Informed consent, assent, and the counseling of adolescent minors

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DEDICATION PAGE

To all my family, friends, and colleagues: A simple thank you will never be enough. Your support and belief in me has made this journey a shared adventure rather than an individual quest.

And especially to Mom: Thank you. Without you I truly would not be here. "It's always been your song." I love you.

TABLE OF CONTENTS

LIST OF TABLES

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ABSTRACT

Informed consent for psychotherapy, 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 voluntary participation. This term and related counseling processes are based upon such concepts as: the therapist's judgment about a potential client's cognitive competencies, and provision of sufficient information for the client to make an informed decision about participation, and voluntariness. When a counselor or therapist considers initiation of treatment with an adult, an individual over 18 years of age, these issues are complex. However, extra consideration is warranted when obtaining informed consent for treatment with adolescent minors. There are numerous legal and research controversies pertinent to whether and what procedures should be used to solicit adolescent informed consent or assent for psychological interventions. This national survey addressed questions such as: How frequently is informed consent or assent sought from an adolescent client? What information is provided in asset versus informed consent? What are the reasons cited by practitioners for seeking informed consent or assent? This study sampled internship training center supervisory psychologists who provide services to adolescents, and it assessed current assent and informed consent practices with adolescent minor clients. The present study replicated and extended a similar prior study (Beeman & Scott, 1991).

INTRODUCTION

Envision the following scenario: You are a psychologist at a local community mental health center. A young woman enters and asks to speak with you about problems she has been having with her parents. This person doesn't want her parents to know she coming to see you. Her concerns do not require reporting to any government agency (no abuse, neglect, illegal acts, etc), she has a job, can pay the fees on her own, and has her own transportation. What are issues to consider before rendering treatment if this person is fourteen years old? Are there different considerations prior to initiating treatment if she is eighteen or twenty-one?

The current ethical principles of psychologists (American Psychological Association, 1992) indicate that the practitioner needs to obtain consent for treatment. This means 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, such a task may be problematic with potential clients who are adolescents. To legally provide informed consent for non-emergency treatment the person must be of legal age according to their state's statutes. Otherwise, a parent, adoptive parent, or guardian must provide informed consent and the minor can only provide assent or dissent to treatment. These latter expressions of intent do not need to be respected if the adolescent's guardian has consented (Batten, 1996; Coffey, 1995; Leikin, 1995; Mammel & Kaplan, 1995; Martindale-Hubbell Law Digests, 1999; McCabe 1996).

However, in the initial scenario the adolescent is in an adult role at work, can independently pay for the sessions, and is not dependent upon parents for transportation. Moreover, society allows adolescents to play adult roles in many areas: sixteen year olds can

drive, teenagers have jobs, some live independently and apart from parents, and some adolescents are parents themselves. Yet they still cannot seek counseling without parental informed consent, even if they are close to legal age, without special considerations (Batten, 1996; Coffey, 1995; Leikin, 1995; Mammel & Kaplan, 1995; Martindale-Hubbell Law Digests, 1999; McCabe 1996). What do practitioners do in these cases, or in cases where the parents have brought in an adolescent for psychological treatment? Should the practitioner seek informed consent or assent? What considerations have to be made in making these decisions? What presenting concerns of the client and processes of clinical decision making would lead a practitioner to seek informed consent over assent or vice versa?

Informed Consent

Informed consent is defined by legal statutes and ethical principles as a requirement mandating an individual to give permission for a treatment and that the choice is made knowingly, intelligently, and voluntarily (Arambula, DeKraai, & Sales, 1993, chap. 22; Beeman & Scott, 1991; Coffey, 1995; Scott, Repucci, & Woolard, 1995). In order for the client to make an intelligent decision, the process 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). The practitioner is responsible for reviewing this information with her/his client and making sure she/he documents the discussion. It is also important to review this information later in counseling, not only for the benefit of the client, but also for the benefit of the practitioner.

For a decision to be voluntary the client must be free from coercion, whether it is real or perceived (Batten, 1996; McCabe, 1996). Two issues related to coercion, which are

especially salient for adolescent clients, are the influence of authority figures and the concept of conformity (Leikin, 1995; Scott et al., 1995). During this stage in life, the adolescent minor is 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).

The tenet of informed consent that causes the most concern is that of competency. Adults are assumed competent, unless demonstrated otherwise, whereas adolescent minors are assumed incompetent (Coffey, 1995; Leikin, 1993; Scott et al., 1995). Therefore, competency of an adolescent minor must be determined on a case-by-case basis. To be competent a person must make a rational decision based on two ideas: appreciation of the information and rational reasoning (Batten, 1996; McCabe, 1996). Appreciation is a vague term, but it is thought of as the ability to make inferences and engage in formal operational thought (Batten, 1996; McCabe, 1996).

Rational reasoning infers the ability to understand the concept of informed consent, the ability to understand the actual wording and the information provided, and the ability to use this information to make a reasonable outcome choice (Batten, 1996; McCabe, 1996). As implied by these qualifications, there is a subjective flavor to the assessment and determination of competency. The practitioner should remember to evaluate competency not only at the beginning of counseling, but also throughout counseling and make note of any potential changes (McCabe, 1996). These changes may influence the way counseling is conducted.

Definition of a Minor

When discussing informed consent in relation to the treatment of adolescent minors, it is important to clarify the term adolescent minor. An adolescent minor is thought of as a

person in the age range of 10-18 and as late as 22, based on some developmental psychologists (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; Coffey, 1995; Martindale-Hubbell Law Digests, 1999). For this discussion a parent will be defined as a biological or adoptive parent or legal guardian of an adolescent (Beeman & Scott, 1991).

As mentioned above, minors are thought, generally, to be incompetent to render totally autonomous decisions. However, there are exceptions to this assumption. An emancipated minor is a minor who is living 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. Therefore, an emancipated minor would be able to provide full informed consent for herself/himself.

An additional and more subjective concept is that of a mature minor. A mature minor is an adolescent at or near the age of majority who is fully able to understand the nature and the consequences for treatment (Arambula et al., 1993, chap. 22). This adolescent can give full consent for treatment provided the minor is competent (Arambula et al., 1993, chap. 22). To determine competency, the practitioner would have to meet with the adolescent minor and evaluate him/her. In conducting this interview, the practitioner encounters the dilemma of whether there needs to be an informed consent to perform a competency evaluation.

Assent versus Consent

The premise of informed consent is of knowledgeable, voluntary, and competent consent. The legal vagueness of adolescent competency clouds the issue of whether or not to seek informed consent from an adolescent minor client. An alternative to informed consent is assent. Assent is often used by practitioners to give the adolescent client the opportunity to express her/his assent, or agreement to treatment, or the opportunity to dissent to treatment, in which case the client is declining to participate.

However, assent or dissent given by the adolescent does not override informed consent or dissent from that adolescent's parent or guardian (Scott et al., 1995). Unlike informed consent, assent or dissent according to some legal scholars (Scott et al., 1995), would be an unenforceable legal contract, and therefore would not constitute legal consent to treatment (Scott et al., 1995). These distinctions between assent and consent are important to note as they demonstrate the inequality of responsibility given to adolescents with respect to consent to mental health treatment.

To assent to treatment, the adolescent minor, usually 15 years of age or older, must provide a verbal affirmative agreement to participate (Leikin, 1995). She/he must understand what is being asked of her/him immediately and in general, must understand permission is being asked of her/him independently of parents/guardians, and she/he must make a free choice to participate in treatment (Leikin, 1995).

The critical difference between assent and informed consent is that while a degree of competency must be inferred to even ask for assent, the practitioner does not have to perform a formal assessment of cognitive competency of the adolescent as she/he would if informed consent was being sought.

When the Adolescent says "No."

What the practitioner should do in the instance the adolescent does not agree to treatment, 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). This controversy raises the question: 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?

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 autonomy, improved communication, cooperation, to give the adolescent a sense of control, to show respect for the adolescents capabilities, and to provide opportunities for further development (McCabe, 1996; Melton, 1983 cited in McCabe, 1996). In general, if a person engages in an activity of her/his own volition based on their desire to do so, they are more

likely to follow through and participate more fully in the activity. Counseling would no doubt follow the same principle. If an adolescent chooses to engage in counseling, she/he are more likely to participate and more likely to comply with treatment suggestions.

Beeman & Scott (1991) discussed what practitioners in their study reported as reasons for not requesting consent from a minor. 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 (Beeman & Scott, 1991). In addition, some practitioners thought that adolescents could not understand the information provided and the implications of the decision, that adolescents are not competent, or that they did not want to impinge on the rights of the parents (Beeman & Scott, 1991).

Legal History of Involving Adolescents in Informed Consent Decisions

Research demonstrates that the more subjective or ambiguous the situation, the more the adolescent minor's input becomes relevant (McCabe, 1996). Even 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. Until the late 1960's, minors were thought to be the property of their parents and had no legal rights (McCabe, 1996), 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. 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 (Arambula et al., 1993; Beeman, 1989).

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).

Current Statutes and Laws

The legal ambiguity continues when considering the exceptions and qualifiers to the general idea of being an adult and independent decision-maker. 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).

Many other states agree that not only can emancipated minors or mature minors consent, but also all adolescents can 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; Coffey, 1995; Leikin, 1995;

Mammel & Kaplan, 1995; McCabe 1996). 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?

Moreover, adolescents are also often allowed to decide 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 provide practitioners statutes to assist in this decision 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). An additional 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.

