Adolescents and consent to counseling: The adolescents' perspectives

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A dissertation submitted to the graduate faculty

in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

Major: Psychology (Counseling Psychology)

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Iowa State University

Ames, Iowa

2004

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DEDICATION PAGE

To all my family, friends, and colleagues: Thank you for walking along this path with me.

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ACKNOWLEDGEMENTS

Thank you to my colleagues for all of your support and assistance and especially to my committee: Dr. Norm Scott, Dr. Susan Cross, Dr. Gloria Jones-Johnson, Dr. Mack Shelley, and Dr. David Vogel, for your support, assistance, and willingness to be a part of my educational journey.

ABSTRACT

Informed consent for counseling is a complex process for both clients and clinicians, even when individuals are over eighteen years of age. When working with adolescent minors, the process requires additional consideration. Informed consent, a legal term and ethical construct, is composed of tenets that require deliberate thought and action on the part of a therapist to ensure the client's understanding of the nature and expectations for counseling and voluntary participation. There are numerous legal and research controversies pertinent to competency of adolescents to accord informed consent for counseling and what procedures should be used to solicit adolescent consent for psychological interventions. Most studies assess competency of adolescent to consent for research participation or medical treatment (e.g. Lewis, C.E., Lewis, M.A., Ifekwunique, 1978 cited in Dorn et al, 1995; Weithorn & Campbell, 1982). Fewer surveys have assessed clinicians' views on informed consent for counseling with adolescents (Taylor et al, 1984; Beeman & Scott, 1991; Brunscheen, 2001). The current study sought to address counseling consent issues with adolescents by gaining the unique perspectives of adolescents ages 12-18 via a survey study. It addressed questions related to adolescents' perceptions as to the information they perceive as necessary for informed consent for counseling and the interactions they would prefer to have with mental health practitioners.

INTRODUCTION

Envision the following scenario: Casey is a 15-year-old middle school student and has been a stellar student. Abruptly her teachers notice her grades have dropped from A's to C's and D's. She is not participating in the classroom nor in any of the extracurricular activities she enjoyed. Casey is listless, withdrawn, and has lost a noticeable amount of weight. A teacher found a notebook of Casey's filled with very morbid poetry and referred Casey to the school therapist. Casey willingly met with the school therapist for two assessment sessions. The therapist determined Casey needed a medication evaluation and further counseling for depression. Casey was willing to seek out these services. However, when the therapist spoke to Casey about contacting her parents, Casey became adamant that her parents not be contacted. Casey began saying that she was feeling better, that everything was fine and that she did not need any more counseling. It was clear to the counselor that this was not true but Casey maintained that she would not return for any counseling if her parents were contacted. What should the therapist do in this situation? At 15 years old can Casey provide consent to counseling?

Before providing counseling, psychologists must obtain consent for treatment (American Psychological Association, 1992). This implies that the practitioner is to solicit voluntary participation based upon presentation of complete and comprehensible information about the nature, risks, costs, and benefits of the treatment. However, adolescents are considered to be incompetent to provide informed consent for many types of treatment (Martindale-Hubbell Law Digests, 1999). A person must be of legal age, according to their state's statutes, in order to legally provide informed consent for non-emergency treatment. Otherwise, a parent, adoptive parent, or guardian must provide informed consent and the

minor can only provide assent or dissent to treatment (Martindale-Hubbell Law Digests, 1999; McCabe 1996).

There are many legal and societal ambiguities, competency controversies, and ethical concerns related to the mental health treatment of adolescents. Adolescents are a special population, not children, but not yet adults. Yet despite not being the age of majority, society allows adolescents to play adult roles in many areas. For example, adolescents are allowed to drive, have jobs, be parents themselves, to testify in divorce cases, and the legal system is also increasingly assigning adult sentences to juvenile offenders (Brooks-Gunn & Rotheram-Borus, 1994; Peterson & Siegal, 1999). However, in most states adolescents cannot seek counseling without parental informed consent, even if they are close to legal age, without special considerations such as emancipation or legal classification of "mature minor" (Batten, 1996; Martindale-Hubbell Law Digests, 1999). How can a practitioner meet the counseling needs of the adolescent and satisfy legal and ethical requirements at the same time? Should the practitioner seek informed consent from the adolescent or get consent from the client's parents or both? What considerations have to be made in making these decisions? Can there be a compromise between the desires of adolescents, parents, clinicians, and the legal and ethical requirements? When should that compromise be attempted?

Definition of a Minor

Adolescents are a special population who create ethical and legal quandaries concerning consent to mental health treatment. The age range of an adolescent minor varies according to developmental theorist. The average age range of an adolescent minor is usually 10-18 years of age with an upper limit of 22 years of age (Santrock, 1995). For this study, the narrower band of 12-17 years of age will be used as it more closely matches legal

definitions and previous research (Beeman & Scott, 1991; Brunscheen, 2001; Coffey, 1995; Martindale-Hubbell Law Digests, 1999).

In general, minors are thought to be incompetent to render totally autonomous decisions. The exceptions to this assumption are emancipated minors and mature minors. An emancipated minor lives independently of her/his parents as a result of being married, or living independently and financially supporting oneself, or by being a member of the armed forces (Arambula et al., 1993, chap. 22; Coffey, 1995; Haliburn, 1996 cited in Batten, 1996). "Emancipated minor" is an objective, legal term, which provides a clear definition of that minor's right to be considered as competent as an adult and as such an emancipated minor may provide full informed consent.

A mature minor is an adolescent at or near the age of majority, usually at least 12-14 years old, who is fully able to understand the nature and the consequences for treatment (Arambula et al., 1993, chap. 22; King & Churchill, 2000). This adolescent can give full consent for treatment provided that the minor is assessed by the practitioner and determined to be competent (Arambula et al., 1993, chap. 22).

Informed consent for counseling

Informed consent is a legal statute and ethical principle. The principles imply that the practitioner is responsible for reviewing complete information pertinent to the counseling process with her/his client and ensuring that the client adequately understands the tenets of informed consent and voluntary participation. Informed consent is often thought of as a one-time conversation. However, it is also important to review this information throughout counseling, for the benefit of the client and the practitioner.

For informed consent an individual must give permission for participation and/or treatment. That choice must be made knowingly, intelligently, and voluntarily (Coffey, 1995; Scott, Repucci, & Woolard, 1995). A discussion of informed consent should include: a complete explanation of the proposed treatment, the risks and benefits, any alternatives, procedures to be used in the proposed treatment, and disclosure that the client is free to withdraw from treatment at any time (Batten, 1996; Beeman & Scott, 1991).

One concern when working with adolescent minors is whether their consent is truly free from coercion (Batten, 1996; McCabe, 1996). Specifically, the influence of authority figures and the concept of conformity are areas to consider when evaluating the voluntariness of informed consent (Leikin, 1995; Scott et al., 1995). Adolescent minors are more susceptible to these forces and therefore, some argue adolescents would not be able to give consent independent of these pressures (Leiken, 1995; Scott et al., 1995).

Competency of adolescents is an area of great concern in regards to their ability to provide viable informed consent. Adolescent minors are assumed incompetent while adults are assumed competent, unless demonstrated otherwise (Coffey, 1995; Leikin, 1993; Scott et al., 1995). Therefore, individual assessments of competency of an adolescent minor client must be performed. Competency is based upon rational decision-making using two concepts: appreciation of the information, or the ability to make inferences and engage in formal operational thought, and rational reasoning (Batten, 1996; McCabe, 1996).

Rational reasoning is assessed by the client's ability to understand the concept of informed consent, the actual wording and the information provided, and the ability to use this information to make a reasonable outcome choice (Batten, 1996; McCabe, 1996). There is a subjective nature to the assessment and determination of competency.

Legal History

A brief overview of the legal history and related research on informed consent in relation to minors illustrates controversies and variations as to the competency of minors and means of determining competency. Interestingly, legal decisions from the United Kingdom have impacted the legal controversy in the United States (Ford & Kessel, 2001; Peterson & Siegal, 1999)

Legal decisions affecting the rights of minors started in the 18th century when the prescribed ages of majority for making independent health care decisions were delineated. Several acts have expanded the rights of adolescents in the United Kingdom (Ford & Kessel, 2001; Peterson & Siegal, 1999). In 1969 the Family Reform Act was established that allowed adolescents 16 years of age and older to consent to surgical, medical, and dental treatments. In 1986, a significant court decision was made in the case of Gillick v. West Norfolk & Wisbech Area Health Authority. The "Gillick competency" was created that stated that a child of any age could petition for competency and consent to treatments without parental involvement based upon sufficient understanding of the nature and consequences of the proposed treatment. This case allowed clinicians to provide adolescents with individual assessments and justification for allowing adolescents to consent to treatment without parental consent. In 1999 the revised Code of Practice to the Mental Health Act of 1983 was published. It restated that 16 and 17 year olds can consent to or refuse treatment (Parkin, 1999). These cases were influential to United States case law. However, for much of the same period in history in the United States, adolescents were deemed unable to provide informed consent for most mental health care procedures (Ford & Kessel, 2001; Peterson &

Siegal, 1999). Most states allowed 14-18 year olds to consent for treatment for substance abuse, sexually transmitted diseases, and birth control information.

In the United States there were many legal cases affecting both the expansion and the restriction of children and adolescents' rights (Crosby & Reppucci, 1993; Lawrence & Robinson-Kurpius, 2000). In 1853 New York Children's Aid Society was established to protect children and remove them from their homes if necessary. The Society for the Prevention of Cruelty to Children was established in 1874. However, it wasn't until 1899 when the first juvenile court system was created (in Chicago, IL). The doctrine of *parens patriae* was outlined to allow state officials to step in and protect children if parents are not fulfilling this duty. Another act that expanded the rights of children was the 1959 United Nations Declaration of Rights of the Child.

However, until the late 1960's, minors were thought to be the property of their parents and had no legal rights, as a means of protection for the minor (McCabe, 1996). In 1967, the Supreme Court applied the 14th Amendment and the Bill of Rights to minors (In re Gault) giving adolescents more adult citizen rights, independent of parents (Crosby & Reppucci, 1993; Lawrence & Robinson-Kurpius, 2000). There are obviously some exceptions to this rule, such as the right to a trial by a jury of peers.

In a landmark case in 1979, Parham v. J.R., the Supreme Court made a decision regarding "voluntary commitment" (Arambula et al., 1993; Parham v. J.R., 1979, p.2505). The Supreme Court declared minors are not competent to make sound decisions regarding their need for treatment; their parents should be responsible for that type of decision (Crosby & Reppucci, 1993; Lawrence & Robinson-Kurpius, 2000).

However, later that day, in Fare v. Michael C., the Supreme Court decided that a sixteen-year old had waived his Miranda Rights and his Fifth Amendment Rights by requesting to see his probation officer rather than an attorney (Fare v. Michael C., 1979). The Supreme Court ruling said, in essence, that a sixteen-year-old had the right and the competence to make a legal decision to waive his rights (Fare v. Michael C., 1979).

This decision appears to be in direct contradiction to Parham v. J.R. In part, this is due to the ambiguity of legal precedents and partially due to the subjective nature of determining competency. However, most states still require the parent's consent for treatment until the minor is 17 or 18 years old (Coffey, 1995). The result of the case law from the United Kingdom and the United States presents a picture of legal controversy that continues today.

Current Statutes and Laws

The legal ambiguity is especially salient to mental health counseling when considering the exceptions and qualifiers to the general idea of being an adult and independent decision-maker and what this means for providing informed consent. Unambiguously autonomous decision-making is accorded only after the person reaches 18 years of age. However, some states will allow an adolescent to consent for treatment of mental or emotional disorders (Moore, 1994, chap. 3). The District of Columbia is one example (Martindale-Hubbell's District of Columbia Law Digest, 1999). Some additional states are starting to reassess their stance on mental health consent policies for adolescents and are beginning to allow more instances when adolescents can consent to treatment. Some of these states include: Colorado, Georgia, Maryland, North Carolina, Tennessee, and Virginia (Crosby & Reppucci, 1993).

Many other states maintain that not only can emancipated minors or mature minors consent, but they also provide contingencies for all adolescents to consent for certain treatments. Among those treatments are emergency care, treatment for sexually transmitted diseases, substance abuse treatment, and contraception counseling and treatment (Batten, 1996; Ford & Kessel, 2001; Leikin, 1995; Mammel & Kaplan, 1995; Peterson & Siegal, 1999). So clinicians and researchers now ask: If adolescents can make decisions about their bodies in those instances, then why are they not accorded the same prerogatives in the domain of mental health counseling?

There are other exceptions that are related to the acts created for the protection of children's right. Adolescents are often allowed to make treatment decisions when their parents are judged incompetent or judged as not acting in the minor's best interests (Batten, 1996; Coffey, 1995; Martindale-Hubbell Law Digests, 1999; McCabe, 1996). Some states purposefully provide practitioners statutes to assist in this decision-making by phrasing their statutes to give an adolescent similar decision-making rights as an adult when the adolescent "lives separate and apart from parents and supports her/himself" (Martindale-Hubbell Law Digests, 1999).

However, there is the notable irony is that many states allow adolescent minors to consent for medical treatment for children of their own, when they still cannot consent to treatment for themselves (Martindale-Hubbell Law Digests, 1999)! (See Table 1 for a delineation of statutes and qualifiers for each state.)

Table 1. State legal ages and statutes

State	Legal Age	Rights of Minor Adolescents and Emancipation Qualifiers
Alaska	18	16
Arizona	18	Minors can contract for medical care for dx & tx of VD minors who are emancipated, married, or homeless can contract for hospital, medical, & surgical care
Arkansas	18	16
California	18	14
Colorado	21	19
Connecticut	18	15 for some issues, not clearly stated
Delaware	18	15 for some issues, not clearly stated
D.C.	18	No provisions, minors of any age may consent to health care for PG or its lawful termination, substance abuse, psychological disturbance, & STD, liable for payment if consented to by self, Minor parent can consent for health care for own child.
Georgia	18	No age set but is by marriage or if self-supporting, can consent for tx of VD, PG & childbirth, must be 18 or older for medical tx consent
Hawaii	18	No age specified, marriage
Idaho	18	marriage
Illinois	18	16, married or PG minor, parent who is a minor or anyone 18 yrs can consent to performance of medical or surgical procedures by a licensed physician; 12, can consent to STD & drug tx, consent for medical care or counseling related to tx of disease; 17, can give blood
Indiana	18	16, certain types of insurance
Iowa	18	Marriage, if incarcerated as an adult may consent for medical tx
Kansas	18	Married & 16, "rights of majority may be conferred on minors by proceedings in district court, minors can enter into binding contracts
Louisiana	18	15, conferring power of administration; 16, marriage,
Maine	18	Not emancipated by marriage but can handle related real estate
Maryland	18	Marriage; 15, certain types of insurance
Massachusetts	18	No emancipation discussion; 16, motor insurance; 12 substance abuse tx; minor or emergency medical or dental tx if married, widowed or divorced, parent of a child, in armed forces, PG or believes PG, lives sep and apart from parents and supports self
Michigan	18	Under 17 may be fingerprinted, marriage, 16 for life or liability insurance
Minnesota	18	If married can handle related real estate; binding contracts for necessaries

Table 1 continued

State	Legal Age	Rights of Minor Adolescents and Emancipation Qualifiers
Mississippi	21	No statutory provisions; married minors tx'ed as adults in suits for divorce, sep. maintenance & support, child custody, & other related claims; for matters related to personal property & personal injury Minor, minor parent, minor w/consent or referral (from a helping professional)
Missouri	18	No emancipation statutes mentioned
Montana	18	Marriage, consent for health services if married or once was, has child, graduated HS, emancipated, separate & self-supporting from parents, PG, communicable disease, or in need of emergency care.
Nebraska	19	Marriage
New Hampshire	18	May hold shares (& liability) in part. Investments, savings accounts, minors & spouses with related real estate
New Jersey	18	Deposit accounts;15, certain insurance
New Mexico	18	Marriage, death, adoption, or majority or minor, or death, resignation or removal of guardians; minors can have bank accounts
New York	18	Can sue or be sued, may disaffirm most contracts except for certain loans married infant can buy a home, providing medical care for self or child; 14 ½: life insurance, special exceptions for artists and athletes
N. Carolina	18	Consent to licensed physician for dx, tx, & preventions of VD, PG, drug abuse, or emergency tx, or if parents refuse tx in a life-threatening situation; in an emergency minor who is mentally ill or substance abuser may be admitted to a tx facility
N. Dakota	18	Marriage
Ohio	18	No age, minors may apply for emancipation from probate court
Oklahoma	18	Court may emancipate (no age mentioned); marriage
Oregon	18	Marriage; by act of parent or court decree; any minor may consent to tx of reportable VD, BC info & services; 15 & older may consent for medical or dental tx; 16 may donate blood
Pennsylvania	21/18	Legal age is 21 by the PA Statutory Construction Act, Legal age is 18 by Probate, Estates, & Fiduciaries Code 18, may enter in to contracts; minors may have bank deposits; minors who are 18, graduated HS, been married or been PG may contract for medical service; any minor may make contracts for medical service relating to tx of PG or VD; special procedures may apply in cases of nonemergency abortions for unemancipated infants under 18; 17, loans; 18, make a will; 18, execution or administration & as a guardian for a minor
Rhode Island	18	Governed by common law; parent's approval of employment contract emancipates minor as to wages earned under contract
S. Carolina	18	
S. Dakota	18	Parents, minor, & court approval agreement will emancipate; marriage; active duty w/armed forces, judicial decree; emancipated minor may consent to health care, contracts, sue and be sued
Tennessee	18	No provision for emancipation by marriage
Texas	18	Emancipation if self-supporting and managing own affairs at 17, or 16 & living apart from parents may petition to have disabilities removed
Utah	18	marriage emancipates, may have their own bank accounts

Table 1 continued

State	Legal Age	Rights of Minor Adolescents and Emancipation Qualifiers
Vermont	18	Marriage or active duty w/ armed forces emancipates, or if 16 or 17 Probate Court may order emancipation
Virginia	18	No emancipation statutes mentioned, 15 for certain insurances
Washington	18	Any minor married to a person of full age, may have bank accounts
W. Virginia	18	At 16 may petition for emancipation, or if 16 and married
Wisconsin	18/17	17 full age for prosecution or investigating a crime, marriage
Wyoming	18	Marriage, military service, court decree at 17, lives apart from parents, parents consent, managing own affairs, subject to adult criminal jurisdiction

[a] Note: PG = pregnant, VD = venereal disease, STD = sexually transmitted disease, tx = treatment, dx = diagnosis

Competency of Adolescents to Accord Informed Consent

Research on informed consent in relation to minors reflects differing opinions as to how and when to determine the competency of minors. Research regarding competency of adolescents is plentiful, as indicated below. However, most of this research pertinent to research participation or medical treatment decision-making. While the results can be generalized to implications for mental health counseling, more research specific to consent for psychological services is recommended.

There are many variables to take into consideration, in addition to the age of the adolescent. Practitioners are encouraged to examine the intelligence of clients, the cognitive processing skills, moral development, and socialization levels (Levine, 2000). According to Institutional Review Boards, assessments should be made as to the minor's age, maturation, and psychological state (Leikin, 1995). Although this recommendation by Institutional Review Boards was made in reference to adolescent research participation, it can also be applied to counseling.

Utilizing this information provides the practitioner with additional information, the ability to offer shared decision-making, and the opportunity to honor the minor's dissent

during the informed consent process (Leikin, 1995). Similar to the prior legal controversies there is also controversy in the research findings relevant to adolescent decision-making for counseling and medical procedures.

In 1972, Schwartz conducted research in medical settings asking adolescents if they understood their hospitalization was for research purposes. Schwartz found that none of the minors younger than 11 years of age and only one-third of those over 11 years of age in the study were aware of purpose (Schwartz, 1972 cited in Dorn, Susman, Fletcher, 1995). Schwartz used age as a determination for competency and asserted that eleven year olds would not be able to demonstrate knowledge and understanding of the information provided to them regarding the medical procedure in which they were involved.

In contrast, in 1978, researchers found that in classroom discussions of research participation, children were meaningfully involved in the consent process (Lewis, C.E., Lewis, M.A., Ifekwunique, 1978 cited in Dorn et al, 1995). However, the researchers did not examine all aspects of informed. However, what the children knew about risks, benefits, and other aspects of informed consent were elements the researchers did not investigate in this study.

Some researchers have found adolescents are capable of, at minimum, understanding the basic concepts of informed consent, such as benefits of participation, and that adolescents can understand more of the abstract concepts, such as scientific versus therapeutic purpose, than children (Susman, Dorn, Fletcher, 1992 cited in Mammel & Kaplan, 1995).

Principles of child development, such as socialization to conform to the wishes of adults, concept manipulation, or their concept of time, may influence consent and assent and should not be ignored (Koocher & DeMaso, 1990 cited in Dorn et al., 1995). In 1995, Dorn

et al., found that the knowledge of research participation was related to psychological factors such as control and trait anxiety more than developmental factors such as chronological age or cognitive development (Dorn et al, 1995).

Weithorn and Campbell (1982) conducted informed consent research that is frequently citied in competency research. They found that nine year olds focused more on information that was salient or concrete for them at the time, such as considering the benefits, but not the long-term risks (Batten, 1996; Coffey, 1995; Dorn et al., 1995; Leikin, 1995). Nine-year old children made the same consent choices as the eighteen and twenty-one year olds in the study. Weithorn and Campbell also found that fourteen-year-olds did not differ significantly from eighteen and twenty-one year olds in evaluating information and making decisions.

In a similar study examining decision-making in psychological contexts, Keith-Spiegal and Mass agreed that the "reasoning of minors above nine years of age, about research, is similar to that of adults" (Leiken, 1995). Kaser-Boyd found no significant age differences between 10-19 year olds in the ability to identify and evaluate risks and benefits for psychological treatment (1986, cited in Leiken, 1995).

Melton (1980) suggested that adolescents' ability to understand the concepts of minors' rights develops as moral judgement develops through three stages: the rights minors perceive adults allow them to have, rights based on fairness, and finally their rights based on universal principles (cited in Leikin, 1995). Based upon this, Melton notes that by approximately 14 years old, adolescents appear to have the same decision-making abilities as adults (Melton, 1980 cited in Leikin, 1995).

More recent research is also endorsing findings that adolescents, especially older adolescents make similar responses as adults in treatment decision-making situations. However, there may be some differences in adolescents' and adults' decisions regarding certain components of informed consent. Halpern-Felsher & Cauffman (2001) found that adults still consider more options to treatment, more risks, and suggest additional consultations. However, there were no significant differences in adolescent versus adult discussions of long-term effects and considerations of the benefits (Halpern-Flesher & Cauffman, 2001). Bruzzese & Fisher (2003) found that informed consent processes could be adapted to enhance all clients' capabilities to provide truly informed consent. They recommended that short video presentations and simple bills of rights might enhance consent capabilities (Bruzzese & Fisher, 2003).

This research leads us to believe that while younger children cannot provide consent, adolescents may reach a maturational level in which they could meaningfully consent to counseling. As these researchers state, older adolescents display decision-making abilities similar and adults. These research findings would indicate then that practitioners should be more concerned with other indicators of competency than just the adolescent's age, and should be looking for more ways to involve the adolescent in the counseling process. Although state laws may not require practitioners to seek informed consent from adolescent minor clients, it appears that they would be able to give it.

A survey study of clinical training directors participating in the Association of Psychology Postdoctoral and Internship Centers (APPIC) program, by Brunscheen in 2001, sought out the current practices of counseling practitioners and found that practitioners in the study used state laws, agency policies, the age of the adolescent, and the adolescent's

cognitive capabilities to determine whether to seek informed consent. The clinicians noted that the practice of seeking informed consent from adolescents has become more common over the past ten years. Of the respondents in that study, 56% of the practitioners sought informed consent from both parents and adolescents, 40% sought informed consent from the parents only, and 4% sought informed consent from the adolescents only (Brunscheen, 2001). Consistent with the above research, the results showed that practitioners in that study were starting to seek informed consent from adolescents at a mean age of 14.4 (Brunscheen, 2001). Ladd & Forman (1995) commented the field seems overly concerned with the age specific decisions adolescents make. They go so far as to state that age specific values may mean that adolescents make different treatment decisions that adults would make for them, but that parents and clinicians should not be so quite to discount them. Ford & Kessel, 2001 comment that we should increasingly trust the autonomy of adolescents. After all, the adolescent is the one who has to live with their decision.

