 1996) is the most prominent national standard pertaining to confidentiality. HIPAA ensures protection of client privacy and established national standards for protecting client’s medical information. The HIPAA privacy rule provides limits for how and when professionals can disclose information to
third parties with or without client consent. The rule also states clients have ownership of their medical records and may have access to them at any time (HIPAA, 1996).

HIPAA (1996) identifies parents as adolescents’ personal representative. According to the HIPAA privacy rule, minors may act as their own representative and maintain privacy in specific medical situations such as when the parent or court has consented to the care or when the parental guardian and provider have an agreement of confidentiality. The HIPPA privacy rule goes on to identify scenarios in which adolescents may acts as an independent representative. These exceptions include cases of suspected abuse or neglect and when informing parents of confidential information may place the adolescent at risk. Although HIPAA grants minor clients the ability to maintain privacy in healthcare, the HIPAA rule ultimately defers to state laws (English & Ford, 2004).

Individuals seeking treatment for drug and alcohol abuse from programs that are regulated or funded by the federal government are further protected by Title 42, Part 2 of Federal Law (42 CFR Part 2). 42 CFR Part 2 involves counselors who work with addictions, including treatment centers, and is more restrictive than HIPAA. This rule prohibits counselors from disclosing information about clients with drug and alcohol addictions to law enforcement or other officials even with a subpoena (42 CFR Part 2). Although, these guidelines appear to be clear in protecting minor client’s privacy, when deferred to state law, the guidelines for counselors become significantly less clear.

In 1999, The United States Supreme Court made the following endorsement of confidentiality in counseling:

Effective psychotherapy. . . depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions,
memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment. (Jaffe v. Redmond, p.10)

Clear support of confidentiality occurred when the U.S. Supreme Court decided to legally protect client privilege in federal courts (Jaffe vs. Redmond, 1996). In this seminal court case, Karen Beyer a clinical social worker, refused to release her client’s psychotherapy notes to the federal court without her client’s consent. The Supreme Court supported Beyer’s decision to withhold her client’s records and established case law for confidentiality in psychotherapy.

State Law

The participants in the proposed study will be primarily licensed by the state of Texas, therefore I will primarily focus on Texas law. Texas law clearly mandates that the contents of a confidential record should be made available to parents if the patient is a minor (Texas Health and Safety Code 611). Because parents hold the privilege of the files, parents may request access to the minor’s file at any time, gaining significant information about adolescent disclosures. Despite this, HIPPA (1996) does note for the benefit of the counseling process, counselors should ask parents to refrain from intruding on the confidential nature of counseling. This is an example of HIPPA encouraging a greater level of adolescent privacy than state law, and as mentioned previously HIPPA ultimately defers to state law.

Further, according to Texas Family Code 32.001, Consent to Medical, Dental, Psychological, or Surgical Treatment by a Minor, children may consent for psychological treatment if seeking assessment and treatment of drug addiction, chemical dependency, or any
condition directly related to drug or chemical use. The Texas Family Code 32.001 also allows adolescent clients to consent to counseling for suicide prevention, sexual abuse, and psychical abuse. This law allows adolescents to enter into counseling without parental consent based on these parameters. The Texas Family Code 32.003 advises health care providers may advise parents with or without the consent of the child. In Texas adolescents can consent to treatment in given circumstances independently, yet parents are ultimately the adolescents’ personal representative and have rights to treatment information. Next I will review case law which can often influence state law.

Case Law

Case laws are based on court rulings and impact how federal and state laws are interpreted (Welfel, 2012). For example, Tarasoff vs Regents of The University of California (1976) impacted how states interpret imminent harm. In this groundbreaking case, The California Supreme Court ruled against a psychotherapist who did not warn an identified victim of possible harm after his client reported wanting to kill her. Some states interpret Tarasoff as a need for counselors to warn potential victims of foreseeable harm, yet others, such as Texas, do not impose such a statute (Welfel, 2012). The Tarasoff rule is the most identifiable difference between states, yet other differences exist.

Similar to ethical codes, the laws surrounding confidentiality do not provide a road map for counselors. Federal, state, and case laws all mandate counselors’ minimally accepted behavior and can be interpreted in different ways. When considering adolescent confidentiality, counselors must weigh the ethical codes, the laws, and the best interest of the adolescent. In the following section I will address how adolescents’ perceive confidentiality in counseling and in
medical treatment. I will then present the literature on when counselors breach confidentiality. Finally I will discuss recommendations for counseling adolescents and confidentiality.

Adolescent Confidentiality Research

Adolescents may be especially sensitive to issues surrounding confidentiality and, at times, expect greater levels of confidentiality than counselors are able to provide (Gonzalez, 2003; Kobocow et al., 1983; Messenger & McGuire, 1981). Along with a heightened concern about confidentiality, adolescents may fear a breach in confidentiality, leading to reluctance to enter into counseling (Collins & Knowles, 1995; West & Kayser, 1991). In this section, I will review selected literature surrounding confidentiality and adolescents, including research on adolescents’ perceptions of confidentiality, breach of confidentiality, and standards set by medical professionals. This review will include existing literature and illustrate the limited amount of research on counseling and adolescent confidentiality.

Collins and Knowles (1995) investigated adolescents’ beliefs about confidentiality and outcomes in counseling. Students were asked about their beliefs regarding confidentiality in situations involving the use of contraceptives, pregnancy, and abuse. Nearly every adolescent (99%) reported confidentiality was either necessary or important for perceived successful counseling; 53% of the students reported confidentiality was necessary, and 46% of the students reported confidentiality was important within the therapeutic relationship. Participants acknowledged the need for confidentiality to be breached in instances of clear and imminent danger to themselves or others (Collins & Knowles, 1995). These findings highlight the importance adolescents place on confidentiality.

Gonzalez (2003) surveyed adolescents (N = 51) who received counseling through their high schools in Canada. Participants completed a questionnaire developed by McGuire et al.
(1994), which included ten vignettes in which participants indicated how confidential they thought the counselor should be and how confidential they preferred the information to be. The adolescents also completed questionnaires focused on their perception of confidentiality within the current client/counselor relationship and responded to a measure of working alliance. Gonzalez hypothesized adolescents would prefer a higher level of confidentiality than they received in their actual counseling relationship. Interestingly, the adolescents indicated an expectation of less confidentiality than they received in actual counseling situations. Additionally, adolescents who perceived high levels of confidentiality also had higher working alliance scores (Gonzalez, 2003), suggesting that adolescents may have recognized the importance of adult intervention and guidance for concerns beyond the counseling relationship. These findings provided an alternate view of adolescent confidentiality and their awareness of the need for limits to confidentiality.

McGuire, Parnell, Blau, and Abbott (1994) studied adolescents’ perceptions of confidentiality and understanding of limits of confidentiality among 30 adolescents undergoing drug and alcohol treatment. Participants were given ten vignettes depicting common confidentiality issues and rated expectation for no privacy, partial privacy, and absolute privacy for each vignette. Adolescents in the study desired a high level of confidentiality and consistently chose partial or absolute privacy over no confidentiality. Although the participants appeared to highly value confidentiality, results indicated they understood and accepted limitations to confidentiality. For example, adolescents chose lower levels of confidentiality when vignettes depicted harm to self or a court ordered disclosure, and they reported the highest need for confidentiality for less threatening vignettes featuring cannabis use and sexual activity
Overall, adolescents in this study demonstrated an understanding for the limitations of confidentiality along with a desire for the greatest level of confidentiality possible. Although adolescents appreciate the presence of confidentiality, it appears the assurance of confidentiality does not impact their ability to self-disclose within the counseling relationship. Kobocow, McGuire, and Blau (1983), hypothesized that adolescent self-disclosure would be greatest under assurance of ultimate confidentiality. The researchers found that there was not a statistically significant relationship between assurance of confidentiality and adolescent self-disclosure. During a post-test, 60% of adolescents recalled the researchers statements of confidentiality. When asked to describe the most salient point during the interview, 57% of females and 39% of males reported assurance of confidentiality was the most important statement during the interview. Although assurance of confidentiality did not significantly affect level of self-disclosure, discussion of confidentiality was a salient point for adolescent clients during the onset of the counseling relationship.

A counselor’s verbal assurance of confidentiality is not as powerful as the adolescent’s real-life experience with confidentiality (Messenger & McGuire, 1981). Similarly to Kobocow, McGuire, and Blau (1983) Messenger and McGuire found levels of self-disclosure were not significantly different between adolescents who were and were not assured confidentiality. However, students reported statements regarding confidentiality as the most important statements made during the interview. These finding indicate adolescents may not have confidence in the counselor’s verbal assurance of confidentiality before a therapeutic relationship has been established and confidentiality experienced.

Breaching Confidentiality in Counseling
Inevitably, there are times when counselors must share information with parents without the adolescent’s consent. Researchers have explored counselors’ and other mental health practitioners’ perceptions regarding confidentiality based on hypothetical counseling scenarios. Gustafson and McNamara (1987) developed five aspects for counselors to consider when determining when to breach confidentiality with minors: age, cognitive maturity, identified problem, wishes of the client, and wishes of the parents. For the most part, counselors based level of confidentiality granted on a client’s age and maturity (Issacs & Stone, 2001). The following studies revealed counselors often considered these five aspects, and paid particular attention to age and identified problem.

Rae et al. (2002) surveyed 92 members of the Society of Pediatric Psychology and examined six areas of adolescent risk-taking behavior through vignettes depicting varied levels of risk severity. Participants were asked to rate the degree they felt disclosure would be ethical for each vignette. The rate of ethical confidentiality breach rose in correlation with the severity of risk depicted in the vignette. For example, participants were less likely to disclose information involving once monthly alcohol consumption than they were for alcohol consumption several times a day. These findings indicated that the psychologists considered the potential harm of the behaviors prior to deciding to breach confidentiality.

In 2008, Moyer and Sullivan adapted the survey by Rae et al. (2002), to include behaviors likely seen by school counselors. In all, they asked 204 middle and high school counselors across the U.S. to determine which situations warranted parental notification. The researchers sent middle school counselors forms indicating the student was 13; high school counselors received forms indicating the student was 15. Results indicated school counselors’ decisions to breach confidentiality correlated with the intensity and duration of the risk-taking
behaviors. The suicidal behavior domain demonstrated the highest level of confidentiality breach and greatest agreement between the counselors, indicating the majority of school counselors would breach confidentiality due to suicidal behavior. There was lack of agreement between the respondents in determining clear and imminent danger for several of the risk-taking behaviors, such as smoking cigarettes and sexual activity. It appeared the school counselors’ interpretations and personal ethics varied on non-life-threatening behaviors. The researchers also found the middle school counselors were more likely to breach confidentiality, indicating the high school counselors may have perceived risk-taking behaviors as more or less developmentally appropriate based on age. Sullivan, and Growcock (2012) conducted a national study exploring school counselors’ decisions to disclose student information to school administrators. Similar to Moyer and Sullivan’s (2008) findings, school counselors reported students’ age and severity of behavior impacted their decision to breach confidentiality with administrators. Counselors seemed to value maintaining their relationships with students over maintaining relationship with administrators, thus highlighting the importance of the therapeutic relationship (Moyer et al., 2012).

Isaacs and Stone (2001) surveyed members of the American Mental Health Counselors Association to explore when counselors breach confidentiality with minors. The questionnaire listed eight scenarios of adolescents engaging in risky behaviors and varied client age from 11, 14, and 17. Participants identified which of three actions they would take: breach confidentiality, not breach confidentiality, or unsure about whether they would breach confidentiality for each situation and age group. Participants were more likely to breach confidentiality with younger children compared to older adolescents. Although the researchers noted several limitations to the study, their findings were congruent with previous research (e.g.,
Moyer et al., 2012; Moyer & Sullivan, 2008; Rae et al., 2002), and emphasize that age impacts counselor’s decisions about confidentiality.

These studies all investigated when mental health professional would breach confidentiality. Across studies, age and severity of behavior were the most impactful factors in whether participants would breach confidentiality. While these studies are successful in describing when mental health providers would hypothetically breach confidentiality, they do not investigate actual counseling experiences or provide understanding about how those decisions are made.