Table 1. (continued)

State	Legal Age	Rights of Minor Adolescents and Emancipation Qualifiers
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 while incarcerated
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
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

Table 1. (continued)

State	Legal Age	Rights of Minor Adolescents and Emancipation Qualifiers
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
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 is deemed to be of full age, minors may have bank accounts
W. Virginia	18	At 16 may petition for emancipation, or if 16 and married considered emancipated
Wisconsin	18/17	17 full age for prosecution or investigating a crime, marriage emancipates
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. When deciding to seek informed consent or assent, there are many variables to take into consideration, in addition to the age of the adolescent. 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 (Leikin, 1995). In 1972, 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 that their hospitalization was for research purposes (Schwartz, 1972 cited in Dorn, Susman, Fletcher, 1995). Schwartz used age as a determination for competency and showed 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 and cited in Leikin, 1995). However, the researchers did not examine all aspects of informed consent (Lewis, C.E., Lewis, M.A., Ifekwunique, 1978 cited in Dorn et al, 1995 and cited in Leikin, 1995). What the children knew about risks, benefits, and other aspects of informed consent were elements

the researchers did not investigate in this study (Lewis, C.E., Lewis, M.A., Ifekwunique, 1978 cited in Dorn et al, 1995 and cited in Leikin, 1995).

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 Dorn et al, 1995 and cited in Mammel & Kaplan, 1995). 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.

Koocher and DeMaso asserted that the 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).

In a much-cited study, Weithorn and Campbell (1982) 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). The nine-year olds did still make the same choices as the eighteen and twenty-one year olds in their study (Batten, 1996; Coffey, 1995; Dorn et al., 1995; Leikin, 1995). They also found that fourteen-year-olds did not differ significantly from eighteen and

twenty-one year olds in evaluating information and making decisions (Batten, 1996; Coffey, 1995; Dorn et al., 1995; Leikin, 1995).

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 the 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). Melton notes that about the age of fourteen, adolescents appear to have the same decision-making abilities as adults (Melton, 1980 cited in Leikin, 1995).

As these researchers state, older children and young adolescents display decision-making abilities similar to older adolescents 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.

Theoretical Approaches to Assessment of Competency of Adolescents for Informed Consent

Since the law requires practitioners to determine competency of adolescents on an individual basis, there are various ways to approach the determination. By looking at 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.

One approach to this assessment of competency is that of stage development for cognitive and social development. Stage development implies 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.

According to Piaget, the stage of cognitive development that must be reached to give consent is that of formal operational thought, the most advanced of his developmental stages. At this level the adolescent should be able to engage in abstract reasoning, inductive and deductive reasoning, and be able to flexibly consider and evaluate information (Coffey, 1995; McCabe, 1996; Scott et al., 1995). Ironically, these skills are usually attained about the age of eleven or twelve years of age (Coffey, 1995). In addition, the adolescent must have an "appreciation" for the risks and benefits and the concepts of their illness/problem and its treatment (Coffey, 1995; McCabe, 1996; Scott et al., 1995).

Another familiar "stage" theorist is Lawrence Kohlberg. According to Kohlberg, people go through three stage of moral development, the first being that of Preconventional Morality (Gill & Magee, 2000; Santrock, 1995; Shweder, Mahapatra, & Miller, 1987). Preconventional morality is said to be the stage of moral development concurrent with the ages of 4 to 9 or 10 (Gill & Magee, 2000; Santrock, 1995; Shweder, Mahapatra, & Miller, 1987). It is in this stage when moral value concerns the needs and wants of the child (Gill & Magee, 2000; Santrock, 1995; Shweder, Mahapatra, & Miller, 1987).

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; Santrock, 1995; Shweder, Mahapatra, & Miller, 1987). 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 (Gill & Magee, 2000; Santrock, 1995; Shweder, Mahapatra, & Miller, 1987). 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.

The next stage of Kohlberg's theory is that of Conventional Morality (Gill & Magee, 2000; Santrock, 1995; Shweder, Mahapatra, & Miller, 1987). This too has two substages and is associated with the ages of 10 to 13 (Gill & Magee, 2000; Shweder, Mahapatra, & Miller, 1987). The first substage 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 (Gill & Magee, 2000; Shweder, Mahapatra, & Miller, 1987).

The second substage is labeled Law and Order orientation and is when the, typically, 11-13 year old individual seeks to avoid criticism by true authority figures (Gill & Magee, 2000; Shweder, Mahapatra, & Miller, 1987). The motivations behind decisions at this age and in this stage provides the concerns that informed consent might not be independent, voluntary, and free from influence of authority figures, whether it be parents or the practitioner.

The final stage Kohlberg proposes is called Postconventional Morality (Gill & Magee, 2000; Santrock, 1995; Shweder, Mahapatra, & Miller, 1987). Notice that the age

range for this stage is 14 years of age(adolescence) through adulthood (Gill & Magee, 2000; Shweder, Mahapatra, & Miller, 1987). 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 the individual identifies with (Gill & Magee, 2000; Santrock, 1995; Shweder, Mahapatra, & Miller, 1987). There are two substages in Postconventional Morality (Gill & Magee, 2000; Santrock, 1995; Shweder, Mahapatra, & Miller, 1987).

The first substage is that of Legalistic Orientation where judgments are made considering the good of the community, respecting laws, and social order (Gill & Magee, 2000; Santrock, 1995; Shweder, Mahapatra, & Miller, 1987). The second stage is Universal, Ethical Orientation in which the individual's conscience plays the largest part in decision-making (Gill & Magee, 2000; Santrock, 1995; Shweder, Mahapatra, & Miller, 1987). The comment is made that most people never reach this level. As mentioned above, Kohlberg states that these substages can occur from age fourteen all the way into adulthood. Thus, if we follow Kohlberg's delineation of moral decision-making then 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?

A second and additional general approach to the assessment of an adolescent's development, distinct from stage development notions, is that of "trend" development. Trends imply an overlapping of skills that are attained in varying degrees and at varying times rather than in distinct levels (Leikin, 1995). Because of the variation in developmental

rate of the following skills, a person advocating trend development would find it difficult to use a specific age or stage to delineate when an adolescent has the cognitive capacity to understand informed consent and when she/he does not (Leikin, 1995). This style of evaluation encourages adolescents to be assessed as individuals rather than assuming they are incompetent because of their minor age status (Leikin, 1995; Scott et al., 1995). A practitioner would evaluate 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 at the same time a more individualized picture of the adolescent minor client. This evaluation is less of a formal testing and assessment procedure and more of a 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 are threefold, including emotional, physical, and intellectual functioning (McCabe, 1996). The minor's emotional state, such as anxiety, depression, or confidence, is

important (McCabe, 1996). Emotional states such as these can affect the adolescent's understanding, memory, reasoning, and participation (McCabe, 1996). 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 functioning such as 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 information she/he provides the adolescent about informed consent, what types of information to provide to the adolescent, 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, and family-structured roles (McCabe, 1996). 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).

Situational factors include whether the situation is an approach/avoidance or an avoidance/avoidance decision, the first type of situation often being much easier to decide between than the latter type of situation (McCabe, 1996). Another situational factor is 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).

Whether the adolescent is uncertain or trustful of the individuals in the position to help is another situational factor. Trust can influence 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 whether she/he is an adult or an adolescent, but when concerning adolescents, the issues are made more complicated because the adolescents are not legally in control. These child, family, and situational factors can provide a therapist with more detailed information about the adolescent and whether she/he should be providing assent or informed consent for psychotherapy.

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 to do no harm to their clients whatever their age and must aim to help them. Practitioners must 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. 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 things a practitioner must be aware of when counseling an adolescent minor. It is important to consider the law regarding informed consent in the state in which you are practicing (Coffey, 1995). It is important to carefully record any and all conversations regarding informed consent with both the adolescent and the parent(s) (Moore, 1994, chap. 17).

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). The practitioner should be sensitive to the minor's "language" and be active in obtaining the minor's preferences (McCabe, 1996).

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). 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.

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 on page 9 for specific statutes and qualifiers for informed consent situations for each state.)

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. The message we receive from 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 and to solicit the adolescent's opinions and wishes regarding psychological treatment.

Moreover, in response, practitioners should provide those 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. This also implies 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.

Definitions for the Purpose of the Current Study

For the purposes of this study some terms need to be operationally defined. An adolescent is an individual whose age is 12-17 years. A parent is defined as a biological or adoptive parent or legal guardian of an adolescent. Informed consent is defined as requiring an individual to voluntarily give permission for a treatment and that that choice is made free of coercion, on the basis of sufficient information, and proven client competency to make a decision pertinent to participation in therapy.

Finally, assent is defined as asking client to verbally agree or disagree to voluntarily enter into or continue treatment. It requires that the individual understand what treatment is being assented to and to understand their permission is being sought independently of parental permission. Formal assessment of the competency of the adolescent is not required for solicitation of adolescent assent.

The Present Study

This study assessed the attitudes and practices of psychologists regarding informed consent for psychological interventions with adolescent minors. It assessed these domains by surveying a sample of psychologists who provide treatment to adolescents, and who supervise trainees in the provision of service to adolescents. Few studies have directly

addressed the issue of consent practices with minors and the attitudes and practices of training center psychologists, those who supervise and train future doctoral level psychologists. An assessment of this type would reflect the current perspective of psychologist practitioners with adolescent minor clients.

Two previous studies, Taylor et al. (1984) and Beeman & Scott (1991), have specifically addressed this topic. The current study sought to replicate and extend Beeman & Scott's 1991 study. In addition, this research extended prior research by examining assent procedures along with informed consent procedures. It addressed the general question: What are the consent to mental health treatment practices of clinicians who render services to adolescents?

Specifically, seven questions are posed by this survey study: (See questionnaire in Appendix on page 77.)

(1) Do practitioners who provide mental health services to adolescents make a distinction between informed consent and assent for psychotherapy? (See questionnaire items 3-9.)

(2) What elements, besides the adolescent's age, do practitioners use to determine whether to seek informed consent, beyond assent, from an adolescent client? (See questionnaire item 4.)

(3) What information is provided to parents versus adolescents in consent procedures for psychotherapy? For adolescent informed consent versus assent? (See questionnaire items 10 and 11.)

(4) What reasons do practitioners believe are important for not seeking informed consent from an adolescent client? (See questionnaire item 12.)

(5) What reasons do practitioners believe are important for seeking informed consent or assent? (See questionnaire item 13.)

(6) What are the current practices of clinicians rendering mental health services to adolescent when the adolescent is unable to provide assent or informed consent? (See questionnaire items 14-16.)