Theoretical Approaches to Assessment of Competency of Adolescents for Informed Consent

The law requires practitioners to determine competency of adolescents on an individual basis and competency research states there are various ways to approach the determination. By focusing not only the age of the adolescent, but also psychological and sociological variables, we can obtain a clearer picture of the adolescent's abilities and influences. There are several theoretical approaches that can be used to assist in assessing competency for informed consent for mental health counseling.

One approach to this assessment of competency is that of stage development for cognitive and social development where there are discrete developmental levels that must be attained and understood before consent can be given (Leikin, 1995). This traditional manner

of evaluating the development of an adolescent and it is often based on the work of Piaget and Kohlberg (Leiken, 1995; Petersen & Leffert, 1995).

According to Piaget, Formal Operational Thought is the stage of cognitive development that represents adequate cognitive development to give consent. Formal Operation Thought is the most advanced of his developmental stages. Cognitive functioning at this level includes: the ability to engage in abstract reasoning, inductive and deductive reasoning, and be able to flexibly consider and evaluate information (Coffey, 1995; McCabe, 1996). Ironically, these skills are usually attained about the age of eleven or twelve years of age, but even adults in their twenties may not have achieved this stage (Coffey, 1995). However, in a study by Peterson & Siegal (1999) 57% of the participants under 18 years old had already reached this stage and made treatment decisions similar to adults.

Another "stage" theorist is Lawrence Kohlberg. According to Kohlberg, people go through three stages of moral development and this moral development can affect clients' consent capabilities (Gill & Magee, 2000; Petersen & Leffert, 1995; Santrock, 1995). The first stage is Preconventional Morality concurrent with the ages of 4 to 9 or 10 years old. It is in this stage when moral value concerns the needs and wants of the child.

While in this stage of Preconventional Morality, children also go through a substage called Obedience and Punishment Orientation where they would be motivated to make appropriate choices in order to avoid punishment (Gill & Magee, 2000; Petersen & Leffert, 1995; Santrock, 1995). The second half of the stage is the substage of Instrumental-Relativist Orientation, in which children would make judgments based on attempts to satisfy their wants and needs. It would be argued that children making decisions based on these

criteria would not be candidates for making informed consent decisions in regard to counseling or psychotherapy, and would likely be asked for assent.

Conventional Morality is the next stage of Kohlberg's theory and is associated with children 10 to 13 years of age (Gill & Magee, 2000; Petersen & Leffert, 1995; Santrock, 1995). The first substage within Conventional Morality is titled the Good boy/ Good girl Orientation and postulates that 10 to 13 year olds make decisions based upon a need to avoid rejection, negative regard, or disapproval of others. The second substage is labeled Law and Order orientation and is when 11-13 year olds seek to avoid criticism by true authority figures. Adolescents in this stage would not be able to provide informed consent that is truly independent, voluntary, and free from influence of authority figures, whether it is from parents or the practitioner.

The final stage Kohlberg proposes is called Postconventional Morality (Gill & Magee, 2000; Petersen & Leffert, 1995; Santrock, 1995). The hypothesized age range for this stage is 14 years of age (adolescence) through adulthood. This is the stage when moral values reside in principles, separate and apart from authority figures who also hold principles and enforce them, and apart from the groups with whom the individual identifies. There are two substages in Postconventional Morality.

The first substage is that of Legalistic Orientation where judgments are made considering the good of the community, respecting laws, and social order. The second stage is Universal, Ethical Orientation in which the individual's conscience plays the largest part in decision-making. Most people never reach this level. Kohlberg states that these substages may be manifested in people from 14 years old through adulthood. Thus, if we follow Kohlberg's outline of moral decision-making we could argue that adolescents around the age

of 14 could be capable of making the same decisions, for the same reasons, as adults do. Then the question becomes, if adolescents are theorized to be as capable decision-makers as adults in adolescence, why wait until they are 18 or older to ask for informed consent?

Another approach to the assessment of an adolescent's development, distinct from stage development notions, is "trend" development. This approach implies overlapping skills are attained in varying degrees and at varying times (Leikin, 1995). Because this, a person advocating this approach would encourage clinicians to assess adolescents as individuals rather than assuming they are incompetent because of their minor age status (Leikin, 1995; Scott et al., 1995). The evaluation would include an assessment of the adolescent's information processing capacity, their acquisition of knowledge in specific areas, and their level of concrete operations or how the adolescent "bases judgments on perceived appearances," their level of formal operations or how the adolescent "bases judgments on inferences that go beyond surface appearance to the underlying reality" (Leikin, 1995, p. 2).

In addition, the adolescent's ability to engage in quantitative thinking, metacognition or "monitoring and evaluating one's cognitive enterprises," to have a sense of order in cognitive enterprises, and to show improvement in cognitive strategies are all indicators of the adolescent development (Leikin, 1995, p2). It is interesting to note that experts now believe more in trend development rather than in stage development (Leikin, 1995).

A third approach to evaluating an adolescent's ability to provide informed consent is the factor approach. This approach provides a much broader, but more individualized picture of the adolescent client. This evaluation is a more personalized interview during which three important factors about the adolescent and her/his environment are examined. Child, familial, and situational factors are the three factors that are evaluated (McCabe, 1996).

Child factors include emotional, physical, and intellectual functioning (McCabe, 1996). The minor's emotional state and socioemotional maturity are important to examine (McCabe, 1996; Peterson & Siegal, 1999). Emotional states such as these can affect the adolescent's understanding, memory, reasoning, and participation (McCabe, 1996; Peterson & Siegal, 1999). Physical states, such as pain, length of attention span, and any medication she/he is taking, are elements to consider as they can influence concentration (McCabe, 1996).

Intellectual capacity indicated by information processing, the adolescent's beliefs/attributions, and the minor's preferences for amount of involvement are also pertinent (McCabe, 1996). These factors will influence the actions of the therapist such as how much and what types of information is provided to the adolescent about informed consent, and when or if, to do so (McCabe, 1996).

Familial factors are those factors that apply to the system of caregivers surrounding and caring for the adolescent whether they are extended families, foster families, or a nuclear-type family (McCabe, 1996). These familial elements are variables such as cultural background, religious affiliation, personal values, style of interaction, family cohesion and level of influence and family-structured roles (McCabe, 1996; White, Howie, Perz, 2000). These elements influence how the parents and adolescents view psychotherapy, how they interact with the therapist, the level of communication, and the level of involvement that is considered appropriate for both the parents and the adolescent when the adolescent is in psychotherapy (McCabe, 1996, Peterson & Siegal, 1999).

Situational factors include whether the situation is an approach/avoidance or an avoidance/avoidance decision and whether the minor sees the situation as a long-term or

immediate problem ((McCabe, 1996). The adolescent may be able to see the immediate consequences much better than the long-term consequences even if they are beneficial ones (McCabe, 1996). How trustful the adolescent is of individuals in the position to help is another situational factor. Trust influences disclosure or willingness to engage in psychotherapy (McCabe, 1996). The adolescent's level of stress, and if there are any differences in opinion are two additional situational factors (McCabe, 1996). The complexity of the problem and the varying perspectives of the problem can be factors in facilitating or impeding the adolescent's use of developmental capacities when making decisions such as consent to psychotherapy (McCabe, 1996).

These factors and the resulting implications will vary with every client no matter what their age, but with adolescents the issues are more complex due to their lack of legal control. These child, family, and situational factors can provide a therapist with more detailed information about the adolescent and her/his capacity to consent for treatment.

Reasons For and Against Involving Adolescents in Consent Determination

There are varying reasons for involving or not involving adolescents in treatment decisions. Among the reasons to involve adolescents in treatment decisions are: respect for their autonomy, avoiding denying adolescents access to care they are seeking, to improve communication, to increase compliance with a treatment regime, to give the adolescent a sense of control, to show respect for the adolescents capabilities, and to provide opportunities for further development (McCabe, 1996; Peterson & Siegal, 1999).

Several studies have discussed what practitioners report as reasons for not requesting consent from a minor (Beeman & Scott, 1991; Brunscheen; 2001). Responses ranged from concern about refusal, that it was not required to seek informed consent from an adolescent in

their setting, or it, at the time of the study, was not ethically required. Peterson & Siegal (1999) found that clinicians had concerns regarding adolescents' abilities to evaluate long-term consequences, concerns about social and emotional immaturity and naivety, and the effects of authority figures on adolescents.

When the Adolescent is unable or unwilling to consent

What the practitioner should do in the instance the adolescent is unable to consent or does not agree to treatment, or when the parents have already provided consent, is a complex issue that has evoked varied clinician responses. Practitioners' responses to this dilemma have changed over time. Research done by Taylor, Adelman, & Kaser-Boyd in 1984 indicated that the most common response was to discontinue counseling if the adolescent minor client did not consent to counseling (Taylor, Adelman, & Kaser-Boyd, 1984 cited in Beeman & Scott, 1991).

According to Beeman & Scott (1991), practitioners' responses to this situation have evoked a wide range of potential responses: from trying to work through the resistance, seeking parental help to convince the adolescent, contracting for a trial period, proceeding with only parental consent to treatment, and less often, discontinuing treatment (Beeman & Scott, 1991). Brunscheen (2001) found that practitioners were likely to use parental consent if the adolescent was unable to consent. If the adolescent refused to consent practitioners reported that they would try to work through the adolescent's resistance. It is apparent that the legal, ethical, and competency controversy has had an affect on clinicians' practices when counseling adolescents. The changing responses to inability to consent and refusal to consent continue the controversy: What is in the best interests of the child? Is it preferable to respect the adolescent's autonomy and refusal of treatment, or is it advantageous to try to convince

the adolescent to continue despite resistance, or even to proceed with only parental consent to treatment?

Related Biomedical Ethical Principles

The fundamental philosophical, ethical, and biomedical principles related to informed consent and the counseling of adolescent minors are nonmaleficence, beneficence, justice, and autonomy (Beauchamp & Childress, 1979, Kitchener, 1984). Practitioners must aim for beneficence, or to do no harm to their clients whatever their age and must aim to help them. Practitioners must also be just, or seek to be fair to the adolescent minor client and respect their autonomy when considering whether to ask for informed consent or assent. These ethical principles are evident in the implications and recommendations that follow.

Implications

The recent trend in informed consent research in relation to adolescent minors appears to be the belief that mid-late aged adolescents should be allowed to consent (not just assent), at least in minimal risk situations. The reasoning for this is that adolescents around the age of fifteen are less likely to defer to authority figures, are less conformist, have more self-awareness and seek respect for their autonomy and rights (Leikin, 1995; McCabe, 1996; Scott et al., 1995). The problem with this idea is that adolescents are still tied to their parents financially, legally, and emotionally.

In addition, there are many other factors a practitioner must be aware of when counseling an adolescent minor. It is important to consider the laws regarding informed consent in the state in which you are practicing, the practitioner should be sensitive to the minor's "language," and should be active in obtaining the minor's preferences (Coffey, 1995; McCabe, 1996).

The practitioner must be aware of her/his own values and how they will influence the therapeutic process with minors and their parents (McCabe, 1996). When assessing competency of an adolescent minor, the assessment of capabilities should be a continuing process (McCabe, 1996). All conversations regarding informed consent with both the adolescent and the parent(s) should be documented (Moore, 1994, chap. 17).

It is important to address the concerns of parents while being respectful of both the minor's and the parent's rights and autonomy. She/he should be cautious not to put the minor in a decision-making capacity the adolescent is not ready for (McCabe, 1996). Harrison & Hunt (1999) note that supporting autonomy may concurrently stifle beneficence or nonmaleficence. Batten (1996) argues that to respect an adolescent minor's autonomy, assessing competency should be done by "individually assessing each case from the degree of their cognitive ability, rationality, and psychopathology" (Batten, 1996).

With the new legal decisions giving minors more rights and responsibilities (e.g. suing their parents, the increase in child protection laws, and the increase of minors assuming adult roles such as working full-time or even becoming parents themselves) practitioners counseling adolescent minors will have to be more cognizant of the procedures they follow and why. Practitioners should be at least seeking assent from their adolescent clients, if not informed consent.

The overall theme from the legal decisions is one that requires practitioners to assume all adolescents are incompetent and to evaluate competency on an individual basis. As the research has shown, a practitioner can make a case for an adolescent client who is at least 15 years old to be a mature minor. However, if the parents disagree with that opinion or psychologist's determination or subsequent counseling, the subjective nature of labeling an

adolescent a mature minor could lead to problems if the practitioner is forced to defend her/his decision in court. (See Table 1 for specific statutes and qualifiers for informed consent situations for each state.)

Behavioral research indicates that adolescent minors, especially those fifteen and older, do have the cognitive and social abilities to make an informed consent decision. To combine these ideas, we realize that it is important for practitioners to carefully assess their adolescent minor clients, to solicit the adolescent's opinions and wishes regarding psychological treatment and provide clients with the opportunity to be as involved in their counseling as deemed appropriate for their competency level. As the law in most states would require, the practitioner must seek informed consent from the adolescent minor client's parents. However, this statutory requirement should not prevent the practitioner from also seeking informed consent from the adolescent minor client. However, this means that if the adolescent assents or dissents, appropriate steps must be taken to integrate her/his wishes into the counseling process, even if it means discontinuing counseling.

The Present Study

This study sought to assess the attitudes of adolescents regarding assent and informed consent for psychological interventions. It assessed these domains by seeking to survey of a sample of adolescents between the ages of 13-18 years old in two Midwestern states. Few studies have directly addressed the issue of consent practices with minors and the desires of the adolescent clients. A literature review of social sciences and medical indexes found no similar studies. Ginsberg, Forke, Cnaan, Slap (2002) assessed adolescents' preferred health provider characteristics and found that adolescents seek professionals who are caring, compassionate, allow the adolescent to be an active participant in her/his treatment, and

provide confidentiality. Sullivan, Marshall, Schonert-Reichl (2002) assessed help seeking practices and found that adolescents prefer to seek out parents for their expertise and friends for their nurturance, but prefer to friends and family to seeking professional help. The study most similar to this survey study was a study that was conducted in the United Kingdom. Woolfson & Harker (2002) consulted with adolescents to get their views about psychological services they received. The opinions sought were related to evaluating the quality of the relationship, the communication with the psychologist, the psychologists' respect for the adolescents' rights and fulfillment of adolescents' outcome expectations. The study did find that adolescents prefer more information and decision-making opportunities.

Three previous studies, Taylor et al. (1984), Beeman & Scott (1991), and Brunscheen (2001) have specifically addressed the topic of informed consent with minors from the practitioner perspective. This current study sought to extend those studies by gaining the unique perspectives of 13-18 year old adolescents in an exploratory survey study.

It addressed the general question: What are the perspectives of adolescent minors in regards to consent to mental health treatment? Moreover, this study also addressed specific questions such as:

- What types of information do adolescents consider to be an important part of the consent process for entering counseling?
- How does the importance adolescents place on these different types of information compare to the types of information they believe are important to be provided to parents?
- From whom do adolescents think the counselor should seek consent from if the adolescent is the client?

- At what age do adolescents believe they should be able to provide consent for mental health counseling?
- What should the counselor do if the adolescent is unable or unwilling to consent to counseling?
- Are there differences in the attitudes between younger adolescents (13-15) versus older adolescents (16-18)?
- Are there differences in the attitudes between adolescents who have had counseling before and those who have not?

There are several ethical principles that are considered in the proposal of this research study. King & Churchill (2000) state that research must have sufficient importance. This research study was intended to add to the existing literature on informed consent by gaining adolescents' perspectives. It is believed that these perspectives may help adapt informed consent procedures to address the needs of adolescents today and may have implications for adolescent help seeking.

Another ethical consideration is scientific soundness. A vignette was developed to increase adolescents' interest in the topic and feelings of relevance. Attempts were made to reduce gender stereotyping by using a gender-neutral name. The vignette was purposefully developed to address a mental health concern especially relevant to adolescents: Attention Deficit Hyperactivity Disorder (ADHD). Attention Deficit Hyperactivity Disorder (ADHD) was chosen for the vignette due to more public familiarity with its symptoms and because ADHD is recognized globally though prevalence rates vary by country (Mash & Barkley, 1996). This study attempted to respect adolescents' autonomy by seeking information on how counseling practitioners may do so and also by seeking adolescent and parental consent

to participation. The study was not anticipated to have any adverse effects on the adolescent participants. Indeed, no adverse affects were reported. Participation and responses were confidential and anonymous to the greatest extent possible, and the survey did not question adolescents about overly sensitive areas of their lives.

MATERIALS AND METHODS

Sample

One enduring issue when conducting research with participants aged below the legal age of consent is finding a sufficient number of adolescents to survey so that there is sufficient power to assess to questions posed. Vigorous and ongoing efforts were made to invite adolescent and parent participation in the research over the course of almost two years. This process was augmented by consultation with a committee of nine licensed psychologists from two different Midwestern states. Input was solicited and received from a headmistress of a private school, an institutional review board at a community mental health center and another at a public school.

Feedback was given by these multiple sources regarding survey structure, procedure, and the incentive program for this study. For example, based upon feedback provided by consultants, the gift certificate process was changed from a drawing for several gift certificates per site to providing each participant with a small monetary incentive in the form of a gift certificate to local businesses. One school district contact person noted the likelihood of lower return rates if students had to transport materials home to their parents/guardians and then complete the survey independently and thus spoke to their administrators about the possibility of having students transport consent materials to their parents/guardians and then completing the survey during a class period that would involve all the students in the desired age range of 13 to 18 years old. The administrators of this school district commented that time restraints created by the demands of teaching basic curriculum with the added demands of increased testing and evaluation times created by tracking

demands of the No Child Left Behind program left little time for added activities. Thus they would not allow the survey to be completed during class time.

Several different sites were approached for the purpose of this research. An outline of these thirteen sites is provided below with more detailed information provided in the following paragraphs. Applications were made in two different states: State 1 was a Midwestern state with a population of 2,944,062 (United States Census Bureau, 2003) and State 2 was a Midwestern State with a population of 2,723,507 (United States Census Bureau, 2003).

Within State 1, application attempts were made to four sites across the state.

- Site A was a public school district in the Central region of the state that included one middle school and one high school.
- Site B was a public school district in a rural area of the Central region of the state that included one middle school and one high school.
- Site C was a public school district in a large metropolitan center in the Eastern region of the state with several middle schools and high schools.
- Site D included a group of parents in the same metropolitan area as Site C in the Eastern region of the state.

Within State 2, application attempts were made to nine sites across the state.

- Site E was a large public school system consisting of multiple middle schools and high schools within the largest metropolitan area in the state, located in the South-central region of State 2.
- Site F included a parent group in a small public school district adjacent to the largest city in the South-eastern region of the state.

- Site G was a rural public school system in the Central region of State 2.
- Site H included a parochial high school in the above-mentioned metropolitan area in the South-central region of the state.
- Site I was a private school system consisting of a campus with one middle school and one high school in the same large city in the South-central region of State 2
- Site J was a community mental health center serving one South-central county in State 2 with a population of 462,896 (United States Census Bureau, 2003).
- Site K was a regional community mental health center serving several rural counties in the South-central region of State 2.
- Site L was a local leadership group organized by a local church in the large metropolitan city in the South-central region of State 2.
- Site M was a youth leadership program organized through a local university in the South-central region of State 2.

Site A was a public school district in State 1, located in a Midwestern town of approximately 50, 000 people. The school district maintained a middle school and high school consisting of approximately 2, 250 students. An additional application was made to Site B, another public school system, in a more rural setting, in State 1. This school system also consisted of a middle school and a high school. The total number of students within this middle school and high school system was 923 students out of a town and surrounding area with a population of approximately 6, 600 people.

Upon notification from contact personnel at Site C, a larger school system in a larger metropolitan area in another part of the state, that the school board was not accepting research studies not directly related to evaluating achievement in math, science, or reading

(due to demands from federal testing requirements related to the No Child Left Behind program and subsequent time constraints during the school day), study materials were presented to local parents of the area that might be willing to have their adolescents participate or assist in locating other sites that might be willing to participate in this study (Site D). Those avenues did not produce any additional sites for conducting this survey study of adolescents' attitudes regarding counseling attitudes. Similar attempts were made during the course of the next year in another Midwestern state, State 2.

In State 2, as mentioned above, applications were made in several different counties in the South-Central region of the state. Site E was a public school system for the large metropolitan area within this Midwestern state consisting of over 500, 000 people was also contacted for participation in this study. The public community school district to which an application was made contained eighteen middle schools and eleven high schools serving almost 50, 000 adolescents from 13 to 18 years of age (United States Census Bureau, 2003) with a variety of household types and socioeconomic strata. Parents in another nearby town of approximately 6, 600 people (adjacent to the largest city in State 2) (United States Census Bureau, 2003) were also contacted for participation in this study. These parents constituted Site F. Contact was made though personnel at Site G, a more rural public school system that consists of a small town of 17, 190 people but incorporates a total of seven small surrounding communities for a county total of 32, 869 people were contacted. This school system had two middle schools and one high school serving a total of 1, 841 students in these three schools.

In addition to seeking participation from public schools, attempts to recruit private and non-secular schools were also made. A local Catholic high school, Site H, serving

approximately 800 adolescents was approached for participation in this study (United States Census Bureau, 2003). Site I was a local private school serving approximately 400 adolescents between 13 to 18 years of age who also received an application seeking their participation as a site for this study. This site included one middle school and one high school located in a campus setting within the large metropolitan area of this Midwestern state.

Site J was a community mental health center that was the largest community mental health center in State 2. It consisted of six programs serving different populations located throughout the metropolitan/county area, including: outpatient services, family and children community based services, addiction treatment services, community support services for adults with severe and persistent mental illness, a program for adults experiencing serious mental illness and homelessness, and their crisis intervention services.

The other community mental health center, Site K, consisted of a psychiatric hospital, partial hospital, residential, and outpatient office located on the outskirts of a small town in this Midwestern state and had community mental health center offices and private practice offices in other cities. Services were divided among three counties and consisted of child/adolescent, adult, and older adult services, with specialty areas such as chemical dependency treatment, behavioral healthcare, sexual health, sex therapy, community support, trauma-related disorders, expressive and recreational therapies and recreational therapies. This site also maintained an accredited school for inpatient children and adolescents; residential care recipients and outpatient adolescents and children who are not functioning in the public school arena.

In a further attempt to recruit adolescents for participation personnel directing youth programs through a local area church were contacted. Site L was a youth leadership/scholarship group, predominantly for African Americans, met in separate gender groups and approximately 20-30 students in each of the groups. These groups processed teen issues in general, issues related to spirituality, and processed community and leadership/scholarship issues as well.

Another program, Site M, consisting of approximately thirty adolescents that were a part of a residential academic program, was also recruited. This program was federally funded and hosted by the local university. Participants were drawn from the metropolitan area and public schools and consisted of freshmen, sophomores, juniors and seniors. The program averaged sixty-five participants a year and provides group and individual attention for each of the residents in the program. The participants are multi-ethnic with a potential for success in post-secondary education and many are from lower income families.

Thus, applications were made to thirteen sites (more information on the application procedures is available in the Procedure section below). Of the thirteen sites, four agreed to participate for a participation rate of 30.77%. All four sites were located in State 2 and consisted of Site I (the private school), Site K (the regional community mental health center), Site L (the youth group), and Site M (the university leadership group).

However, the programs that had been approved for participation at Site K ended. Thus, three sites were accessible for data collection participation in the study. This is equivalent to a 23.08% final site participation rate. Site I (the private school) distributed 400 surveys to adolescents in their middle school and high school programs, aged 13-18 years old. Surveys were distributed during the English class, as all students were required to take

these English courses. Site L's youth group handed out twenty-seven surveys to the adolescents in their groups. Site M's leadership program distributed fifty surveys to the students in their groups. There were a total of 477 surveys that were distributed between these three sites.

The demographic characteristics for the metropolitan area in which these three participating sites were located and in which the participating adolescents resided were approximated as follows based upon the 2000 census data: 75.20% Caucasian, 11.42% African-American, 3.96% Asian , 0.06% Pacific Islander, 1.16% American Indian or Alaskan Native, 5.10% from other races, 3.10% from two or more races, with 9.62% of the population Hispanic or Latino of any race (United States Census Bureau, 2003).

Participants were recruited via handouts and announcements by their teachers or group leaders inviting them to participate in the hour long survey study. Parental informed consent and adolescent assent was obtained for the adolescents to participate in the study (see Procedure section below).

Materials

The materials consisted of nine elements: an announcement note given to teachers/group leaders to alert potential participants of the research opportunity, and information letter provided to the adolescents, an information letter provided for the parents, a survey packet consisting of the survey, separate informed consent statements for both the adolescent and the parent/guardian respectively, two postage paid return envelopes, the debriefing form, the gift certificate entry form, and the gift certificate letter. These materials can be viewed in their entirety in Appendix A.