The previous sections explored when counselors may breach confidentiality and adolescents’ perceptions of confidentiality in counseling. Age and severity of behavior impact counselors decisions about breaching confidentiality (Moyer et al., 2012; Moyer & Sullivan, 2008; Rae et al., 2002). Adolescents are aware of and value confidentiality in the client/counselor relationship (Collins & Knowles, 1995; Gonzalez, 2003; Kobocow et al., 1983; Messenger & McGuire, 1981). The counseling literature has addressed these two aspects yet has neglected to deeply investigate adolescent clients’ resistance to counseling based on fear of privacy breach. The medical literature has explored how who fear of privacy breach impacts adolescents’ seeking medical treatment. In the following section, I review the research addressing adolescent confidentiality in medical treatment. As noted, this research is included due to the limited amount of research in the counseling literature and while the findings not directly generalizable the overarching commonality of adolescents’ fearing privacy breach can be influential in understanding adolescent confidentiality in counseling.

Adolescent Confidentiality in Medical Treatment

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Although literature addressing adolescent concerns of confidentiality in counseling is limited, the medical community has examined how adolescents’ beliefs regarding their confidentiality impacted their decision to seek medical treatment. The Commonwealth Fund Survey of the Health of Adolescent Girls (Klein, Wilson, McNulty, Kapphahn, & Collins, 1999) assessed adolescents’ beliefs regarding confidentiality when receiving medical treatment from providers such as primary care physicians and emergency room staff. The survey was distributed to 6,748 middle and high school students at 256 randomly selected public, private, and parochial schools across the U.S. Approximately one quarter (27%) of the adolescents reported not seeking needed medical treatment for concerns. Of those adolescents, 35% reported the primary reason was not wanting parents to know about treatment. Females (38%) were more likely than males (31%) to forgo necessary medical care for this reason. Adolescent females (41%) also reported an increased desire to seek health care without their parents present than adolescent males (19%). These findings align with previous research highlighting a higher level of confidentiality concerns in females compared to males (Cheng, Savageau, Sattler, & DeWitt, 1993; Klein et al., 1998). Although counseling services were not included in the survey, the results shed light on how fear of parental notification may deter adolescents, particularly girls, from seeking the help they need.

Similarly, The National Longitudinal Study of Adolescent Health (ADDHEALTH) investigated decision-making among adolescents who forwent health care in the past year (Ford, Bearman, & Moody, 1999). ADDHEALTH initially surveyed 90,118 students across the U.S. (Wave 1); 27,000 of students initially surveyed were interviewed in their homes (Wave 2; Bearman, Jones, & Udry, 1996). Researchers found 18.7% of adolescents forewent health care in the previous year. The most common reason for not seeking health care was a belief the
problem would simply “go away” without treatment (Ford et al., 1999); however, 11.8% reported fears regarding confidentiality as the primary reason for forgoing care.

An examination of the adolescents who forwent health care revealed higher rates of high-risk behaviors than adolescents who sought out medical care (Ford et al., 1999). This included: daily cigarette use (26.0% vs. 16.8%), frequent alcohol use (30.3% vs. 18.1%), and sexual intercourse (21.1% vs. 15.1%). The researchers also asked participants about mental health concerns, such as frequent crying. Among adolescents who reported frequent crying, 38.5% reported having forgone needed mental health care in the past year.

More recently, another team of researchers utilized findings from the ADDHEALTH (1994) survey to explore characteristics associated with forgone medical care among adolescents. Lehrer, Pantell, Tebb, and Shafer (2007) examined relationships between risk-taking behaviors and forgone medical care. Of the 14.3% of girls who reported forgoing medical care in the past year, 59.4% reported using alcohol, 43.5% reported having had sexual intercourse, 18.3% reported not using birth control during sexual intercourse, 23.3% reported high levels of depression, 36.6% reported moderate levels of depression, 40.2% reported low levels of depression, 30.0% reported suicidal ideation, and 12.6% reported suicidal attempt in the past year. Of the 10.5% of males who reported forgoing medical care in the past year, 58.2% reported using alcohol in the previous year, 41.5% reported having had sexual intercourse, 14.0% reported not using birth control during sexual intercourse, 14.0% reported high levels of depression, 43.7% reported moderate levels of depression, 42.3% reported low levels of depression, 15.7% reported suicidal ideation, and 3.7% reported suicidal attempt in the past year.

In all, there was an increased prevalence of depressive symptoms, suicidal ideation, and previous suicide attempts among female and male adolescents who forwent medical care.
compared to those who sought medical care (Lehrer et al., 2007). Further, girls who cited confidentiality as the primary reason for forgoing health care reported higher rates of high-risk behaviors than adolescent girls who did not focus on confidentiality: alcohol use (73.1% vs. 57.1%), significant depressive symptoms (38.7% vs. 20.7%), suicidal ideations in past year (49.8% vs. 26.7%), and a suicide attempt in past year (24.3% vs. 10.7%). Males who cited confidentiality as the primary reason for forgoing health care reported higher levels of depressive symptoms (29.1% vs. 12.3%), suicidal ideations (24.9% vs. 14.6%), and suicide attempts (13.4% vs. 2.6%) in past year compared to males who did not cite confidentiality as a concern.

The ADDHEALTH research by Lehrer et al. (2007) illustrated several correlations have implications for confidentiality in counseling. Adolescents who forwent medical care based on confidentiality concerns had elevated rates of risk factors as well as risk taking behavior. Adolescents who have the greatest need for health care may also be more likely to avoid treatment due to fear of confidentiality.

Although this research focused on medical health care, one can postulate how the phenomenon may translate to fear of confidentiality in counseling. If adolescents forgo health care due to fear of parental involvement it is likely they would also forgo mental health treatment, including counseling. The preceding sections have review important information about confidentiality with adolescent clients. With an understanding of how important confidentiality is to adolescents and the instances in which counselors feel the need to breach confidentiality, the following section addresses recommendations for counselors about how navigate confidentiality with adolescents.

Confidentiality Recommendations
The ACA *Code of Ethics* (2014) requires counselors to inform parents and legal guardians about the confidential nature of the counseling relationship. To achieve this, it is imperative for counselors to work towards establishing a collaborative relationship with parents or guardians to best serve minor clients (ACA, 2014). Taylor and Adelman (1989) suggested engaging parents in initial sessions to encourage collaboration and educate regarding the importance of confidentiality within the therapeutic relationship. Nevas and Farber (2001) recommended that parents directly address confidentiality with their child and commit to respect their child’s confidentiality within the counseling relationship. Ideally, this conversation should occur before counseling begins (Koocher, 2008).

According to Gilbert, Rickert, and Aalama (2014), 89% of parents trusted the nature of the therapeutic relationship and believed adolescents should be able to speak to counselors alone. Although parents may pledge their respect for their adolescent’s confidentiality, they may also change their mind through the course of counseling (Koocher, 2008; Sommers-Flanagan & Bequette, 2013). Unfortunately, adolescents who have poor communication with their parents are also more concerned about their level of confidentiality (Lehrer et al., 2007).

One way counselors can promote adolescent understanding of confidentiality is through an assent process, similar to informed consent with adult clients. Assent is when a minor consents to participate in counseling (Welfel, 2012). Informed assent refers to adolescent consenting to participate in counseling, being fully aware of the parameters of the counseling relationship, including confidentiality (Welfel, 2012). Adolescents perceive themselves as competent to make decisions regarding treatment, therefore should be included in the informed consent process to demonstrate respect for their ability to make decisions (Taylor, Adeleman, & Kaser-Boyd, 1983).
Taylor and Adelman (1989) expressed concern that ethical and legal requirements may lead practitioners to under or over share information and act out of legal obligation rather than what is truly best for the client. They described strategies for counselors to communicate confidentiality to adolescents and their parents including an emphasis on reframing the dilemma of breaching confidentiality to one of appropriate sharing of information. The authors’ recommendations for appropriate sharing included actively involving the adolescent’s parents in the informed consent process and repeatedly addressing concerns about confidentiality. The authors recommend focusing on establishing a working relationship wherein the adolescents take the lead in sharing information (Taylor & Adleman, 1989).

Given the impact confidentiality has on adolescent clients counselors must consider their approach to confidentiality with adolescent clients. Hendrix (1991) identified four positions one could take concerning confidentiality with minors: (a) complete confidentiality with no disclosure of treatment to parents; (b) limited confidentiality where minors waive the right, in advance, to know what will be disclosed to parents; (c) informed forced consent, when a child is provided advance notice information will be revealed to parents but has no say in what will be revealed; and (d) no guarantees made about confidentiality at all. Each approach has its limitations and strengths.

Ideally counselors, adolescent clients, and parents together have a collaborative trusting relationship. As Taylor and Adelman (1989) recommended, counselors must consider what is best for each individual client when faced with confidentiality dilemmas. What is truly best will vary greatly between clients and families. Prior research about when counselors’ breach confidentiality is void of the process counselor decision-making that includes variables that cannot be captured by surveys and hypothetical scenarios. This section reviewed several
examples of recommended ways to approach confidentiality with adolescents, but again the recommendations are hypothetical. The literature needs the real experience of counselors who have successfully navigated the confidentiality dilemma with adolescent clients.

Conclusion

Adolescence is a unique time of rapid, exciting, and potentially challenging development. Due to emotional, physical, cognitive, and social changes, adolescents may benefit from a trusting counseling relationship (Geldard & Geldard, 2013). Problems arise when counselors are faced with the decision to share clients’ information without their consent, potentially damaging the counseling relationship. The ACA *Code of Ethics* (2014) and relevant laws provide counselors with minimal guidelines for behaviors; however, they cannot provide counselors clarity about how to proceed in individualized cases.

In addition, adolescent’s decision-making may appear comparable to adults (Grisso & Verrling, 1978; Weithorn & Campbell, 1982) but may deteriorate during times of stress or peer pressure (Modeki, 2008). Inconsistent decision-making coupled with risk-taking behavior further complicates confidentiality. Risk-taking is a normal part of adolescent development yet determining when risk-taking transcends normative development and becomes dangerous is subjective and difficult. Adolescents tend to place more emphasis on immediate needs rather than long-term consequences, resulting in increased risk-taking behavior such as experimenting with alcohol and other drugs and reckless driving (Sullivan et al., 2002). Adolescents may engage in risks as a way to test limits of independent decision-making; therefore, some level of risk taking is developmentally appropriate for adolescents (Rae et al., 2001). Again, determining when adolescent risk-taking warrants a breach of confidentiality is a complicated process that is compromised of a myriad of variables; such as client/counselor relationship, home environment,
age of client, client support system, parental involvement, and many other factors that influence
counselor decision-making. On factor that may influence decision-making is the counselors’
development and level of experience.

Counselor Development

I believe master therapists can best provide insight into the complicated process of adolescent confidentiality. Research indicated counselors with more years of experience counseling were positively correlated with higher levels of cognitive complexity (Granello, 2010). High levels of cognitive complexity in counseling are associated with increased flexibility, less prejudice, more confidence, and a greater tolerance for ambiguity (Jennings & Skovholt, 1999). Those who possess higher levels of cognitive complexity are also less self-focused as counselors (Birk & Mahalik, 1996). Skovholt and Ronnestad (1992) noted counselors appeared move into a period of authenticity and individuation after 10 years of practice, based on qualitative interviews.

Through a grounded theory approach, I hope to develop a theory of how master therapists make decisions about adolescent confidentiality and provide examples of how advanced counselors have navigated this complicated terrain. As illustrated, the literature is void of a qualitative approach to adolescent confidentiality in counseling, therefore the literature is void of the relationships that exist between clients and counselors. I believe the relationship between client and counselor cannot be captured quantitatively therefore the proposed study is necessary to explore the process of decision-making in adolescent counseling. In Appendix C, I describe the methodology for this study, applying GT to the following questions: what is the theory that explains master therapists’ decision-making process for managing adolescent confidentiality with adolescent clients?
Appendix C: Extended Methodology

The purpose of this study was to explore master therapists’ decision-making surrounding adolescent confidentiality. In this appendix, I introduce the theoretical underpinnings of Grounded Theory (GT), briefly describe core characteristics of GT, and describe the procedure of the study. I outline the research questions, describe participants, identify data collection and analysis procedures, and evaluate the trustworthiness and limitations of the design.

Research Question

The study addressed the following research question: what is the theory that explains master therapists’ decision-making process for managing confidentiality with adolescent clients? Through the process of developing a GT, the researcher also sought to increase understanding of the following questions:

(1) What are the strategies master therapists use to resolve ethical dilemmas regarding breach of confidentiality with adolescent clients?

(2) What conditions influence the decision making process of master therapists?

(3) What consequences arise from decisions made about adolescent confidentiality?

The questions were explored through GT methodology. In the following section I will review the development of GT, the primary constructs of GT, and how I utilized GT in order to investigate the research question.