(7) What are the current practices of clinicians who render mental health services to adolescents when the adolescent refuses to provide assent or informed consent? (See questionnaire items 17-18.)

Demographic information about the training director psychologists was also examined in association to informed consent and assent procedures in psychotherapy for adolescent minor clients.

MATERIALS AND METHODS

Sample

Training director psychologists at selected internship sites listed in the Association of Psychology Postdoctoral and Internship Centers (APPIC) directory comprised the national sample for this study. The sites sampled were ones that provide pre-doctoral internship training with major adolescent rotations or training experiences. Specifically, the APPIC directory lists 334 sites with major adolescent training rotations in the United States (out of 497 total U.S. sites). All of these sites were included in the initial sampling plan.

The study's sampling procedure used the APPIC directory as a means of obtaining a sample of training focused practitioners who work with adolescent clients. The sites and training director names and addresses were obtained from the world-wide-web listing at <www.appic.com>. They also appear in the 29th Edition of the APPIC Directory of Internship and Postdoctoral Programs in Professional Psychology (2001).

It was believed that responses from training directors/psychologists at these major adolescent rotation sites would reflect current attitudes and practices. Moreover, it is likely that they would provide information relevant to practitioners' current knowledge, attitudes, and practices pertinent to informed consent or assent with adolescent minor clients.

For purposes of sampling and data tabulation, the sites were organized by geographic region. Specifically, nine regional categories based on the delineation used by the American Psychological Association for training and accreditation reports and data, were used in this study. The categorization of states within each region is displayed in Table 2 on page 28, as well as return rates by region.

To clarify, respondents to this study were referred to not only as "respondents," but also as "training directors," "practitioners," and "participants," throughout. Variation in terms is not meant to confuse, as all the terms are referring to the same people, but to decrease repetitiveness.

Materials

The materials used in this study can be viewed in Appendix. The materials consisted of eight elements: a postcard sent to alert the potential participants of the survey to follow, a survey packet that consisted of the cover letter, the survey, a participation postcard, and return envelopes. Additional materials included a reminder postcard, reminder fax letter, and a gift certificate award letter. Please see Appendix on page 75.

Training Directors at the selected APPIC Directory Internship sites with adolescent rotations received a postcard (Post card 1 in Appendix on page 76), approximately one week prior to the mailing of the survey packet, alerting them that a survey was being sent. They were informed that this questionnaire would seek their responses regarding informed consent and assent with adolescent clients. The ensuing survey packet (see Appendix on page 76) consisted of a letter of introduction letter that delineated how the training directors were selected for participation, and it requested participation or the forwarding of the survey to an appropriate staff person.

In addition, the letter briefly summarized the research and stressed its importance. Moreover, the letter also served as informed consent for participation by explaining what was being asked of the training director, how the survey results would be maintained and analyzed, and it gave a timeline to complete and return the survey. As an incentive for participation there was the description of a drawing for two <Amazon.com> gift certificates.

The drawing was for one of two $50.00 gift certificates to <Amazon.com> (drawn randomly and without replacement). Please see survey cover letter (Appendix on page 76).

Table 2. Geographic representation of training sites; number and percent of response by Region, Returns, and Sample

Region	Returned n (79)	Sent n (278)	% Regional Representation	% of Total Returns	Number of responses by gender	
					Male n	Female n
New England CT, ME, MA, NH, RI, VT	4	17	23.53	5.06	2	2
Middle Atlantic NJ, NY, PA	8	56	14.29	10.13	5	3
East North Central IL, IN, MI, OH, WI	18	45	40.00	22.78	11	8
West North Central IA, KS, MN, MO, NE, ND, SD	8	18	44.44	10.13	4	4
South Atlantic DE, DC, FL, GA, MD, NC, SC,VA,WV	14	54	25.93	17.72	8	5
East South Central AL, KY, MS, TN	2	13	15.38	2.53	0	2
West South Central AR, LA, OK, TX	10	23	43.48	12.66	4	6
Mountain AZ, CO, ID, MT, NV, NM, UT, WY	3	15	20.00	3.80	1	2
Pacific AK, CA, HI, OR,WA	12	37	32.43	15.19	5	7

The survey was adapted from two studies, Taylor et al. (1984) and Beeman & Scott (1991). It was formatted to provide definitions of "adolescent" and "parent", "informed consent," and "assent." The survey involved multiple option checklists, ratings, and fill in the blank items. It also provided opportunities for participants to write in answers and

opinions. Completion of the questionnaire was estimated to take 30-45 minutes. Please see Appendix on page 77 to 81 for exact questions.

A description of the questionnaire items is as follows: The first two questions asked about the laws or statutes the clinician would use to seek informed consent or assent from adolescent clients (see questions 1 and 2).

The third question asked the clinician to state her/his practice of seeking assent when informed consent had already been obtained from the parent (see question 3). Question 4 requested that the practitioner choose which types of information she/he viewed as important elements in determining the necessity of seeking informed consent beyond assent by checking all relevant options. The training directors were also asked to provide information on what percentage of their clients they seek assent or informed consent from (see question 5) and at what age they seek each (see question 7).

Respondents were also requested to provide their opinion on whether the practices of informed consent and parental access have changed in the past ten years (from the Beeman & Scott, 1991 study) (see questions 6, 8, and 9). In question 10, training directors accorded ratings of how important they considered providing different elements of informed consent to be when seeking informed consent from parents. Question 11 asked the same type of information but in reference to both assent and informed consent when addressing these elements with the adolescent clients.

Participants were given the opportunity to rate the importance of reasons they would use when choosing to not seek informed consent from an adolescent client (see question 12). The next question asked participants to rate the importance of reasons for seeking assent or informed consent (such as "to increase motivation for therapy") (see question 13).

Question 14 was posed so that training directors could estimate the percentage of adolescent clients that were unable to assent or provide informed consent. This question was followed up by asking the participants to rate how likely they were to engage in different options when the adolescent was unable to assent or provide informed consent (see questions 15 and 16). The same types of questions were posed for when the adolescent would refuse to provide assent or informed consent (see questions 17 and 18).

The training directors were requested to indicate whom they considered as their primary client (see question 19). Items 20-24 requested demographic and educational information about respondents while items 25-31 inquired about the site and employment activities of the respondent.

At the end of the survey participants were accorded the opportunity to provide additional comments and they were invited to send back their informed consent/assent documents separately from the questionnaire.

Also included in the survey packet was a postcard for the individual to indicate whether they wanted to participate and receive a summary of the results, if they wanted to be included in the drawing, or if they would prefer to not participate. (See Postcard 2 in Appendix on page 82.) The postcard and drawing were attempts to track the surveys that were completed and returned and provided additional inducement for completing the task.

There were two return postage-paid envelopes. One envelope was for the return of the survey. The other was for any informed consent materials the respondent wished to convey. This procedure allowed the training directors to maintain anonymity.

A follow-up postcard was sent to remind the training directors of the timeline and opportunity for participation in the drawing (see Reminder Postcard in Appendix on page 83). The final material sent to the initial sites sampled was a reminder fax letter sent to the sites that had not yet replied in order to encourage their participation (see Appendix on page 84). This faxed letter also served as a way for training directors to remove themselves from the sample if they considered themselves to be inappropriate sites ("rarely or never see adolescent clients"). The final contact with sample sites was the winner letter sent to inform the two winners of the drawing (see Appendix on page 85).

Procedure

The mail survey involved sequential steps intended to ensure a maximal return rate. Approximately one week prior to mailing the complete survey packet, a post card was sent to potential participants informing them of the forthcoming survey asking for and encouraging their participation. The survey packets were mailed one week later. Returned participation postcards were used to determine which potential participants were to receive a second survey packet that was sent out to increase the return rate. Three weeks from the date of the first mailing, reminder cards were sent out to those sites that had not responded. The second mailing, sent five weeks after the first survey mailing, included a complete survey packet to facilitate returns. Three weeks after the second mailing, sites that had not returned a response from the second mailing received an additional reminder card.

Finally, four weeks after the second reminder card, as an extra measure to foster participation, a faxed letter was sent to each site that had not yet responded. The fax letter served as a reminder and as an opportunity for sites to delineate themselves as being inappropriate for the study due to rarely or never seeing adolescents as clients.

The drawing for the two <Amazon.com> gift certificates was completed three months after the initial mailing. Included in the drawing were the forty-two participants that had indicated on their return postcard that they wished to be entered into the drawing. The drawing was random without replacement for two $50.00 gift certificates. Winners were sent their gift certificates along with a letter informing them about the selection process and their prize.

RESULTS

Descriptive statistics, such as means, modes, standard deviations, and number of respondents for each question, were reported to summarize responses when appropriate. When groups of information were compared, SPSS statistical package's general linear model repeated measures analysis of variance test was used to test for overall differences in the means of importance ratings or likelihood ratings (Howell, 1997).

This test was followed up with paired sample t-tests to examine differences of mean importance ratings or likelihood ratings for individual options applied to a different subject groups (i.e. comparing the importance of disclosing limits to confidentiality to parents versus adolescents when seeking informed consent) (Howell, 1997). Bonferroni adjustments were made to significance levels to compensate for possible increased Type I error when performing multiple t-tests (Howell, 1997).

In addition, a non-parametric test, Friedman's rank test, was used in a similar manner as the repeated measures analysis of variance in order to test for differences in central tendency (means) when using ranks instead of raw scores (Howell, 1997). Some questions were also examined in a more qualitative manner by examining the percent of respondents who endorsed items as being extremely important to attend to or actions in which they would be extremely likely to engage.

Return Rate

From the initial sampling of 334 sites, there were 38 training director responses to the fax letter indicating that their site was not appropriate for this study, that adolescents were rarely or never treated, even though the site listed a major adolescent rotation in the APPIC Directory.

There may have been training directors at other sites in similar situations that did not respond. For example, there were 56 university counseling centers included in the initial sample. Of these sites, eight training directors chose to participate, nineteen returned responses to the fax letter that their site was not appropriate, but twenty-nine did not respond.