A letter of request was sent to site officials as part of the application process (more information on this application procedure is available below in the Procedure section and a sample letter is located in Appendix A). It explained the purpose of the study and how the study's results could be used to develop interventions appropriate for their site. For school systems, especially, the importance of mental and emotional health and its link to academic achievement was stressed as well as how the study's results could be implemented into current state and federal reporting guidelines. This study would provide information as to the attitudes of students in their school regarding receipt of counseling and could help the schools design interventions to attend to the counseling needs of their students and thus relate to academic achievement. For applications to the community mental health centers, the letter addressed how the attitudes assessed in this study from the adolescents in their program could be used to inform their own informed consent procedures and to assist in outcome research for their facilities.

The announcement letter (in Appendix A) was provided to teachers/group leaders with the request they make the announcement in their homeroom sessions. The letter briefly outlined the purpose of the study, the procedures for participating, and stressed the study's importance. The information letters for adolescents and parents explained what was being asked of the adolescent, how the survey results would be maintained and analyzed, and instructions for participation.

As an incentive for participation there was the option for adolescents to request to receive a $5.00 gift certificate from a local area business. A list of eligible local businesses was provided to participants in the informed consent statements and on the gift certificate

enrollment page (located in Appendix A). The list of businesses included bookstores, restaurants, and discount stores, in an attempt to promote a positive use of the money. The survey was adapted from three studies: Taylor et al. (1984), Beeman & Scott (1991), and Brunscheen (2001). In addition, the vignette concept of Weithorn & Campbell's (1982) Depression Dilemma of the Measures of Competency to Render Informed Treatment Decisions was used. The vignette used was inspired by the Weithorn & Campbell (1982) study and was designed to elicit interest and feelings of personal relevance (see survey instrument in Appendix A). As mentioned above, the vignette related a brief story about a gender and age neutral adolescent struggling with the symptoms of Attention Deficit Hyperactivity Disorder (ADHD) (American Psychiatric Association, 2000). After the vignette adolescents were asked questions relating to the vignette, to elements of informed consent, questions related to parental access to counseling information, and questions related to their perceptions of adolescents who receive counseling.

Procedure

Consent procedures

The issue of adolescent consent for mental health counseling, while the purpose of conducting this study, also became a factor in the actual research conducted for this study. Consent and assent issues for participation in research had to be carefully considered.

The consent procedure was carefully evaluated. The process of contacting area adolescents without school or program contact was not practical. Researchers would not have been able to obtain lists of all adolescents, their parents' names, and their home addresses due to regulations and policies that tightly protect adolescent/family privacy. Given that the purpose of this survey was to study to evolving autonomy and decision-

making process of adolescents, investigators sought to respect adolescents' opinions, interests, and willingness to participate by seeking an alteration to the sequence of federally mandated consent procedures for studies involving minors. In effect, researchers asked that adolescents have the opportunity to view the survey before parental consent is obtained. All other procedures remained consistent with federal guidelines.

Investigators sought an alteration in the procedures implied in the research statute 45 CFR 46.116 (d) where "An IRB may approve a consent procedure set forth in this section which does not include, or which alters some of all of the elements of informed consent set forth in this section, or waive the requirements to obtain informed consent provided the IRB finds and documents that:

1. the research involves no more than minimal risk to the subjects
2. the waiver or alteration will not adversely affect the rights and welfare of the subjects
3. the research could not practicably be carried out without the waiver or alteration
4. whenever appropriate, the subjects will be provided with additional pertinent information after participation

In this study, there was minimal risk to the adolescent:

- The survey was anonymous.
- There was no long term pairing of responses with identifying information.
- Envelopes were numbered to match each other (e.g. 1A, 1B) for the explicit purpose of verifying a parent consent form and adolescent assent form has been received so that the survey may be used. Immediately upon verification the envelopes were destroyed and the consent forms, surveys, and gift certificate forms were separated to maintain anonymity of the responses.

- All materials were returned separately.
- No intrusive information was sought.
- Also, separate adolescent assent and parental consent were sought for participation in this survey.

The alteration in usual consent and distribution procedure was accepted by the Iowa State University Institutional Review Board and the Iowa State University Psychology Department Research Review Committee allowing for the following procedures to be implemented. The research survey study was submitted to the applicable Human Subject Review Boards at each of the sites by the principal investigator.

Site Specific Application procedures

In addition to gaining research study approval from the investigators' institutions, additional requests to conduct research were sent to contact persons at each site including: school superintendents, program review board administrators, school principals, group leaders, and school/program directors.

Application procedures included submitting research applications often to multiple persons within an organization for study review. Multi-level reviews followed most application submissions. One interesting finding was the different focuses of various contact persons within organizations. For example, counselors and teachers within several of the schools commented on how they found this study to be interesting and useful for them and indicated that they would be willing to hand out surveys but would even be willing to use class time to have students complete the surveys. Administrators such as school principals in several schools agreed with their teachers and were willing to conduct the study in their school. However, research protocol demands approval by school district administrators such

as school boards. It was here there was a divergence. The school board officials, in efforts to manage the demands of curriculum and new reporting requirements congruent with the No Child Left Behind mandates in schools, found it difficult to appropriate classroom time for endeavors not directly related to basic academic skill acquisition. Given the emphasis on academic achievement, efforts were made by investigators in this study to address these concerns in application materials (see above discussion in the Materials section) and to create a study that would use minimal classroom time and minimize classroom disruption for distribution of the study. For example, teachers and group leaders were asked to distribute the survey to their students and read a brief paragraph long description of what the survey entailed as opposed to having the investigator come to the classrooms or groups to distribute surveys. The survey was also designed to be completed outside of the groups' official time together as to not consume instructional time in schools.

For each site, follow-up to the application included letters sent via US Mail as well as phone call and e-mail contacts. Each site where an application had been submitted was contacted a minimum of three times. (For more discussion on the effects of this process on the study, please see the Discussion section below.)

Survey procedures

Upon approval of the study survey packets were distributed to teachers and group leaders along with a letter briefly describing the study and asking the teachers or group leaders to distribute the packets to their students during the their class or group period. (Please see letter in Appendix A.)

Adolescents were given the survey packets that included an informational letter regarding the research study on the front of the survey packet. (Please see letter in Appendix A.)

Interested students could choose to keep the packet with the parent information letter, the adolescent assent form, the parental consent form, the survey, the debriefing letter, the gift certificate letter, and the return envelopes sealed inside. (Please see survey packet in Appendix A.) Those not interested could throw away the packet or recycle it. Since all adolescents received a packet, no school or program staff had knowledge of which students actually chose to participate, nor did they have access to any individual's responses. It was reinforced to students that their choice to complete a survey packet would not influence school evaluation or grading nor any services provided.

Students were then required to transport this packet to their parent/guardian for permission. Parents had the opportunity to view the survey documents and decide if they wanted their student to participate. If they consented, the parent and the adolescent separately completed the informed consent documents and mailed them to the investigator. The only questionnaire responses included in this study were those for which both adolescent and parent consent forms had been completed.

Consent forms and the gift certificate forms were mailed to the investigator in one return-postage-paid envelope and the survey was mailed back to the investigator in another. These envelopes were mailed directly to the investigator so that no school or program staff members were involved and separately to protect confidentiality. As mentioned above, envelopes were numbered to match each other for the explicit purpose of verifying a parent consent form and adolescent assent form has been received so that the survey could be used. Immediately upon verification the envelopes were destroyed and the consent forms, surveys, and gift certificate forms were separated to maintain anonymity of the responses.

Completion of the survey should have taken approximately forty-five minutes to one hour at most. The survey began with instructions and definitions for adolescents to use for the purposes of this survey instrument. Following this, the vignette was presented. Attention Deficit Hyperactivity Disorder (ADHD) was used as the stimulus in this vignette due to its global recognition among clinicians and the general population. Attentive Deficit Hyperactivity Disorder (ADHD) has a prevalence of 3-7 % of the childhood population with rates slightly lower for adolescents. There is an average ratio of six males having ADHD for every one female with ADHD with females being described as showing more Inattention symptoms (Mash & Barkley, 1996). The prevalence of ADHD among adolescents ranges from 3%-6.3% with a mean of 4.3% (Mash & Barkley, 1996). This condition has significant enough prevalence that adolescents would likely have knowledge of the condition or contact with peers exhibiting ADHD symptoms. A vignette was used because it allowed for presentation of a contrived, systematic, detailed and explicit situation in a manner consistent with the design of the study. These types of vignettes produce more valid and reliable measures of respondent opinions than simple statements comprising limited information (Alexander & Becker, 1978 cited in McDivitt, 2001). The vignette uses the gender-neutral name of "Casey" and the issue of ADHD.

Once the students were in the mindset of counseling and related issues, students were asked questions and provided with multiple option checklists asking their attitudes about various aspects of treatment decision-making, elements of consent and assent, and attitudes regarding parental access to information. Adolescents were also presented adjectives that people might use to describe their perceptions of another person. They were asked to select adjectives that they felt would describe an adolescent in counseling. Questions regarding

demographic information and familiarity with counseling end the survey. The survey also provided opportunities for participants to write in answers and opinions. The survey itself can be viewed in Appendix A.

Following receipt of the adolescent and parental consent forms (for participation and for receiving a gift certificate); a $5 gift certificate to a local store (e.g. Target or Walmart) or local restaurant was mailed to the participant. Gift certificates were used to ensure that adolescents could not purchase illegal or negative items (such as tobacco products, alcohol, etc.) with the funds. The gift certificate letter can be viewed in Appendix A/

The investigators' contact information was provided on all forms. If parents/guardians or adolescents had questions or comments, they could contact the primary investigator, supervising professor, the Iowa State University Research Compliance Officer, or school or program officials.

RESULTS

Return Rate

From the three different sites, forty-one surveys were retuned. However, two of the surveys were not valid to due to lack of associated consent and assent forms and one of the surveys was invalidated to due having over 92% of the items left unanswered. Below is a table outlining the returns from each of the participating sites. The overall return rate for valid surveys was 7.97%.

Table 2. Valid returned surveys from each site

Site	Number of Surveys Distributed	Number of Surveys Returned	Return Rate
Site I: Private School	400	8	2.00%
Site L: Leadership Group	50	28	56.00%
Site M: Youth Group	27	2	7.41%
Totals	477	38	7.97%

The participants were asked to specify gender, age, and ethnicity demographics for the purposes of the study. In addition there was a place on the survey for adolescents to write in their ethnicity if an appropriate option was not listed. The distribution gender, age, and ethnicities are listed in the tables below.

Of the thirty-eight participants, 31.58% were males; thus 68.42% of the sample consisted of female respondents. The ages of the participants ranged from 13 to 18 years of age. According to United States Census Bureau (2003) data from the 2000 census there are approximately 25,419 adolescent males ages 13 to 18 and 24,501 adolescent females of the same age range in this large metropolitan area in State 2 for a total of 49,920 adolescents aged 13 to 18 years old. This translates to approximately 50.91% of the adolescent population being male and 49.09% being female. This distribution of gender is different

from the sample obtained in this study, as there were a greater percentage of females participating in this study than would be representative of the population in the general area.

Table 3. Distribution of respondents' gender by site

	Site I	Site L	Site M	Total	Total percentages
Males	1	12	0	13	34.21%
Females	7	16	2	25	65.79%
Total	8	27	2	38	100.00%
Total percentages	21.05%	71.05%	7.90%	100.00%	100.00%

Below is a table outlining the ages of the adolescents from each site that participated in this study. As described in the studies above, research is often conducted to examine differences in informed consent decision-making between adolescents of different ages. Adolescents are often classified into "younger" adolescents who are 12/13 years of age to 15 years of age and "older" adolescents, or those adolescents who are 15/16 to 18 years old. Given the sample size for this study, the separation of younger (13-15 years old) versus older adolescents (16-18 years old) will be used rather than analysis by each year of age.

Table 4. Ages of adolescent respondents listed by site

	Site I	Site L	Site M	Total	Total percent
13 years old	1	1	0	2	5.26%
14 years old	0	4	0	4	10.53%
15 years old	0	3	0	3	7.89%
16 years old	3	10	0	13	34.21%
17 years old	2	7	0	4	10.53%
18 years old	2	3	2	7	18.42%
Totals	8	28	2	38	100.00%

Ethnicity

As outlined above the demographic characteristics for the metropolitan area in which these three participating sites were located and in which the participating adolescents resided were approximated based upon the 2000 census data (United States Census Bureau, 2003):

- 75.20% Caucasian,
- 11.42% African-American,
- 3.96% Asian ,
- 0.06% Pacific Islander,
- 1.16% American Indian or Alaskan Native,
- 5.10% from other races, 3.10% from two or more races,
- 9.62% of the population Hispanic or Latino of any race

Below is a table outlining the ethnicities of the adolescents who participated in this study. As can be ascertained from comparing the population demographics to the sample demographics, African Americans were over-represented in this sample. This was attributable to the enrollment status of the various sites. While applications were made to sites that would create a sample more representative of the general population statistics for the area, self-selection of the sites for participation in this study created a preponderance of sites with more racial and ethnic diversity than in the area's population.

Table 5. Ethnicity of participating adolescents

	Site I	Site L	Site M	Totals	Total percentages
Caucasian/White	6	4	2	12	33.33%
African American	0	14	0	14	38.89%
Latino/a American	0	5	0	5	13.89%
Asian American	0	1	0	1	2.78%
Multiracial	1	1	0	3	5.56%
Other	1	1	0	2	5.56%
Total	8	26	2	36	100.00%
Total percentages	22.22%	72.22%	5.56%	100.00%	

Note: Two participants did not specify their ethnicity. Percentages listed in parentheses represent percentages of valid ethnicity responses (36 participants in this case).

Guardianship

According to the 2000 census conducted by the United States Census Bureau (2003), the distribution of guardianship for adolescents in this metropolitan area of State 2 is as follows: There were 107,280 children under eighteen years of age living in a married family household. There were 7,880 children under eighteen years of age living in a male headed household with no wife present, compared to 25,542 children under eighteen years of age living in a female headed household with no husband. There were 9,247 children under eighteen years of age living with other relatives. Separate estimates for adolescents were not available.

Thus approximately, 71.54% of the children under the age of eighteen in this metropolitan area live in married households, 5.26% of children younger than eighteen years of age living in a male headed household with no wife present, 17.03% of children in this metropolitan area residing in a female headed household with no husband present, and 6.17% of children younger than eighteen residing with other relatives.

In this sample adolescents were able to further delineate with whom they were residing such as having divorced or separated parents, but living with each parent part-time or living with a biological parent and a step-parent. Such delineations were not possible within the census data (United States Census Bureau, 2003). As can be observed by comparing this to the table below the adolescents in the sample and the adolescents from the general population in the area in general had similar patterns of guardianship: 71.05% reside in a multiple parent setting, 23.68% reside with their mother, 2.63% reside with their father, and 5.26% reside with another guardian or relative.

Table 6. Guardianship of respondents

Site	I	L	M	Totals	Total percentages
Both biological parents	7	12	2	21	55.26%
Divorced/separated, but with both biological parents	0	1	0	1	2.63%
Biological mother only	1	8	0	9	23.68%
Biological father only	0	1	0	1	2.63%
Other relatives	0	1	0	1	2.63%
Stepmother and father	0	2	0	2	5.26%
Stepfather and mother	0	3	0	3	7.89%
Other guardians	0	0	0	1	2.63%
Totals	8	28	2	38	100.00%
Total percentages	21.05%	73.68%	5.26%	100.00%	

Note: Other relatives/guardians: one student living with an aunt and another living with an adoptive mother. Site I: Private School, Site L: Leadership Group, Site M: Youth Group.

Adolescents' Estimates of Socioeconomic Status

Adolescents were given the opportunity to estimate their socioeconomic status. Adolescents in this sample indicated their perceptions of their family's socioeconomic status

to be middle to upper middle class (x=2.87, median and mode = 3.00, where lower class=1, lower middle class=2, middle class=3, upper middle class=4, and upper class=5). The table below shows the frequency of each response.

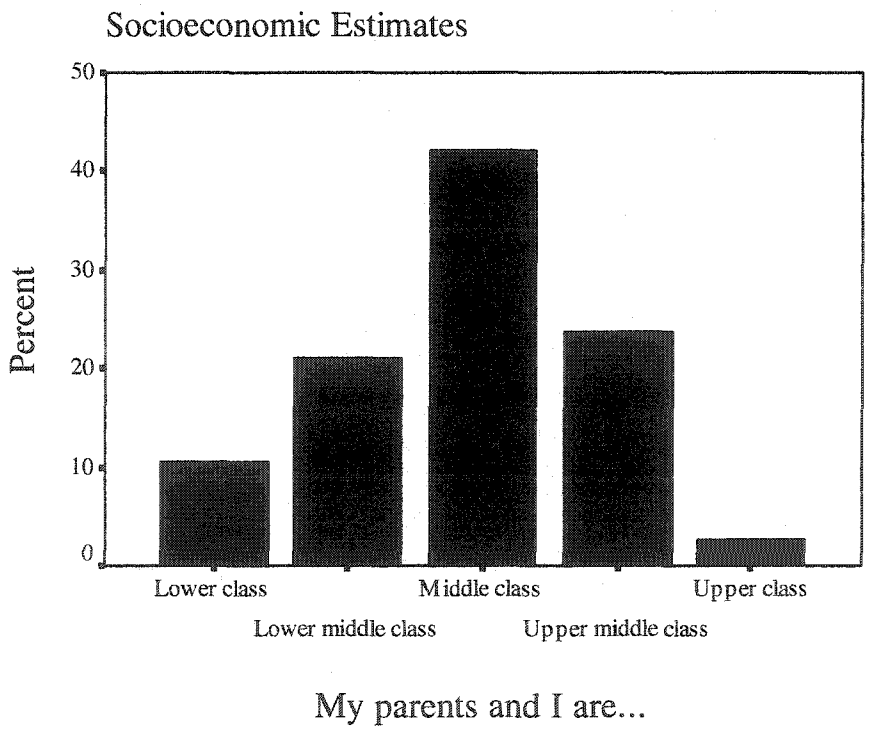
Table 7. Adolescents' perspectives of socioeconomic classification

Site	Lower class	Lower middle class	Middle class	Upper middle class	Upper class
Site I	0	1	1	6	0
Site L	4	6	14	3	1
Site M	0	1	1	0	0
Totals	4	8	16	9	1
Total percentages	10.53%	21.05%	42.11%	23.68%	2.63%

Note: Site I: Private School, Site L: Leadership Group, Site M: Youth Group.

The graph below demonstrates the percentage of adolescents who endorsed each socioeconomic classification.

Figure 1. Graph of socioeconomic classification estimates



Adolescents who had received counseling

Adolescents were asked if they had received counseling before, but we not asked specific details related to subject matter. Counseling was specified as counseling other than for schedule changes or regular school issues. Questions that followed assessed their experiences during the consent process and how helpful they found the counseling. Table 8 below shows the distribution of adolescents from each site who had received counseling. Of the thirty-eight adolescents who responded to this question, seven or 18.42% had received counseling and thirty-one or 81.58% had not.

Table 8. Respondents' history of past counseling

Site	Yes	No	Totals
I	1	7	8
L	6	22	28
M	0	2	2
Totals	7	31	38
Total percentages	18.42%	81.58%	100%

Note: Site I: Private School, Site L: Leadership Group, Site M: Youth Group.

For those who had received counseling, the survey asked for more information about the format of the counseling such as how old the adolescent was when she/he was in counseling, for how long, how helpful it was, and from whom the counselor obtained permission for the counseling. Two of them had been twelve at the time, two had been fourteen, two had been sixteen, and one was seventeen at the time counseling was received ($x=14.43$, $sd=1.99$).

The length of the counseling relationship ranged from one week to two years. Six adolescents who had received counseling responded to the question asking them to rate the helpfulness of that counseling using a four-point Likert scale ranging from not helpful (1) at all to very helpful (4). The mean response was that counseling was somewhat helpful ($x =$

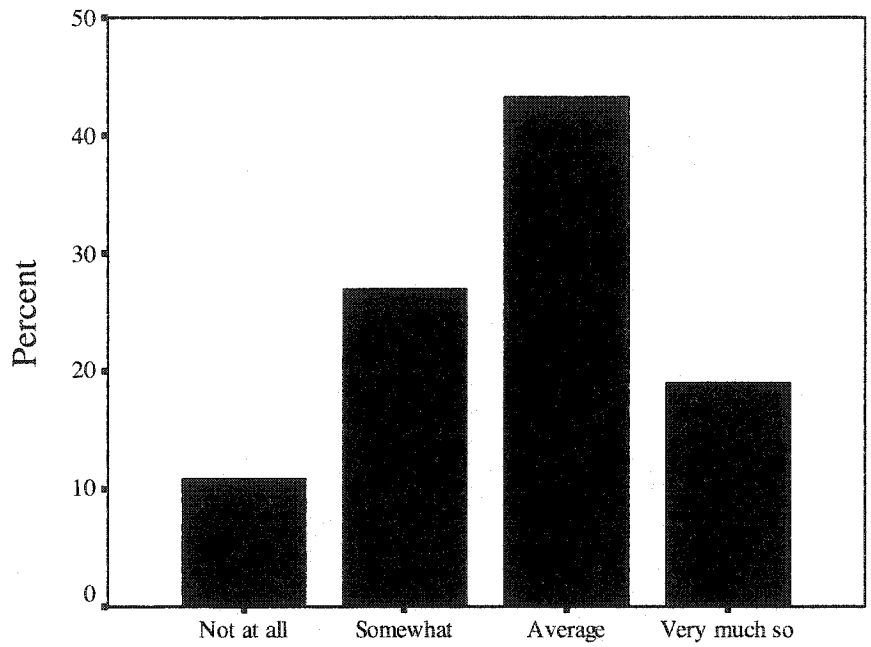
2.67 sd = 1.21 median = 2.50 mode = 2.00). Adolescents were asked to indicate whether their counselor asked them, their parents, or both the adolescent and her/his parents or guardians for permission for counseling. Six of the seven adolescents who had received counseling answered this question. There was 33.33% (n=2) of the respondents who said their counselor asked only them for permission. There were three, or 50% who indicated the counselor asked only their parents or guardians for permission and 16.67% (n=1) reported their counselor asked both them and their parents or guardians for permission for counseling. Thus, on average, the adolescents from this sample who had previously participated in counseling, had counselors who sought permission for counseling from parents and gained assent from adolescents. This is consistent with the current ethical/legal practices engaged in by counselors as indicated from previous studies (Brunscheen, 2001).

Identification with vignette

Responses regarding vignette, relevancy was be assessed by two questions following the brief story of "Casey" and Casey's struggles with the symptoms of ADHD. It was hypothesized that the age ambiguity, the lack of emphasis on gender, and the use of a prevalent mental health concern that participants would be able to project their own age, gender, grade level, and understanding of people with ADHD onto the vignette and thus relate better to the story of Casey, imagine themselves in that situation, and thus be more interested by the vignette. Participants were provided a Likert scale to rate how well they felt they understood how Casey felt. The Likert scale ranged from "not at all (1)" to "very much so (4)." The mean rating of similarity for thirty-seven valid responses (one participant did not respond to this question) was 2.70 with a median and mode of 3.00 (sd= .9087), indicating that the adolescent participants felt an "average" level of understanding how Casey

felt from this brief vignette. Below is a graph showing the percentage of respondents for each level of identification with the vignette.

Figure 2. Graph 2. Ratings of understanding Casey's feelings



Participants were asked another relevancy question: Do you know anyone your age that has had a problem similar to Casey's? Participants were asked to circle "yes" or "no" to this question. Of the valid thirty-seven responses (again, one adolescent did not respond to this question), twenty-nine or 76.3% of the participants knew someone with ADHD problems similar to Casey's. There were eight or 21.1% of the adolescents who did not know anyone with problems similar to Casey's.

These results are commiserate with the research regarding ADHD, it is a salient struggle for many adolescents and that even adolescents not experiencing these problems probably know someone who does have ADHD. From the ratings indicating an average understanding

of Casey's feelings and the high percentage of adolescents who knew someone with ADHD, it is believed that this vignette was effective in its attempt to elicit interest and feelings of personal relevance for the adolescents in this study and thus set the stage for a discussion of the adolescents' counseling attitudes.

What information do you think the counselor should give **you?**

Adolescents were provided a list of specific information (elements included in informed consent statements and discussions) that a counselor might give to an adolescent. The questions was phrased to provide continuity from the vignette and asked the adolescents: "If you were Casey, how important do you think it would be for the counselor to give you the following types of information as part of getting permission for counseling?" (See questionnaire in Appendix A.)