Grounded Theory

GT is “derived from data, systematically gathered and analyzed through the research process” (Strauss & Corbin, 1990, p. 12). Glaser and Strauss developed GT in response to their observation of excess use of quantitative research to test existing theories and their perceived
need to generate new theories free from constraints of quantitative research (Heppner et al., 2008). Rather than attempting to validate pre-existing theory, GT is an inductive method that allows a theory to emerge through data analysis (Bryant & Charmaz, 2012). In the 1990’s Charmaz began applying constructivist principles to GT, creating another wave of grounded theorists. According to Charmaz (2006), grounded theorists co-create and construct abstract theoretical explanations to processes with participants through the analysis of data. The different approaches to GT created much debate, although GT theorists share many common characteristics that I will summarize below. I most align with Charmaz’s constructivist principles in GT and will focus the meanings that may be constructed from the data (Charmaz, 2000).

**Procedures**

In this section, I will describe how I used GT methodology to develop a theory about the decision-making process of adolescent counselors and confidentiality. GT theorists (Charmaz, 2005; Stern, 2007) suggested that a thorough literature review aids researchers to communicate about the subject area and increases the researchers’ ability to notice nuances during the interview and coding process. I agreed with this assertion and immersed myself in the literature prior to data collection. I believe the knowledge gained through the literature review aided my ability to interview expert counselors in the complex issue of adolescent confidentiality. The literature review also helped me identify my research question with greater clarity and precision. Once armed with an understanding of the phenomenon of adolescent confidentiality I began by assembling a research team.

**Research Team**
The research team consisted of three doctoral students at The University of North Texas and one supervising researcher. I, the primary researcher, am a Licensed Professional Counselor- Supervisor (LPC-S) in the state of Texas. I am a 34-year-old White female who is a doctoral candidate at The University of North Texas and a private practice counselor in Fort Worth, Texas. My primary focus is child and adolescent counseling with the bulk of my counseling experience with adolescents. My clinical focus, along with life experiences, will inherently impact my interpretation of the data. In GT researchers accept and acknowledge the impossibility of approaching data with a “clean slate” (Charmaz, 2006; Creswell, 2009) and I will do the same.

The remaining two members of the coding team were recruited through The University of North Texas counseling program. The second coding team member was a third year doctoral student in The University of North Texas counseling program. The third coding team member was a first year doctoral student at The University of North Texas counseling program. Both had an interest in working with adolescents in the future but at the time of the study had not had any adolescent client experience. Including coding team members who did not have insight into the subject matter was an attempt further avoid bias and will serve as a sounding board for alternative interpretations of the data. A supervising researcher who has experience with qualitative research methods, ethical dilemmas, and adolescents supervised the research process. The supervising researcher was a faculty member at The University of North Texas and served as an expert consultant throughout the research process. She possesses a doctoral degree in counselor education and significant research experience.

Participants
The population for the study was master therapists who had significant experience working with adolescents. Additional criterion for participation included: a minimum of fifteen years counseling experience, at least 25% of counseling practiced dedicated to adolescents, and current licensure as Licensed Professional Counselor in Texas. All participants received training in professional counseling programs, and the bulk of their clinical experience occurred in Texas.

Individuals who have lived through or observed the experience being studied are potential informants for qualitative research (Morse, 2007). Excellent informants are articulate, reflective, and willing to share their experiences. Researchers recruit intentionally in GT (Morse, 2007), and it seemed important that I intentionally sought out master therapists.

Master therapists have unique clinical experiences due to being advanced practitioners (Jennings & Skovholt, 1999). For the purpose of this study, four qualities seemed especially relevant: master therapists are voracious learners, master therapists draw heavily on accumulated experiences, master therapists value ambiguity and cognitive complexity, and master therapists believe in the working alliance (Jennings & Skovholt, 1999). I identified master therapists the same way as Jennings and Skovholt: through nomination from peers.

I did not select a predetermined number of participants consistent with grounded theory methodology (Corbin & Strauss, 2008). Qualitative research generally has significantly smaller sample sizes than qualitative research (Mason, 2010), and researchers collect data until saturation (i.e., when data collection ceases to reveal new insight or perspectives) (Charmaz, 2006). The sample must be large enough to account for multiple perspectives on the topic yet small enough to ensure feasibility and reduce unnecessary repetitiveness (Mason, 2010). Charmaz (2006) recommended the project drive number of participants and noted the more complicated the
research question the more participants needed to fully explore. I followed Charmaz’s recommendation and allowed the project to drive the number of participants.

Recruitment Procedures

I secured approval of the Institutional Review Board (IRB) before data collection began. Once I secured IRB approval, I began to recruit participants. I initial used purposeful sampling to target two master therapists who are known for their work with adolescents in Fort Worth, Texas. I will then utilized “snowball sampling” by asking the initial counselors to identify other master therapists who may serve as information-rich informants (See Appendix F for a copy of the recruitment request) (Glense, 2011).

I began with two master therapists identified by myself, the primary researcher. I chose these two counselors based on reputation and personal clinical impression. Both counselors had significant experience working with adolescents and were my two primary referrals for adolescent clients. Participant 1 had 22 years of experience and holds a Doctoral Degree in Counseling and Counselor Education. Participant 2 had 37 years of experience and has maintained a weekly adolescent group for the past twenty years. I felt confident that these two participants would provide information rich data as well as the ability to identify additional master therapists.

In line with GT methodology, I utilized theoretical sampling, a process through which the researcher directs sampling based on emerging categories and theory (Glaser & Strauss, 1967; Morse, 2007). Researchers target participants who may add richness to a developing theory or who may contradict a developing theory (Morse, 2007). Through constant comparative analysis, I determined who may provide data that will enhance the study.
Once potential participants were identified, I contacted them by telephone for an initial invitation and screening (see Appendix F for a copy of the phone script). After potential participants reported interest in being a part of the study, I sent them a Qualtrics demographic survey that included the informed consent (Appendix F). Included in the demographic form were questions about: age, gender, racial and ethnic identity, years of experience, education level, theoretical orientation, degrees, current or previous licensure, advanced certifications, and information about participants’ counseling practices. Questions also included percentage of child, adolescent, adult clients, practice settings, and areas of clinical focus. This demographic form served as another form of data and aided the researcher in selecting the most diverse and purposeful sample possible. After participants read the informed consent, I explained key elements verbally and encouraged participants to ask questions or voice concerns about procedures.

Once participants consented to participate in data collection and completed the demographic survey, I scheduled one-hour interviews at a location of participants’ choosing, six interviews occurred in the participants’ offices and four occurred at the participants’ homes. I audio recorded all interviews and store recordings on a password protected device.

Data Collection

Participants were asked to complete a brief demographic form (Appendix F) and provide a copy of their informed consent used with adolescent clients. I utilized semi-structured interviews to provide consistency across interviews but allowed for flexibility in each unique interview (Heppner et al., 2008). I initially used six types of questions to gain understanding of the participant’s experiences from different levels: background, behavioral, opinion or belief, feelings, knowledge, and experience (Heppner et al., 2008). I also used prompts within the
questioning framework to further delve into the participant’s experiences (see Appendix F). The following five questions aim to assist the participants in exploring their five areas described by Heppner et al. (2008).

Table 1

*Interview Questions*

<table>
<thead>
<tr>
<th>Question</th>
<th>Goal</th>
</tr>
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<tbody>
<tr>
<td>What is your background working with adolescents?</td>
<td>Gain understanding about their experience working with adolescents</td>
</tr>
<tr>
<td>What do you usually do when confidentiality becomes an issue with adolescent clients?</td>
<td>Gain understanding about what participants do when presented with confidentiality issues</td>
</tr>
<tr>
<td>What is your belief about the best way to handle confidentiality with adolescents?</td>
<td>Gain understanding about participants’ beliefs about confidentiality.</td>
</tr>
<tr>
<td>How do you feel when a situation arises that may warrant a breach of confidentiality?</td>
<td>Gain understanding about participants’ emotional experiences with adolescents and confidentiality.</td>
</tr>
<tr>
<td>Describe your experience(s) of handling adolescent confidentiality issues.</td>
<td>Gain understanding about participants’ experiences with adolescents and confidentiality.</td>
</tr>
</tbody>
</table>

Prior to data collection, I engaged in practice interviews with counselors who work with adolescents who were not candidates for the study due to lack of prolonged experience. The practice interviews allowed me to hone my interview skills and adapt interview questions from feedback to best elicit information about the phenomenon.

The five questions above provided the interview with consistency and structure. For the remainder of the interview, I was flexible and followed the participant’s lead while using
prompts when necessary. I chose participants based on their ability to help me understand the experience of master therapists and adolescent confidentiality, therefore I felt confident all of the information gathered was valuable. The more focused the interviews are, the less interviews needed (Morse, 2007); therefore, I will strive to remain on focused on adolescent confidentiality throughout the interviews. I added two additional questions based on observations from the first two interviews, for example I began to ask about parental fitness impacting decision making directly after the first two participants’ indicated that was a factor in their decision-making. I began to ask about participants experiences of being parents of adolescent impacting decision making about adolescent confidentiality based on the first two participants discussing how parenting their teens has impacted their work with adolescents. I also began to ask more specifically about how parents may react to information or the fitness of the parents impacts decisions about confidentiality.

I also asked participants to produce copies of their informed consent for minors and adolescent client assent when available. Participants’ informed consent provided information about their practice and how they approach ethical issues with adolescents from the initial meeting.

I discontinued interviews once saturation was reached and new data did not contribute differences to the existing data (Corbin & Strauss, 2007). We knew saturation has occurred once all emerging codes from the new data were encompassed by preexisting codes or categories. By the seventh interview, the coding team and I discussed the lack of new codes or categories. During interviews 8, 9, and 10 I sought confirmation or disconfirmation of the components of the emerging theory consistent with recommendations from Glasser and Strauss (2008).

Data Analysis
Each interview was de-identified and transcribed verbatim. Interview transcriptions along with all data were be stored in the primary researcher’s password protected computer. Identifying information, such as informed consent and demographic forms, will be stored in the supervising researcher’s office at the University of North Texas for three years after the research has been conducted. I will destroy audio recordings of interviews upon dissertation defense.

The constant comparative method occurred throughout the coding process and ultimately resulted in the development of a theory (Birks & Mills, 2011). Although different scholars have different names for types of GT coding, three primary types of coding occur in GT and within the constant comparative method: open, focused, and theoretical (Charmaz, 2006; Glaser & Strauss, 1967). These are not three distinct phases, rather three waves of an integrated process that occur within the constant comparative method. The four steps of the constant comparative method are: assign codes to segments of the text, identify shared meaning between the identified codes, merge codes with shared meaning, and discontinue sorting codes once new categories no longer emerge (Heppner et al., 2008).

Codes are labels researchers use to identify reoccurring conceptual units and similarities between participants’ experiences (Birks & Mills, 2011; Bryant & Charmaz, 2011). We used both in vivo codes and –ing codes to capture participants’ experience and process of decision-making. When using in vivo codes the researcher uses the participants’ words as closely as possible to capture participants’ intended meaning. When using –ing codes, the researcher attempts to capture the process of participants’ experience.

The coding team began by reading through each transcript in order to gain an overall sense of the interview. Next the coding teams individually re-read the interviews and coded each line of the transcripts. Each coding team member made notes on the right margin of the
transcript noting themes, key terms, and emerging categories. The researchers also reviewed each of the informed consents collected and to look for similarities or difference between the participants. The coding team compared new and existing codes throughout the constant comparative process.

The purpose of initial coding process was to fracture the data and to name each phenomenon. The coding team met to discuss and compare codes for each interview. We identified themes that were emerging from the data. Within the identified categories, we will looked for potential subcategories encompassed by a larger category (Corbin & Strauss, 2008).

In the focused coding phase, the coding team will drew categories together from the open coding phase paying attention for the following categories: causal conditions that prompted decision making, strategies and actions that are used in the decision making process, intervening conditions that influence the decision made, and consequences of the decision (Bryant & Charmaz, 2012). Through coding these categories, the researcher hoped to reveal information about ethical decision making in regard to adolescent confidentiality, strategies counselors use to resolve ethical dilemma, conditions that influence the decision-making, and consequences that arise from decisions made. The coding team met after each interview analysis to compare individual codes and began combining individual codes to develop categories.