With the removal of the 38 inappropriate sites, due to infrequent contact with adolescents, there were a total of 296 training directors at APPIC sites that were considered to be the actual sample pool. Of those 296 sites appropriate for the study, 18 sites asked not to participate.

The response rate for those appropriate for the sample and willing to participate was 79/278 or 28.42%.

Gender

There were 110 female (39.57%) and 168 male (60.43%) respondents in the sample of 278 training directors. Thirty-nine females returned the survey, or 39.45% from the original sample of females. Forty males returned surveys, or 23.81 % from the original sample of males. (See Table 2 on pages 28 for the delineation of gender by geographical region.)

Geographical Regions

Returns were tracked by the geographical regions delineated in Table 2. The West North Central region had the greatest regional return rate (8 out of 18) for a 44.44% return rate for that region. The region with the most representation in the sample of 79 respondents is the East North Central region representing 22.78% of the sample. The survey return-rate for each geographic region is also displayed in Table 2 on page 28.

Respondents' Educational Background

Nearly all of the respondents, 94%, had attained a doctoral degree. The majority, 74.7% (consisting of 31 males and 28 females), of the respondents had attained a Ph.D. The delineation of the educational degrees can be seen in Table 3 on page 36.

The years in which the respondents' highest degree was obtained ranged from 1959-2000 (n = 72, M year = 1986, Mdn year = 1987). Thirty-four terminal degrees (47.2%) were obtained during or before 1986, while thirty-eight degrees (52.8%) were obtained during or after 1987. Moreover, there were 72.2% (30 male, 22 female) respondents who had obtained their highest degree before 1990, thus nearly three fourths of the sample had eleven or more years of postgraduate degree experience.

The APA Ethical Code of Conduct was revised in 1992 (American Psychological Association, 1992), and it serves as an important tool in ethical decision-making. It includes the discussion of assent and informed consent. Thus this date was also used to examine the distribution of clinician responses. Fifty-five psychologist respondents obtained degrees before 1992 (69.62%) and seventeen respondents (21.52%) had doctoral degrees conferred during or after 1992.

Thus, the majority of respondents, 76.4% had attained their degree before the most recent revision of the APA Ethical Code of Conduct in 1992. The majority of respondents, 68.5%, reported their area of specialization as to be clinical psychology. The distribution of specializations can be viewed in Table 3 on page 36.

Table 3. Educational and work-setting characteristics of respondents.

Demographic Information	n	percent
Highest degree achieved		
Ph.D.	59	74.7
Psy.D./Ed.D	15	19.0
M.A./M.S.	5	6.3
Area of specialization		
Clinical Psychology	52	65.8
Counseling Psychology	17	21.5
School Psychology	6	7.6
Theoretical Orientation		
Cognitive/Behavioral	29	36.7
Eclectic/Integrative	18	22.8
Systems/Family	14	17.7
Adlerian/Psychoanalytic	8	10.1
Existential/Humanistic/Gestalt	5	6.3
Brief/Solution-focused	2	2.5
Primary Settings		
Community Mental Health Center	18	22.8
Child/Adolescent Non-Hospital Facility	14	17.7
Psychiatric Hospital	11	13.9
Student Counseling Center	7	8.9
General Hospital	6	7.6
Private Practice	6	7.6
Other	8	10.1

Theoretical Orientations

The 8 original primary theoretical orientations (see questionnaire in Appendix on page 77) were collapsed into 7 areas, due to infrequent responses in categories of Adlerian, Gestalt, Psychoanalytic, and Existential/Humanistic. The 7 new categories of theoretical orientations are presented in Table 3 on page 36. Of these, the most common theoretical orientation was Cognitive/Behavioral. It characterized 36.7% of respondents. The percent delineation of the other theoretical orientations is presented in Table 3.

Primary Settings

Respondents were asked to choose the primary setting in which she/he practiced. As noted in Table 3 on page 36, the most common setting was a Community Mental Health Center (22.8% of respondents), followed closely by Child/Adolescent Non-Hospital Facilities (17.7% of the respondents).

Percentage of Time Spent Conducting Therapy

Respondents estimated the percent of time she/he spent in conducting therapy (questionnaire item 27). The mean percent of time devoted to therapy was 33.8% (n = 79, Mdn = 30%, mode = 50%, SD = 23.49%). The large standard deviation was due to a wide range (0 to 100%) of time spent conducting therapy. The mean number of clients the respondents had seen for therapy in the last year was 59 (n = 76, SD = 58, median and mode = 40). This mean was determined after two outliers, respondents that had indicated agency rather than personal data, were removed since they were more than three standard deviations away from the mean.

Therapy and Assessments

The mean number of clients the respondents had seen for assessments in the last year (questionnaire item 29) was 43 clients (n = 75, SD = 50, median = 25). The mean number of clients the respondents had seen for both therapy and assessment in the last year (questionnaire item 30) was 46 clients (n = 70, SD = 60). This mean was determined after the two outliers, respondents that had indicated agency rather than personal data, were removed. Respondents reported that the mean percent of total clients who were adolescents was 83% (n = 77, mean number = 38, SD = 39). Again, this mean was determined after one outlier, a respondent that had indicated agency rather than personal data, was removed.

What Guides Informed Consent and Assent Practices with Adolescents?

The majority of respondents reported they were guided by institutional policies or state laws when deciding whether to seek assent or informed consent from adolescent clients (75.9% for each, n = 79). Some other guidelines also mentioned by participants included APA guidelines, research guidelines, and local guidelines for treating clients.

From Whom is Informed Consent Generally Gained when Treating Adolescents?

Responses to questionnaire item 2 indicated that: 43 respondents, or 56%, generally gain both parent/guardian and adolescent informed consent when working with adolescents (17 males, 26 females); 31 respondents, or 40%, generally gain only parent/guardian informed consent (18 males, 13 females); and just 3 respondents, or 4%, generally gain only adolescent informed consent (3 males, 0 females) (total n = 77). As mentioned above, the APA Ethical Code of Conduct, revised in 1992, is an important tool for practitioners for ethical decision-making. A chi-square test was performed to see if there was any difference in who informed consent was sought from when practitioners received their training and degree before the 1992 revision of the APA Ethical Code of Conduct compared to those who received their training and degree after the revision. There was no statistical difference between the two groups ($X^2 = 2.157$, df = 2, p = .340).

Do You Seek Assent from Adolescents In Addition to Informed Consent from Parents?

A majority, 61 of 77, or 79.2%, of respondents replied that they would seek assent from adolescent clients in addition to gaining informed consent from the adolescent's parent/guardian (26 males, 35 females). (See questionnaire item 3 in Appendix on page 77.)

Additional Elements

Other than age of the adolescent, the following elements would be used to determine the necessity of gaining an adolescent client's informed consent beyond seeking assent. They are listed in rank order in Table 4 below according to the number of respondents that endorsed each element. Summary data demonstrated that the adolescent's cognitive capabilities to read and understand the informed consent statement was the most commonly endorsed element with 48 of 77, or 62%, of the respondents endorsing this element. This result is consistent with previous research mentioned in the above.

Table 4. Additional elements considered when determining appropriateness of seeking informed consent from an adolescent client [a]

Additional elements	% endorsements	n
Comprehension of consent statement	62.3	48
Decision-making without influence	54.5	42
Degree of emancipation	46.8	36
Comprehension of costs & benefits	41.6	32

[a] There were 77 respondents for each of the elements.

The non-parametric test, Friedman's test of rank orders, was performed and demonstrated a statistically significant difference in the rank order of the four types of elements ($X^2 = 9.484$, df = 3, p = .024).

Some of the other elements mentioned by respondents included whether the treatment being sought was substance abuse treatment, whether the adolescent was a part of the juvenile correctional system, and whether the adolescent was seeking emergency treatment.

Informed Consent versus Assent in this sample: Which is More Frequent?

Questionnaire item 2 asked respondents to indicate from whom they generally gained informed consent when treating adolescents. Questionnaire item 5 asked respondents from what proportion of adolescents they actually seek informed consent or assent from.

The mean percent of adolescents from who assent was sought was 83.3% ($n = 68$, $SD = 33\%$). The mean percentage of adolescents from whom informed consent was sought was 54.7% ($n = 70$, $SD = 44.76\%$). Proportionately more APPIC training site directors seek assent than informed consent from adolescent clients.

Is Seeking Informed Consent a Practice that has Increased?

Even though the preponderance of APPIC training site directors still seeking assent over informed consent with adolescent clients, the participants expressed the belief that the practice of seeking informed consent with adolescent clients has risen from the past.

When asked, "In your opinion, has the practice of obtaining informed consent from adolescents increased in the past ten years," 67.1% (consisting of 25 males and 22 females), or 47 of the 70 participants who responded to this question answered "yes." (See questionnaire item 6 in Appendix on page 78.)

At What Age?

The mean age that training directors in this sample seek assent from their adolescent clients was 10.6 years of age ($n = 68$, $SD = 4.4$). The mean age the directors seek informed consent from their adolescent clients is 14.4 years of age ($n = 59$, $SD = 3.3$). This difference in age is statistically significant, $t(55) = -6.363$, $p < .000$). The age of 14 is consistent with previous research mentioned above.

Parental Access

It appears that APPIC training site directors still seek assent more often than informed consent, but that seeking informed consent is reported to be increasing, and the age informed consent is sought is roughly four years younger than the legal age in most state. Moreover, in answer to the question, "Do parents have free access to information regarding the therapy of their adolescent (apart from family sessions)," 47 of the 76 participants, or 61.8%, who answered the question said, "No, parents do not have access" (17 males, 30 females).

Participants were then asked the question, "In your opinion, has the practice of providing parental access to information regarding the therapy of their adolescent increased over the past decade?" Seventy-three participants answered this question, with the majority, 48 respondents, or 65.8%, saying that, "No, parental access has not increased" (20 males, 28 females).

What Information is Important to Give Parents?