The participants were given a Likert scale to rate the importance of each element of informed consent. The Likert scale was as follows: 1 = Not important, 2 = Slightly important, 3 = Important, 4 = Very important. The elements of informed consent that were included were having the counselor explain: the time, place, and length of sessions; the general way the sessions will go and what will take place; limits to who knows what is talked about; the goals of counseling; the cost of counseling; the training and education of the counselor; possible good and bad things about counseling; and other things the person can do to get help besides counseling. Participants were also given space to write in and rate other elements they might want the counselor to explain to an adolescent seeking counseling.

Participants were asked to consider how important they thought it would be for an adolescent seeking counseling to receive information about details such as the time and place where counseling will take place and the length of sessions. All thirty-eight adolescent

participants responded to this question. The mean level of importance was 3.55 with a median and mode of 4.00 (sd= 0.69). There were 34 out of 38, or 89.47%, of the adolescents who thought knowing this information would be important or very important. This indicates that adolescents in the sample, ages 13-18 years old, found these details about counseling to be very salient for them. The responses by age are outlined in Table 9 below.

Table 9. Frequency of ratings for time, place, length of sessions distributed by age.

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of total
Not important	0	0	0	0	0	0	0	0.00%
Slightly important	0	0	0	3	1	0	4	10.53%
Important	0	1	1	3	3	1	9	23.68%
Very important	2	3	2	7	5	6	25	65.79%
Totals	2	4	3	13	9	7	38	100.00%

Participants were then asked to contemplate how important they thought it would be for an adolescent seeking counseling to receive information about the general process and procedures for counseling sessions and what might occur during session. All thirty-eight adolescent participants responded to this question. The mean level of importance was again 3.55 with a median and mode of 4.00 (sd= 0.76). There were also 34 out of 38, or 89.47%, of the adolescents who thought knowing this information would be important or very important.

Adolescents in the sample indicated a desire to have general information regarding the format of counseling relayed to them. The responses by age are outlined in the table below.

Table 10. Frequency of ratings for session format distributed by age.

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total
Not important	0	1	0	0	0	0	1	2.63 %
Slightly important	0	0	0	2	1	0	3	7.89%
Important	0	1	0	3	1	3	8	21.05%
Very important	2	2	3	8	7	4	26	68.42%
Totals	2	4	3	13	9	7	38	100.00%

Participants were then asked to contemplate how important they thought it would be for an adolescent seeking counseling to receive information about the limits of confidentiality in counseling. (Such limitations include situations in which the counselor may be legally and ethically obligated to release counseling information such as situations in which there is a clear and present danger that someone's life is at risk, cases of apparent abuse of a child or a dependent adult, or other situations required by state or federal law, such as subpoenas and court orders.) Again, all thirty-eight adolescent participants responded to this question. The mean level of importance was 3.58 with a median and mode of 4.00 (sd= 0.76).

There were 36 out of 38, or 94.74%, of the respondents who considered receiving this information to be important or very important. This implies that adolescents in this sample found restrictions to confidentiality in counseling to be a very substantial issue for discussion. The responses by age are outlined in Table 11 below.

Table 11. Frequency of ratings for limits of confidentiality distributed by age.

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Total percentages
Not important	0	1	0	1	0	0	2	5.26%
Slightly important	0	0	0	0	0	0	0	0.00%
Important	0	2	0	4	1	3	10	26.32%
Very important	2	1	3	8	8	4	26	68.42%
Totals	2	4	3	13	9	7	38	100.00%

In addition, participants were then asked to reflect on how important they thought it would be for an adolescent seeking counseling to have the counselor provide them with information concerning the goals that might be set in counseling. Each of the thirty-eight participants responded. The mean rating of importance was 3.18 with a median of 3.00 and mode of 4.00 (sd= 0.87). There were 31 out of 38, or 81.58%, of the respondents who deemed receiving this information to be important or very important. However, compared to the previously discussed elements of informed consent, there was slightly more variation in the responses to this question.

You can see the distribution of responses separated by age in the table below. The column on the left listing the totals for each rating of importance (not important, slightly important, important, and very important) delineates the slightly more variant distribution of ratings. This still signifies that adolescents in this sample found the goals of counseling to be an issue for discussion.

Table 12. Frequency of ratings for goals of counseling distributed by age.

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Total percentages
Not important	0	1	0	1	0	0	2	5.26%
Slightly important	0	0	0	1	1	3	5	13.16%
Important	0	1	1	5	6	2	15	39.47%
Very important	2	2	2	6	2	2	16	42.11%
Totals	2	4	3	13	9	7	38	100.00%

The next element of informed consent participants were asked to rate was the issue of having the cost of counseling discussed with them if they were seeking counseling as an adolescent. All thirty-eight participants responded. The mean rating of importance was 3.26 with a median and mode of 4.00 (sd= 1.06). There were 29 out of 38, or 76.32%, of the respondents who judged receiving information about the cost of counseling to be important or very important.

Again, compared to several of the previously discussed elements of informed consent, there was more variation in the responses to this question (sd=1.06). The distribution of responses organized by age is listed in the table below. The column on the left listing the totals for each rating of importance (not important, slightly important, important, and very important) delineates the slightly more variant distribution of ratings. This still signifies that, overall, adolescents in this sample found the goals of counseling to be an issue for discussion, but there appeared to be more variety in how relevant adolescents found cost of counseling to be for them. Older adolescents (16 years to 18 years) appeared to find this issue to be more salient and more important to them than younger adolescents (13 years to 15 years). \

Table 13. Frequency of ratings for costs of counseling distributed by age.

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Total percentages
Not important	1	0	0	2	0	1	4	10.52%
Slightly important	0	1	0	2	1	1	5	13.16%
Important	1	0	0	1	3	1	6	15.79%
Very important	0	3	3	8	5	4	23	60.53%
Totals	2	4	3	13	9	7	38	100.00%

This would consistent with research and experience indicating that as adolescents get older and take on more responsibilities, they consider the costs of items or services more relevant. However, a one-way ANOVA conducted to test the differences in the means between younger and older adolescents in this sample was not significant. Due to the small sample size and the unequal variances across groups, the Welch adjustment to F is reported here ($F(1, 12.78) = 0.05$, $p = 0.83$). This lack of statistical significance may be due to the low sample size.

After this, participants were asked to consider how important they thought it would be for an adolescent seeking counseling to receive details about the counselor's training and education. All thirty-eight adolescent participants responded to this question. The mean level of importance was 3.29 with a median of 3.50 and mode of 4.00 (sd= 0.80). There were 30 out of 38, or 78.95%, of the adolescents who indicated that learning about the counselor's training and education was important or very important to them. This indicates that adolescents in the sample found this information about counseling to be very salient for them. The responses by age are outlined in the table below.

Table 14. Frequency of ratings for counselor training distributed by age.

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Total percentages
Not important	0	0	0	0	0	0	0	0.00%
Slightly important	0	1	0	2	4	1	8	21.05%
Important	1	0	1	2	4	3	11	28.95%
Very important	1	3	2	9	1	3	19	50.00%
Totals	2	4	3	13	9	7	38	100.00%

Another listed element of informed consent asked participants to ponder how important they thought it would be for an adolescent seeking counseling to have the counselor give them information about the positive and negative aspects of receiving counseling. Each of the thirty-eight participants responded. The mean rating of importance was 3.13 with a median of 3.00 and mode of 3.00 (sd= 0.70). There were 31 out of 38, or 81.58%, of the respondents who considered receiving this information to be important or very important. This still signifies that adolescents in this sample found the pros and cons of counseling to be something they found important to know about. The frequencies of responses by each age can be viewed in the table below.

Table 15. Frequency of ratings for positive and negative aspects of counseling by age.

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Total percentages
Not important	0	0	0	0	0	0	0	0.00%
Slightly important	0	0	0	3	2	2	7	18.42%
Important	2	2	2	5	4	4	19	50.00%
Very important	0	2	1	5	3	1	12	31.58%
Totals	2	4	3	13	9	7	38	100.00%

The last listed element of informed consent required participants to contemplate how important they thought it would be for an adolescent seeking counseling to have the counselor review with them the alternative treatments to receiving counseling. All thirty-eight participants responded to this question. The mean rating of importance was 3.11 with a median of 4.00 and mode of 4.00 (sd= 1.11). There were 27 out of 38, or 71.05%, of the respondents who rated receiving this information as important or very important. As demonstrated by the larger standard deviation and the distribution, which can be viewed in the table below, there was slightly more variation in the responses to this question compared to several other elements of informed consent.

Adolescents in this sample demonstrated differing attitudes about the importance of receiving this type of information from their counselor if they were seeking counseling. Unlike other aspects of informed consent that have been discussed, this element had several participants who responded that this information was not important for them to know.

Table 16. Frequency of ratings for alternatives to counseling distributed by age.

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Total percentages
Not important	0	1	0	2	0	2	5	13.16%
Slightly important	1	1	0	2	2	0	6	15.79%
Important	0	0	1	1	4	1	7	18.42%
Very important	1	2	2	8	3	4	20	52.63%
Totals	2	4	3	13	9	7	38	100.00%

Participants were also given space to write in and rate other elements they might want the counselor to explain to an adolescent seeking counseling. There were ten valid responses with a mean importance rating of 3.50 (between important and very important). Respondents

indicated a variety of responses, from asking for more specific information on how the counselor plans to help them, what the long term results might be, the success rates, what the adolescent could do to help him/herself to more general desires such as making a connection using topics the adolescent is interested in, anything that is important, and feeling like the counselor really wants to help them.

For a quick examination of how important adolescents in this sample considered each element of informed consent, the various elements of informed consent have been listed in Table 17 according to the rank order of the mean importance ratings.

Table 17. Rank order of importance for elements of informed consent for adolescents to know about

	Mean	Standard Deviation
Limits to who knows what is talked about	3.58	0.76
The general way the sessions will go and what will take place	3.55	0.76
Time, place, and length of sessions	3.55	0.69
Training and education of the counselor	3.29	0.80
Cost of counseling	3.26	1.06
The goals of counseling	3.18	0.87
Possible good and bad things about counseling	3.13	0.70
Other things the person can do besides counseling	3.11	1.11

In order to ascertain differences in the mean importance ratings for the listed elements of informed consent a repeated measures analysis of variance (ANOVA) was conducted. The null hypothesis was that there was no difference in the means for each of the eight listed elements of informed consent. The validity of the F statistic used in this univariate approach can be assured if the variance-covariance matrix is circular in form. To test this for this

assumption, Mauchly's Test of Sphericity was used. Mauchly's Test of Sphericity performs a test of sphericity on the variance-covariance matrix of an orthonormalized transformed dependent variable. In this study, with its small sample size, this test may not be very powerful. If the significance of the test is large, the hypothesis of sphericity can be assumed. However, if the significance is small and the sphericity assumption appears to be violated, an adjustment to the numerator and denominator degrees of freedom can be made in order to validate the univariate F statistic. Mauchly's Test of Sphericity indicated that sphericity cannot be assumed in this analysis ($W(1, 27) = 0.179$, $p = 0.00$, where $p < 0.05$ indicates the null hypothesis is rejected). Thus, an adjusted value, epsilon, was used to multiply to numerator and denominator degrees of freedom in the F test and the significance of the test was evaluated with the new degrees of freedom. In accordance with the small sample size, the Greenhouse-Geisser epsilon was used. The results indicated that there were significant differences between the mean importance ratings for the eight elements of informed consent ($F(1, 4.76) = 2.80$; $p = 0.02$; $\acute{\eta}^2 = 0.07$). In addition, pairwise comparisons were made to examine which of the eight elements demonstrated statistically significantly different mean importance ratings.

Bonferroni adjustments were made because it the procedure uses t-tests to perform pairwise comparisons between group means, and the adjustment controls overall error rate by setting the error rate for each test to the experiment-wise error rate divided by the total number of tests. Therefore, the observed significance level is adjusted for the fact that multiple comparisons are being made. Pairwise comparisons showed that the difference in mean importance ratings between general session information and goals for counseling was statistically significantly different, with general session information being considered more

important (p=0.05; CI=-5.33 to 0.74). The difference in mean importance ratings between limits to confidentiality and goals for counseling was also statistically significantly different (p<.05; CI=0.003 to 0.75) with adolescents indicating that knowing the limits to confidentiality were slightly more important than the goals for counseling.

Repeated measures ANOVA's were also conducted to test for differences between younger and older adolescents and for differences between adolescents who had received counseling and those who had not. The null hypothesis for the repeated measures ANOVA assessing differences between younger and older adolescents was that there was no difference in the means between the two groups. Mauchly's Test of Sphericity indicated that sphericity cannot be assumed in this analysis (W (1, 27) =0.17, p=0.00, where p<0.05 indicates the null hypothesis is rejected). Again, in accordance with the small sample size, the Greenhouse-Geisser epsilon was used to be conservative. The results indicated that there were not significant differences between the mean importance ratings for the eight elements of informed consent for younger versus older adolescents (F (1, 4.22) =0.47; p=0.79; $\acute{\eta}^2$=0.01).

The repeated measures ANOVA results for differences between mean importance ratings for informed consent elements for adolescents who have received counseling and those who have not received counseling demonstrated that sphericity cannot be assumed (W (1, 27) =0.17, p=0.00) and that there were also not significant differences in the mean importance ratings for adolescents who had received previous counseling and those who had not (F (1, 4.74) =0.69, p=0.63, $\acute{\eta}^2$=0.02).

Regarding Parents receiving this information

Participants were provided the same elements of informed consent as before (having the counselor explain: the time, place, and length of sessions; the general way the sessions will go and what will take place; limits to who knows what is talked about; the goals of counseling; the cost of counseling; the training and education of the counselor; possible good and bad things about counseling; and other things the person can do to get help besides counseling) and were then asked: "If you were Casey, how important do you think it would be for the counselor to give your parents/guardians the following types of information as part of getting permission for counseling?" Again, the same Likert scale was used (1 = Not important, 2 = Slightly important, 3 = Important, 4 = Very important). Participants were also given space to write in and rate other elements they might want the counselor to explain to a parent when an adolescent is seeking counseling.

Again, the first question asked participants to consider how important they thought it would be for an adolescent's parent to receive information about details such as the time and place where their adolescent's counseling will take place and the length of sessions. Each of the thirty-eight adolescent participants responded. The mean level of importance was 3.58 with a median and mode of 4.00 (sd= 0.83). There were 34 out of 38, or 89.47%, of the adolescents who thought knowing this information would be important or very important.

This indicates that adolescents in the sample, ages 13-18 years old, deemed these details about counseling to be very salient for their parents to know. The responses by age are outlined in the table below.

Table 18. Frequency of ratings for time, place, length of sessions distributed by age.

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Not important	0	1	0	1	0	0	2	5.26%
Slightly important	0	0	0	1	1	0	2	5.26%
Important	0	0	2	2	1	1	6	15.79%
Very important	2	3	1	9	7	6	28	73.69%
Totals	2	4	3	13	9	7	38	100.00%

Participants were then asked to think about how important they thought it would be for an adolescent's parents to receive information about the general rocedures for counseling sessions and what might occur during session. All thirty-eight adolescent participants responded to this question. The mean level of importance was 3.55 (median and mode of 4.00 (sd= 0.69). There were 36 out of 38, or 94.74%, of the adolescents who considered having their parents know this information to be important or very important.

Adolescents in the sample indicated a desire to have general information regarding the format of counseling relayed to their parents even if the adolescent was the client. The responses by age are outlined in the table below.

Table 19. Frequency of ratings for session format distributed by age.

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Not important	0	0	0	1	0	0	1	2.63%
Slightly important	0	1	0	0	0	0	1	2.63%
Important	0	1	1	4	3	3	12	31.58%
Very important	2	2	2	8	6	4	24	63.16%
Totals	2	4	3	13	9	7	38	100.00%

The next question asked participants to contemplate how important they believe it to be for an adolescent's parents to receive information about the limits of confidentiality in counseling when the adolescent is the one seeking counseling. (As mentioned above, such limitations include situations in which the counselor may be legally and ethically obligated to release counseling information such as situations in which there is a clear and present danger that someone's life is at risk, cases of apparent abuse of a child or a dependent adult, or other situations required by state or federal law, such as subpoenas and court orders.) Again, all thirty-eight adolescent participants responded to this question. The mean level of importance was 3.61 with a median and mode of 4.00 (sd= 0.72).

There were 35 out of 38, or 92.11%, of the respondents who highly valued having the counselor relate this information to their parents if they were going to be seeking counseling. The responses by age are outlined in the table below.

Table 20. Frequency of ratings for limits of confidentiality distributed by age.

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Not important	0	0	0	1	0	0	1	2.63%
Slightly important	0	0	0	1	1	0	2	5.26 %
Important	0	2	1	0	4	1	8	21.05%
Very important	2	2	2	11	4	6	27	71.06%
Totals	2	4	3	13	9	7	38	100%

Participants were next asked to reflect on how important they felt it would be for the counselor to provide their parents with information concerning the goals that might be set in counseling if they, as an adolescent, were seeking counseling. All thirty-eight participants

responded. The mean rating of importance was 3.47 with a median and mode of 4.00 (sd= 0.69).

There were 34 out of 38, or 89.47%, of the respondents who deemed having their parents receive this information to be important or very important. You can see the distribution of responses separated by age in Table 21.

Table 21. Frequency of ratings for goals of counseling distributed by age.

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Not important	0	0	0	0	0	0	0	0.00%
Slightly important	0	1	0	1	2	0	4	10.53%
Important	1	1	0	3	2	5	12	31.58%
Very important	1	2	3	9	5	2	22	57.89%
Totals	2	4	3	13	9	7	38	100%

The next element of informed consent participants were asked to rate was the issue of having the cost of counseling discussed with their parents or guardians if the adolescent was the party seeking counseling. Again, all thirty-eight participants responded. The mean rating of importance was 3.53 with a median and mode of 4.00 (sd=0.92).

There were 33 out of 38, or 86.84%, of the respondents who judged receiving information about the cost of counseling to be important or very important. The distribution of responses regarding the cost of counseling and having it discussed with parents organized by age is listed in Table 22.

Table 22. Frequency of ratings for costs of counseling distributed by age.

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Not important	1	1	0	1	0	0	2	5.26%
Slightly important	0	0	0	1	1	0	2	5.26%
Important	1	1	0	2	1	0	9	23.68%
Very important	0	2	3	9	7	7	25	65.80%
Totals	2	4	3	13	9	7	38	100%

Following this, participants were also asked to consider how important they thought it would be for an adolescent seeking counseling to have his/her parents receive details about the counselor's training and education from the counselor. All thirty-eight adolescent participants responded. The mean rating of importance was 3.50 with a median and mode of 4.00 (sd= 0.83). There were 89.47%, or 34 out of 38 of the respondents who concluded that having their parents learn about the counselor's training and education was important or very important to them. This indicates that adolescents in the sample found this information about counseling to be important, but perhaps not quite as salient as other elements of informed consent. The responses by age are outlined in the table below.

Table 23. Frequency of ratings for counselor training distributed by age.

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Not important	0	1	0	1	0	0	2	5.26%
Slightly important	0	1	0	0	1	0	2	5.26%
Important	1	0	1	2	4	1	9	23.68%
Very important	1	2	2	10	4	6	25	65.80%
Totals	2	4	3	13	9	7	38	100%

The second to last listed element of informed consent asked the adolescents in the sample to ponder how important they thought it would be for their counselor to talk to their parents or guardians about the positive and negative aspects of receiving counseling if the adolescent was the person receiving said counseling. Each of the thirty-eight participants responded. The mean rating of importance was 3.39 with a median and mode of 4.00 (sd= 0.86). This mean rating was slightly lower than the other elements of informed consent with a slightly higher standard deviation, but as demonstrated by the median and the mode responses adolescents still rated having their parents receive this information as very important.

There was 86.84%, or 33 out of 38 of the respondents who considered receiving information about the pros and cons of counseling to be important or very important. The frequencies of responses by each age can be viewed in the table below.

Table 24. Frequency of ratings for positives and negative aspects of counseling distributed by age.

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Not important	0	1	0	1	0	0	2	5.26%
Slightly important	0	1	0	1	1	0	3	7.89%
Important	1	1	1	3	3	2	11	8.95%
Very important	1	1	2	8	5	5	22	7.90%
Totals	2	4	3	13	9	7	38	100%

The last of the listed elements of informed consent required participants to contemplate how important they thought it would be for an adolescent seeking counseling to have the counselor review with his/her parents the alternative treatments to receiving

counseling. All thirty-eight participants responded to this question. The mean rating of importance was 3.37 with a median of 4.00 and mode of 4.00 (sd= 0.85). There were 31 out of 38, or 81.58 %, of the respondents who rated receiving this information as important or very important.

As demonstrated by the slightly lower mean compared to several other elements of informed consent, adolescents found this element to be a lesser importance to relate to their parents than elements such as limits to confidentiality.

Table 25. Frequency of ratings for alternatives to counseling distributed by age.

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Not important	0	1	0	0	0	0	1	2.63%
Slightly important	1	1	0	4	0	0	6	15.79%
Important	1	0	1	2	4	1	9	23.68%
Very important	0	2	2	7	5	6	22	57.90%
Totals	2	4	3	13	9	7	38	100%

As in the earlier section about elements of informed consent to be discussed with the adolescent, participants were also given space to write in and rate other elements they might want the counselor to explain to their parents or guardians if the adolescent was the party seeking counseling. There were five valid responses with all rated with a 4.00 (very important). Respondents indicated a variety of responses, from asking for more specific information on how the counselor plans to help them and how this will benefit the adolescent, success rates, to asking for more specific information about how the parents should be involved with their adolescent's counseling, as well talking about ways the counselor might make a better connection using topics the adolescent is interested in.

For ease of comparison, Table 26 shows the elements of informed consent to be provided to parents or guardians rank ordered by mean level of importance as rated by the adolescents in this sample. As before, when adolescents were rating the elements as to how important they considered it to be for the element to be provided to them, adolescents also rated having limits of confidentiality as the most important element to be explained to parents. .

Table 26. Rank order of the mean ratings of importance for elements of informed consent for parents to know about

	Mean	Standard Deviation
Limits to who knows what is talked about (confidentiality)	3.61	0.72
Time, place, and length of sessions	3.58	0.83
The general way the sessions will go and what will take place	3.55	0.69
Cost of counseling	3.53	0.92
Training and education of the counselor	3.50	0.83
The goals of counseling	3.47	0.69
Possible good and bad things about counseling	3.39	0.86
Other things the person can do besides counseling	3.37	0.85

Repeated measures ANOVA's were performed to test for a difference between the mean importance ratings of the various elements of informed consent when adolescents rated how important they thought each element would be to have provided to their parents or guardians, as well as for differences in the ratings for younger versus older adolescents, and adolescents who had received previous counseling and those who had not. For the first repeated measures ANOVA testing the difference in the mean ratings of importance of

informed consent elements to be provided to parents, Mauchly's Test of Sphericity indicated that sphericity could not be assumed in this analysis ($W(1, 27) = 0.22$, $p = 0.00$, where $p < 0.05$ indicates the null hypothesis is rejected). Again, in accordance with these results and the small sample size, the Greenhouse-Geisser epsilon was used with the F statistic to be conservative. The results indicated that there were not significant differences between the mean importance ratings for the eight elements of informed consent to be provided to adolescents versus parents ($F(1, 4.66) = 0.86$; $p = 0.50$; $\acute{\eta}^2 = 0.02$).

Repeated measures ANOVA's were also conducted to test for differences between younger and older adolescents and for differences between adolescents who had received counseling and those who had not. The null hypothesis for the repeated measures ANOVA assessing differences between younger and older adolescents and the importance ratings of the informed consent elements for parents was that there was no difference in the means between the two groups. Mauchly's Test of Sphericity indicated that sphericity could not be assumed in this analysis ($W(1, 27) = 0.23$, $p = 0.01$, where $p < 0.05$ indicates the null hypothesis is rejected). The results indicated that there were not significant differences between the mean importance ratings for the eight elements of informed consent to be provided to parents according to younger versus older adolescents ($F(1,4.77) = 1.478$; $p = 0.20$; $\acute{\eta}^2 = 0.04$).

The repeated measures ANOVA results for differences between mean importance ratings for informed consent elements to be provided to parents for adolescents who have received counseling and those who have not received counseling demonstrated that sphericity could not be assumed ($W(1, 27) = 0.21$, $p = 0.00$) and that there were not significant

differences in the mean importance ratings for adolescents who had received previous counseling and those who had not ($F(1,4.57)=0.80$, $p=0.54$, $\acute{\eta}^2=0.02$).

To summarize this section and for ease of comparison, the elements of informed consent are listed below with their relative ratings of importance for adolescents and then for parents as well.