In the third phase of coding, selective or theoretical, a story line will began to emerge through integrating the categories from the axial coding phase. Selective or theoretical coding occurs after the researcher identifies potential core categories (Bryant & Charmaz, 2012). After the seventh interview analysis, the coding team identified four potential core categories: safety as a priority, counselor development impacting decision-making, counselor/client/parent relationships, and the use of therapeutic intuition. From that point on, further coding and data
gathering was purposeful and relevant to the emerging conceptual framework. In the following interviews the primary researcher asked participants about these four categories in order to elicit confirmatory or non-confirmatory information.

Through the constant comparative process, a core category emerged (Bryant & Charmaz, 2012). The core category accounted for most of the variation in the process and can explain the concern of the study conceptually. The core category occurred repeatedly in the data and can be seen as a pattern throughout participants’ experiences (Bryant & Charmaz, 2012). The primary researcher and coding team met and diagram existing categories to identify relationships between the categories. The coding team discussed the emergence of a core category and used theoretical memos to support the core category to develop a theory.

Once the tentative theory emerged, the researcher conducted member checks in order to triangulate data. The member checks ensured the emerging theory accurately describes participants’ experiences. I conducted a final member check with all participants and present the GT before concluding data collection. All participants expressed satisfaction with the developed theory and diagram. Member checks aided in the development of the theory and also added to the trustworthiness of the study. In the following section I will describe the trustworthiness of the proposed study, including member checks.

Trustworthiness

In qualitative research, the researcher is tasked with presenting trustworthy information that is an accurate representation of participants’ experience. An inherent threat to trustworthiness in qualitative research is researcher bias. Corbin and Strauss (2011) recommended researchers stay vigilant during the interviews and analysis, maintaining connection with the respondents while maintaining enough distance to think analytically and be
aware of their own internal processes. I utilized the coding team and supervising researcher throughout the research process. I strove to maintain awareness about what beliefs of mine may enter into the interview. I acknowledged my potential for bias throughout the research project and upon dissemination of the results. As a counselor who works with adolescents it was at times difficult to separate my personal experiences and beliefs. I remained transparent about my potential biases and utilize my coding team as support to remain aware of my personal process to reduce impact on the data collection and coding.

As mentioned, I recruited two doctoral level-counseling students for the coding team, in order to triangulate the analysis. I purposefully recruited coding team members who did not possess significant experience with adolescents in order to reduce bias. I engaged the team members in discussion about their own biases and expectations prior to coding. I asked the coding team members to explore their experiences as adolescents, experiences counseling adolescents, and beliefs about adolescents. These discussions revealed significant differences of experiences between the coding team members in regard to experiences as adolescents, experiences with parents during adolescence, and experiences working with adolescents. I believe the differences among us added to the trustworthiness of the study by promoting a multidimensional view of the data.

Memos are important component of GT data analysis. GT experts agree researchers must establish an audit trail in order to enhance trustworthiness of findings (Birks & Mills, 2012; Charmaz, 2006; Creswell, 2008; Corbin & Strauss, 2008). Memos comprise a written record that contains information about the process of analysis and the products of the analysis (Corbin & Strauss, 2008). The primary researcher and the coding team kept memos throughout the data analysis process. Memos will consist of information, new and old, that is relevant to how master
therapists make decisions about adolescent confidentiality, as well as coders’ reactions to the information and developing themes. Memos provided information about the open data exploration, properties and dimensions of categories, comparison, questions, elaboration, relationships, and the development of a story line (Corbin & Strauss, 2008). Memos are essential to aid the researcher in the complex task of developing a theory. Memos will also become a part of the researcher’s audit trail to ensure trustworthiness of the analysis.

Trustworthiness has also been enhanced through the write up of the study. I continue to acknowledge my bias and also use thick, rich descriptions to bring the participant’s experiences to life. I did not rely on the coding team’s analysis alone; rather, exposed the reader to the participants’ experiences through my descriptions. Although I strove to conduct the most trustworthy study possible there are inherent limitations in all research.
APPENDIX D:

UNABRIDGED RESULTS
The purpose of this study was to use grounded theory methodology to develop a theory about master therapists’ decision-making process surrounding adolescent confidentiality. Through constant comparative analysis, a grounded theory emerged from the data in which participants converged understanding of client safety, relationships, and clinical intuition in a process of integrated experience and consultation. With the exception of mandated reporting and mortal danger, rules, ethical guidelines, and laws did not seem to factor into participants’ decision making. Table A illustrates the core component of mortal safety encircled by the counselor as a person and the relationships involved. Ethical codes, legal regulations, and informed consent practices sit below as a foundation for the decision-making model. Counselors did not report adherence to an ethical decision making model, yet they described integrated knowledge and consultation as guiding the process in their decisions.

Table A

Decision-Making Process
In the following paragraphs, I describe the decision making process of master therapists surrounding adolescent confidentiality. I include excerpts from the participants to illustrate components of the decision-making process and how each factor impacted decision-making. I use pseudonyms to protect the participant’s confidentiality. I start where the participants started, by describing the informed consent process. The participants reported a clear informed consent as a foundation for their decision-making process.

Informed Consent

Each counselor described their informed consent process with adolescent clients and parents. While counselors generally did not directly link the informed consent process to their
decision-making process, it was clear that participants strove to stress the importance of confidentiality to parents up front and to communicate the limits of confidentiality to parents and adolescents. Participants described a similar process of establishing a relationship with parents, expressing the importance of and boundaries of confidentiality, assuring parents they would be informed of any life-threatening behavior, and assuring adolescents they will be privy to information shared with parents. It appeared that participants were intentional about using informed consent to set the groundwork for future ethical decision-making.

*It’s really important to me that everybody knows what the ground rules are. What I tell them is, your child is not going to be very likely to open up to me: if they think everything they say is going to go right back to mama.* (Faith)

One participant reported giving parents the choice to continue with her as their counselor understanding the importance of confidentiality,

*I began to develop my own, I don't know, style, maybe, of engaging parents and educating them to respect that. That's needed and helping them see why. Then, just further developing my own boundaries that you don't have to choose me as your therapist, but if you do, this is how I work. It becomes more of a knowing myself as a therapist, not being desperate for clients, not being really ... Also seeing the benefit of so much being said ahead of time so the informed consent really being, "You need to know this."* (Betsy)

Participants reported variations in the informed consent process, such as the decision to meet with parents alone initially or together with adolescent. One participant explicitly informed parents information would not be kept confidentiality from the adolescent either, warning parents...
“If you tell me something, you are giving me permission to use that information in a session” (Faith).

Participants described the importance of informed consent early and rarely referenced it again, but it was apparent they felt the process was essential for future decision-making. Similarly, participants mentioned their ethical codes and laws early on in the interviews, or almost in passing later, indicating an integration of those codes and laws that inform their decision-making in a foundational manner. In the words of Tom, “Always adhere to your baseline code of ethics”. Participants also referenced relevant laws, particularly in regard to mandated reporting, as a foundation piece of their decision-making. I will further describe participants’ use of ethics and laws in a future section. In general participants moved onto safety after their description of informed consent and ethical/legal requirements

Safety

Counselors most clearly agreed upon one area surrounding adolescent confidentiality: safety. All 10 counselors identified life or death danger as a clear-cut factor that influenced their decision-making. All counselors agreed upon informing parents about life threatening behaviors. Throughout the interviews, participants mentioned these considerations almost off hand. For example, “what they talk about here is going to be private unless danger to self or others, court proceedings, child abuse, elder abuse, those are the conditions under which I break confidentiality” (Faith). Many of the participants introduced “The 3… Injury to self, injury to others, and somebody hurting them” (Trish) when describing their communication of confidentiality limits with parents. “Harm to self in my definition is: imminent intent to kill themselves or to kill someone else” (Faith). “Obviously a suicide, homicide, or abuse. Also, if
they're being abusive to somebody else. Those are the things that are an immediate stop” (Stephen).

Tom most clearly described his boundaries of physical safety. He reported working hard to avoid informing parents about an adolescent’s behavior against the client’s will, but when his or her life is in danger, he does not hesitate to intervene with the family. Tom described how he might communicate his decision to inform parents about life-threatening behavior to the adolescent:

“Look, I can't hold this secret. I can't do it. I can't do it and serve you. I can't do it in good judgment, and in keeping with my first thing about keeping you safe. You can sit here with me and we can tell your parents, or you can know I'm going to tell your parents, but one of us is”….they'll be bitching and moaning about it, but then they'll do it. In a situation where I really do believe that it is life in danger, not quality of life, not protecting some future I want to be a doctor thing, but are you going to die…. It won't matter, will it? There are times when I think I have to adhere to a higher ethic.

When further probed about what constituted life threatening behavior, Tom responded with “bleeding on the carpet.” Although this comment was part joking and Tom’s sense of humor was present throughout the interview, there was seriousness about his commitment to uphold confidentiality unless the adolescent is in imminent danger, hence “bleeding on the carpet.”

Faith had a softer description of her interpretation of safety and harm to self. When describing how she communicates the limits of confidentiality to parents and clients, she identified her stance on safety: “Literal safety… the phrase I use with my clients is, ‘safety
trumps everything." She described her belief that by putting clients’ safety first, she is helping adolescents understand their safety must be a priority for them too.

As mentioned above, every participant identified life-threatening behavior as clearly impacting decision making; however, there was variance in how participants interpreted harm to self. With regard to non life-threatening behavior, Nancy articulated markers described by many participants: “severity, intensity, and duration.” Although the other participants did not use those terms, they described similar factors in their decision-making.

I just say, "Well, let's look at it. Your grades are dropping. Your face is breaking out a lot. I'm concerned about what drug you're using, how often you're using it." I'll look at that intensity, duration, and severity... We look at that all, the client and I, "Okay, let's look at this. How often is it happening?" It depends I guess on how severe it is. (Nancy)

In addition to severity, intensity, and duration, participants generally included age in their considerations about client risk taking behavior. The following participants described age as an impacting factor in the level of risk for sexual activity.

I guess I have a lot of clients at 15 that are having sex. If they're 14 and it's another 14 year old, I still think it's dangerous. I still think they don't have quite the mindset. I still don't think they're old enough at 15 to really understand what they're doing, but I think they have a little bit more maturity to at least be able to talk about it more clearly.

(Stephanie)

If a child is let's say 14 and seeming sexually active I think that's high risk. If they're 18 and sexually active I would consider that more moderate risk. (Olivia)

Seven counselors mentioned Non-Suicidal Self Injury (NSSI), and five of those seven reported encouraging adolescents to share with parents but not sharing against the adolescents’
will unless the self-harm intensified. Participants described decisions based on non-lethal behaviors including severity, intensity, duration of the NSSI.

And cutting. Cutting I- Cutting I usually give them a little bit of leeway, and then say, “Hey, if this continues, we're going to call your parents, get them to make sure.” I give them a chance to talk to their parents first, because different people view cutting differently...but its not something that can go on and on. (Trish)

I don't report cutting until I feel like it's gotten to a dangerous point. (Stephanie)

Tom provided an in-depth of his decision-making process regarding disclosing NSSI:

Are they truly a cutter in the relieve emotion sense, or are they a cutter in the no I really want to die sense, kind of crossing that line, or in their actions that they really are cutting deeper, cutting longer, that kind of a thing. That would be one of my criteria and I would use that as my measuring stick with the client. When we first started talking and you first started trusting me, we were talking about scratching, we were talking about superficial cuts...Now we're talking about your arm looking like a roadmap. We're talking about you can't wear shorts. We're talking about you can't use a public bathroom. We're talking about very different things now. We're talking about the different instruments. You've got rusty razor blades going on now. Your stash is getting bigger...You've got to know that this is getting dangerous and it's not under control.

Similarly, Stephen discussed differentiating NSSI and suicidal behavior:

Self-harm is the one that's ... that I most often see. I think what I see there is the skill of understanding the difference between truly being dangerous, the suicidal ideation and thoughts of death. Being able to navigate that with a teenager and understanding where they are on that scale, if it's purely self-harm or if it's leaning a lot farther that way, then
"it's letting them know we're going to bring the parents in, going to talk through a safety plan. You know there are steps for you to move them forward. If it's on the side of cutting, burning, something that's less lethal, then if there's investment in trying to improve and the parents don't yet know, then I may give it a couple of sessions to see what's going on there. (Stephen)"

Similarly many participants seemed to share in an ambiguity about drug use. Some counselors identified specific drug behaviors that would warrant parental notification while others were willing to withhold all information about drug use. One participant described her hesitation to inform parents of drug experimentation with marijuana or alcohol but saw disclosure about use of drugs she conceptualized as more severe (e.g., cocaine, methamphetamine, and heroin) as “non-negotiable. That's immediate danger to self, in my opinion” (Trish).