The question, " How important do you consider the provision of the following types of information to the parents of an adolescent with whom you are working?" Participants were to rate each of the types of information on a scale from 1 (not important) to 5 (extremely important). (See questionnaire item 10 in Appendix page 78.)

The type of information with the highest mean was telling the parents the limits to confidentiality (n = 79, M = 4.75 SD = .69). Please refer to Table 5 on page 43 for a comparison of the means and standard deviations of the importance of different types of information endorsed by participants as information to provide to parents of adolescent clients.

A repeated measures general linear one way analysis of variance model was used to determine if there was a difference in the mean importance ratings for the eleven types of information to provide to parents. There was a statistically significant difference in the mean importance ratings ($F(1, 63) = 18.963$, $p < .01$, $\eta^2 = .751$).

Examination of Table 5 on page 43 indicated the rank order of means for the types of information to provide to parents, was: Limits to confidentiality; Financial cost; Intended outcome of therapy or goals and objectives; Possible negative side effects; Possible advantages to therapy; Time, place, setting, & duration of sessions; Probability of the intended outcome; Description of alternatives; Nature of the sessions; Training and qualifications of therapist; and a Description of therapist's orientation to therapy.

The non-parametric test, Friedman's test of rank orders, demonstrated a statistically significant difference in the rank order of the eleven types of information ($X^2 = 183.532$, $df = 10$, $p < .01$)

Another way of exploring the importance of the different types of information to provide to parents of adolescent clients is to examine the proportion of respondents that found each type of information to be "extremely important." The rank order of the types of information according to the proportion of "extremely important" ratings can be viewed in Table 6 on page 44.

The limits to confidentiality was rated as extremely important by the highest percent of respondents, with 66 of 79, or 83.5%. Other types of information written in by respondents included: how parents' requests for information would be handled, how information might be related to parents' needs, the reporting laws of the state (i.e.: Tarasoff), and how the therapist would handle any school related issues.

What Information is Important to Give Adolescents for Assent versus Informed Consent?

The question, " How important do you consider the provision of the following types of information to the adolescents with whom you are working when seeking informed consent or when seeking assent?" Participants were asked to separately rate each of the types of information on a scale from 1 (not important) to 5 (extremely important) for assent and for informed consent. (See questionnaire item 11 in Appendix on page 78.)

Table 5. Types of information provided to parents for informed consent; to adolescents for assent and for informed consent [a]

Types of Information	Parents			Adolescent Assent			Adolescent Consent		
	n	Mean	SD	n	Mean	SD	n	Mean	SD
Confidentiality	79	4.75	.69	75	4.81	.54	65	4.62	1.00
Cost	79	4.46	1.72	70	2.47	1.14	61	2.72	1.13
Intended outcome	79	3.92	.97	75	4.33	.76	63	4.22	1.04
Negatives	79	3.71	1.00	75	3.60	1.10	63	3.56	1.20
Advantages	79	3.65	.85	75	3.71	.91	63	3.59	1.11
Time, etc	79	3.63	1.12	75	4.00	1.07	61	3.95	1.13
Probability of outcome	78	3.53	1.00	74	3.61	.99	62	3.56	1.13
Alternatives	79	3.51	.97	75	3.40	1.14	63	3.35	1.18
Therapists' training	79	3.28	1.10	75	2.68	1.10	63	2.78	1.13
Therapists' orientation	79	2.90	1.18	75	2.55	1.13	63	2.51	1.15

For assent, the type of information that ranked the highest was telling the adolescent the limits to confidentiality (n = 75, M = 4.81, SD = .54). The ranking of the respondents' mean ratings for assent, of provided types of information, was as follows (and can be viewed in Table 5): the Limits to Confidentiality; the Intended outcome of therapy, or goals and objectives; the Nature of the sessions; the Time, place, setting, and duration of sessions; the

Possible advantages; the Probability of the intended outcome; the Possible negative side effects; a Description of the alternatives; the Training and qualifications of the therapist; a Description of the therapist's orientation to therapy; and the Financial cost.

A repeated measures general linear one way analysis of variance model was performed to determine if there was a difference in the mean importance ratings for the eleven types of information to provide to adolescents for assent. There was a statistically significant difference in the mean importance ratings ($F(1, 58) = 34.054$, $p < .01$, $\eta^2 = .854$). See Table 5 on page 43 for a comparison of the means and standard deviations of the different types of information provided to adolescent clients when seeking assent.

Table 6. Rank order of types of information to provide to parents based on the proportion of "very important" endorsements made by respondents

Type of Information	% endorsements	n
Limits to confidentiality	83.5	66
Financial cost	57.5	42
Intended outcome	32.9	26
Time, place, setting, duration	25.3	20
Possible negative side effects	25.3	20
Probability of intended outcome	20.5	16
Description of alternatives	17.7	14
Nature of sessions	17.7	14
Possible advantages	15.2	12
Training and qualifications	15.2	12
Therapist's theoretical orientation	11.4	9

For informed consent, the type of information that ranked the highest was, again, telling the adolescent the limits to confidentiality ($n = 65$, $M = 4.62$, $SD = 1.0$). The ranking of the respondents' mean ratings for informed consent, of the listed types of information, differed slightly from the ranking for assent (see Table 5 on page 43) and was as follows: the

Limits to confidentiality; the Intended outcome, or goals and objectives; the Nature of the sessions; the Time, place, setting, and duration of sessions; the Possible advantages of therapy; the Probability of the intended outcome and the Possible negative side effects tied, a Description of the alternatives followed, the Training and Qualifications of the therapist; and the Therapists' theoretical orientation to therapy.

A repeated measures general linear one way analysis of variance model was used to determine if there was a difference in the mean importance ratings for the eleven types of information to provide to adolescents for informed consent. There was a statistically significant difference in the mean importance ratings ($F(1, 47) = 16.352$, $p < .01$, $\eta^2 = .777$). See Table 5 on page 43 for a comparison of the means and standard deviations of the different types of information endorsed by participants as information to provide to adolescent clients when seeking informed consent.

The mean ratings for assent and informed consent were quite similar, but notice that there were fewer respondents providing opinions on informed consent. As shown in Table 5 on page 41 there was a modal number of responses of seventy-five for assent questions and sixty-three for informed consent questions. One possible reason for this is that if the respondent does not seek informed consent for her/his clients, she/he may chosen not to provide an opinion on what types of information is important to give adolescent clients when seeking informed consent.

An additional way of examining the importance of the different types of information to provide to adolescent clients is to examine the proportion of respondents that found each type of information to be "extremely important." The rank order of the types of information

according to the proportion of "extremely important" endorsements for assent with adolescents can be viewed in Table 7 below and in Table 8 on page 47 for informed consent.

The non-parametric test, Friedman's test of rank orders, was performed on the ranking for assent and for informed consent and demonstrated a statistically significant difference in the rank order of the eleven types of information for assent ($X^2 = 341.169$, $df = 10$, $p < .01$) and informed consent ($X^2 = 247.906$, $df = 10$, $p < .01$).

Table 7. Rank order of types of information to provide to adolescents for assent based on the proportion of "very important" responses made by respondents [a]

Type of Information	% responses	n
Confidentiality	88.0	66
Nature	51.4	38
Intended outcome	49.3	37
Time, etc.	44.0	33
Negatives	25.3	19
Alternatives	24.0	18
Probability of outcome	21.6	16
Advantages	21.3	16
Therapist's orientation	11.4	9
Therapist's training	10.7	8
Cost	8.6	6

[a] There were 75 respondents for each variable except for Nature & Probability of outcome where there were 74, Cost where there were 70, & for Therapists' orientation there were 79 respondents.

For assent, expressing the limits to confidentiality were again ranked the highest with 88% (n = 66/75). The only other type of information that respondents had added to the list as being important information to disclose to the adolescent client when seeking assent was information about the reporting laws of the state in which the practice is located.

And for informed consent, explaining the limits to confidentiality was still ranked the highest type of information to disclose to an adolescent with whom you are working when

seeking to gain informed consent with 83.1% of the participants declaring it "extremely important" (n = 54/65). And as before, the only other type of information that respondents had added to the list, as being important information to disclose to the adolescent client when seeking assent, was information about the reporting laws of the state in which the practice is located.

Table 8. Rank order of types of information to provide to adolescents for informed consent based on the proportion of "very important" responses made by respondents [a]

Type of Information	% responses	n
Confidentiality	83.1	54
Intended outcome	50.8	32
Nature	50.8	32
Time, etc.	42.6	26
Negatives	27.0	17
Advantages	23.8	15
Alternatives	22.2	14
Probability of outcome	21.0	13
Cost	14.8	9
Therapist's orientation	11.1	7
Therapist's orientation	7.9	5

[a] There were 63 respondents for each variable except Confidentiality, Time, etc., Probability of outcome, and Cost, for which there were 65, 61, 62, and 61 respondents for each respectively.

Comparison of Types of Information Provided to Parents versus Adolescents When Seeking Informed Consent

Paired sample t-tests were conducted to examine differences in the mean importance ratings of each type of information when provided to parents for the purpose of seeking informed consent as compared to when the information is provided to an adolescent. Bonferroni adjustments were made to address the potential for Type I error. Thus the level of significance became more stringent than .05; it became .0045. As noted in Table 9 on

page 49, there were statistically significant differences in the means for: Nature of sessions; Financial Cost; Description of therapist's theoretical orientation; and Therapists' training and qualifications. Each type of information that was significantly different was rated as more important to tell the parents than the adolescent client. Results can be viewed in Table 9 on page 49.

Comparison of Types of Information Provided to Adolescents for Assent versus Informed Consent

Paired sample t-tests were conducted to examine differences in the mean importance ratings of each type of information when provided to adolescents for the purpose of seeking assent compared to when the information is provided for seeking informed consent. Again, Bonferroni adjustments were made to address the issue of Type I error. Thus the level of significance became more stringent than .05; it became .0045. As noted in Table 10 on page 50 there were no statistically significant differences in the mean importance ratings for information given to adolescents for assent compared to the mean importance ratings for information given for informed consent.