Table 27. Rank order of the mean ratings of importance for elements of informed consent for adolescents to know about compared to the rank of importance for elements of informed consent for parents to know about.

Ratings of importance for adolescents	Mean	Standard Deviation	Ratings of importance for parents	Mean	Standard Deviation
Limits to who knows what is talked about	3.58	0.76	Limits to who knows what is talked about	3.61	0.72
The general way the sessions will go and what will take place	3.55	0.76	Time, place, and length of sessions	3.58	0.83
Time, place, and length of sessions	3.55	0.69	The general way the sessions will go and what will take place	3.55	0.69
Training and education of the counselor	3.29	0.80	Cost of counseling	3.53	0.92
Cost of counseling	3.26	1.06	Training and education of the counselor	3.50	0.83
The goals of counseling	3.18	0.87	The goals of counseling	3.47	0.69
Possible good and bad things about counseling	3.13	0.70	Possible good and bad things about counseling	3.39	0.86
Other things the person can do besides counseling	3.11	1.11	Other things the person can do besides counseling	3.37	0.85

Attitude about parental consent and knowledge of participation in counseling

Participants were asked the following question: Do you think you should be able to go to counseling without your parents' knowledge or permission? They were then asked to circle yes or no in response. Thirty-seven of the respondents answered this question. (One

fourteen year old left this item blank.) As shown in the table below, the split between the beliefs that an adolescent should be able to go to counseling with their parents' knowledge of permission is fairly even until the age of seventeen. Then adolescents in this sample more frequently endorsed, "yes, adolescents should be able to go to counseling without their parents' knowledge or permission."

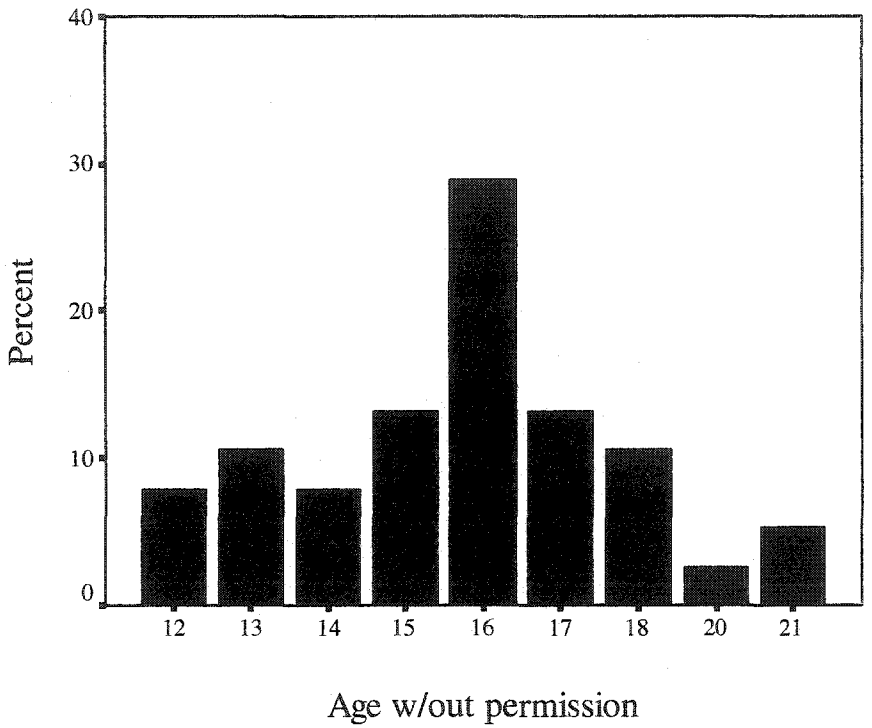
Table 28. Seeking counseling without parental consent delineated by age

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Total	Percent of Total Responses
Yes	1	2	3	7	7	6	26	68.42%
No	1	1	0	6	2	1	11	31.58%
Totals	2	3	3	13	9	7	37	100%

As a follow-up question to this, adolescents in the sample were also asked at what age they thought they should be able to attend counseling without their parents' permission or knowledge. Participants were asked to circle the age they thought would be appropriate from a given list that started at age 12, increased by one year at a time, and ended with the option of "older than 21." There were thirty-seven adolescents who responded to this question. The mean age for this question was 15.84 (sd= 2.25) with a mean and mode of 16 years of age, indicating that adolescents in this sample thought that, on average, counselors should ask adolescents for permission to attend counseling around the age of 16 years old with a range of a little over two years either way, or 14-18 years old. The age receiving the highest number of endorsements was 16 years of age. There were 11 of the 38 adolescents who endorsed this answer.

The graph below shows the percent of adolescents from the sample who responded to each age level.

Figure 3. Graph 3: Age should be able to attend counseling without parental consent



Also, below is a table showing the frequency of responses arranged by the age of the respondent. As visible in the chart, despite the current legal statues requiring parental consent until the age of eighteen, there were 81.58% of the adolescents in this sample who thought that adolescents under the age of eighteen should be able to receive counseling without gaining permission from their parents.

Interestingly, there were three adolescents in this sample of adolescents (n=3 or 7.89%) who indicated a belief that people should be over eighteen or perhaps even over twenty-one years of age to receive counseling without first gaining parental consent.

Table 29. Age to receive counseling without permission by age of respondent

Age for permission	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Total Responses	Percent of Total Responses
12	0	0	2	0	0	1	3	7.89%
13	0	0	0	2	1	1	4	10.53%
14	0	2	0	1	0	0	3	7.89%
15	0	0	0	2	1	2	5	13.16%
16	1	0	0	5	4	1	11	28.95%
17	0	1	0	1	1	2	5	13.16%
18	1	0	1	0	2	0	4	10.53%
20	0	0	0	1	0	0	1	2.63%
≥21	0	1	0	1	0	0	2	5.26 %
Total	2	4	3	13	9	7	38	100.00%

A one-way analysis of variance (ANOVA) was performed to examine differences in the mean ages for younger adolescents (13-15 years old) versus older adolescents (16-18). The results ($F(1, 37) = .051$; $p = .822$) indicated that there was not a statistically significant difference between the age at which younger adolescents in this sample thought that adolescents should be able to receive counseling without parental consent or knowledge versus the mean age at which older adolescents in the sample indicated adolescents should not have to receive parental consent for or have knowledge of the adolescent's counseling.

Likelihood of going to a counselor if parents MUST be informed

Adolescents in this study were asked: If you had a problem, how likely are you to go to a counselor if you must have your parents' permission? They were presented with the following options: Not at all likely (1), Maybe I would go (2), Probably would go (3), or I would go (4), and were asked to circle their answer (the numbers in parentheses indicated the coded value corresponding to the answer). All thirty-eight adolescents in the sample responded to this question. There were thirteen adolescents, or 34.21%, in this sample who

said that it was not at all likely that they would see a counselor if they had to have their parents' permission.

There were fifteen adolescents, or 39.47%, in the sample that said they might see the counselor even if their parents had to give permission. Of the remaining ten adolescents, eight said they probably would still go to the counselor (21.05%) and two said they would still go get counseling even if they had to have parental consent first (5.26%).

The mean response was 1.97 (sd=.88) with a median and mode of 2.00 indicating the average response of adolescents in this sample was that they only "maybe" would seek counseling if they had to have parental consent to attend counseling.

Table 30 outlines the frequency of responses organized by the age of the respondent.

Table 30. Likelihood of seeing a counselor if parents must give consent delineated by adolescent age

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Total	Percent of Total Reponses
Not at all likely	1	2	1	4	3	2	13	34.22%
Maybe	0	1	1	4	5	4	15	39.47%
Probably	1	0	1	4	1	1	8	21.05%
I would do it	0	1	0	1	0	0	2	5.26%
Totals	2	4	3	13	9	7	38	100%

To examine the relationship between age and autonomy related to seeking counseling, a one-way analysis of variance (ANOVA) was conducted. The ANOVA examined the differences between younger and older adolescents in this sample regarding their likelihood of attending counseling if their parents were required to give consent for them to attend counseling. The ANOVA results, $F(1, 37) = 0.01$; $p = 0.92$, indicated that there was no

statistically significant difference between the likelihood of attending counseling without parental consent or knowledge for younger versus older adolescents in this sample. Both younger and older adolescents were uncertain ("maybe, I would attend") as to whether they would attend counseling if their parents must provide consent for them and thus have knowledge that the adolescent is seeking counseling.

Likelihood of going to a counselor if parents did NOT have to be informed

A related question on the survey asked participants: If you had a problem, how likely are you to go see a counselor if you do not have to get your parents' permission? They were then asked to circle their answer from the following options: Not at all likely (1), Maybe I would go (2), Probably would go (3), or I would go (4) (the numbers in the parentheses correspond to coding for each response).

Again, there were thirty-seven responses to this question with one fourteen year old leaving the item blank. The mean response for this item was 2.51 (between "maybe" and "probably") with a median and mode of 3.00 ("probably") (sd=1.07). The distribution of responses by age of the adolescent can be viewed in the table below.

Table 31. Likelihood of attending counseling without parental consent delineated by age of the adolescents

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Total	Percent of Total Reponses
Not at all likely	1	1	2	3	0	1	8	21.62 %
Maybe	0	1	0	5	2	2	10	27.03%
Probably	1	0	0	2	5	3	11	29.73%
I would do it	0	1	1	3	2	1	8	11.62%
Totals	2	3	3	13	9	7	37	100%

This response is slightly higher than the previous question, indicating that adolescents in this sample are somewhat more likely to attend counseling if their parents would not have to provide consent for them to do so. In order to further examine the relationship between age and likelihood of attending counseling if parental consent was not necessary a one-way ANOVA was performed. The results $F(1, 36) = 1.36$; $p = 0.25$ demonstrated no statistically significant differences in the likelihood of seeking counseling when no parental consent is necessary existed between the younger and older adolescents in this sample.

Who should give permission for counseling?

Adolescents were presented with the following question: Pretend that you are Casey and have chosen to get counseling. When you start counseling, the counselor talks with you about who gets to know what you and the counselor talk about. The counselor also talks about the good and bad things that might happen from counseling. They ask you if you understand and freely agree to come to counseling. From whom do you think the counselor should ask permission when you start counseling? They were then asked to circle their answer from the following options: Parent/Guardians, Adolescent, and Both the Parent/Guardian and Adolescent.

All thirty-eight adolescents in the sample responded to this question. There were three adolescents (7.89 %) that said the counselor should get permission from the parents or guardians. There were eleven adolescents (28.95%) who indicated the counselor should seek permission from the adolescent. The majority of the adolescents, 24 of the 38 adolescents (63.16%), thought the counselor should seek permission from both the parent/guardian and the adolescent.

A follow-up question was then asked that served to somewhat educate the participants about the consent process they would likely experience if they sought counseling and also to ask how active the adolescents would want to be in regards to providing assent if the they knew before starting counseling that the counselor would ask parental consent. The question was as follows: If you were start counseling, for most types of counseling the counselor must ask your parents/guardians for permission to work with you. If the counselor gets permission from your parent/guardian, do you think the counselor should also get permission from you? Participants were then asked to circle yes or no.

Only one of the adolescents in the sample replied in the negative. The other thirty-seven adolescents indicated that yes, they would want the counselor to get permission (seek assent) from them for counseling, even if the counselor gets permission (consent) from their parents or guardians. Thus adolescents in this sample expressed a strong desire to be included in the consent procedure for counseling even if the ultimate decision resided with their parents.

Age for assent/consent

In addition to asking adolescents whether they thought they should be able to provide consent or at minimum, assent, the survey also questioned the adolescents about the ages at which they thought adolescents should be able to provide assent and consent when the adolescent is seeking counseling. The question was presented as follows: How old do you think you should be before a counselor should ask your opinion about coming to counseling? Adolescents were then asked to circle the age they thought would be appropriate from a listing of ages beginning at 12 years old and ending with "older than 21."

The mean age at which adolescents in this sample thought counselors should begin asking adolescent clients their opinion about attending counseling was 14.45 years of age (sd=1.87) with a median and mode of 14 years. The table below outlines the ages the adolescents in this sample endorsed separated by the age of the respondent.

Table 32. Age counselor should ask for assent delineated by respondents' ages

Age to ask opinion	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Total Responses	Percent of Total Responses
12	1	1	0	2	1	2	7	18.42%
13	0	0	1	2	3	0	6	15.79%
14	0	2	0	3	1	2	8	21.05%
15	0	1	0	3	1	1	6	15.79%
16	1	0	1	1	1	2	6	15.79%
17	0	0	0	0	1	0	1	2.63%
18	0	0	1	2	1	0	4	10.53%
20	0	0	0	0	0	0	0	0.00%
≥21	0	0	0	0	0	0	0	0.00%
Total	2	4	3	13	9	7	38	100%

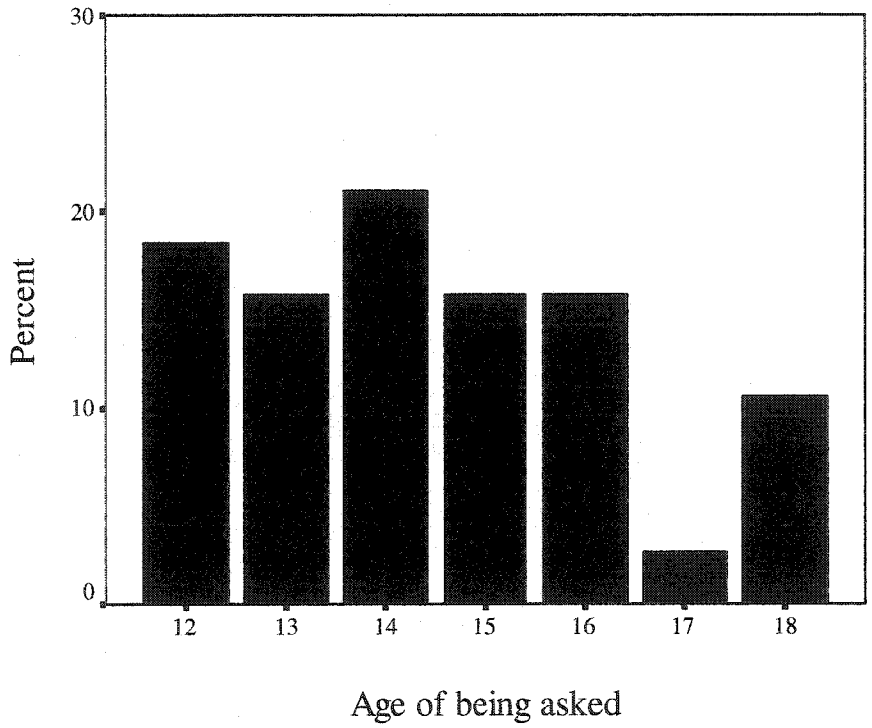
As summarized in the "total response" column on the left of the table, and as can be seen in the graph below (showing the overall percentages of responses for each age), the majority (74.13%) of the adolescents in this sample indicated that adolescents under the age of 18 should be asked their opinion about being in counseling.

Furthermore, a large percentage, 55.26%, of the adolescents in this sample advocated for adolescents from the ages of 12 to 14 to be able to provide their opinion about counseling in addition to the counselor obtaining parental consent.

To determine if there were any significant differences between younger versus older adolescents in this regard a one-way ANOVA was performed, however, it demonstrated no statistically significant differences in the mean ages for the younger versus the older adolescents in this sample for how old they thought adolescents should be for the counselor

to ask the adolescents' opinion in addition to gaining consent for counseling from parents. (Again, the more conservative Welch statistic and degrees of freedom were used for F (F (1, 12.59) =.00; p=.99).

Figure 4. Graph 4: Age counselors should ask adolescent clients for permission for counseling



Reasons why a counselor would ask for assent

In addition to questioning whether adolescents would want to provide assent and at what age they thought their opinion should be sought by the counselor, the survey also asked adolescents to provide input regarding possible reasons why counselors might seek assent from adolescents in addition to obtaining consent from parents or guardians. Asking this provides more information about the reasoning adolescents are using when making informed consent decisions by asking them to consider reasons why adults, particularly counselors,

would be seeking the adolescents' permission in the consent process. Participants were presented with eight reasons that are commonly provided by clinicians when clinicians are questioned as to why they seek assent from adolescents when parental consent is the legal consent for counseling (Beeman and Scott, 1991; Brunscheen 2001). The reasons listed were as follows:

- To make me want to be in therapy more,
- To help make sure I have the right idea about what to expect,
- To make our relationship better,
- To satisfy legal and ethical rules,
- To select only those adolescents who want to be in therapy,
- To make me feel more independent,
- To lower the number of possible problems if I am a part of a blended family (i.e. if my parents are divorced or separated, or if I live with step-parents, foster-parents, other family members), and
- To recognize the independence of older adolescents.

Along with each reason, a Likert scale from 1-5 (1=Not important, 2=Slightly important, 3=Important, 4=Very important) was presented, asking adolescents to rate how important they considered each of the listed reasons. There was also an opportunity for participants to write in and rate their own ideas about why a counselor might ask them for permission for counseling in addition to getting consent from their parents.

Personal investment

The first reason presented as to why a counselor might ask for an adolescent's permission was related to personal investment in the counseling process. Participants were

asked to consider how important they thought it would be for the counselor to ask the adolescent for assent in order to encourage the adolescent to want to be in therapy more. Each of the thirty-eight adolescent participants responded. The mean level of importance was 2.89 with a median and mode of 3.00 (sd= 0.89). A mean of 2.89 falls between "slightly important" and "important."

There were 27 out of 38, or 71.05%, of the adolescents who deemed this reason as an important or very important reason why counselors should ask adolescents for assent. The responses by age are outlined in the table below.

Table 33. Frequency of ratings for the reason: "to make me want to me in therapy more"

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Not important	0	1	0	1	0	1	3	7.89%
Slightly important	0	1	0	4	2	2	8	21.05%
Important	1	2	2	3	6	2	17	44.74%
Very important	1	0	1	5	1	2	10	26.32%
Totals	2	4	3	13	9	7	38	100.00%

Expectations

The next reason listed was related to expectations for counseling and asked participants to contemplate how important they believe it to be for a counselor to ask an adolescent for assent so the adolescent would know what to expect from counseling.

Again, all thirty-eight adolescent participants responded to this question. The mean importance rating was 3.37 with a median and mode of 4.00 (sd= 0.85). The responses by age are provided in the table below.

Table 34. Frequency of ratings for the reason: "to make sure I have the right idea about what to expect"

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Not important	0	1	0	1	0	0	2	5.26%
Slightly important	0	0	0	0	1	2	3	7.89%
Important	1	0	0	4	5	2	12	31.58%
Very important	1	3	3	8	3	3	21	55.26%
Totals	2	4	3	13	9	7	38	100%

There were 33 out of 38, or 86.84%, of the respondents who valued having the counselor talk to them about assent procedures so that they knew what to expect from it.

Relationship building

Participants were then asked to rate how important they thought it would be for a counselor to ask them for assent in order to make their relationship better. All thirty-eight adolescent participants responded to this question. The mean level of importance was 3.45 with a median and mode of 4.00 (sd= 0.80). The responses by age are outlined in the table below. There were also 33 out of 38, or 86.84%, of the adolescents who considered having the counselor ask for assent to be important or very important for relationship building.

Table 35. Frequency of ratings for the reason: "to make our relationship better"

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Not important	0	0	0	1	0	0	1	2.63%
Slightly important	0	0	1	2	1	0	4	10.53%
Important	0	0	0	3	4	3	10	26.32%
Very important	2	4	2	7	4	4	23	60.53%
Totals	2	4	3	13	9	7	38	100.00%

Legal and ethical rules

Participants were next asked to reflect on how important they felt it would be for the counselor to ask their opinion for the reason of satisfying legal and ethical responsibilities. There were thirty-seven responses to this question. One eighteen year old did not respond. The mean rating of importance was 3.05 with a median of 3.00 and mode of 4.00 (sd= 0.85).

There were 25 out of 37, or 67.57%, of the respondents who deemed this reason to be important or very important. The distribution of responses separated by age can be viewed in the following table.

Table 36. Frequency of ratings for the reason: "satisfying legal and ethical rules"

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Not important	0	0	0	0	0	0	0	0.00%
Slightly important	2	0	1	5	3	1	12	32.43%
Important	0	1	0	3	4	3	11	29.73%
Very important	0	3	2	5	2	2	14	37.84%
Totals	2	4	3	13	9	6	37	100.00%

Selection of clients who will be invested in counseling

The reason why a counselor might ask an adolescent client for assent was to select those adolescent who want to be in therapy. Thus participants were asked to rate how important they thought it would be to ask the adolescents' opinions about being in counseling so the counselor would be able to work with adolescents who want to be in counselor and perhaps make other arrangements with adolescents who don't. All thirty-eight participants responded. The mean rating of importance was 3.11 with a median and mode of 3.00 (sd=0.86).

There were 30 out of 38, or 78.95%, of the respondents who judged selection adolescents invested in counseling to be an important or very important reason to ask for adolescents' opinions. The distribution of responses organized by age is listed in the table that follows.

Table 37. Frequency of ratings for the reason: "selecting on those adolescent who want to be in therapy"

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Not important	0	1	0	1	0	0	2	5.26%
Slightly important	1	0	0	2	2	1	6	15.79%
Important	0	2	3	5	2	4	16	42.11%
Very important	1	1	0	5	5	2	14	36.84%
Totals	2	4	3	13	9	7	38	100.00%

Independence

As noted in the discussion of adolescent development, a sense of independence and decision-making are important elements of adolescence. Thus, the next listed reason is related to this. While adolescents in most states cannot independently provide informed consent for counseling, asking an adolescent client for assent is one way the counselor can make the adolescent at least feel more independent. Participants were then asked to consider how important they thought it would be for an adolescent seeking counseling to have his/her counselor ask them for assent so that they could feel more independent. All thirty-eight adolescent participants responded.

The mean rating of importance was 2.89 with a median of 3.00 and mode of 4.00 (sd= 0.1.03). There was more variation in the ratings for this reason. The responses by age are outlined in the table below.

Table 38. Frequency of ratings for the reason: "making me feel independent"

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Not important	0	1	0	2	0	1	4	10.53%
Slightly important	0	1	2	1	2	4	10	26.32%
Important	1	0	1	2	4	2	10	26.32%
Very important	1	2	0	8	3	0	14	36.84%
Totals	2	4	3	13	9	7	38	100.00%

There were 63.16%, or 24 out of 38 of the respondents who concluded having a sense of independence was important or very important reason to ask for assent.

Complicated custody issues

The second to last listed reason was related to problems that may arise when adolescents from a "non-nuclear" family (e.g. when parents are separated or divorced or if the adolescent lives with other family members or guardians). In such situations it is important for the counselor to clarify which adult has the legal ability to provide informed consent for the adolescent and this may take some investigation on his/her part. However, an additional method to verify that the adolescent is actually interested in attending counseling and perhaps reduce the number of possible problems that may arise is to make sure the counselor seeks the adolescent's assent in addition to parental consent. Thus respondents were asked how important they thought it would be for a counselor to ask for assent in such a situation. Each of the thirty-eight participants responded. The mean rating of importance

was 3.26 with a median and mode of 4.00 (sd= 1.00). Again, as indicated by the standard deviation there was more variability in the responses to this reason than many of the other reasons. The frequencies of responses by each age can be viewed in Table 39.

Table 39. Frequency of ratings for the reason: "reducing problems if I am part of a blended family"

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Not important	0	1	0	0	0	2	3	7.89%
Slightly important	0	0	1	2	2	1	6	15.79%
Important	2	1	0	2	4	0	9	23.68%
Very important	0	2	2	9	3	4	20	52.63%
Totals	2	4	3	13	9	7	38	100.00%

There was 81.56%, or 31 out of 38 of the respondents who considered reducing possible problems when there are blended family issues to be an important or very important reason why the counselor would ask for adolescent assent.

Older adolescents

As mentioned above, the task of developing a sense of independence is an important one. This is especially true for older adolescents (16-18 years of age) as they begin to prepare for adulthood and often begin to engage in some adult roles during this time. For example, in most states sixteen year old adolescents can now obtain their driver's licenses and drive independently. Given these considerations and the more advanced cognitive development that developmental theorists purport older adolescents to have, special considerations in counseling may be made for these older adolescents. The last of the listed reasons to ask for assent asked participants to rate how important they thought it would be for

a counselor to ask an adolescent client for assent in order to recognize the independence of an older adolescence. The mean rating of importance was 3.21 with a median of 4.00 and mode of 4.00 (sd= 0.99). The distribution of ratings by age can be found in the subsequent table.