Two themes emerged when talking about drug use. Some participants talked about parents already having a good idea about drug use, therefore they did not need to have a decision-making process around talking to parents. Olivia stated, “I can't think of a time I've had to tell the parent about sexual activity or drugs or alcohol because most of the time the parent suspects.”

When asked about the process of decision-making surrounding non-lethal behavior, such as drug use, several counselors described asking themselves the question “Can I sleep tonight?” (Terri). Participants described the tension of knowing their adolescent client could be engaging in potentially dangerous behavior without the parents’ knowledge. Several participants described the discomfort of holding information and gauged the severity of the behavior based on their ability to sleep that night knowing the behavior may occur.
I'm not going to go home and sleep well if I'm thinking, "Am I going to hear from them tomorrow?" … I have to be able to sleep that night. (Betsy)

It's a discernment that I have to look at, will I be able to sleep at night? That's one of the questions I ask myself, “am I going to be able to sleep at night?” Can I sleep at night if something really happened? (Nancy)

Generally, participants used examples of suicidality, drug use, NSSI, and sexual activity when talking about confidentiality. Stephanie included a unique element of client safety. She described seeing an alarming number of children and adolescents who were routinely watching pornography and developing pornography addictions. During the interview, she came back to children and pornography on several instances and described her fear for the clients’ sexual development. She reported informing parents about pornography because, “I do feel like it's my duty to protect the minds of young children.” Below are her beliefs about the long-term negative consequences of pornography addiction in children and adolescents,

\textit{I think that being exposed to the porn can hurt a child's development. That's what I'm very concerned ... and hurt their development and their thoughts about what sex is supposed to look like.” “how does that affect them as an adult? Would it make them a predator?...Kids are becoming immune to porn at the age of eight...What they have in their hands is the loaded gun of the iPad... I have not seen any kids who have looked at a lot of porn who've come out being okay.}

I include Stephanie’s inclusion of pornography as self-harm because it was clear through her descriptions and her affect that she feels passionate about protecting adolescents from the impact of pornography even through one may argue “harm to self” does not include visual stimuli.
Discussions around safety arose early in the interviews. Participants organically discussed safety without prompting from the researcher. Similarly, all participants discussed consideration of the relationships involved when making decisions about confidentiality independent of question. In the following section I present the importance of the parent, adolescent, and counselor relationships in the decision-making process.

Parent, Adolescent, and Counselor Relationships

Participants’ decision-making process included consideration of the impact of maintaining confidentiality or sharing information on all relationships. There appeared to be a relationship triad that impacted counselor decision-making: the client-counselor relationship, counselor-parent relationship, as well as the adolescent-parent relationship. These three relationships were interwoven throughout the interviews and impacted decisions about confidentiality in a multitude of ways. Ethan succinctly described the balance of the relationships involved, “the balance between maintaining trust with adolescent and providing parents with just enough to stay off my back and let me work with their kid; and to provide parents with enough information to make their own changes for their own benefit.” In the following sections, I present participants’ descriptions of how relationships impact the decision-making process.

Parent-Adolescent Relationships

Although participants generally described the importance of parents “staying off their back” in order work therapeutically with adolescents, all participants addressed the importance of parent-child relationships. Generally, counselors reported they were more likely to share information if they believed it would improve the child/parent relationship. For example, Olivia clearly valued parental involvement in the counseling process. She discussed her protocol
around creating a pattern of communication with parents early on in the counseling process. She also talked about how she is more likely to breach confidentiality if information is likely to improve the child/parent relationship or improve parenting. “On the rare occasion that I do feel like I have to share something, it's really only to help the parent in terms of parenting.” Her beliefs about the importance of parents’ involvement in the process was evident, and Olivia discussed how those beliefs makes decisions about confidentiality blurry:

> On the other hand, the way that child is being parented is a very close second to how that child's functioning and healing that family communication. Parents can do the therapy if they're responding in a way that's helpful. Sometimes that's part of what brings a teenager in, is just the disconnect that's happening at home. That's where I guess it gets blurry is because the parents have to be part of the healing process.

Tom also described the importance of the family unit when working with adolescents when he stated that it is “very rare that if you have an issue with a teenager that does not intricately involve the family system.” How much he includes parents and how much he shares is based on a multitude of factors:

> I always want to include them, the level of inclusion is really determined by the level of trust that the client had in me in branching out, and the level of capabilities that the parents have. If I can use them a lot, I will. It makes my job easier. If I can't use them very much, well, then I use them for information, I keep a conduit of conversation open, making sure that they know what I'm doing.

Stephen appeared to have established boundaries about his role as counselor and his influence. He seemed to value the family relationship above the therapeutic relationship and talked about the purpose of confidentiality to protect “relationships,” not just therapeutic
relationships. When asked about how his experiences and development as a counselor have impacted his beliefs about confidentiality he discussed how he has shifted away for placing emphasis on the therapeutic relationship:

*I'm a little more okay in risking the therapeutic relationship if it means that it's going to help the family relationship a little bit more, that's what has changed over time. I'm not as guarded with my relationship. I think I've done a better job as I've grown conceptualizing that relationship. It's more important than my relationship but I will sacrifice what I have in order to make it better out there...I think that's what confidentiality is for is to protect a relationship” “if the parent is dis-regulated, I typically am very careful what I tell the parent. (Stephen)

Yeah, just gauging on the parents. I always want to include them, the level of inclusion is really determined by the level of trust that the client had in me in branching out, and the level of capabilities that the parents have. If I can use them a lot, I will. It makes me job easier. If I can't use them very much, well, then I use them for information, I keep a conduit of conversation open, making sure that they know what I'm doing, but that's about it. The range is kind of why. (Tom).

Similarly, Stephanie described involving parents for the good of the parent-child relationship while maintaining some confidentiality with the adolescent, “I'll involve the parent when I feel like their relationship may have deteriorated and I feel like there are some things I can do to help mend that relationship as well. That doesn't mean I have to tell the parent everything that the child has been up to.” Throughout descriptions of parent-child relationships the master therapists continually returned to the importance of the client-counselor relationship.

Client-Counselor Relationship
When making decisions about confidentiality, participants considered the impact of potentially losing the trust of the client, therefore impacting the effectiveness or continuation of counseling. “I also know that if I do that (inform parents) I am risking losing the client or the losing the relationship, and if I lose the client, then ethically what have I done to this family and this child?” (Olivia). She also expressed a hope that through trusting her adolescents are feel secure in her communication with parents.

*I hope that they trust that ... That because I've tried to communicate that they're my top priority, that I'm not going to do anything that wouldn't be in their ... What they would perceive as in their best interest.* (Olivia)

*I have a really, really, really strong respect for the client confidentiality in the relationship.* (Betsy)

Another participant talked about how informing parents of drug use may impact her ability to counsel adolescents.

*If I called every single parent on every single child that told me they smoked weed, I wouldn't have any kids talking to me. It's very important to me to work with the child on making better choices before I just run to them...I can't work with them, they're not going to work for me, trying to work through and make better choices about drugs.* (Trish)

In recognition of an ongoing process of relationship, Tom described an increased willingness to share information with parents if the adolescent has pulled away or stopped engaging in counseling.

*Sometimes if the client is doing that and shutting down on me, so I know I'm losing the client. Even by keeping the secret, I can't keep that client. They're moving on... It's like I know I'm losing it. Well, you know, I guess I'm going to scream as the ship goes down.*
The last thing I was able to do for you was get you in treatment, get you hospitalized, get your parents aware of what's going on.

Participants also described a point at which they were willing to risk the relationship with a client due to concern about safety. Generally, participants reported high regard of confidentiality and the counseling relationship, yet several counselors described a decision point in which the clients’ safety trumped everything, including the counseling relationship.

At that point I was willing to risk my relationship with the girl for her safety. (Olivia)

I want you to trust me, I want you to like me, I want you to stay in therapy, I don't want to compromise your trust in mental health professionals for the rest of your life, blah blah blah blah, but if you're dead, none of that will matter. You're just dead, or if you're brain dead. (Tom)

Safety. There's not much question. She just couldn't agree to it. I'm not willing to take that risk. (Ethan)

Even if she was pissed off and alive and didn't ever want to see me again. That was better than the possibility of her being dead. (Terri)

Parent-Counselor Relationship

Participants described a strong desire to include and garnish the trust of parents. Several participants described instances of positive relationship with parents resulted in increased ability to work effectively with adolescent. The participants’ regard for the parent-counselor relationship was integrated their descriptions of the parent-adolescent relationship therefore are more difficult to isolate into Stephen described an example of parents trusting him with their son due to the relationship developed between parent and himself.
I think parents also are a little more willing to be in alliance with me. I don't know if it's because they feel like I know where I'm going with them or they trust my experience but they will often say, you don't need to tell me everything, you can give me broad brush strokes.

Olivia used an example of working with parents to garner trust and encourage a collaborative relationship,

*Having that collaborative relationship with the parent where I say, "Oh, you know I got some resources about that or I learned this approach." That sort of thing has been helpful. Because then we're working together collaboratively on some issues sometimes.*

Parental Response. All but one participant described assessing parents’ ability to respond in a helpful manner when deciding when or how to breach confidentiality. When I asked Ethan if how parents may respond to information impacts his decisions to share information, he responded with an enthusiastic, “Yes. Ten times fold!” Stephanie explained, “If I feel like they are the type to be really combative about things, then maybe I'll be less apt to bring them in.” Tom described assessing how much information parents can handle, “Yeah I've got to take a look at the quality of my parent and figure out for myself, what's that line? ‘You can't handle the truth.’” More specifically, how well a parent may respond to information influenced the amount participants shared with them, “yes, if a parent can be trusted with information ... There's a kid that I work with and the mom was always very volatile and reactive and so I was very careful what I told her, very careful” (Stephen). Olivia also discussed what the parents are likely to do with the information impacts how much or what she shares with the parents. She gave an example of a client who was engaging in unsafe behavior and due to mental health issues and noted that her decision to communicate with the parents without the teen’s knowledge was based
on her trust in the parents’ ability to handle the information and take appropriate action while preserving the client’s trust in counseling.

The only participant who reported her assessment of parental fitness did not impact her decision-making process was also the only participant who counseled in a school setting. She appeared regretful that she was required to inform parents about circumstances regardless of parental fitness to respond to the information well:

*A lot of these parents aren't necessarily going to handle it the way I want them to.*

*Because sometimes it is worse calling the parents. But it doesn't change. It's in the back of my head and I could be positive, but it doesn't change what I have to do.* (Trish)

Trish also described policies that require her to take action that involves a breach of confidentiality to parents and/or school administrators that did not allow for her clinical judgment about what is in the best interest of the adolescent. She described the difficulty of managing her ethical guidelines and school policy, “Is this school policy, is this my ethical guidelines? And sometimes they conflict”.

As illustrated by the participants’ interview excerpts, all relationships involved impacted counselors’ decision making. The necessity of the client/counselor relationship was clear in the participants’ interviews, participants discussed confidentiality as an essential component in establishing relationship with participants through trust. Participants’ reverence for the parent and adolescent relationship came through in the interviews as participants described increased likelihood of sharing information in an attempt to improve parent/adolescent relationship and the importance of parental involvement for therapeutic success. Participants desire for positive working relationships with parents as well as adolescents was another consistent theme.
Participants generally described positive relationships with parents lead to increased trust from parents in the counselor and the counseling process.

Counselor as a Person

All participants discussed use of self as a component of their decision-making. Some clinicians described an unspoken way of knowing information about the client. Others discussed the use of their gut in decision-making. Many directly credited intuition as a major influence in their decision-making process. Several participants discussed the difficulty of separating themselves from the counseling process, therefore decisions about adolescent confidentiality and safety often stemmed from their concern as people, not as a counselors. Participants also discussed how their development, personal and professional, has impacted their decision-making. In the following paragraphs I use excerpts from participants to bring these components to life.