Why Not Seek Informed Consent From an Adolescent?

For the question, " How important do you consider each of the following reasons for not requesting informed consent from an adolescent," participants were asked to separately rate each reason on a scale from 1 (not important) to 5 (extremely important) for assent and for informed consent. (See questionnaire item 12 in Appendix on page 79.)

Table 9. Paired sample t-tests of mean importance ratings for types of information provided to parents when seeking informed consent compared to types of information provided to adolescents when seeking informed consent [ab]

	Mean difference	SD of difference	95% CI	t	df	Sig. (2-tailed)
Time, etc.	-.23	1.41	-.60 to .13	-1.27	60	.208
Nature	-.62	1.31	-.95 to -.29	-3.74	62	.000*
Confidentiality	.15	.94	-.08 to .39	1.32	64	.191
Intended outcome	-.25	1.19	-.55 to .05	-1.69	62	.096
Probability of outcome	.02	1.06	-.25 to .29	.12	61	.905
Cost	1.62	1.49	1.23 to 2.00	8.43	59	.000*
Therapists' orientation	.38	.99	.13 to .63	3.05	62	.003*
Therapists' training	.56	.91	.33 to .79	4.84	62	.000*
Advantages	.05	1.16	-.24 to .34	.33	62	.745
Negatives	.16	1.00	-.09 to .41	1.26	62	.214
Alternatives	.21	.74	.02 to .39	2.20	62	.031

[a] Note. Paired t-tests: Parent informed consent minus adolescent informed consent; means and standard deviations found in Table 5 on page 43.
[b] Note. * Difference statistically significant at $p < .0045$ or less.

As indicated by Table 11 on page 51, the most cited reason was that the adolescent might refuse to consent ($n = 75$, $M = 2.49$, $SD = 1.32$). A repeated measures general linear one way analysis of variance model was used to determine if there was a difference in the mean importance ratings for the nine reasons for not seeking informed consent. There was a statistically significant difference in the mean importance ratings ($F(1, 62) = 4.058$, $p < .01, \eta^2 = .344$).

See Table 11 on page 51 for a delineation of the means and standard deviations of the different reasons to not seek informed consent. However, note that none of the ratings exceeded the mid-point of the rating scale. They were all rated in the relatively not important range. The non-parametric test, Friedman's test of rank orders, was also performed. It again

demonstrated a statistically significant difference in the rank order of the nine reasons for not seeking informed consent ($X^2 = 30.589$, df = 8, $p < .01$).

Table 10. Paired sample t-tests of mean importance ratings for types of information provided to adolescents when seeking assent compared to when seeking informed consent [ab]

	Mean difference	SD of difference	95% CI	t	df	Sig. (2-tailed)
Time, etc.	.07	.83	-.15 to .28	.614	60	.542
Nature	.21	.90	-.02 to .44	1.86	60	.068
Confidentiality	.20	.88	-.02 to .42	1.86	63	.068
Intended outcome	.11	.70	-.07 to .29	1.26	61	.211
Probability of outcome	.10	.72	-.09 to .28	1.06	60	.293
Cost	-.15	.82	-.36 to .06	-1.42	59	.162
Therapists' orientation	.03	.57	-.11 to .18	.44	61	.658
Therapists' training	-.02	.53	-.15 to .12	-.24	61	.811
Advantages	.19	.79	-.006 to.39	1.94	61	.057
Negatives	.10	.69	-.08 to .27	1.10	61	.277
Alternatives	.06	.57	-.08 to .21	.89	61	.375

[a] Note. Paired t-tests: Adolescent assent - adolescent informed consent; means and standard deviations found in Table 5 on page 43.
[b] Note. * Difference statistically significant at $p < .0045$ or less.

Current Assent or Informed Consent Seeking Practices

Of the 75 respondents who answered the question about their current assent and informed consent practices, 27 seek only assent from the adolescent client (36.0%), 22 seek both informed consent and assent from adolescent clients (29.3%), 16 seek informed consent from the adolescent client only (21.3%), and 10 seek neither assent nor informed consent from the adolescent client (13.3%).

Why Seek Informed Consent versus Assent from Adolescents?

The question, questionnaire item 13, asked " How important do you consider each of the following reasons for requesting assent and for informed consent from an adolescent?" Participants were to separately rate each of the types of information on a scale from 1 (not important) to 5 (extremely important) for assent and for informed consent.

Table 11. Reasons for not seeking informed consent

Reason	n	Mean	SD
Adolescent may refuse	75	2.49	1.32
Not legally required	74	2.46	1.46
Clients are too young	74	2.41	1.31
Not ethically required	75	2.25	1.20
Not a practice in this setting	74	2.24	1.31
Increase anxieties & exacerbate problems	75	1.97	1.10
May reduce self-disclosure	73	1.96	1.07
Too much information	74	1.91	1.04
Infringes on parents' rights	73	1.88	1.05

As noted in Table 12 on page 52, training directors rated enhancing the therapeutic relationship as the most important reason to seek assent ($n = 66$, $M = 4.06$, $SD = 0.93$). The highest rated reason for requesting informed consent was "to satisfy ethical requirements" ($n = 59$, $M = 3.86$, $SD = 1.30$). A repeated measures general linear model was used to determine if there was a difference in the mean importance ratings for the nine reasons to seek assent and another for the nine reasons for seeking informed consent.

There was a statistically significant difference in the mean importance ratings for assent ($F(1, 56) = 23.958$, $p < .01$, $\eta^2 = .774$). There was also a statistically significant difference in the mean importance ratings for informed consent ($F(1, 49) = 14.928$, $p < .01$,

$\eta 2 = .709$). See Table 12 below for a delineation of the means and standard deviations of the different reasons endorsed by participants as reasons for requesting informed consent or assent from adolescent clients.

Paired sample t-tests were conducted to examine differences in the mean importance ratings for each reason to seek assent from adolescents compared to importance ratings for each reason to seek informed consent. Again, Bonferroni adjustments were made to address the issue of Type I error. Thus the level of significance becomes more stringent than .05; it becomes .0055. As noted in Table 13 on page 53, there was a statistically significant difference in the means for Motivation, which was rated as a more important reason when seeking assent than when seeking consent. Results can be viewed in Table 13 on page 53.

Table 12. Reasons for seeking assent or informed consent

Reasons	Assent			Consent		
	n	Mean	SD	n	Mean	SD
Therapeutic relationship	66	4.06	.93	59	3.78	1.12
Appropriate expectations	66	4.05	.87	59	3.85	1.08
Autonomy and control	65	3.94	1.00	59	3.66	1.18
Motivation	66	3.94	1.04	59	3.56	1.18
Ethical requirements	65	3.78	1.15	59	3.86	1.30
Accommodate older adolescents	65	3.38	1.34	58	3.36	1.45
Legal requirements	65	3.34	1.36	59	3.54	1.42
Minimize complications	64	2.50	1.31	58	2.62	1.37
Those who want therapy	65	2.35	1.07	59	2.24	1.13

The different reasons were also qualitatively examined to see how they ranked compared to each other in importance as ranked by participants as "extremely important." These rankings of percent of respondents who find the reasons "extremely important" can be

viewed in Table 14 on page 54 for assent and informed consent. The non-parametric test, Friedman's test of rank orders, was performed and demonstrated a statistically significant difference in the rank order of the nine reasons for seeking assent ($X^2 = 159.356$, df = 8, $p < .01$) and also in the rank order of the nine reasons for seeking informed consent ($X^2 = 105.888$, df = 8, $p < .01$).

The most important reason cited for seeking assent and informed consent from adolescents was satisfying ethical requirements with 38.5% of respondents listing this reason as an "extremely important" one (n = 25/65) for seeking assent and 45.8% for seeking informed consent (n=27/59) .

Table 13. Paired sample t-tests comparing assent reasons compared to consent reasons [ab]

	Mean difference	SD of difference	95% CI	t	df	Sig. (2-tailed)
Motivation	.33	.82	.11 to .55	2.97	54	.004*
Appropriate expectations	.25	.87	.02 to .49	2.18	54	.034
Therapeutic relationship	.29	.94	.04 to .54	2.30	54	.025
Legal requirements	-.22	.90	-.47 to .02	-1.81	54	.077
Ethical requirements	.06	1.04	-.23 to .34	.39	54	.695
Those who want therapy	.07	.75	-.13 to .28	.73	54	.470
Autonomy and control	.30	1.00	.02 to .57	2.17	54	.034
Minimize complications	-.13	.71	-.33 to .06	-1.36	52	.180
Accommodate older adolescents	.02	.66	-.16 to .20	.21	52	.837

[a] Note. Paired t-tests: Reasons to seek assent minus reasons to seek informed consent; means and standard deviations found in Table 12 on page 52.
[b] Note. * Statistically significant at $p < .0055$.

Table 14. Ranking of reasons to seek assent and consent by percent of "extremely important" ratings [ab]

Type of Information	Assent		Consent	
	% endorsements	n	% endorsements	n
Ethical requirements	38.5	25	45.8	27
Motivation	34.8	23	25.4	15
Therapeutic relationship	34.8	23	28.8	17
Appropriate expectations	33.3	22	32.2	19
Autonomy and control	30.8	20	27.1	16
Legal requirements	30.8	20	40.7	24
Accommodate older adolescents	23.1	15	27.6	16
Those who want therapy	16.9	11	3.4	2
Minimize complications	7.8	5	10.3	6

[a] There were 65 respondents for all reasons except for Motivation, Expectations, Relationship which had 66 respondents each, and Minimizing complications which had 64 respondents.
[b] There were 59 respondents for each of the variables except for Minimizing complications and Accommodating older adolescents with 58 respondents each.

Almost all of the reasons for seeking informed consent from an adolescent client showed more even distribution between "important," "very important," and "extremely important" as evidenced by the consistently larger standard deviations (shown in Table 13).

Unable to Assent or Consent?