Table 40. Frequency of ratings for the reason: "recognizing the independence of older adolescents"

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Not important	0	1	0	0	0	2	3	7.89%
Slightly important	0	0	1	2	2	1	6	15.79%
Important	2	1	0	2	4	0	9	23.68%
Very important	0	2	2	9	3	4	20	52.63%
Totals	2	4	3	13	9	7	38	100.00%

There were 29 out of 38, or 76.32 %, of the respondents who rated this reason to be important or even a very important reason to ask for assent.

Other reasons to seek assent from an adolescent

As in the previous sections related to elements of informed consent participants were also given space to write in and rate other reasons why they thought a counselor should ask for their opinion about being in counseling even if parental consent was given. There were two responses. One related to rapport building when seeking assent, talking about subjects the adolescent is interested. The other indicated that all the reasons for seeking assent were important and that everything should be discussed with the adolescent as well as parents.

For ease of classification, the table below shows the rank order (by magnitude of the mean ratings of importance) for the reasons why counselors seek assent from adolescents when parental consent is the legally binding permission.

Repeated measures ANOVA's were performed to test for a difference between the mean importance ratings of the various elements of informed consent when adolescents rated how important they thought each element would be to have provided to their parents or guardians, as well as for differences in the ratings for younger versus older adolescents, and adolescents who had received previous counseling and those who had not. For the first repeated measures ANOVA testing the difference in the mean ratings of importance of informed consent elements to be provided to parents, Mauchly's Test of Sphericity indicated that sphericity could not be assumed in this analysis ($W(1, 27)=0.22$, $p=0.00$, where $p<0.05$ indicates the null hypothesis is rejected).

Table 41. Rank order mean ratings of importance for the reasons why a counselor would seek assent from an adolescent

	Mean	Standard Deviation
To make our relationship better	3.45	0.80
To help make sure I have the right idea about what to expect	3.37	0.85
To lower the number of possible problems if I am part of a blended family	3.26	1.00
To recognize the independence of older adolescents	3.21	0.99
To select only those adolescent who want to be in therapy	3.11	0.86
To satisfy legal and ethical rules	3.05	0.85
To make me want to be in therapy more	2.89	0.89
To make me feel more independent	2.89	1.03

Again, in accordance with these results and the small sample size, the Greenhouse-Geisser epsilon was used to be conservative. The results indicated that there were not significant differences between the mean importance ratings for the reasons to seek assent ($F(1, 4.66) = 0.86$; $p = 0.50$; $\acute{\eta}^2 = 0.02$).

Repeated measures ANOVA's were also conducted to test for differences between younger and older adolescents and for differences between adolescents who had received counseling and those who had not. The null hypothesis for the repeated measures ANOVA assessing differences between younger and older adolescents was that there was no difference in the means between the two groups. Mauchly's Test of Sphericity indicated that sphericity could not be assumed in this analysis ($W(1, 27) = 0.23$, $p = 0.01$, where $p < 0.05$ indicates the null hypothesis is rejected). Again, the Greenhouse-Geisser epsilon was used for the F statistic. The results indicated that there were not significant differences between the mean importance ratings for the eight reasons to seek assent according to younger versus older adolescents ($F(1, 4.78) = 1.48$; $p = 0.20$; $\acute{\eta}^2 = 0.04$).

The repeated measures ANOVA results for differences between mean importance ratings for informed consent elements to be provided to parents for adolescents who have received counseling and those who have not received counseling demonstrated that sphericity could not be assumed ($W(1, 27) = 0.21$, $p = 0.00$) and that there were not significant differences in the mean importance ratings for adolescents who had received previous counseling and those who had not ($F(1,4.57) = 0.80$, $p = 0.54$, $\acute{\eta}^2 = 0.02$).

Actions you want the counselor to take if you did NOT assent

Adolescents were also asked their opinion about what they would want the counselor to do if they were in counseling with parental consent, but they, as the adolescent, did not

assent to counseling. The question was presented as follows: "If you were Casey and your parents wanted you to get counseling, but you did not want counseling, what would you want the counselor to do? Please use the following scale and circle your answer." Along with each action a counselor might take if the adolescent refused to assent to counseling, a Likert scale from 1-4 (1=Definitely should not do, 2=Probably should not do, 3=Maybe should do, 4=Definitely should do) was presented, asking adolescents to indicate their opinion about each option. There was also an opportunity for participants to write in and rate their own ideas about what a counselor could do if they did not assent to counseling despite parental consent. The actions that were presented are listed below and range from completely abiding by the adolescent's decision, attempting to work through resistance, to abiding by the parental decision.

The actions listed were as follows:

- Do not treat me
- Make an agreement with me to come to counseling for a few sessions
- Use my parent's permission
- Get my parents' help in convincing me to give my agreement
- Do family therapy without my permission
- Do not counsel me and send me to another counselor
- Talk to me about why I don't want to give permission for counseling

Discontinue counseling

The first action listed asked participants to consider whether they thought the counselor should discontinue counseling if the adolescent did not assent. This action is one that gives the adolescent the power to decide whether being in counseling is something

she/he really wants to do even if parents have already provided consent for counseling. Thirty-seven of the thirty-eight adolescent participants rated this action. The mean rating for this action was 2.76 with a median and mode of 3.00 (sd= 1.01). There were 25 out of 37, or 67.57%, of the adolescents who thought the counselor maybe should do this or definitely should do this. The responses by age are outlined in the table below.

Table 42. Frequency of ratings for the action: "do not treat"

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Definitely should not do	0	1	0	1	3	1	6	16.22%
Probably should not do	1	0	0	2	1	2	6	16.22%
Maybe should do	1	1	3	7	2	2	16	43.24%
Definitely should do	0	2	0	2	3	2	9	24.32%
Totals	2	4	3	12	9	7	37	100.00%

Contracting for attendance

Many times when a counselor is working with a client who is unsure about coming to counseling, the counselor will contract with the client for an agreed upon number of sessions as a trial period. The next action the study asked adolescents to evaluate is related to this practice. Adolescents were asked to rate how much they thought the counselor should or should not make an agreement with her/him to attend counseling for a contracted number of sessions if the adolescent's parents have consented to counseling, but the adolescent has not. Again, thirty-seven adolescent participants responded to this question. The mean level of importance was 3.32 with a median and mode of 3.00 (sd=0.78). There were 34 out of 37, or

91.89%, of the respondents who rated this action as one a counselor maybe or definitely should do if an adolescent client refused assent. The responses by age are outlined in the table below.

Table 43. Frequency of ratings for the action: "contracting for attendance"

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Definitely should not do	0	0	0	1	1	0	2	5.41%
Probably should not do	0	0	0	1	0	0	1	2.70%
Maybe should do	1	3	1	5	5	2	17	45.95%
Definitely should do	1	1	2	5	3	5	17	45.95%
Totals	2	4	3	12	9	7	38	100.00%

Utilizing parental consent

Participants were next asked to consider the option of having the counselor utilize parental consent and proceed with counseling. This would be an option for the counselor given the current legal statutes that provide parental consent more legal standing than adolescent assent. There were thirty-sever out of thirty-eight adolescents who responded to this treatment option. The mean action rating was 2.19 (between "probably should not do" and "maybe should do" with a median and mode of 2.00 (sd= 1.10). There was a more even split between endorsing this as an action a counselor should take (16 out of 37, or 43.24% of the sample) versus endorsing it as one a counselor should not utilize (21 out of 37, or 56.76% of the sample). However, adolescents in this sample indicated a greater preference for the

counselor to not use parental consent only and continue counseling when the adolescent has not assented. The responses by age are outlined in the table below.

Table 44. Frequency of ratings for the action: "utilizing parental consent"

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Definitely should not do	0	3	0	3	5	3	14	37.84%
Probably should not do	0	0	2	3	0	2	7	18.92%
Maybe should do	1	1	0	3	4	2	11	29.73%
Definitely should do	1	0	1	3	0	0	5	13.51%
Totals	2	4	3	12	9	7	37	100.00%

Enlisting parental assistance

Another possible action for a counselor to take if there is parental consent for counseling, but the adolescent has not assented would be for the counselor to have the adolescent and her/his parents attend the session together to discuss the reasoning for seeking counseling for the adolescent. The counselor, the parents or guardians can present their concerns and why they felt counseling would be the best treatment option. Thus, adolescents were asked to rate how much they would want or not want the counselor to enlist their parental assistance if the adolescent did not provide assent. Thirty-seven participants rated this action. The mean rating of importance was 2.86 with a median and mode of 3.00 (sd= 1.00). There were 24 out of 37, or 64.86%, of the respondents who deemed this to be an action the counselor maybe or definitely should take if the adolescent's parents had

consented to counseling but she/he had not. The distribution of responses separated by age is located in Table 45.

Table 45. Frequency of ratings for the action of: "enlisting parental assistance"

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Definitely should not do	0	2	0	1	1	0	4	10.81%
Probably should not do	0	0	2	2	4	1	9	24.32%
Maybe should do	2	0	0	4	3	3	12	32.43%
Definitely should do	0	2	1	5	1	3	12	32.43%
Totals	2	4	3	12	9	7	37	100.00%

Conducting family therapy

When parents have consented for counseling and the adolescent has not assented, one avenue for counselors and the family is engaging in family therapy. The adolescent could be seen for counseling in the context of the family. The approach used would depend on the theoretical orientation of the counselor. Here, the family becomes the client, not just the adolescent. Participants Thirty-six participants responded. The mean rating of importance was 1.83 with a median and mode of 1.00 (sd=1.03). There were 26 out of 36, or 72.22%, of the respondents who indicated that family counseling was a less than adequate response to an adolescent's refusal to assent for counseling. The distribution of responses organized by age is listed in the table below.

Table 46. Frequency of ratings for the action of: "conducting family therapy"

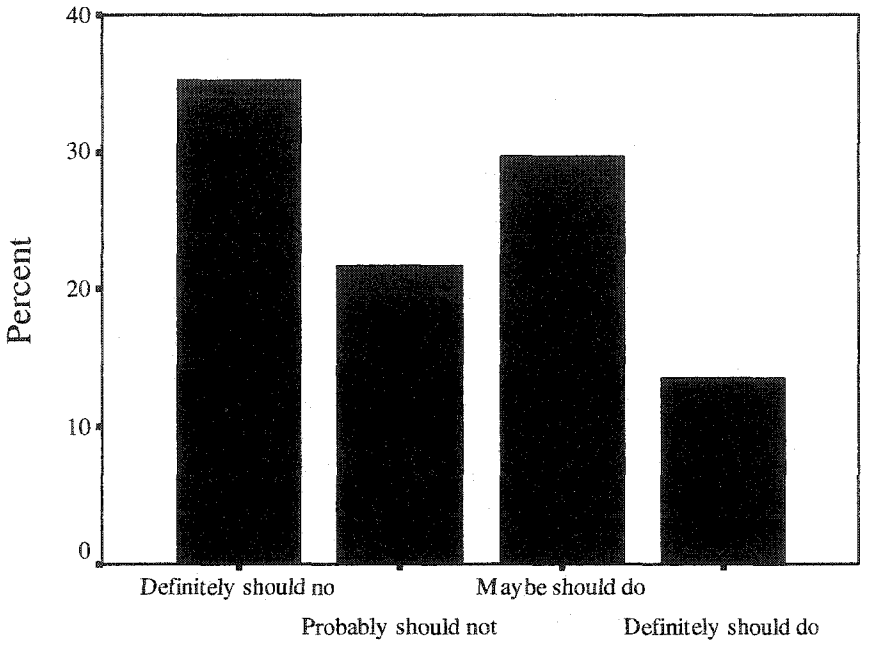
	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Definitely should not do	0	3	1	7	5	3	19	52.78%
Probably should not do	1	0	2	2	1	1	7	19.44%
Maybe should do	0	0	0	2	3	2	7	19.44%
Definitely should do	1	1	0	1	0	0	3	8.33%
Totals	2	4	3	12	9	6	36	100.00%

Discontinue counseling and refer elsewhere

An important aspect to a successful counseling relationship is the rapport that is built between the client and counselor. Having a good match between the client and the counselor can help provide the basis for this rapport building.

One action that a counselor may take if an adolescent refuses to assent for counseling is to make a referral to another counselor with whom the adolescent might better match. Thus this option was presented to adolescents in this study for them to provide their opinion as to whether they would want a counselor to do this. Thirty-seven adolescent participants rated this option. The mean rating was 2.22 with a median of 2.00 and mode of 1.00 (sd= 1.08). There was a greater distribution of opinions regarding this action as can be seen in the graph in Figure 4. Adolescents in this sample found this option to be a less than satisfactory action for a counselor to take if they, as the adolescent client, refused to assent for counseling.

Figure 5. Graph 5: Referring to another counselor



The responses for the ratings for the action "refer to another counselor" listed by age are outlined in the table below.

Table 47. Frequency of ratings for the action: "refer to another counselor"

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Definitely should not do	0	3	0	3	3	4	13	35.14%
Probably should not do	2	0	0	5	1	0	8	21.62%
Maybe should do	0	1	2	2	3	3	11	29.73%
Definitely should do	0	0	1	2	2	0	5	13.51%
Totals	2	4	3	12	9	7	37	100.00%

Process reasons underlying non-assent

The last of the listed actions a counselor might take if she/he had parental consent for an adolescent client but the adolescent refused assent was that of processing the reasons the adolescent has for not providing assent to determine if an agreement could be met. Again thirty-seven participants responded to this question. The mean rating this action was 3.24 with a median of 4.00 and mode of 4.00 (sd= 0.95).

There were 30 out of 37, or 81.08%, of the respondents who indicated that this would be an option the counselor maybe or definitely should do. The distribution of those ratings can be viewed in the table that follows where the ratings are delineated by the age of the respondent.

Table 48. Frequency of ratings for the action: "discuss reasons for non-assent"

	13 years old	14 years old	15 years old	16 years old	17 years old	18 years old	Totals	Percent of Total Returns
Definitely should not do	0	2	0	1	0	0	3	8.11%
Probably should not do	0	0	0	3	0	1	4	10.81%
Maybe should do	2	0	1	4	2	2	11	29.73%
Definitely should do	0	2	2	4	7	4	19	51.35%
Totals	2	4	3	12	9	7	37	100.00%

As in the earlier sections, participants were also given space to write in and rate other actions they might want the counselor to take if the adolescent did not assent to counseling after even if there was parental consent for counseling.

There were three valid responses with all rated with a 4.00 (definitely should do) with responses varying from talking with the client about an interest of hers/his to built rapport, to responses discussing how parents should listen to their children's preferences on this issue or how the adolescent should be allowed to just leave the situation.

Below is a table rank ordering the actions that adolescents in this sample rated. It is ordered from the most desired action to the least desired action.

Table 49. Rank order of mean ratings for the action a counselor should take when the adolescent cannot or refuses to assent

	Mean	Standard Deviation
Make an agreement with me to come to counseling for a few sessions	3.32	0.78
Talk to me about why I don't want to give permission for counseling	3.24	0.95
Get my parents' help in convincing me to give my agreement	2.86	1.00
Do not treat me	2.76	1.01
Do not counsel me and send me to another counselor	2.22	1.08
Use my parents' permission	2.19	1.10
Do family therapy without my permission	1.83	1.03

Repeated measures ANOVA's were performed to test for a difference between the mean importance ratings of the various actions rated by adolescents for counselors to take if the adolescent was unable or refused to assent for counseling. Repeated measures ANOVA's were also conducted to examine between-group differences in the ratings for younger versus older adolescents, and adolescents who had received previous counseling and those who had not. For the first repeated measures ANOVA testing the difference in the mean ratings of

actions a counselor could take, the Mauchly's Test of Sphericity indicated that sphericity could be assumed for this analysis (W(1, 20)=0.47, p=0.20). The results indicated that there were significant differences between the mean importance ratings for the ratings a counselor could take if the adolescent was unable or refused assent when comparing the ratings of younger versus older adolescents (F(1,6)=14.47; p=0.00; $\acute{\eta}^2$=0.29).

Pairwise comparisons showed that the difference in mean preferred action ratings between discontinuing treatment and conducting family therapy instead, without the adolescent's assent, was statistically significantly different, with discontinuing treatment the more preferred action (p=0.00; CI=0.19 to 1.59). The difference in mean importance ratings between contracting for a number of sessions & using parental consent was also statistically significantly different (p=0.00; CI=0.45 to 1.83) with adolescents preferring the counselor to contract for sessions.

There was a statistically significant difference between the actions of contracting for sessions and conducting family therapy (p=0.00; CI=0.75 to 2.19) with adolescents preferring the counselor to contract for sessions. Contracting for sessions was also statistically significantly preferred over being referred to another counselor (p=0.00; CI=0.32 to 1.90). Using parental consent and enlisting parental assistance were two actions that were statistically significantly different, with adolescents preferring the counselor to enlist parental assistance rather than just using their consent (p=0.01; CI=-1.22 to -0.11).

There was a statistically significant difference between using parental consent and processing with the adolescent why she/he doesn't want to assent for counseling with adolescents preferring the counselor to talk with them rather than just using parental consent and continuing with counseling (p=0.00; CI=-1.82 to -0.40). Enlisting parental assistance

was a statistically significantly preference over conducting family therapy without the adolescent's assent (p=0.00; CI=0.40 to 1.60). Processing the adolescents' reasons for not assenting was statistically significantly more preferred by adolescents in this sample compared to engaging in family therapy without the adolescent's assent (p=0.00; CI=-2.17 to -0.72). And finally, processing reasons for not assenting was also more preferred than being referred to another counselor (p=0.00; CI=-1.80 to -0.36).

Repeated measures ANOVA's were also conducted to test for differences between younger and older adolescents and for differences between adolescents who had received counseling and those who had not. The null hypothesis for the repeated measures ANOVA assessing differences between younger and older adolescents was that there was no difference in the means between the two groups. Mauchly's Test of Sphericity indicated that sphericity could be assumed in this analysis (W (1, 20) =0.46, p=0.21, where $p<0.05$ indicates the null hypothesis is rejected). The results indicated that there were not significant differences between the mean preference ratings for the seven actions a counselor could take if the adolescent was unable or refused to assent when examining the mean ratings between younger versus older adolescents ($F(1,6)=0.40$; p=0.49; $\acute{\eta}^2=0.82$).

The repeated measures ANOVA results for differences between mean preference ratings for actions for the counselor to take if the adolescent cannot or refuses assent between adolescents who have received counseling and those who have not received counseling demonstrated that sphericity could be assumed ($W(1, 20)=0.47$, p=0.25) and that there were not significant differences in the mean importance ratings for adolescents who had received previous counseling and those who had not ($F(1,6)=0.34$, p=0.92, $\acute{\eta}^2=0.92$).

Release of information

As part of the informed consent process, clients are given information about the limits to confidentiality. This includes information about how their protected health information will be handled and notification that they will need to sign releases of information for others to have access to information discussed in session. As discussed above, one of the exceptions to the confidentiality of counseling sessions is when the client is a minor. In this situation the adolescent's parents or guardians have the right to access counseling information. However, ethical counselors will make arrangements with the adolescents and his or her parents at the outset of counseling regarding the information that will be disclosed and the manner in which that information is disclosed. Counselors are also mandatory reporters for abuse issues and for instances where there is an imminent and identifiable danger to the client or someone identified by the client (per Tarasoff). Partly to educate adolescents about the limits to confidentiality this information was relayed to participants in this study.

It was presented in the following manner: "In counseling there are some times when the counselor may have to let others know what you talked about, even without your permission. These are: Times when there is a clear and present danger that someone's life is at risk, when there is suspicion or evidence of child abuse or neglect, if the counselor feels she/he needs to place you in the hospital for your protection. However, for most kinds of counseling, parents/guardians can also get information from their child's records." In accordance with gaining adolescents attitudes about the aspects of informed consent for counseling, this study sought more detailed opinions about the aspect of informed consent regarding the limits of confidentiality. Participants were questioned specifically about

whether they thought their parents should be able to get information about what the adolescent talked about with the counselor (when it is individual and not family counseling)? There were thirty-eight who responded to this question. Of this thirty-eight adolescents, thirteen or 34.21% indicated that yes, parents should be able to get information about what the adolescent talked about with the counselor and twenty-five, or 65.79% said, no parents should not be able to get information about what the adolescent talked about with the counselor.

In many states there are statutes indicating that some types of information are protected regardless of minor status. These include sexual reproductive information and substance use/abuse information. To further examine what adolescents in this sample thought about parental access to counseling information the survey then asked participants: If you talked about some of the things written below with your counselor, which of them do you think your parents should be able to find out about? Participants were then asked to check all the kinds of information they thought parents should be able to find out about. Options listed were as follows:

- Parents should not be able to find out about anything I talk about with my counselor
- Whether I came to the session or not
- Drug/Alcohol use
- Birth control/sexual relationships
- What the counselor is doing to help me
- In general, what you and your counselor talk about in sessions
- Psychological test results

Participants were also given space to write in additional information to which they thought parents should have access.

There were 26.32% of adolescents, or ten, of the thirty-eight respondents said that they would be comfortable with parents having access to anything that was talked about in session. Similar to this only eight adolescents, or 21.05% of adolescents in the sample were comfortable with disclosure to parents of general issues discussed during counseling. A greater percentage, 55.26%, or twenty-one adolescents of the thirty-eight respondents indicated more comfort with more restricted information being provided to parents such as attendance, substance use, or what interventions the counselor was using. An even greater number of adolescents in the sample, twenty-five or 65.79%, approved the release of psychological test results to parents. Disclosure of birth control and sexual relationship issues to parents was a more controversial issue with sixteen, or 42.11% adolescents indicating they would be comfortable with parents having access to this information and twenty-two, or 57.89% of adolescents in the sample not comfortable with disclosures about these issues to their parents.

In the space provided for adolescents to write in other topics of counseling for possible disclosure to parents, seven adolescents wrote comments. The comments indicated that these adolescents thought their parents should be informed if they were in danger or suicidal or if they were a danger to someone else. These adolescents also noted that parents should be informed of the progress being made in counseling and if the adolescent needs to be placed on medications. One adolescent commented that the only disclosures about counseling made to parents should be ones made by the adolescent.

Perceptions of people in counseling

Participants were then presented with pairs of adjectives containing one positive and one negative and asked to select which adjective they thought described someone receiving counseling. The pairing of the adjectives can be viewed in the survey instrument in Appendix A. In this section, the number of respondents varied more as some participants did not complete parts of the section, thus due to inconsistent missing data, the responses are reported in a descriptive manner.

The frequency of the responses can be viewed in the table below along with the calculated valid percent in accordance percent of the adolescents who responded to each pair presented.

Table 50. Adjectives to describe adolescents who receive counseling

Adjective	Frequency	Valid Percent	Adjective	Frequency	Valid Percent
Generous	20	64.52%	Cheap	11	35.48
Smart	24	77.42	Dumb	7	22.58
Happy	9	25.71	Unhappy	26	74.29
Easygoing	8	25.81	Bad tempered	23	74.19
Funny	7	20.59	Serious	27	79.41
Friendly	17	50.00	Unfriendly	17	50.00
Popular	7	22.58	Unpopular	24	77.42
Reliable	16	50.00	Unreliable	16	50.00
Important	22	66.67	Unimportant	11	33.33
Nice	16	48.48	Mean	17	51.52
Good-looking	15	53.57	Ugly	13	46.43
Determined	20	57.14	Doesn't care	15	42.86
Playful	10	30.30	Serious	23	69.70
Quiet	21	67.74	Talkative	10	32.26
Cares about others	12	42.86	Self-centered	16	57.14
Strong	11	31.43	Weak	24	68.57
Honest	19	59.38	Dishonest	13	40.30

Positive adjectives associated with adolescents receiving counseling included: generous, smart, friendly, reliable, important, good-looking, quiet, and honest. More

negative perceptions related to adjectives such as unhappy, bad-tempered, serious, unfriendly, unpopular, unreliable, mean, self-centered, and weak.

Adolescents were also asked to provide their own descriptions of what they thought about people their age who go to counseling. The opportunity was presented as such: "I think people who see a counselor are… (Please write in the words you would use to describe a person your age if you knew they were in counseling.)." Of the thirty-five responses, only one description characterized adolescents who seek counseling negatively, stating they are losers who cannot help themselves. Otherwise the comments were quite positive. Comments included characterizations such as having bravery for admitting they need help, strength in facing and fixing their problems, normal adolescents with problems who need help, people who need to talk to someone who can help them and people who are taking steps to better themselves. Other descriptions included adolescents being smart or wise in realizing they need help and being determined to get it, adolescents who have deep feelings and can't get them out or problems that affect their daily life and are looking for constructive ways to cope. Some responses noted problems adolescents face such as depression, fitting in with peers, abusing drugs, feeling confused, ignored, unhappy, dealing with gangs, swearing, or having concerns about sex. Overall, adolescents described counseling as a proactive way to constructively deal with problems. How do these impressions fit with the other results contained in this study? Results are discussed in the sections that follow.