Intuition

Participants described trusting their intuition, gut, or feeling. The phenomenon of intuition arose when participants were asked about how they determined when adolescent clients were in danger and warranted parental notification. As included in the following excerpts several counselors included a spiritual element in the decision making and included that influence when talking about the feeling, intuition, or knowing. These discussions included an ineffable component; often participants’ speech slowed and they appeared to be searching for the right word. Several clients pointed to their chest or abdomen when describing a feeling, knowing, or gut reaction.
Faith described trusting her intuition, “all these little hairs on the back of my neck, there's a hidden agenda here. I had to learn to really trust my intuition ... be willing to be vulnerable, rather than being the expert.” She also described a spiritual type of knowing, 

*I think there's a spiritual element in this as well. Because I have had experiences where, I felt like there was more at work than just my own knowledge. There was something greater at work in the room. I don't mean I'm seeing visions, or there are angels flying around the room ... but sometimes there's a moment, that I think its really hard to do when you are a new counselor. To just sort of stop and listen, I don't mean like you are not listening to the client, but almost take the temperature of the room. ‘What's going on in here beneath the words?’ Certainly, countertransference is another part I think of taking that temperature. ‘What I'm I feeling in response to this client?’ And using that information.*

Other counselors described intuition or feeling impacting the process of their decision-making.

*I think there's so much truth to that because so much is happening that I don't know how to put words to it but that perception, if I was given enough time I could tell you exactly how I came to that conclusion. You look at them and you just get something’s not right here ... It is sort of clinical intuition but there are markers that you see.... A lot of life is lived on intuition” (Stephen)*

*You know something is off...It's like when you're really connecting, it's great, and then when you're not, you know something within your spirit or your intuition, something is off. You can't help but, in my mind, I think you're putting it through all these filters...Just rapidly, of like, okay, I have felt this before somehow. What was that?...I think that is a*
part of intuition but I think intuition can also be a lot more than that too. Of that knowledge that somehow you have, and you're not really sure why you have it.”

“That's when my intuition will come in and I'm really determined to make sure ... Yes, I mean call it intuition. I'm not totally for sure. Call it seeing a bunch of clients ... You know, I have to admit, I can't deny the fact that I feel like God helps me have intuition as well in sessions. There are times I feel like I'll know something about a kid that they haven't shared that I'll say I'm really feeling this way. (Stephanie)

Gut... Do I believe the person, do I trust them?... I'm sorry I care about you too much to let you go. I know you're saying you're okay, but there's something inside of me that's saying 'Don't let you go.” (Betsy)

As illustrated in these segments, participants were unable to identify the exact source of their knowledge, but they agreed it came from within. Similarly, many counselors described the use of personhood/self when making decisions about adolescent confidentiality. These descriptions included an emotional component similar to the description of intuition, although counselors described the personhood of themselves with more certainty and confidence. The factor of the personhood of the counselor impacting decision-making arose repeatedly through comments about feeling comfortable with a given decision as a human, as an adult, and as someone who cares. For example, Trish stated, “it's hard to separate yourself from the counseling process.” Betsy described, “I think that we all have our personal ethics. I'm not talking about putting my own belief system on people, that I have to be comfortable with who I am in this field.” Betsy and Olivia elaborated,

You can't separate who you are and be a therapist. It's about being genuine and finding a place where your values are also the way you practice. That has to be grounded in some
kind of theory, you're not just out there doing whatever you want because it's how you feel. Then if you can make it a clinical decision based on how I feel about things, based on my theory, based on my research, based on what is happening, how does it fit in the treatment plan, how's it going to affect this family, then absolutely, I think you cannot separate who you are from your practice, from you as a therapist in the room.” (Betsy)

Being a person, myself, in that relationship and not just being a sounding board. That sort of thing. That I'm also a human being and showing concern that way”...” I said to him, "I'm saying that as a human being. I'm an adult in your life and I care about your safety.” (Olivia)

Descriptions of being a human, the person in the room as well as their use of intuition occurred as participants groped to describe the in-effable component of their decision-making, the human component. I asked one participant about the development of her intuition and use of self in decision-making,

*I think what I've noticed, at least in my beginning counselors is a lot of times they'll see the exact same thing I saw, they just don't trust themselves to either act on it, or that it's there, or they don't know how to say it, but they already see it. I can't teach somebody to see it, I can only teach somebody on how to deliver it. Helping them trust what is innately in there, maybe in all of us. (Betsy)*

The described components of safety, relationships, and intuition impacted these master therapists decisions. Participants described a process of integrated decision-making that encompassed these components as well as assimilated knowledge of ethical codes and laws. In the following section I present the integrated decision-making of participants.

Integrated Decision-Making
Many of the participants referenced the *ACA Code of Ethics* (2014); however, they did not refer to the code while discussing their decision-making process. Generally, participants mentioned the codes of ethics at the beginning of the interviews and did not elaborate beyond a few sentences. It appeared participants either felt obligated to mention the ethical codes or assumed I knew the codes and they did not need to expand. The following excerpts include participants’ references to the ethical codes.

*Always you adhere to the baseline code of ethics.* (Tom)

*I think its multiply based, I mean certainly ethically and legally. Those are just a part of what we do.* (Faith)

*We have legal obligations, we have ethical guidelines, and I really try to operate more according the meaning of our umbrella guidelines and not specifics.* (Betsy)

Two participants discussed the ambiguity of ethical decision-making:

*Unfortunately, even in the beginning, when it comes to ethical dilemmas with adolescents, it's not always so cut and dry ... But it is kind of a gray area with all of that. I know there are ethical dilemmas. You also have to look at the Code of Ethics, you have to look at CPS, you have to look at the safety of the kid. Then where it gets really gray.*

(Stephanie)

Stephen stated,

*I used to look at it and think, I have to figure out a way to find a black and white method here because I think that's what I'm expected to do but I have come to figure out I'm expected to do no harm even though do no harm is like, according to who?... Do no harm? What in the heck does that mean?... That can be interpreted a million different ways.* (Stephen)
I included the question, “Do you follow an ethical decision making model?” in the interview protocol due to the prevalence of ethical decision-making models in the literature and academic recommendations. It quickly became clear that participants were taken aback by the questions about ethical decision-making models. Not one counselor reported following an ethical decision making model. Rather, each counselor looked momentarily guilty or embarrassed when I asked if he or she used an ethical decision making model. The pause and uncertainty did not come through on the transcripts, but I began asking participants in the most casual and non-judgmental manner possible. More than one participant needed clarification on what an ethical decision-making model.

Although participants did not follow formal ethical decision making models, their responses typically contained a summary of their decision making process and included two themes: integration of knowledge and consultation. I will first provide participant excerpts to illustrate the impact of integrated knowledge on the counselors’ decision-making process. The following experts followed some initial chuckling about not adhering to an ethical decision making model:

*I think they become almost intrinsic, just like your skill set.* (Betsy)

*I think it's just ingrained in the way that I think, because ethically we're suppose to protect our clients. By extensions the client’s family is like our client as well, but we have our primary client. Everything is about protecting the client. All the decisions are about protecting the client.* Protecting and assisting. (Terri)

Typically, participants used the question about ethical decision-making models to springboard into discussing the importance of consultation. The following excerpts illustrate the importance of consultation in the counselors decision making process:
I think consultation has been my best bet... That's not a formal model, but consultation...So what I did was, again, great deal of thought, consulting, called my mentor from graduate school. (Faith)

I mean, quite often my model is that, okay, an ethical dilemma comes up, and I'm not totally for sure. I will call a colleague first. We'll discuss it. If they don't know for sure, there are times I actually will call CPS and say, "Don't have a clue on this one."

(Stephanie)

It really is about client care, it really is about let me consult somebody who knows more than I do so that I can give the best. (Terri)

In particularly challenging situations, participants often reached out to multiple professionals for consultation. Terri described an ethical dilemma with a client during which she called three colleagues and mentors for consultation. Faith also described an ethical dilemma where she reached out to several colleagues for consultation. Nancy described the importance of her supervisors and mentors throughout her counselor development and ethical decision-making:

I had amazing supervisors that I worked for, clinical supervisor for my license, and just mentors in the field that I could just call that were always available, whether it was an email, back then it was an email, or a phone call, and just saying, "Hey, I've got this situation. What do you think?" It wasn't ever a, "Okay, here you go, this is what you need to do." It was always, "Okay, let's talk about it. What do you think?" It was helping me think and process through it instead of just giving me this answer...which gave me the ability to think for myself." (Nancy)

Nancy further described how questions were “logged back at me instead of just giving me the answers.” She described using that same technique as a supervisors and that “my interns get
frustrated, ‘Just Tell Me!’” It was clear she valued her supervision experience and strove to provide a similar experience for her interns. Participants clearly valued the impact of consultation from peers and supervisors. Their responses contained a sense of humility and honesty about the limits of their knowledge. In the following section I provide description and examples of participants informed consent process, an integral piece of confidentiality with adolescents.

Conclusion

Participants were open about their decision-making process and struggles with adolescent confidentiality. They all described an upfront process of informed consent that appeared to be a way to set the stage for the decision-making process. Also counselors did not follow an ethical decision-making model but described a process of tapping into an integration of knowledge and consulting with trusted others. The model of decision making for these master therapists consists of a consideration of client safety, the relationships involved, and the use of clinical intuition converge through a process of integrated experience and consultation when making decisions about confidentiality.
APPENDIX E:

DISCUSSION
The purpose of this study was to explore master therapists’ decision-making process surrounding adolescent confidentiality. Through constant comparative analysis, a grounded theory emerged from the data in which participants converged understanding of client safety, relationships, and clinical intuition in a process of integrated experience and consultation. In the following chapter, I explore how the grounded theory of master therapists’ decision-making surrounding adolescent confidentiality supports, challenges, or expands the current literature. I will then consider limitations of the present study. I conclude with implications for clinical practice, training, and further research.

Safety

The *ACA Code of Ethics* (2014) is founded upon five moral principles including beneficence, the responsibility of counselors to promote and safeguard the welfare of their clients (Kitchener, 1984). Suicide is the third leading cause of death in adolescents and results in approximately 4,600 deaths per year in this population (CDC, 2013). Previously, counselors reported being most likely to break confidentiality and inform parents if an adolescent is presenting as suicidal (Moyer & Sullivan, 2008; Moyer et al., 2012; Rae et al., 2002). In the current study, participants also identified suicidal ideation as the most common reason for breaching confidentiality with adolescents. This finding is consistent with literature that identifies mortal risk as the most cohesive deciding factor for counselors when considering informing parents against adolescents’ will.

As noted in the literature (Rae et al., 2001) and throughout participants’ interviews, some degree of risk taking is developmentally appropriate in adolescence. Thus, counselors must determine when adolescents’ risk taking behavior has become dangerous and in need of parental notification. Whether overt or implied in their assessment, master therapists in this study

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considered severity, intensity, and duration when considering potential level of harm for their adolescent clients. Previously, researchers found severity and intensity of behavior as well as age as related to decisions about confidentiality (Isaac & Stone, 1999; Moyer & Sullivan, 2008; Moyer et al., 2012; Rae et al., 2002). The added consideration of duration of behavior extends the current literature. The master therapists in this study appeared to perceive short-term adolescent risk taking as more likely to be developmentally normal and risk risking with longevity of behavior.

Although studies used different methodologies making directly comparison inadvisable, it appears the master therapists in this study were less likely to disclose to parents than school counselors who responded to hypothetical scenarios in previous studies (e.g., Moyer & Sullivan, 2008; Moyer et al., 2012). Interestingly, the only participant who indicated patterns of decision-making similar to those found in research about school counselors’ decision-making worked in a school setting. This participant described her strong belief in the importance of confidentiality and therapeutic relationship, yet she reported school district regulations often impacted her decision-making about confidentiality, at times against her clinical judgment.

Four participants discussed the impact of age on their decision-making, and one participant reported granting more confidentiality to clients at age 15. She was unable to articulate why 15 but reported feeling a shift in responsibility with clients around 15. Her clinical impression is consistent with the research that found 15 year olds to have comparable decision-making skills to adults (Belter & Grisso, 1984; Grisso & Vierling, 1978). Regardless of age, participants discussed the importance of parental involvement in the adolescent counseling process and how parental involvement enhanced their decision-making process.
The *ACA Code of Ethics* (2014), requires counselors to engage clients, or those who are eligible to make decisions for clients, in a thorough informed consent process. Consistent with previous recommendations (e.g., Taylor & Adelman, 1989) participants in this study described the importance of using the informed consent process to educate parents about their procedures around confidentiality and described ways in which they intentionally involved parents throughout the counseling process.

The United States Supreme Court endorsed a private relationship between client and counselor declaring “confidential relationship necessary for successful treatment” (Jaffe v. Redmond, 1999, p. 10). Participants in this study described their belief in the necessity for a confidentiality counseling relationship. Nevas and Farber (2001) recommended that parents directly address confidentiality with their children and commit to respect their children’s confidentiality within the counseling relationship. Similarly, counselors in this study described encouraging parents to communicate their commitment to confidentiality within the counseling relationship. One counselor described bluntly informing parents they needed to find another counselor if they could not respect confidentiality. Although a firm stand for confidentiality sends a strong message to parents, the counselor also acknowledged that parents ultimately have the right to know all that goes on in session.