Respondents reported that an average of 9.38% of the adolescents with whom the training directors had had contact with were unable to assent due to an insufficient understanding of the information provided to them (n = 69, SD = 10.94). A mean of 17.22% of the adolescents were reported by training directors as being unable to provide informed consent for the same reason (n = 60, SD = 18.49). (See questionnaire item 14 in Appendix on page 79.)

Actions taken when Adolescents are Unable to Assent or Consent

Participants were asked in questionnaire item 15, "Please rate each course of action listed below, indicating how likely you are to follow that course of action when the

adolescent is unable to give valid assent?" The same was asked for when the adolescents are unable to give valid consent in questionnaire item 16. Participants were asked to separately rate each of the actions listed on a scale from 1 (definitely not) to 5 (definitely would) for assent and for informed consent as to how likely they would be to engage in each type of action if the adolescent was unable to provide assent or informed consent. See Appendix on pages 79 and 80.

A repeated measures general linear one way analysis of variance model was again used to determine if there was a difference in the mean importance ratings for the six actions to take when the adolescent was unable to give assent and when the adolescent is unable to give informed consent. There was a statistically significant difference in the mean likelihood ratings for assent ($F = 25.311$, $df = 63$, $p < .01$, $\eta^2 = .668$) and also for informed consent ($F = 17.113$, $df = 55$, $p < .01$, $\eta^2 = .609$).

The action that received the highest rating for engaging in when the adolescent is unable to assent was to go ahead and proceed with parental consent only ($n = 69$, $M = 3.97$, $SD = 1.01$). The type of action that ranked the highest for engaging in when the adolescent is unable to provide informed consent was proceeding with only parental consent ($n = 61$, $M = 3.98$, $SD = 1.06$). A comparison of the means and standard deviations of the different actions taken by participants when the adolescent is unable to provide assent or informed consent can be viewed in Table 15 on page 56.

Paired sample t-tests were conducted to examine differences in the mean likelihood ratings for each action for when the adolescent is unable to assent compared to likelihood ratings for each action for when the adolescent is unable to provide informed consent.

Table 15. Action taken when adolescent is unable to assent or consent

Action	Assent			Consent		
	n	Mean	SD	Mean	SD	N
Use parental consent	69	3.97	1.01	3.98	1.06	61
Contract	69	3.55	1.08	3.28	1.10	61
Enlist parents' help	69	3.52	1.13	3.52	1.22	61
Family therapy	68	2.90	1.22	2.82	1.24	60
Refer elsewhere	69	2.36	1.01	2.26	.96	61
Do not treat	69	2.12	.99	2.18	1.10	61

Bonferroni adjustments were again made to address the issue of Type I error. Thus the level of significance was then more stringent than .05; it became .0083. As noted in Table 16, with this more stringent significance level, there were no statistically significant differences in the mean likelihood ratings. Results can be viewed in Table 16 below.

Table 16. Paired sample t-tests comparing actions for when the adolescent is unable to assent to actions taken when the adolescent is unable to provide informed consent [ab]

	Mean difference	SD of difference	95% CI	t	df	Sig. (2-tailed)
Do not treat	-.10	.09	-.28 to .09	-1.06	60	.293
Contract	.23	.10	.03 to .43	2.29	60	.026
Parental consent	.00	.07	-.15 to .15	.00	60	1.000
Enlist parental help	.02	.11	-.20 to .23	.15	60	.880
Family therapy	.13	.09	-.05 to .32	1.43	59	.159
Refer elsewhere	.10	.07	-.04 to .24	1.43	60	.159

[a] Note. Paired t-tests: Actions when unable to assent minus actions when unable to consent; means and standard deviations found in Table 15 on page 56.
[b] Note. * Statistically significant at $p < .0083$.

The different actions were again also examined qualitatively to see how they ranked compared to each other in importance as ranked by participants as "definitely would" follow this course of action. The non-parametric test, Friedman's test of rank orders, was again performed and demonstrated a statistically significant difference both in the rank order of the

six actions to take when the adolescent is unable to assent ($X^2 = 128.625$, df = 5, $p < .01$) as well as the actions to take when the adolescent is unable to consent ($X^2 = 101.999$, df = 5, $p < .01$). These rankings of percent of respondents who "definitely would" engage in that action can be viewed in Table 17 below for both assent and informed consent.

The action most endorsed as something the practitioner would definitely do was to proceed with therapy using the parents' consent: 22 participants said they would definitely do this, 32 said they would probably do this (31.9% and 46.4% respectively, n = 69 overall).

The actions that participants would take in the event the adolescent client was unable to consent ranked in the same order as assent. They would continue therapy using parental consent. Of the 61 responses, 36.1% (n = 22) definitely would continue and 39.1% said they probably would continue with only parental consent (n = 24).

Table 17. Ranking of actions when adolescent is unable to assent or consent [ab]

Type of Information	Assent		Consent	
	% endorsements	n	% endorsements	n
Use parental consent	31.9	22	36.1	22
Enlist parents' help	17.4	12	21.3	13
Contract	11.6	8	3.3	2
Family therapy	8.8	6	6.7	4
Refer elsewhere	4.3	3	3.3	2
Do not treat	1.4	1	3.3	2

[a] For the assent variables there were 69 respondents for each of the variables except Family therapy with 68 respondents.

[b] For the consent variables there were 61 respondents for each of the variables except Family therapy with 60 respondents.

Refuse to Assent or Consent?

In item 17, respondents reported an average of 7.26% of the adolescents with whom they had contact with had refused to assent (n = 65, SD = 13.81). A mean of 5.22% of the adolescents were reported as having refused to provide informed consent (n = 49, SD = 7.55).

Actions taken when Adolescents Refuse to Assent or Consent?

Participants were asked, in item 18, to, "Please rate each course of action listed below, indicating how likely you are to follow that course of action when the adolescent is refuses to give valid assent? Refuses to give valid consent?"

Participants were to separately rate each of the actions listed on a scale from 1 (definitely not) to 5 (definitely would) for assent and for informed consent as to how likely they would be to engage in each type of action if the adolescent was refused to provide assent or informed consent. See Appendix page 80.

As noted in Table 18 on page 59 the action that received the highest rating for when the adolescent was refusing to assent was trying to work through the resistance (n = 63, M = 3.90, SD = 1.07). The type of information received the highest rating for when the adolescent has refused to provide informed consent was, also in this case, trying to work through the resistance (n = 52, M = 3.73, SD = 1.29).

Again, a repeated measures general linear analysis of variance model was used to determine if there was a difference in the mean importance ratings for the seven actions to take when the adolescent refuses to assent and the seven actions to take when the adolescent refuses to consent. There was a statistically significant difference in the mean likelihood ratings for actions when the adolescent refuses assent ($F(1, 56) = 15.171$, $p < .01$,

$\eta^2 = .619$) and also for informed consent ($F(1, 45) = 8.723$, $p < .01$, $\eta^2 = .583$). Table below presents the means and standard deviations of the different actions taken by participants when the adolescent refuses to provide assent or informed consent.

Table 19 on page 60 shows the results of the paired sample t-tests that were conducted to compare the means of each action when the adolescent refuses assent and its corresponding action when the adolescent refuses to provide informed consent. The Bonferroni adjusted significance level became .0071. The results demonstrated no statistically significant differences of the means between actions taken when the adolescent refuses to assent compared to when she/he refuses to assent.

The different actions were again also examined qualitatively to see how they ranked compared to each other in importance as ranked by participants as "definitely would" follow this course of action.

Table 18. Action taken when adolescent refuses to assent or consent

Action	Assent			Consent		
	n	Mean	SD	n	Mean	SD
Work through resistance	63	3.90	1.07	52	3.73	1.29
Contract	63	3.78	.99	52	3.62	1.12
Enlist parents'	63	3.65	1.14	52	3.67	1.15
Use parental consent	63	3.29	1.30	52	3.23	1.44
Do not treat	63	2.76	1.13	52	2.79	1.23
Refer elsewhere	63	2.63	1.15	52	2.73	1.25
Family therapy	62	2.61	1.27	51	2.51	1.29

Table 19. Paired sample t-tests comparing actions for when the adolescent refuses to assent to actions taken when the adolescent refuses to provide informed consent [ab]

	Mean difference	SD of difference	95% CI	t	df	Sig. (2-tailed)
Do not treat	-.13	.53	-.28 to .03	-1.63	47	.110
Contract	.10	.56	-.06 to .27	1.30	47	.200
Use parental consent	.04	.58	-.13 to .21	.50	47	.622
Enlist parental help	.00	.46	-.13 to .13	.00	47	1.000
Family therapy	.04	.29	-.13 to .04	-1.00	47	.323
Refer elsewhere	-.15	.62	-.33 to .03	-1.63	47	.109
Work through resistance	.13	.53	-.03 to .28	1.63	47	.110

[a] Note. Paired t-tests: Actions when refuse assent minus actions when refuse informed consent; means and standard deviations found in Table 18 on page 59.
[b] Note. Statistically significant at $p < .0071$.

Finally, the non-parametric test, Friedman's test of rank orders, was performed and demonstrated a statistically significant difference in the rank order of the seven actions taken when the adolescent refuses to assent ($X^2 = 86.101$, $df = 6$, $p < .01$) and in the rank order of actions when the adolescent refuses to consent ($X^2 = 61.509$, $df = 6$, $p < .01$). See Table 20 on page 61 for rankings of actions endorsed as "definitely would do" for when the adolescent refuses to assent and for when the adolescent refuses to provide informed consent.

The action most endorsed as something the practitioner would definitely do if the adolescent refused to assent would be to try to work through the resistance: twenty-one participants said they would definitely do this and twenty-four said they would probably do this (33.3% and 34.6% respectively, $n = 63$ overall).

The first course of action endorsed by participants for when adolescents refuse to accord consent was to try to work through the resistance. There were 34.6% that said they would definitely proceed in this fashion ($n = 18$). Another 30.8% said they would probably do this ($n = 16$), and another 17.3% were uncertain ($n = 9$).