DISCUSSION

Summary

This study sought to address the general question: What are the perspectives of adolescent minors in regards to consent to mental health treatment? Smaller than anticipated sample size permit guarded interpretations regarding the power and generalizability of the results. However, the resulting exploratory study contributed to the still-limited, but expanding fund of research literature on adolescents and informed consent for counseling. Findings regarding the importance of informed consent elements for both adolescents and parents, the process of seeking informed consent and assent, actions a counselor might take if the adolescent client refuses assent, and issues surrounding parental access to counseling information have implications for counselors who work with adolescents and families. In addition, adolescents were provided the opportunity to present their perceptions of adolescents who receive counseling; information which could be useful in developing interventions to reduce the stigma surrounding mental health treatment. This study addressed specific questions such as:

- What types of information do adolescents consider to be an important part of the consent process?
- How does the importance adolescents place on these different types of information compare to the types of information they believe are important for parents to have?
- From whom do adolescents think the counselor should seek consent from if the adolescent is the client?
- At what age do adolescents believe they should be able to provide consent for mental health counseling?

- What should the counselor do is the adolescent is unable or unwilling to consent to counseling?
- Are there differences in the attitudes between younger adolescents (13-15) versus older adolescents (16-18)?
- Are there differences in the attitudes between adolescents who have had counseling before and those who have not?

The answers to the questions posed are summarized and their implications discussed in the paragraphs below.

A significant consideration in this study was the development of a strategy to pique the adolescents' interest and to induce a perspective of how an adolescent client in counseling would want their counselor to handle issues of informed consent and access to information. Another consideration was educating adolescents on relevant issues for which people their age might see a counselor and draw them into this perspective by providing a specific problem for reference. Thus, the vignette stimulus approach was implemented to elicit responses. The content of the vignette reflected a prevalent adolescent-relevant disorder, attention-deficit-hyperactivity-disorder (ADHD). It is likely that adolescents would be more familiar with ADHD than other disorders, having experienced these symptoms themselves or interacted with others who have ADHD. This disorder is also less likely to trigger intense emotional or overly personalized reactions than other adolescent concerns, such as suicidal ideation, that would make engaging in this study emotionally traumatic for an adolescent. As assessed by the evaluative questions following the age and gender neutral vignette of Casey, participants indicated that they had an average level of understanding how Casey felt. In addition to understanding how Casey felt in this situation, the majority of

adolescents in this sample (76.3%) also stated that they knew someone with problems similar to Casey's. Thus, it can be concluded that adolescents in this sample identified with the vignette to at least a moderate degree, making it effective in its goal of eliciting interest in the study and creating feelings of personal relevance for the adolescents in this study. In addition, there were no reports of adolescents having any adverse reactions to participating in this study.

In this study, the first question posed asked: What types of information do adolescents consider to be an important part of the consent process? The usual information included in informed consent statements and discussions include: the time, place, and length of sessions; the general format of session; limits to who knows what is talked about; the goals of counseling; the cost of counseling; the training and education of the counselor; possible benefits and risks associated with counseling; and sources, other than counseling, to receive help. Concerns pertinent to asking adolescents to provide informed consent often center on whether adolescents cognitively understand the information being presented by the counselor, the significance of this information, and the implications of their decisions regarding the consent.

The results of this study indicated that adolescents considered all the informed consent elements to be important to consider. They indicated that they considered it moderately to quite important for the counselor to discuss all these issues with them. Moreover, there was little difference between the levels of importance assigned to each of the separate informed consent elements. However, adolescents in this study found it relatively more important to be informed about general session information and the format of counseling, as well as the limits of confidentiality compared to specific goal for counseling.

The study also asked adolescents to consider what information should be provided to adults. Subsequently, the study examined the ratings of importance the adolescents provided for elements of informed consent in the context of having parents receive this information. Consistent with the findings relevant to the provision of information to adolescent clients, all of the elements of informed consent were also rated as moderately to very important for parents. When comparisons were made between the ratings of importance for the provision of information to adolescents versus the provision of information to parents there were no differences in importance ratings. Thus adolescents in this study believed they should receive similar information to their parents.

Examination of the ranking of importance of the elements of informed consent revealed that the rank order of the importance of these elements were quite similar for both adolescents and parents. A highly significant issue in counseling, discussing limits to confidentiality, was ranked as most important thing for both parents and adolescents. Adolescents in this sample appeared to place value on confidentiality commiserate with the value clinicians place on the importance of the informed consent process (Brunscheen, 2001).

An additional question posed by the study asked adolescents from whom do they thought the counselor should seek consent from if the adolescent is the client. The majority of adolescents believed that counselors should ask both the adolescent and the parent for consent for counseling. A related question asked adolescent at what age they believed they should be able to provide consent for mental health counseling. Over 81% of the adolescents in this sample believed they should be able to go to counseling without parental consent, at least by age sixteen. Adolescents in this sample advocated having counselors ask them for consent starting at sixteen years of age and if the counselor had to get consent for counseling,

the adolescents wanted the counselor to ask them for assent, at least by the age of 14 years old. Many adolescents advocated for a lower age range of 12-14 years of age.

These finding are similar to the Brunscheen (2001) study where clinicians indicated they would start seeking informed consent about the age of fourteen. It was of note that there were three adolescents in the sample who said that parents should still give consent even if child is over eighteen years old and even over twenty-one years old! Adolescents in this sample showed some reluctance to attend counseling if their parents had to consent first, less reluctance if their parents did not have to give consent, but still expressed some reservation about the likelihood of attending counseling.

In addition to addressing how to handle the consent process, adolescents were asked to contemplate the reasons why a counselor would go through the consent or assent process. They were presented with options from previous studies (Beeman & Scott, 1991; Brunscheen, 2001) that included: to make me want to be in therapy, to that I know what to expect, to make the counseling relationship better, to satisfy legal and ethical rules, to select only those adolescents who want to be in therapy, to make me feel more independent, to lower the number of possible problems if I am a part of a blended family (i.e. if my parents are divorced or separated, or if I live with step-parents, foster-parents, other family members), and to recognize the independence of older adolescents. Adolescents in this sample thought there were many of the reasons were important, but most especially the reasons related to making the relationship better and other reasons associated with being an ethical counselor who is invested in the opinion of the adolescent client.

To further investigate adolescents' perceptions about the counseling process, the study asked: What do adolescents think the counselor should do if the adolescent is unable or

unwilling to consent to counseling? In the survey, adolescents were presented with several options created from previous studies (Beeman & Scott, 1991; Brunscheen, 2001) that included: do not treat me, make an agreement with me to come to counseling for a few sessions, use my parent's permission, get my parents' help in convincing me to give my agreement, do family therapy without my permission, do not counsel me and send me to another counselor, talk to me about why I don't want to give permission for counseling. Consistent with the above findings related to adolescents finding all of the informed consent elements to be important, for the purposes of improving the counseling relationship, the trend of answers provided by adolescents indicated they wanted their clinician to use more collaborative interventions if their parents consented to counseling but they did not assent.

In this study the question of whether there are differences in the attitudes between younger adolescents (13-15 years old) versus older adolescents (16-18 years old) was also investigated. In this sample of adolescents, there were no differences between older adolescents and younger adolescents. This finding suggests that, in this sample, younger adolescents find all the elements of informed consent to be as important information as do older adolescents. This lends itself to the impression that adolescents younger than eighteen years of age, perhaps as young as thirteen, may be able to make informed consent decisions, above and beyond assent. However, the small sample size associated with this study places considerable caution on this statement.

In addition to as assessing differences between younger versus older adolescents, the study posed the question as to whether there are differences in the attitudes between adolescents who have had counseling before and those who have not. While the sample sizes for comparison were small and unequal, analyses indicated there were no difference between

adolescents who have been in counseling versus those who had not in this sample of adolescents.

Subsequent questions in this study were associated with the informed consent element of limits to confidentiality and specifically, to parental access to information. The majority of adolescents in this study (65.79%) indicated that parents should not be granted unlimited access to information from the adolescent's counseling. However, 34.21% of the adolescents in this survey thought parents should have access to counseling information. In response to education included in the survey that parents are allowed access to a minor child's counseling record, adolescents indicated that if parents are going receive counseling information it should not be specific information discussed during counseling or general issues from counseling. Adolescents in this sample desired to have the information restricted to specific kinds of information such as attendance, psychological test results, and if the adolescent is a danger to her/himself or someone else. Whether the adolescent was engaging in substance use, birth control and/or sexual relationships, and specific interventions the counselor is utilizing were all types of information that adolescents in this sample found more controversial in whether this information should be relayed to parents. This finding is consistent with many state laws that allow adolescents to consent for drug and alcohol treatment and sexual counseling independent of their parents as a way to encourage adolescents to seek these services and to protect the adolescents' privileged information.

Another section of survey that allowed for the collection of exploratory qualitative data was the provision of adjectives and space for adolescents to write and describe how they would characterize adolescents who are in counseling. Descriptions were predominantly positive, characterizing adolescents in counseling as adolescents with problems rather than

making negative characterological assumptions about the adolescent as a person. Descriptions also emphasized seeking counseling as constructive problem solving. One concern regarding this information is the similarities in the open-ended responses, perhaps due to participants consulting with each other as they completed their answers. This is information that can be used in psychosocial information and in interventions to encourage adolescents to seek out counseling when they are experiencing troubles.

As with any study, there were strengths and limitations to this study and areas of future research that can be recommended on the basis of this study. Those evaluative conclusions and recommendations are discussed in the following sections.

CONCLUSIONS

Strengths

Two of the strengths of this research study were the uniqueness of the format of the survey and of the information collected. This study provided an additional context to the existing informed consent studies where clinicians' perspectives were sought. As previously mentioned, few studies have attempted to gather this breadth of adolescents' perspectives in one study. The study utilized the presentation of a vignette to entice adolescent interest, feelings of personal relevance, and greater participation. In addition, questions on the survey encouraged adolescents to think about what information they would want for themselves, for their parents, why they would want this information, and what they would want their counselor to do if they could not or would not assent for counseling.

Vigorous, focused, and persistent attempts were made to maximize generalizability of this study by seeking permission to gather data from a diversity of sites. A variety of sites were approached to participate in this study, including public, private, and parochial schools, youth groups, church groups, community mental health centers, and parent groups. These groups were located in rural and metropolitan areas and spanned two states in the Midwest region of the United States. The sites also encompassed a variety of socioeconomic levels, had racial and ethnic diversity, and attempts were made to include a variety of participants who had received counseling as well as those who had not. While, not all of these sites participated in this study, there were significant variations in the demographic characteristics of participants.

This study's sample had a more diverse group of participants, with more African Americans in the sample than would be expected given the population's census data. While

no comparisons were made between different racial and ethnic groups in this sample due to the overall small sample size, the study should serve as encouragement to researchers in areas with more restricted racial and ethnic diversity, that it is possible to obtain more diversity in a sample.

This study encountered problems similar to problems encountered by other investigators when conducting research with adolescents (Harrell, Bradley, Dennis, Frauman, & Criswell, 2000). Thus, while transforming this study into a more exploratory study, the challenges encountered when attempting to gain access to adolescents, the consent process for research, and issues surrounding return rates are commiserate with the experiences of other researchers conducting studies with adolescent participants (Harrell, et al., 2000). This study provided the opportunity to learn more about the procedures that make doing research in this field so difficult, such as gaining cooperation of agency officials and gaining parental consent via active consent, part of what leads to a current lack of breadth and depth of research in this area. Hopefully the exploratory nature of this study and the information gained from it will provide a basis for future research and will spur researchers, counselors, and lawmakers to engage in greater discussion of informed consent issues for adolescents related to increasing access to mental health counseling.

Limitations

Although there were distinct strengths to this study, the major limitations included low levels of participation by sites and a much smaller than expected return rate. Both of these limitations affected the ability to detect potential differences and to generalize the results of the study. The smaller sample size affected the power of the study, the types of analyses that could be utilized and reduced the number of comparisons that could be made.

For example, due to small and unequal sample sizes, adjustments to the degrees of freedom for F statistics in the repeated measures ANOVA's had to be made because of lack of sphericity. More conservative statistics had to be implemented due to the likelihood of violating assumptions of normal distributions. A larger sample size would have allowed for more degrees of freedom, fewer violations of assumptions for statistical tests, greater power to detect statistical differences, and greater generalizability of findings. Efforts to obtain more equal sample sizes between males and females, younger and older adolescents, as well as adolescents who have received counseling and those who have not are encouraged for future studies in this area.

One of the issues related to the small sample size was the active consent process utilized in this study. The nature and sequence of the informed consent for research was an active process requiring parental consent prior to participation rather than a passive consent process where parents receive an information letter and adolescents are restricted from participation only if the parent returns a dissent form. Despite IRB granted alterations to the usual sequence of obtaining active assent and consent from adolescents and their parents, this process was a difficult one to negotiate. Utilizing access modes where direct investigator-parent-adolescent contact is not feasible requires the development of consent procedures that are often less ideal and affect the return rate. In the instance of this study, the requirement that adolescents bring materials home to their parents often results in materials not actually being transported home for consent or the adolescents dismiss the study due to having to initiate the added step of seeking active parental consent prior to participation. One way to eliminate having adolescents transport materials for consent would be to obtain mailing addresses for parents and directly send materials to the adolescents' parents. However, this

requires obtaining those addresses from participating sites, information that is often protected for privacy reasons. This also increases the financial investment required of investigators due to additional mailing costs beyond those already incurred by including two postage paid envelopes in the survey packets to maintain anonymity as much as possible (one envelope for consent/assent forms and the gift certificate enrollment form and the other for the survey).

In some instances, as happened in this study as well, surveys are returned without parental consent and therefore cannot be included in the study. Also, asking adolescents to complete the study on their own time as opposed to a structured/guided time may contribute to the reduction in returns. Another complication to having adolescents complete the survey on their own is that adolescents may complete the survey in groups and thus not provide independent answers. Another concern is the social desirability of the answers provided. The options presented in this study were predominantly positive. One might wonder how the responses might change if there were more open-ended questions without socially desirable prompts provided to choose from, or how the findings might change if participants were to rank order their responses instead of rating the importance or desirability of each option. Given these strengths and limitations, several recommendations can be generated for future research endeavors.

Suggestions For Future Research

Adolescents in this sample provided information that can be utilized by counselors, school and youth group leaders, parents, and researchers for the development of future education efforts regarding counseling, interventions with adolescent clients and their parents, and as the basis for additional research. Armed with information about the preferences of adolescents, school staff, group leaders, parents, and other influential adults

can utilize this information to approach adolescents about seeking mental health counseling when warranted. They can address the concerns of adolescents and provide psychoeducation about counseling that may assist adolescents in making informed decisions about avenues of resolving their concerns. Counselors and researchers can use the information gained in this study and future studies like it to modify their informed consent processes when working with adolescents and their families. Collecting information about the preferences of adolescents and their satisfaction with current practices can be utilized in outcome research as well. Continued research in this area is highly recommended and several suggestions are made below.

Given the success in this study regarding the use of the vignette it would be beneficial to conduct future studies that also utilize this method. To further assess the influence of the vignette, maintaining the age and gender neutrality, but varying the disorders presented within the vignette would be recommended. In addition to varying the disorders presented, more questions should be asked to assess familiarity with the disorder before the vignette is presented. Another suggestion would be to manipulate how informed consent is handled in a vignette and ask adolescents to provide their reactions to each of the vignettes. For example, how would they feel if they were the adolescent in the vignette where the counselor talks only to the parent, or only to the adolescent, or to both the adolescent and the parent, or if the counselor ignores the dissent or refusal of the adolescent for counseling.

Another suggestion, briefly mentioned above would be to continue to seek participation from a variety of sites, in addition to schools, that serve adolescents. This serves to increase generalizability of findings and may affect the researcher's ability to generate more participating sites. If investigators continue to attempt to access adolescents

within school systems, it is highly recommended that they include public, private, and parochial school whenever possible. In addition, the use of treatment centers such as community mental health centers may allow for more comparisons among different groups of adolescents and may provide research that can be used in conjunction with outcomes research.

Related to the structure and administration of the survey itself, there are several recommendations that may be helpful in future studies. While having several different, but related topics included in one survey was helpful for the integration of information, it considerably lengthened the survey. A less imposing length, a simpler arrangement, and reduced amount of time to complete the survey would likely assist in increasing the return rate and encouraging sites to participate in the research. It may also be helpful to send consent forms to the adolescents and parents and then have session times set aside for the adolescents to complete the survey independently but in a group setting with an investigator present to answer questions and present adolescents with their rewards for participation. When determining format, one should attend to the social desirability concerns mentioned above and to the option of rank ordering possible responses and/or having more open-ended questions.

One final suggestion regarding the continuation of research on informed consent with adolescents can be made. Previous studies have addressed clinician attitudes, this study and hopefully more like it will address adolescents' views. A logical next step would be to gain the perspectives of parents and guardians on the informed consent process for mental health counseling. A goal of research in this field should be to compare these perspectives, the findings of adolescent competencies, and the legal and ethical requirements of counselors to

develop informed consent procedures that can best benefit all parties involved and encourage adolescents to seek mental health counseling when in need. This research has the potential educate and inform adults and adolescents alike and provide for prevention of and interventions for mental health issues in our youth.

APPENDIX

IOWA STATE UNIVERSITY
Psychology Department
W112 Lagomarcino Hall
Ames, Iowa 50011-3180
(515) 294-1742

Date, 2004

Group Administrator:

My name is Summer Brunscheen. I am a doctoral student in Counseling Psychology at Iowa State University and a Psychology Intern at Prairie View, Inc. and Wichita State University Counseling and Testing Center, though the Wichita Collaborative Psychology Internship Program (WCPIP). I am conducting a research study regarding adolescents and attitudes about counseling. I would like to submit a proposal to seek participation from adolescents in your programs. The Iowa State University's Human Subjects Review Board has approved this study.

I wish to gain information about how adolescents view their role in the counseling process, especially related to informed consent. Your program's adolescents could help provide a better understanding of practices and attitudes in this domain.

This study has potential impact in counseling and in educational arenas as well. One recent study indicated that approximately 17% of the adolescents in their study had unmet emotional needs. That 17% of adolescents can generalize into large numbers of adolescents whose unmet emotional needs could be a place for intervention in promoting the No Child Left Behind program in schools. Studies have shown that the emotional and mental health concerns of adolescents have a significant impact on their academic functioning. Poor mental health is highly correlated to poor academic achievement, posing a problem for parents, educators, and mental health practitioners. This project involves exploring the perceptions of adolescents regarding counseling and in the initiation of counseling

Enclosed are the materials I am asking you to consider. I understand that time is at a premium during interactions with the adolescents in your school/program. I would like teachers/group leaders to spend five minutes to speak with the adolescents and/or parents about the study using the enclosed announcement and provide them with the information letter and survey packet (see attached). Other than providing this opportunity, no other services will be required of your staff. I would ask that distributors emphasize that this is an opportunity that adolescents may take advantage of if they would like, but that in no way are their services in your school/program contingent upon participation nor will any staff have access to individual responses. The adolescents are asked to get parental permission and then to fill out the survey on their own. All materials will be mailed directly to the investigator.

Completion of this anonymous research survey should take at most 45 minutes to one hour. The adolescent's name is not required anywhere on the survey. The survey is not anticipated to have any adverse effects on the adolescent. No individual responses obtained from this survey will be reported. Summaries will report group data only. All responses will be kept anonymous and confidential to the extent permitted by applicable laws and regulations. Surveys will be stored in a secure cabinet in a locked office. Only qualified researchers associated with this project will have access to the data.

There is an incentive for participation. Adolescents are given a consent form to fill out with their parent that would allow them to select a local eatery or store to receive a $5 gift certificate from as a thank you for their participation. Participation in this study may not provide a direct benefit to individual adolescents, other than the small financial award, but findings may affect how counseling services are approached with adolescents. Since counseling services are provided to your adolescents in many different ways, it is hoped that this study will help inform administrators, mental health providers, and school officials, as to the perspectives of adolescents who have both participated in counseling. The adolescents' knowledge, opinions, and ideas are critical to a better understanding this complex area. Thus, your permission and cooperation is needed, valued, and will be greatly appreciated. A summary report of the results will be made available to you if you so desire.

If you have any questions please feel free to contact me via phone at Prairie View at 1-800-362-0180 x6212, via my cell phone at 515-231-6563, or e-mail at sbrunsch@iastate.edu. If you have any questions about the rights of human participants in research please contact the Iowa State University Research Compliance Officer, Diane Ament, 2810 Beardshear Hall, 515-294-3115, dament@iastate.edu.

Thank you for your time and cooperation.

Sincerely,

Summer K. Brunscheen, MS, LMLP-T
Doctoral Adolescent
Psychology Intern
(nascott@iastate.edu)

Norman A. Scott, Ph.D.
Associate Professor of Psychology
Project Supervisor

IOWA STATE UNIVERSITY
Psychology Department
W112 Lagomarcino Hall
Ames, Iowa 50011-3180
(515) 294-1742

Dear Teacher/Group Leader:

My name is Summer Brunscheen. I am a doctoral student in Counseling Psychology at Iowa State University and a Psychology Intern at Prairie View, Inc. and Wichita State University Counseling and Testing Center with Kids Training Team, though the Wichita Collaborative Psychology Internship Program (WCPIP). I am conducting a research study regarding adolescents and attitudes about counseling. I am requesting participation from adolescents that you work with. This research is being conducted by Psychology Department investigators from Iowa State University in conjunction with WCPIP and your agency. Iowa State University's Human Subjects Review Board and your administrators approved this study.

Would you please read the following paragraphs about the study and then hand out the attached packets to the adolescents with whom you are working? Please emphasize that this is merely an opportunity they may take advantage of, but that their services are in no way tied to their participation. Thank you very much for your time and effort. It is greatly appreciated.

"This is a research study about adolescents' attitudes about counseling. Here is a letter describing the study for you. If you are interested in participating in this study, please fill out this packet. There is a permission form for you to fill out and one for your parents. Both must be completed in order for you to participate. You do not have to participate if you are not interested. Our work with you is not related to this study in any way so you can choose to do it or you can choose to say no. It is up to you and your parents (guardian)."

"The survey is anonymous and confidential. That means that you will NOT put your name on the survey. It should take about 45 minutes to one hour to do it. None of us will have to know whether you chose to participate or not and none of us will have access to any of your answers. **If you choose to participate and send in completed consent forms and the survey, you may choose to select an area business to receive a $5 gift certificate from. It will be sent to you as a thank you for your time and effort.** Envelopes are included so that you can mail your permission forms, survey, and drawing entry forms back to people running this study. If you have any questions please feel free to contact Summer Brunscheen via phone at 1-800-362-0180 x6212 or e-mail her at sbrunsch@iastate.edu."

Thank you very much,

Summer K. Brunscheen, M.S.

Iowa State University Psych Dept.
WCPIP Psych Intern
316-284-6432
sbrunsch@iastate.edu

Norman A. Scott, Ph.D., Project Supervisor

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515-294-1509
nascott@iastate.edu

IOWA STATE UNIVERSITY
Psychology Department
W112 Lagomarcino Hall
Ames, Iowa 50011-3180
(515) 294-1742

Dear Parent:

My name is Summer Brunscheen. I am a doctoral student in Counseling Psychology at Iowa State University and a Psychology Intern at Prairie View, Inc. and Wichita State University Counseling and Testing Center, though the Wichita Collaborative Psychology Internship Program (WCPIP). We are requesting your adolescent's participation in a research study of attitudes towards counseling. Iowa State University's Human Subjects Review Board, as well as your school/program administrator, has approved this study. We wish to gain information about how adolescents view counseling. Your adolescent is in a unique position to help provide an understanding of practices and attitudes in this domain.

Completion of this anonymous research survey should take at most 45 minutes to one hour. Your adolescent's name is not required anywhere on the survey. We ask that once you review the survey, you allow your adolescent to complete the survey by him/herself. The survey is not expected to have any adverse effects on your adolescent. However, if you, or your adolescent, have any concerns or questions, you can contact me at my office or via e-mail. (Contact information is listed below.) Participation in this study may not provide a direct benefit to you but may affect how counseling services are approached with adolescents. Your adolescent's knowledge, opinions, and ideas are critical to a better understanding this complex area. Thus, your permission and cooperation is needed, valued, and will be greatly appreciated.