A unique aspect of the decision-making model endorsed by the master therapists in this study include participants’ assessment of parents’ capacity to understand and do good with information that is shared. Participants expressed high motivation to include parents but described scenarios in which they would be wary to share information due to anticipated parental reaction. Counselors talked about potentially volatile parents as well as highly anxious parents responding in a ways that could be harmful for the adolescent or the adolescent-parent.
relationship. This finding highlights the importance participants place on all relationships involved and the added variable that is not considered in hypothetical scenarios. Prior research did not fully attend to this component of parental involvement in decision-making quite possibly due to the difficulty of incorporating all relational influences into vignettes.

Integrated Decision-Making

The existing literature, including the *ACA Code of Ethics* (2014), encourages the use of ethical decision-making models when making difficult decisions. Not only did participating counselors not follow ethical decision-making models, but several participants were not familiar with such models. Although participants appeared startled by questions about decision-making models, their responses were rich with information about their decision-making process. They described an integrated process of decision-making based on a culmination of experience and pattern recognition, and their descriptions included many aspects embedded in decision-making models. In the next paragraph compare Welfel’s (2011) ethical decision-making model to the process of these master counselors.

The first step of Welfel’s (2011) model is the development of ethical sensitivity. These participants were recruited due to their identification as master therapists, a distinction I hope implies ethical sensitivity. The second step is identification of relevant facts, sociocultural context, and stakeholders; participants described identifying the level of safety risk and developmental context as well as the relationships involved. Thirdly, Welfel recommended defining central issues and available options. Participants discussed confidentiality at the central issue and described the most common options of withholding information, disclosing information, or encouraging client to disclose information. Next counselors are to refer to professional ethical standards and relevant laws. As I will further explore, counselors referenced
ethical codes and laws but did not dwell on their impact in our interviews. Welfel’s fifth step includes a search of relevant ethics literature. Participants did not incorporate ethical literature search into descriptions of their decision-making process, although a few counselors referenced literature in ways that implied ingrained knowledge. Next counselors are encouraged to apply fundamental ethical principles (i.e., autonomy, nonmaleficence, beneficence, justice, and fidelity) to the situation. Although participants may have used different language, they spoke of doing no harm, empowering, being trustworthy, and protecting the client. It was clear they considered these principles carefully. Welfel’s seventh step is consultation with colleagues, a step participants described as integral in their process. Next counselors are urged to inform appropriate people and implement decisions. Counselors felt strongly about keeping the adolescent client, the most appropriate person, informed and a part of the implementation process. Finally Welfel recommended counselors reflect on actions taken. Participants described scenarios involving adolescent confidentiality that went well, that went poorly, things they would have done differently, and what they might have changed. Their ability to conjure examples complete with feelings and details indicated a high level of reflection of actions taken. In short, although participants denied following ethical decision-making models, it is clear their actions are in line with a popular model of ethical decision-making.

Participants did not focus on ethical codes or laws while describing their decision-making process, and most participants only briefly included consideration of the ethical codes and laws. It appeared these counselors knew and valued the ethical codes but did not feel a need to consult the codes, perhaps due to knowing the codes well enough their consideration is automatic. Another possible interpretation of participants’ lack of focus on ethical codes could be that these participants did not perceive certain decisions about confidentiality to present an ethical conflict.
Finally, counselors emphasized the importance of consultation in their process. Highly regarded decision-making models (ACA, 2014; Welfel, 2011), encourage the use of consultation. Consultation was a strong similarity between the participants’ process. For example, several participants described seeking multiple perspectives when in ethical dilemma, and counselors in this study seemed to have a strong sense of appreciation for a strong network of colleagues for consultation.

Intuition

Counselors discussed the use of intuition in their decision-making process. Generally, participants described a felt and integrated sense of knowing. Similarly, some scholars have described intuition in counseling as the “synthesis of clinical data, theoretical knowledge, and practical experience” (Eisengart & Faiver, 1996, p.41). One participant described his experiences with clinical intuition and included his increased ability to recognize patterns through experience. Previous literature indicates experienced counselors have shown the ability to act intuitively more often that novices, perhaps due the amount of accumulated experience and increased ability to recognize familiar patterns (Benner, 1982; Prietula & Simon, 1989).

Participants’ description of clinical intuition fits with Jennings and Skovholt’s (1999) descriptions of master therapists. According to Jennings and Skovholt (1999), master therapists value cognitive complexity and ambiguity and draw heavily on accumulated experiences. Participants described the ambiguity and complexity of confidentiality that required them to trust themselves and their clinical knowledge. When asked about how their beliefs or practices about confidentiality changed over time, participants reported an increased trust in themselves and their intuition. One participant reported a belief her supervisees possess the same clinical intuition as she, but the difference is she trusts hers while they questions theirs. The ability to trust oneself
through development is consistent with counselor development literature, particularly the work of Ronnestad and Skovholt (1999, 2003).

Another interesting finding was the variety of theoretical orientations of participants. Participants identified as person-centered, cognitive behavioral, Adlerian, existential, object-relations, and integral. The theoretical differences did not appear to influence these master therapists’ decisions about confidentiality or the way they described their work with clients. The diversity of theoretical orientation adds to the richness of the results and highlights the cross theoretical components of these master therapists’ work.

These master therapists provided a unique perspective on navigating dilemmas related to confidentiality, through their accumulated experience use of intuition and consideration of safety and relationships. Aspects of their process align with current literature, while others enhance our understanding of this process. Perhaps most unique to this study is the participants’ not utilizing a decision-making model yet integrating important aspect of models into their intrinsic process.

In the next section I present the limitations of this study.

Limitations

Qualitative research is inherently not generalizable, although Corbin and Strauss (2011) proposed that GT is abstractly generalizable. Due to geographic limitations, the majority of participants practiced in the North Texas area. North Texas is a historically conservative area of the country, religiously and politically, which may impact the abstract generalizability of the study. The majority of participants were independent private practice counselors rather than counselors who worked in public mental health settings. Many private practice counselors do not accept third party reimbursement and are financially unavailable for many clients, perhaps limiting the individuals served and nature of problems addressed. Additionally, as noted by
participant Stephen, parents who are willing to seek outside help by bringing their adolescents to counseling generally have moderate to high levels of parental involvement. In all, the counselors interviewed generally serve middle to upper class conservative clients with involved parents. One participant was a school counselor who had a small private practice. Another participant had a long history of working for outpatient mental health programs and has recently moved into private practice. These participants’ experiences enhanced the diversity of the study. Still, participants in the study lacked ethnic diversity. Despite efforts to recruit a diverse pool of participants; nine participants identified as Caucasian, and one participant identified as Hispanic.

Participants in this study were seasoned clinicians; a distinction that enhanced yet also limited the emergent theory. I believe master therapists provide an enhanced level of insight and experience, yet this theory may not represent all counselors’ decision-making processes. It is important to note the impact experience has on counselor development and decision-making. The experiences of these counselors are not generalizable to counselors who do not possess the level of experience as the participants.

Grounded theorists encourage researchers to maintain awareness of their potential bias yet acknowledge the impossibility of removing oneself from the process (Charmaz, 2005; Corbin & Strauss, 2011). An unavoidable limitation of this study was my bias as a counselor who primarily works with adolescent clients. I strove to reduce this bias by recruiting coding team members who did not primarily see adolescent clients. I discussed my potential bias with the coding team weekly and addressed bias in my memos, but it is impossible to erase my experiences and beliefs from the process. As a practicing counselor in the area, I knew four of the participants prior to the interviews, which may have impacted the interviews. I did not perceive those participants to be more or less open due to our prior relationship, yet I cannot
know how they may have responded to a more anonymous researcher. The four participants likely had an idea of how I work with adolescents, which may have impacted their responses. I attempted to avoid leading questions or let my beliefs slip out, but those counselors may have had a sense of my beliefs. Regardless of the described limitations this research enhances the current literature and will impact practice, counselor preparation, and future research. In the following section I will explore the potential impact of this study.

Implications

The model of decision-making can have implications for research, counselor preparation, and practice. The bulk of the literature surrounding adolescent confidentiality has focused on when counselors may hypothetically choose to breach confidentiality, especially in school settings. In this study, I focused on the process of how counselors choose to breach confidentiality in clinical settings. As with all qualitative research, the findings cannot be generalized, but the information gleaned from the participants can impact counselors in a variety of ways.

Practice

I doubt many are surprised by the counselors’ emphasis on client safety and the impact of mortal safety on their decision-making. Regardless, I believe the distinction between adolescent risk taking and mortal safety is often blurry. The participants interviewed felt strongly about suicidal clients but were not able to provide definitive markers for danger to self with other behaviors. This finding was consistent with the variety of how participants respond to scenarios including non-lethal behavior in previous research (Moyer & Sullivan, 2008; Moyer et al., 2012; Rae et al, 2002). Their acceptance of the ambiguity with so many situations and a willingness to take each decision as a case by
case may serve as a model for counselors who look for a “right” way to handle a given scenario. The participants described a multitude of variables that influences each decision, and the need to weigh each variable for each case. In all, this grounded theory can help counselors consider the multitude of variables that impact decision-making.

In addition to safety the participants considered the relationship triad of adolescent-parents-counselors. Each relationship informed participant decision-making. This intentional use of relationships, and how parents may react, is new to the literature around adolescent confidentiality. The included consideration of relationships creates allows counselors to make decisions based on all variables and the uniqueness of each situation and client family.

These master therapists began the counseling process in a highly intentional way in order to enhance trust and relationship with parents. One way participants established a positive working relationships with parents and adolescents was through a clear informed consent process. A clear informed consent process at onset of counselor opens up the dialogue of confidentiality and sets expectations of disclosure. The participants can serve as a model for parental engagement and informed consent process.

The participants were selected based on a distinction of master therapist by others in the counseling field. Their colleagues regarded them as experts, yet one of the most salient factors for these counselors decision-making was consultation. This finding is consistent with recommendations for general practice and ethical decision-making (ACA, 2014; Welfel, 2011). This finding can encourage a sense of humility for all counselors to seek out consultation when presented with ethical dilemmas. Counselors may be well
served to foster and maintain relationships with other counselors in order to access the clearly invaluable tool of consultation.

The final recommendation for practice is to step through confidentiality decisions using the model developed by this study. A consideration of safety and relationships along with a value of intuition and experience along with consultation can guide counselors in decisions about adolescent confidentiality. Counselors can consider each element of the model as well as the entirety of the model for practice as well as a method for evaluating current values and process around confidentiality with adolescents.

Counselor Preparation

Counseling students are encouraged to follow ethical decision-making models (ACA, 2014; Welfel, 2011), although advanced counselors in this study are less likely to use or be familiar with decision-making models. Counselor educators may wish to consider ways to create meaningful, personalized experiences when teaching ethical decision-making models. Further, participants’ rich descriptions of decision-making process' included several aspects of ethical decision-making models through an integrated mode of responding. Together, counselor educators may wish to consider the practicality of ethical decision-making models taught in preparation programs and consider developmentally appropriate ways to communicate less formulaic aspects of ethical decision-making models.

In addition, participants addressed many of the steps of ethical decision-making models (ACA, 2014; Welfel, 2011) but were dismissive or unaware of ethical decision-making models. Scholars may wish to consider the degree to which formulaic step-by-step models are relevant for clinical settings. It could be that models are more appropriate at
beginning levels of counselor development or that models need to be revised to be more meaningful.

Several participants reflected on their past supervision experiences and provided examples of how supervisors enhanced their ability to make ethical decisions and trust their decisions. Three participants described the positive impact excellent supervisors had on their decision-making abilities. The participants reported wanting answers from supervisors about ethical dilemmas and appreciating how supervisors returned questions to participants and communicated faith in their ability make sound decisions. This finding highlights the impact of returning responsibility to supervisees rather than providing concrete advice. This can inform supervisors and counseling programs to further instill a sense of counselor efficacy and confidence rather than providing supervisees with answers.

The master therapists’ use of self and intuition was a prominent similarity among participants and highlights the importance of counselors’ use of self and trust of self in decision-making. Supervisors and counselor preparation programs are encouraged to enhance trainees’ trust in self and use of intuition by increased focus on the internal experience of the counselor. Emphasis on personal growth and clinical judgment may encourage counselors in training to notice and trust their intuition.