No individual responses obtained from this survey will be reported. Summaries will report group data only. All responses will be kept anonymous and confidential to the extent permitted by applicable laws and regulations. All students within the program will receive a packet so no program officials will have knowledge of which adolescents actually chose to participate nor will they have access to any individual's responses. The adolescents' choice to participate or not will not influence any of their services. Surveys will be stored in a secure cabinet in a locked office. Only qualified researchers associated with this project will have access to the data.

We must have this consent form signed by you and a separate form signed by your adolescent before she/he will be allowed to participate in the study. Separate envelopes are provided for the consent forms and the survey. Envelopes will be numbered to match each other for the purpose of verifying a parent consent form and adolescent assent form has been received so that the survey may be used. Immediately upon verification the envelopes will be destroyed and the consent forms, surveys, and drawing forms will be separated to maintain anonymity of the responses. These informed consent forms with contact information will also be kept separate from completed surveys to ensure anonymity. After completing the survey, your adolescent may mail it in the return postage paid envelope that has been provided.

Your adolescent may receive a $5 gift certificate for participating. You and your adolescent must give permission on the permission forms to receive this thank you gift. Your adolescent can select a local area business from the list provided. Upon receiving the completed consent forms and the completed survey, the $5 gift certificate will be mailed to your adolescent as a thank you for his/her time and effort.

If you have any questions please feel free to contact me via phone at 1-800-362-0180 x6212 or e-mail at sbrunsch@iastate.edu. If you have any questions about the rights of human participants in research please contact the Iowa State University Research Compliance Officer, Diane Ament, 2810 Beardshear Hall, 515-294-3115, dament@iastate.edu.

Thank you for your time and cooperation.

Sincerely,

Summer K. Brunscheen, M.S.
Psychology Intern
Doctoral Student

Norman A. Scott, Ph.D.
Associate Professor of Psychology
Project Supervisor (nascott@iastate.edu)

Counseling Attitudes Research Study

Thank you for your interest in this study. In this packet you will find:

1. The Parent information letter
2. The Parent/Guardian permission form
3. The Adolescent permission form
4. An envelope to mail the consent forms and drawing entry form
5. The survey (with a debriefing form and drawing entry form in the back)
6. An envelope to mail the survey
7. On the last page of the survey:
    a. a follow-up letter
    b. the gift certificate enrollment page

Instructions:

1. Parent: Please carefully read the parent information letter.
2. Parent/Guardian and Adolescent: Please carefully read the parent/guardian and adolescent permission forms.
3. Parent/Guardian:
    a. Please review the study materials.
    b. If you agree to allow your adolescent to participate in this study please complete the permission form.
4. Adolescent:
    a. If you decide to participate in this study, please fill out the adolescent permission form.
5. Adolescents and Parent/Guardian: Please place both permission forms in the postage-paid envelope marked with a number and the letter A included in the packet.
6. Adolescents:
    a. Please fill out the survey included in this packet on your own. You can follow the instructions on the survey.
    b. Please place the survey in the postage-paid envelope marked with a number and the letter B included in the packet.
7. Adolescents:
    a. Please read the follow-up information located on one of the pages at the end of the survey.
8. Adolescents and Parent/Guardian: If you and your parent/guardian have decided you want to receive the $5 gift certificate,
    a. Fill out the entry form (be sure to include the place you would like to receive a gift certificate from and your name, address, phone number, e-mail address),
    b. Please place the entry form in the postage-paid envelope with your permission forms. (The one marked with a number and the letter A.)
9. Please mail both envelopes via US mail.

If you have any questions please feel free to contact me via phone at 1-800-362-0180 x6212 or e-mail at sbrunsch@iastate.edu. If you have any questions about the rights of human participants in research please contact the Iowa State University Research Compliance Officer, Diane Ament, 2810 Beardshear Hall, 515-294-3115, dament@iastate.edu.

Thank you for your time and cooperation.

Sincerely,

Summer K. Brunscheen, M.S.
Doctoral Student

Norman A. Scott, Ph.D.
Associate Professor of Psychology
Project Supervisor (nascott@iastate.edu)

Parent/Guardian Informed Consent
for Adolescent Participation in the Counseling Study

Your adolescent has expressed interest in participating in the counseling attitudes study. If you are willing to allow your adolescent to participate please complete the following consent form and mail it along with your adolescent's permission form in one of the envelopes provided. If you give consent to allow your adolescent to participate in this study and to receive the $5 gift certificate, please initial in the blanks at the front of each statement and fill in your adolescent's name in the blank provided. Your signature and the date are also required below. Please allow the adolescent to fill out the survey on his/her own. Thank you.

_____ I understand that I am giving permission for my adolescent, _____
_____, to participate in the counseling survey being conducted by Summer K. Brunscheen, M.S. through Iowa State University in conjunction with WCPIP and our program.
I understand that:

- I may withdraw my permission and my adolescent's participation at any time during the study without penalty
- I have voluntarily provided this permission
- My adolescent's teacher/group leader gave all the adolescents a packet but NO school/program staff will have knowledge of my adolescent's actual participation nor will they have access to my adolescent's responses. My adolescent's choice to take or not take a survey packet will not influence any of our services.
- I must provide consent for my adolescent to participate and she/he must also provide assent (on a separate form).
- All responses will be kept anonymous and confidential to the extent permitted by applicable laws and regulations. Envelopes will be numbered to match each other for the explicit purpose of verifying a parent consent form and adolescent assent form has been received so that the survey may be used. Immediately upon verification the envelopes will be destroyed and the consent forms, surveys, and drawing forms will be separated to maintain anonymity of the responses.
- Only group data will be reported
- Surveys will be kept in a secured location with only qualified researchers having access to them.

_____I understand that I am hereby giving my permission for my adolescent, _____
_____, to be receive a $5 gift certificate to one of the locations listed below as a thank you for his/her time and effort. I also understand that I may withdraw my adolescent's name from the drawing at any time during the study without penalty.

_____ _____
Parent/guardian printed name Parent/guardian signature

_____ _____ _____
Date Name and grade level of my adolescent

Locations for gift certificate:

Wal-Mart	Dillon's
Italian Garden	Hollywood Video
Applebee's	Amazon.com
Carlos O'Kelley's	Best Buy
Target	A mall of your choice

If you have any questions please feel free to contact me via phone at 1-800-362-0180 x6212 or e-mail at sbrunsch@iastate.edu. If you have any questions about the rights of human participants in research please contact the Iowa State University Research Compliance Officer, Diane Ament, 2810 Beardshear Hall, 515-294-3115, dament@iastate.edu.

IOWA STATE UNIVERSITY
Psychology Department
W112 Lagomarcino Hall
Ames, Iowa 50011-3180
(515) 294-1742

Dear Adolescent:

We are asking you to complete a survey about your attitudes towards counseling. This research is being done by Psychology Department investigators from Iowa State University and from Prairie View, Inc. along with your school/program. Iowa State University's Human Subjects Review Board as well as your program administrators have both approved this study.

We want to learn about how adolescents view counseling. You do not put your name on any part of the survey and it should take about 45 minutes to one hour to finish. Please fill out the survey by yourself. You will be asked to read a story about a adolescent with a personal problem and then answer questions about what you would do if you were that person.

If you have any concerns or questions you can contact me at my office or via e-mail. (The number and e-mail address is listed below.) We know you are very busy, but hope you will be a part of this study. Your knowledge, opinions, and ideas are very important to help us understand what adolescents think about counseling. Filling out this survey may not help you directly, but it may affect how counseling services are approached with adolescents.

No individual answers from this survey will be reported; all reports will be summaries only. All answers will be kept anonymous and confidential. Envelopes will be numbered to match each other in order to make sure that both you and your parent/guardian signed the permission forms so that your survey may be used in the study. Immediately after making sure of this, the envelopes will be destroyed and the consent forms, surveys, and drawing forms will be separated to keep your answers anonymous. Surveys will be stored in a secure cabinet in a locked office. Only qualified researchers working on this project will have access to the surveys. All the adolescents in this school/program received a packet so no official will have knowledge of whether you actually chose to do the survey. They will not be able to find out what you wrote. None of the services you receive from this school/program will be affected by whether or not you choose to do this survey.

If you are interested in being a part of this study, you may complete the packet given to you by your group leader. We are asking you to take the following packet to your parents/guardian. In this packet you will find the permission form for your parent/guardian to fill out, a permission form for you to fill out, the survey, and paper to fill out for a for a $5 gift certificate for completing the survey. If you choose to participate, it is necessary for both you **AND** your parents to fill out the permission forms BEFORE you complete the survey. We must have a permission form signed by you AND a separate form signed by your parent(s)/guardian before you will be allowed to participate in the study. An envelope has been provided for you to mail the permission forms to us apart from the survey. A separate envelope is provided for you to mail the survey back to us so that it stays anonymous.

You may receive a $5 gift certificate for participating. You and your parent must give permission on the permission forms to receive this thank you gift. You can select a local area business from the list provided. Upon receiving the completed consent forms and the completed survey, the $5 gift certificate will be mailed to you as a thank you for your time and effort.

If you have any questions please feel free to contact me via phone at 1-800-362-0180 x6212 or e-mail at sbrunsch@iastate.edu. If you have any questions about the rights of human participants in research please contact the Iowa State University Research Compliance Officer, Diane Ament, 2810 Beardshear Hall, 515-294-3115, dament@iastate.edu. Thank you for your time and cooperation.

Sincerely,

Summer K. Brunscheen, M.S.
Doctoral Candidate

Norman A. Scott, Ph.D.
Associate Professor of Psychology
Project Supervisor (nascott@iastate.edu)

Adolescent Informed Consent for
Participation in the Counseling Study

If you are interested in being a part of this research study, please fill out this form and mail it in the envelope with your parent/guardian's permission form. If you agree to participate in this study and want to receive $5 as a thank you for your time and effort completing this survey, please initial in the blanks at the front of each statement and fill in your name in the blank provided. Please fill out this survey on your own. Your signature and the date are also needed. Thank you.

_____ I understand that I am giving permission to be a part of the counseling study being done by Summer K. Brunscheen, M.S. through Iowa State University, WCPIP, and with my program. I understand that:

- I may withdraw my participation at any time during the study without penalty
- I have provided this permission voluntarily
- My teacher/group leader gave everyone a survey packet, but will NOT know if I chose to fill out the survey nor will they be able to find out my answers to the survey
- I must provide this signed permission form (on a separate page) from my parent/guardian in order to participate.
- I understand that envelopes will be numbered to match each other in order to make sure that both my parent/guardian and I signed the permission forms so that my survey may be used in the study. Immediately after making sure of this, the envelopes will be destroyed and the consent forms, surveys, and drawing forms will be separated to keep my answers anonymous.
- I do not put my name on the survey so that all my answers stay anonymous and confidential
- None of my individual answers will be reported. Only group information will be reported.
- Surveys will be kept in a secured location with only qualified researchers being about to see them.

_____I understand that I am asking to receive a $5 gift certificate to one of the locations listed below. I also understand that I end my participation and/or ask to not receive the gift certificate at any time during the study without penalty.

_____ _____ _____

Adolescent printed name & grade level Adolescent signature

_____

Date

If you have any questions please feel free to contact me via phone at 1-800-362-0180 x6212 or e-mail at sbrunsch@iastate.edu. If you have any questions about the rights of human participants in research please contact the Iowa State University Research Compliance Officer, Diane Ament, 2810 Beardshear Hall, 515-294-3115, dament@iastate.edu.

Locations for gift certificate:

Wal-Mart
Italian Garden
Applebee's
Carlos O'Kelley's
Target
Dillon's
Hollywood Video
Amazon.com
Best Buy
A mall of your choice

Mental Health Counseling Consent with Adolescents

Dear Student: Please complete this survey on your own. This is an anonymous survey. This means that you do **NOT** put your name on any of these pages. Please complete the following questions by following the directions.

When you are finished, please return the survey in the envelope provided. Please return your permission form in the *separate* envelope so that your answers remain anonymous.

No individual answers from this survey will be reported. All your answers will be kept **anonymous** and **confidential** to the extent allowed by law.

You must have returned a signed parental permission form and a signed student permission form before doing this survey.

Counseling: talking with a counselor about your thoughts, feelings, and behaviors or about problems you are having; counseling in this case is more than seeing your school counselor about classes, schedule changes, or college visits, etc.

Parent/Guardian: A parent is a biological or adoptive parent or legal guardian of an adolescent.

Below is a story about an adolescent who is struggling with a problem. Please read the story and think about how **you** would feel if **you** were in that situation. Then answer the questions that follow the story.

Casey is about your age and grade. Casey has had a really hard time concentrating on things ever since 4th grade. Casey's grades have gone down at school because Casey doesn't give close attention to details. Casey often makes mistakes and loses things. Casey is very distracted by other things going on in the room and has a hard time sitting still. At home Casey is often in trouble for not finishing chores and homework. Casey has trouble organizing things too and is even more active than other kids Casey's age. In fact, Casey's teachers and school counselor think that Casey has Attention-Deficit Hyperactivity Disorder (ADHD). Casey's school counselor suggested a counselor. The counselor met with Casey. The counselor said that she thought Casey could do several different things for the ADHD.

They talked about five choices. Casey could wait and see if these problems go away on their own. Or Casey could set up appointments with the counselor. Casey could be placed on medication by their family doctor or a psychiatrist and still see the counselor at the same time. Casey could be placed on medication by their family doctor without seeing the counselor at the same time. Another option is to try to start a behavior change program at home and at school. Casey, Casey's parents, and Casey's teachers would all work together to work out a program of rewards for good or on-task behavior and consequences for bad or off-task behavior.

1. How much do you feel like you understand how Casey feels? (Circle your answer)
   1 = Not at all 2 = Somewhat 3 = Average 4 = Very much so

2. Do you know anyone your age that has had a problem similar to Casey's? (Circle your answer.)

   Yes No

Casey will be given information to help in making decisions about what to do for the ADHD problems. For example Casey will find out:

- What information stays between Casey and the counselor and what information others may need to know,
- Who can know what Casey and the counselor talk about,
- Who gets to give permission for Casey to get counseling,
- What the good and bad things about counseling,
- Other things Casey might do to help the ADHD symptoms.

3. Here is a list of specific information a counselor might give to Casey. If you were Casey, how important do you think it would be for the counselor to give you the following types of information as part of getting permission for counseling?

Please use the following scale and circle your answer:

1	2	3	4
Not important	Slightly important	Important	Very important

1 2 3 4 a. Time, place, and length of sessions
1 2 3 4 b. The general way the sessions will go and what will take place
1 2 3 4 c. Limits to who knows what is talked about
1 2 3 4 d. The goals of counseling
1 2 3 4 e. Cost of counseling
1 2 3 4 f. Training and education of the counselor
1 2 3 4 g. Possible good and bad things about counseling
1 2 3 4 h. Other things the person can do besides counseling
1 2 3 4 i. Other (specify)_____

4. Here is a list of specific information a counselor might give to the parents/guardians of a client. If you were Casey, how important do you think it would be for the counselor to give your parents/guardians the following types of information as part of getting permission for counseling?

Please use the following scale and circle your answer:

1	2	3	4
Not important	Slightly important	Important	Very important

1 2 3 4 a. Time, place, setting, and length of sessions
1 2 3 4 b. The general way the sessions will go and what will take place
1 2 3 4 c. Limits to confidentiality
1 2 3 4 d. The goals of counseling
1 2 3 4 e. Cost of counseling
1 2 3 4 f. Training and education of the counselor
1 2 3 4 g. Possible advantages and side effects of counseling
1 2 3 4 h. Description of other options
1 2 3 4 i. Other (specify)_____

5. If you had a problem, how likely are you to go to a counselor if you **must** have your parents' permission? (Please circle your answer.)

Not at all likely Maybe Probably I would do it

6. Pretend that you are Casey and have chosen to get counseling. When you start counseling, the counselor talks with you about who gets to know what you and the counselor talk about. The counselor also talks about the good and bad things that might happen from counseling. They ask you if you understand and freely agree to come to counseling. From whom do you think the counselor should ask permission when you start counseling: (Please circle your answer)

Parent/Guardians Adolescent Both Parent/Guardian **and** Adolescent

7. If you were start counseling, for most types of counseling the counselor must ask your parents/guardians for permission to work with you. If the counselor gets permission from your parent/guardian, do you think the counselor should also get permission from you? (Please circle your answer.)

Yes No

8. How old do you think you should be before a counselor should ask your opinion about coming to counseling? (Please circle your answer.)

12 13 14 15 16 17 18 19 20 21 older than 21

9. Do you think you should be able to go to counseling without your parents' knowledge or permission? (Please circle your answer.)

Yes No

10. How old do you think you should be before you could go to counseling without your parents knowing or giving their permission for you to go? (Please circle your answer.)

12 13 14 15 16 17 18 19 20 21 older than 21

11. If you had a problem, how likely are you to go see a counselor if you do **not** have to get your parents' permission? (Please circle your answer.)

Not at all likely Maybe Probably would I would go

12. Below is a list of words that describe people. Circle the word from each pair (a-q) that best fits how you would describe a person your age if he/she were in counseling.

a)	generous	cheap	j)	mean	nice
b)	dumb	smart	k)	good-looking	ugly
c)	unhappy	happy	l)	determined	doesn't care
d)	bad tempered	easygoing	m)	playful	serious
e)	funny	serious	n)	quiet	talkative
f)	friendly	unfriendly	o)	self-centered	cares about others
g)	popular	unpopular	p)	strong	weak
h)	reliable	unreliable	q)	dishonest	honest
i)	important	unimportant			

In counseling there are some times when the counselor may have to let others know what you talked about, even without your permission. These are:

- Times when there is a clear and present danger that someone's life is at risk
- When there is suspicion or evidence of child abuse or neglect
- If the counselor feels she/he needs to place you in the hospital for your protection

However, for most kinds of counseling, parents/guardians can also get information from their child's records.

13. Do <u>you</u> think your parents/guardians should be able to get information about what you talked about with the counselor (when you are not in family counseling)? (Please circle your answer.)

Yes No

14. If you talked about some of the things written below with your counselor, which of them do you think your parents should be able to find out about? (Please check all the kinds of information you think they should be able to find out about.)

_____ Parents should not be able to find out about anything I talk about with my counselor
_____ Whether I came to the session or not
_____ Drug/Alcohol use
_____ Birth control/sexual relationships
_____ What the counselor is doing to help me
_____ In general, what you and your counselor talk about in sessions
_____ Psychological test results
_____ Other:_____

15. There are many reasons why a counselor might choose to ask you for permission before starting counseling with you. How important do you consider each of the following reasons?

Please use the following scale and circle your answer:

1	2	3	4
Not important	Slightly important	Important	Very important

1 2 3 4 a. To make me want to be in therapy more
1 2 3 4 b. To help make sure I have the right idea about what to expect
1 2 3 4 c. To make our relationship better
1 2 3 4 d. To satisfy legal and ethical rules
1 2 3 4 f. To select only those adolescents who want to be in therapy
1 2 3 4 g. To make me feel more independent
1 2 3 4 h. To lower the number of possible problems if I am a part of a blended family (i.e. if my parents are divorced or separated, or if I live with step-parents, foster-parents, other family members)
1 2 3 4 i. To recognize the independence of older adolescents
1 2 3 4 j. Other (specify)_____

16. If you were Casey and your parents wanted you to get counseling, but **you did not** want counseling, what would you want the counselor to do? Please use the following scale and circle your answer:

1	2	3	4
Definitely should not do	Probably should not do	Maybe should do	Definitely should do

1 2 3 4 a. Do not treat me
1 2 3 4 b. Make an agreement with me to come to counseling for a few sessions
1 2 3 4 c. Use my parent's permission
1 2 3 4 d. Get my parents' help in convincing me to give my agreement
1 2 3 4 e. Do family therapy without my permission
1 2 3 4 f. Do not counsel me and send me to another counselor
1 2 3 4 g. Talk to me about why I don't want to give permission for counseling
1 2 3 4 h. Other (specify)_____

17. Have you ever had mental health counseling before? (This is counseling other than for schedule changes or regular school issues.) (Please circle your answer.)

No Yes, I have had counseling before

If you said No to #17, please go to Question 18.

If you said Yes to #17:

a) I was _____ years old.

b) I was in counseling for:
_____ weeks OR _____ months OR _____ years

c) How helpful was the counseling? (Please circle your answer.)
Not helpful at all A little helpful A bit helpful Very helpful

d) Did the counselor get permission from: (Please circle your answer.)

You Your parent(s)/guardian(s) Both you and your parent(s)/guardian(s)

18. I am: (please circle your answer) Male Female
19. I am _____ years old.
20. I am: (please circle your answer)
Caucasian/White
African-American/Black
Latino-American
Asian-American
Multi-racial American
International Student
Other _____

21. I live with: (Please circle your answer.)
Both biological parents
Both adoptive parents
Both foster parents
My mother only
My father only
Other relatives: _____
Step-mother and father
Step-father and mother
My mother and her partner
My father and his partner
Other Guardians: _____

22. My parents/guardians and I are:

Lower class Lower middle class Middle class Upper middle class Upper class

23. I think people who see a counselor are…
(Please write in the words you would use to describe a person your age if you knew they were in counseling.)

24. Please write any comments or questions you have on the back of this page. Thank you for participating.

Attitudes towards Counseling Follow-up information
PLEASE KEEP THIS PAGE.

Thank you for participating in this research study of attitudes towards counseling. This research is being done by Psychology Department researchers from Iowa State University and Prairie View, Inc. along with your program. Iowa State University's Human Subjects Review Board and your program's administrators have approved this study.

With new legal decisions giving teenagers more rights and responsibilities, counselors working with adolescents will have to be more aware of the policies they use and why they use them. This study was made to follow-up an earlier study (Brunscheen, 2001) that asked counselors their views about counseling adolescents. This study was interested in learning the views of adolescents. We were interested in what information adolescents think is important when deciding whether to talk to a counselor, information they feel their parents should be allowed to know about, and how they would the counselor to act if they didn't want to be in counseling. So, while being a part of this study may not directly affect you, it may affect how counseling services are handled with adolescents. Your participation is valued and is greatly appreciated.

Remember, no individual answers from this survey will be reported. Only summaries of the answers from all the people who filled out the survey will be reported. All answers will be kept anonymous and confidential to the extent permitted by applicable laws and regulations. Surveys will be stored in a secure cabinet in a locked office. Only qualified researchers associated with this project will be able to work with the surveys.

The survey was not expected to hurt you in any way. However, if you have any concerns or questions, would like information about seeing a counselor, or would like a summary of the results, please contact Summer Brunscheen, M.S. If you have any questions about the rights of human research participants, please contact Diane Ament. Contact information for individuals involved in this research study is located below.

Summer K. Brunscheen, M.S.
Psychology Department
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W112 Lagomarcino Hall
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316-284-6432
sbrunsch@iastate.edu

Norman A. Scott, Ph.D., Project Supervisor
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nascott@iastate.edu

Diane Ament
ISU Research Compliance

2810 Beardshear Hall
Ames, IA 50011
515-294-3115
dament@iastate.edu

Counseling Attitudes Study Gift Certificate Form

Please mail this page in Envelope A from the packet.
Be sure to mail it with the consent forms and NOT with the survey.

My parent/guardian has filled out and mailed the permission form for me to participate in the study.

_____
Parent/guardian signature Date

I have filled out and mailed the permission form to participate in this study. I have filled out and mailed the survey in its separate envelope.

_____ _____
Student signature Date

_____ I am interested in receiving a summary of the results of this study.
_____ I am interested in receiving a $5 gift certificate.

Locations for gift certificate: *Please circle the place you are interested in receiving a gift certificate from.*

Wal-Mart
Italian Garden
Applebee's
Carlos O'Kelley's
Target
Dillon's
Hollywood Video
Amazon.com
Best Buy
A mall of your choice

My address is:

Name: _____
Address: _____
City, State, Zip: _____
Phone/E-mail:_____

IOWA STATE UNIVERSITY
Psychology Department
W112 Lagomarcino Hall
Ames, Iowa 50011-3180
(515) 294-1742

Month day, 2004

Adolescent's Name
C/O Parent's Name
Address
City, State Zip code

Adolescent's First Name:

Thank you for your participation in the adolescent counseling attitudes study. Upon receiving both your permission forms from you and your parents and your completed survey, we are sending you $5 to thank you for your time and effort in completing this survey. If you have any questions, please contact me at 515-231-6563 or sbrunsch@iastate.edu.

Thank you again for your time and effort. It is greatly appreciated.

Sincerely,

Summer K. Brunscheen, M.S
Graduate Student

Norman A. Scott, Ph.D.
Associate Professor of Psychology
Project Supervisor

SKB/NAS: skb
Encl.: $5 participation award

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