Counselor educators can use the developed model as a format for class discussion complex ethical decisions with adolescents. The components described by participants adhere to ethical codes and laws yet include case-by-case clinical decision-making. There is a void in the counselor preparation textbooks as well as the literature surrounding the complexity of confidentiality and adolescents, students would be well served to study the processes of these master therapists.
Many researchers have explored when counselors may breach confidentiality (Moyer & Sullivan, 2008; Moyer, Sullivan, & Growcock, 2012; Rae, Sullivan, Razo, Geroge, & Ramirez, 2002). There is a significant gap in the literature around what impacts counselor decision-making and how counselors make those difficult decisions.

Several counselors discussed the development of their decision-making throughout their career. Generally counselors described themselves as less rule-bound and described supervisees as wanting concrete answers to complex situations. Counselors’ descriptions of their development process in regard to adolescent confidentiality indicate master therapists may make decisions differently than beginning counselors. Future research could include comparisons of master therapists and beginning counselors’ decision making, or a further look into how counselors’ development impacts their ethical decision-making processes.

Existing literature encourages the use of decision-making models (e.g., ACA, 2014), yet ten advanced counselors, many who supervisee and several who teach, are not familiar with decision-making models. Future research on the functionality or presentation of ethical decision-making models is warranted. The literature would benefit from a quantitative study exploring counselors’ use of decision-making models beyond counselor education programs. The literature would also benefit from a qualitative study about the decision-making practices for counselors in different developmental places. Such an understanding may be helpful in formulating more responsive ethical decision-making models.
All participants in this study primarily work in private practice settings. Further study on the lived experiences and decision-making processes of counselors in agency or school setting could broaden the understanding of counselor decision-making. The settings difference may impact decision-making, particularly if counselors operate under the umbrella of setting protocol.

Conclusion

The limitations described are important but do not detract from the importance of this study and the implications for future research, counselor preparation, and practice. Many aspects of the participants’ experiences and decision-making processes align with the existing literature. Counselors assessed safety and made decisions based on the level of lethal risk as well as the severity, intensity, and duration of behaviors. Counselors valued all relationships involved and the relationships impacted decision-making in a variety of ways. Counselors described an informed consent process that follows the recommendations of many authors. Although their decision-making processes’ contained key components of recommended models (ACA, 2014; Welfel, 2011), clinicians did not report using ethical decision-making models; rather, they described automatic, intuitive processes of managing decisions.

I believe these participants can serve as a model for current and future counselors. They are each a bank of knowledge and experiences in addition to the ability to trust intuition coupled with the humility to ask for help. Ethical dilemmas are often unclear, yet the participants provide guidance on navigating these dilemmas with integrity and intention.
APPENDIX F:
SUPPLEMENTAL MATERIAL
University of North Texas Institutional Review Board
Informed Consent Notice

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the purpose, benefits and risks of the study and how it will be conducted.

Title of Study: Master therapists’ decision-making processes concerning adolescent confidentiality: A grounded theory approach.

Student Investigator: Emily Michero, University of North Texas (UNT) Department of Counseling and Higher Education. Supervising Investigator: Dr. Dee C. Ray.

Purpose of the Study: You are being asked to participate in a research study that involves sharing your experiences with counseling adolescents and decisions about confidentiality. Specifically, (1) what strategies do counselors use to resolve ethical dilemmas about confidentiality, (2) what conditions influence decision-making about confidentiality, and (3) what are the consequences of chosen decisions?

Study Procedures: We will first invite you to complete a brief questionnaire regarding your personal characteristics and professional experiences. Based on responses to the form, we may invite you to participate in a 60-75 minute individual interview. This interview can take place face-to-face if you work within 120 miles of Denton, Texas or via distance communication (e.g., phone, skype, facetime) if you work outside this distance. The interview will be audio recorded. After the initial interview, we may contact you with follow-up questions and ask you to participate in a 15-30 minute interview to verify the accuracy of interpretations and conclusions.

Foreseeable Risks: Participation in this study poses a risk for breach of confidentiality. To minimize this risk, we will not use your name or any other identifying information on any study records, presentations, or publications. We discuss how we will keep your information private below. You will be in control of the interview and can decide whether and how much to share. Otherwise, no foreseeable risks are involved in this study.

Benefits to the Subjects or Others: You may enjoy reflecting on your decision-making with adolescents, but you may not experience direct benefit from participating in this study. Results of the study may help counselors better understand how experienced counselors make decisions about confidentiality with adolescents. This understanding may be used to develop best practices in navigating adolescent confidentiality, inform counselor training, and formulate additional research.

Compensation for Participants: None

Procedures for Maintaining Confidentiality of Research Records: Interested participants will complete a demographic survey on-line through Qualtrics. Your participation in this online
survey involves risks to confidentiality similar to a person’s everyday use of the Internet. We will download the information and keep it on a server secured by the University of North Texas until it is destroyed in three years. Once we select final participants, interviews will take place via face-to-face interviews or distance communication (e.g., skype, facetime). We will audio record these interviews. The recordings will be deidentified and assigned a number before being transcribed by a professional transcriptionist and analyzed by a research team. Only the interviewer and her supervisor will have access to the original recordings. We will destroy the recordings once we complete data analysis. The de-identified transcriptions will be kept on the student researcher’s password protected computer in a location separate from your demographic information. The confidentiality of your individual information will be maintained in any publications or presentations regarding this study.

Questions about the Study:
If you have any questions about the study, you may contact Emily Michero at Emily.Michero@unt.edu or Dr. Dee Ray at Dee.Ray@unt.edu.

Review for the Protection of Participants:
This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-4643 with any questions regarding the rights of research subjects.

Research Participants’ Rights:
Your signature below confirms that you have read all of the above and that you confirm all of the following:

- Emily Michero has explained the study to you and you have had an opportunity to contact her with any questions about the study. You have been informed of the possible benefits and the potential risks of the study.
- You understand that you do not have to take part in this study, and your refusal to participate or your decision to withdraw will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your participation at any time.
- You understand why the study is being conducted and how it will be performed.
- You understand interviews will be recorded.
- You understand your rights as a research participant and you voluntarily consent to participate in this study.
- You understand you may print a copy of this form for your records.
Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the purpose, benefits and risks of the study and how it will be conducted.

**Title of Study:** Master therapists’ decision-making processes concerning adolescent confidentiality: A grounded theory approach.

**Student Investigator:** Emily Michero, University of North Texas (UNT) Department of Counseling and Higher Education. **Supervising Investigator:** Dr. Dee C. Ray.

**Purpose of the Study:** You are being asked to participate in a research study that involves sharing your experiences with counseling adolescents and decisions about confidentiality. Specifically, (1) what strategies do counselors use to resolve ethical dilemmas about confidentiality, (2) what conditions influence decision-making about confidentiality, and (3) what are the consequences of chosen decisions?

**Study Procedures:** We will first invite you to complete a brief questionnaire regarding your personal characteristics and professional experiences. Based on responses to the form, we may invite you to participate in a 60-75 minute individual interview. This interview can take place face-to-face if you work within 120 miles of Denton, Texas or via distance communication (e.g., phone, skype, facetime) if you work outside this distance. The interview will be audio recorded. After the initial interview, we may contact you with follow-up questions and ask you to participate in a 15-30 minute interview to verify the accuracy of interpretations and conclusions.

**Foreseeable Risks:** Participation in this study poses a risk for breach of confidentiality. To minimize this risk, we will not use your name or any other identifying information on any study records, presentations, or publications. We discuss how we will keep your information private below. You will be in control of the interview and can decide whether and how much to share. Otherwise, no foreseeable risks are involved in this study.

**Benefits to the Subjects or Others:** You may enjoy reflecting on your decision-making with adolescents, but you may not experience direct benefit from participating in this study. Results of the study may help counselors better understand how experienced counselors make decisions about confidentiality with adolescents. This understanding may be used to develop best practices in navigating adolescent confidentiality, inform counselor training, and formulate additional research.

**Compensation for Participants:** None

**Procedures for Maintaining Confidentiality of Research Records:** Interested participants will complete a demographic survey on-line through Qualtrics. Your participation in this online
survey involves risks to confidentiality similar to a person’s everyday use of the Internet. We will download the information and keep it on a server secured by the University of North Texas until it is destroyed in three years. Once we select final participants, interviews will take place via face-to-face interviews or distance communication (e.g., skype, facetime). We will audio record these interviews. The recordings will be deidentified and assigned a number before being transcribed by a professional transcriptionist and analyzed by a research team. Only the interviewer and her supervisor will have access to the original recordings. We will destroy the recordings once we complete data analysis. The de-identified transcriptions will be kept on the student researcher’s password protected computer in a location separate from your demographic information. The confidentiality of your individual information will be maintained in any publications or presentations regarding this study.

Questions about the Study:
If you have any questions about the study, you may contact Emily Michero at Emily.Michero@unt.edu or Dr. Dee Ray at Dee.Ray@unt.edu.

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Research Participants’ Rights:
Your signature below confirms that you have read all of the above and that you confirm all of the following:

• Emily Michero has explained the study to you and answered all of your questions. You have been told of the possible benefits and the potential risks and/or discomforts of the study.
• You understand that you do not have to take part in this study, and your refusal to participate or your decision to withdraw will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your participation at any time.
• You understand why the study is being conducted and how it will be performed.
• You understand interviews will be recorded.
• You understand your rights as a research participant and you voluntarily consent to participate in this study.
• You have been told you will receive a copy of this form.

__________________________________________________
Printed Name of Participant

__________________________________________________
Signature of Participant Date

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Initial Recruitment Phone Script

Hello, my name is Emily Michero and I am a doctoral candidate in the Counseling Program at the University of North Texas. I am conducting a qualitative study about the decision-making processes of master therapists concerning adolescents and confidentiality. You were identified by ______________ as a potential participant due to your experience working with adolescent clients. I am hoping to interview you and other master therapists about their experiences making decisions about adolescents and confidentiality in order to develop theory about the decision-making process. Might you be interested in talking with me about your experiences?

If Yes: Ok, thank you. Can I have an email address so I can send you a link to an online demographic survey and informed consent notice to review? If you are interested in proceeding, please fill out the online form. After I receive the information, I will contact you to set up a time to visit.

If No: I understand. Thank you for your time today.
Interview Schedule

Greeting
Thank you for agreeing to talk with me about your experiences with confidentiality and adolescent clients. Before we get started, I would like to share with you a little bit about what to expect from our time together. First and foremost, I am interested in learning about your experiences. My goal is to facilitate an interaction with you that allows you to share your experiences. There is no right or wrong answer to any of the questions I will ask. And it is important that you know your answers will be anonymous.

Some of the questions I ask may seem self-evident, but it is important that I understand your perspective as you see/feel it. I will not be saying very much, so as to keep the focus on you and your experiences. I may take notes as we go along just to keep track of important points that I may want to come back to. Please take as much time as you need to think and to talk.

What questions do you have about how our time together will go today?

Informed Consent
When you completed the demographic survey, you were provided with an informed consent notice. I would just like to mention that this conversation will be audio recorded. I will be transcribing our talk for analysis. The audio and transcriptions will be kept on a password-protected server. What questions do you have about your rights as a research participant?

Introductory Questions
1. Tell me a little about yourself . . . What is your background working with adolescents?
   Prompt: What kind of work do you do? What types of clients do you see? What is your training/licensure?

2. What do you usually do when confidentiality becomes an issue with adolescent clients?
   Prompt: Do you generally inform parents? How do you discuss concerns with the adolescent?

3. What is your belief about the best way to handle confidentiality with adolescents?
   Prompt: Have you always held these beliefs about confidentiality? What has shaped your beliefs about adolescents and confidentiality?

4. How do you feel when a situation arises that may warrant a breach of confidentiality?
   Prompt: Are there any fears that arise when considering confidentiality with adolescents? Do your feelings guide your course of actions?

5. Describe your experience(s) of handling adolescent confidentiality issues.
   Prompt: Are there any cases that stand out in your memory as especially difficult or especially successful? Did you utilize an ethical decision-making model? What have you learned through your experiences? Is there anything you would you do differently now?

Closing
Thank you so much for your time today. I really appreciate your willingness to share about your experiences. I will be in touch and will run my initial findings by you. I will contact you for a member check meeting or phone call, during which we will discuss initial findings and theory about confidentiality and counseling adolescents. I will provide you with a final copy of my analysis at the end of the study.
COMPREHENSIVE REFERENCE LIST

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