Table 20. Rankings of actions for when adolescent refuses assent or consent [ab]

Type of Information	Assent		Consent	
	% endorsements	n	% endorsements	n
Work through resistance	33.3	21	34.6	18
Enlist parents' help	23.8	15	25.0	13
Contract	19.0	12	19.2	10
Use parental consent	17.5	11	23.1	12
Family therapy	6.5	4	5.9	3
Do not treat	4.8	3	5.8	3
Refer elsewhere	3.2	2	5.8	3

[a] There were 63 respondents for each of the variables for assent except Family therapy with 62 respondents.
[b] There were 52 respondents for each of the variables for consent except Family therapy with 51 respondents.

Primary client

Participants were asked "Whom do you consider to be your primary client when providing counseling to adolescents?" Of the 79 respondents, 43 respondents (20 males, 23 females), 54.4%, replied that the adolescent was the primary client, 27 respondents (16 males, 11 females), 34.2%, said that both the adolescent and the parent was the primary client, 6 respondents (3 males, 3 females), 7.6%, replied the parent was the primary client, and 3 respondents (1 male, 2 females), 3.8%, said the agency or institution was the primary client.

DISCUSSION

The current study is a replication and extension of the Beeman & Scott (1991) survey regarding adolescent informed consent and psychotherapy. This study assessed informed consent and assent in relation to adolescents and psychotherapy. This present section discusses current results as well as comparing them to those in the Beeman & Scott (1991) study. Comparisons are made between two cross-sectional samples of two different sets of training directors drawn at two different times approximately a decade apart. Thus these data are not longitudinal.

This Study's Findings

The main findings for this study were as follows:

- There is variability if the application of informed consent. Experienced practitioners in this study with doctoral level education (mostly clinical with a cognitive-behavioral orientation), an average of 11 years of experience, and who spend a majority of their time working with adolescents (83% of clients) say in general, informed consent seeking is a practice that has increased. However, the consent procedures of the practitioners in this sample do not reflect that assertion.
- The mean age that practitioners will seek informed consent is 14.4 years of age and 10.6 years of age for assent.
- State laws and agency policies, the age of the adolescent, and the cognitive capabilities of the adolescent are all used to determine whether to seek assent or informed consent. This indicates an adherence to current legal

policy, previous research results, and a multidimensional assessment approach.

- Seeking informed consent was less common than seeking assent despite practitioners not endorsing any of the given reasons as being extremely or very important reasons for not seeking informed consent.
- Parental involvement, but not unlimited access, is demonstrated by the actions the practitioners take when the adolescent is unable to or refuses to assent and when the adolescent is unable to or refuses to provide informed consent.

To answer "Do practitioners who provide mental services to adolescents make a distinction between informed consent and assent for psychotherapy; What elements, besides the adolescent's age, do practitioners use to determine whether to seek informed consent, beyond assent, from an adolescent client?" the answers to questionnaire items 3-9 were examined.

In the current study, very few practitioners gained informed consent from only the adolescent (4%). It is interesting to note that 67.1% of respondents in this sample said that the practice of seeking informed consent has increased in the past ten years, yet when comparing this study to the Beeman and Scott (1991) study there is a large decrease in the percent of respondents who gain informed consent from adolescent clients. The reason for this? In the intervening decade from the first study to the current study the advent of assent has provided the counselor more options for soliciting cooperation in psychotherapy from an adolescent appropriate to the developmental level of the adolescent client. Assent, apart

from or in conjunction with informed consent, has provided an additional and appropriate method of seeking consent.

That practitioners did make the distinction between informed consent and assent can be demonstrated in two other ways beyond the difference in ages of the adolescent when assent is sought versus informed consent. There was a much higher percent of respondents that gained assent from adolescents in addition to informed consent from the parents (79.2%) than informed consent from the parents and the adolescent (56%). This distinction was also demonstrated by the mean number of adolescents from whom assent was actually sought (83.3%) as opposed to the mean number of adolescents from whom informed consent was actually sought (54.7%).

To answer "What information is provided to parents versus adolescents in consent procedures for psychotherapy? For adolescent informed consent versus assent?" questionnaire items 10 and 11 were examined. The type of information that was ubiquitous as being the extremely important type of information to give parents and adolescents regardless of the type of consent being sought is the limits of confidentiality. The therapist's orientation to therapy was considered to be least important.

The advantages, disadvantages, and alternatives to therapy were considered to be important, with only slightly varying rankings of the mean importance ratings. The logistics of therapy such as time, location, cost, purpose, and nature appeared more important to tell parents than adolescents, but there was little difference in what was considered to tell adolescents for informed consent than assent.

In order to address "What reasons do practitioners believe are important for not seeking informed consent from an adolescent client?" the responses to questionnaire item 12

were examined. The mean importance ratings for the reasons given were relatively midrange (from a possible range of 1-5 the mean importance ratings ranged from 1.88 to 2.49) indicating that the training directors did not find these reasons to be extremely important ones for not seeking informed consent. The reasons considered most important: the adolescent may refuse, it is not a practice in this setting, and the clients are too young, are congruent with the respondents previous indications that they are strongly guided by institutional or agency policies and state laws and the percentages for seeking informed consent.

"What reasons do practitioners believe are important for seeking informed consent or assent?" This question posed by the study can be answered by questionnaire item 13. Overall the mean importance ratings for the reasons to seek assent from an adolescent beyond using parental informed consent were higher than the mean importance ratings for the reasons to seek informed consent from an adolescent (means can be viewed in Table 12 on page 47).

The training directors in this sample considered enhancing the therapeutic relationship, setting up appropriate expectations, increasing the adolescent's motivation, and giving the adolescent a sense of autonomy and control important reasons for seeking assent with greater mean importance than when they are seeking informed consent. Reasons for seeking informed consent followed a similar vein in order of rank but with satisfying ethical requirements receiving the highest mean importance rating.

These results seem intuitive, as these are considerations for therapy that are strongly influenced by the adolescent's perceptions. Seeking assent from the adolescent beyond parental informed consent gives the adolescent a greater sense of power and as indicated by the training directors' responses is something considered by this sample of respondents for

the progression of therapy. Seeking informed consent can, in itself, satisfy the concerns when seeking assent, for informed consent is giving the adolescent the power on her/his own to make decision regarding her/his therapy.

"What are the current practices of clinicians rendering mental health services to adolescents when the adolescent is unable to provide assent or informed consent?" Questionnaire items 14-16 addressed this question. As mentioned about there were very few adolescent clients with whom this sample of training directors had contact with that were unable to assent (9.38%) and only slightly more that were unable to provide informed consent (17.22%). When adolescents are unable to accord consent the training directors in this sample are most likely to use parental consent to continue with therapy, to seek parental assistance or to contract with the adolescent for a specified number of sessions. The practice of training directors in this sample is to continue therapy rather than discontinuing.

A distinction was made between actions training director practitioners might take when the adolescent was unable to assent or consent compared to when the adolescent refuses to assent or consent. Question 7 posed by the study assesses this difference by asking: What are the current practices of clinicians who render mental health services to adolescents when the adolescent refuses to provide assent or informed consent? Participants addressed this occurrence and subsequent possible actions in questionnaire items 17-18.

Similar to the percent of adolescents unable to assent or consent there was a low occurrence of adolescents refusing to assent (7.26% of adolescent clients) and an even lower percent of adolescent clients who refuse to give informed consent to therapy (5.22%).

An additional action was provided for when adolescents refuse to provide informed consent. This is the option of having the practitioner try to work through the adolescent's

resistance. This was the action rated by the training director practitioners in this sample as their most likely course of action when the adolescent refuses to assent and for when the adolescent refuses to consent. Enlisting the parents' help in getting assent or consent or contracting with the adolescent for a specified number of sessions were the next most common actions to take.

It is interesting to note that not treating the adolescent gained a higher mean likelihood rating for when the adolescent refuses assent or consent than when the adolescent is unable to assent or consent. This would be according the adolescent somewhat more power in her/his therapy by acknowledging s/he understands and has made her/his choice to not continue.

Comparative Results

The differences between the current study and the Beeman and Scott (1991) study were as follows:

- The current study had 79/278 (28.42%) respondents compared to the 130/250 (52%) respondents in the Beeman & Scott (1991) study for a return rate somewhat lower than the Beeman & Scott, 1991, study.
- There were 40 males and 39 females in this study, 91 males and 39 females in the Beeman & Scott (1991). Thus the current study had not only a greater number of women respondents, but also a more equal distribution of males and females.
- In the Beeman & Scott (1991) study, 85% of the respondents held doctoral degrees compared to 94% of the respondents in the current study.
- Psychiatric hospitals were tied with community mental health centers the most common settings in the Beeman & Scott (1991) study.

- The most common theoretical orientation was cognitive/behavioral (36.7%) in this study compared to 27% reporting an eclectic theoretical orientation in the Beeman & Scott (1991) study.
- The percent of adolescent clients seen by respondents in the Beeman & Scott study was 54.3% and in the current study it was 83%.
- There were 40% of the training directors that gained parental informed consent 4% that gained adolescent informed consent as opposed to the Beeman & Scott (1991) study, where 70% of the respondents gained adolescent informed consent and 94.4% generally gained parental informed consent.
- The age for informed consent is higher than the age for seeking assent in this study (14.6 up from 10.6 years of age). The mean age for seeking informed consent from the Beeman & Scott (1991) study was 12.8 years (age assent was sought was not assessed in that sample).
- In the current study 61.8% respondents said that parents did not have access compared to 75% of respondents in the Beeman & Scott (1991) study.
- The findings of the Beeman & Scott (1991) study demonstrated overall higher mean ratings for the reasons to not seek informed consent than in the current study.

The similarities between the current findings and the results of the Beeman and Scott (1991) study are as follows:

- The majority of the respondents in both studies declared their specialization of their degrees to be in clinical psychology (65.8% in this study and 74% in the Beeman & Scott, 1991, study).

- The practitioners in both studies had an average of eleven years of experience at the time of the study.
- The most common primary setting in this study was community mental health centers. The percent of respondents practicing in these centers was similar for this study and the Beeman & Scott (1991) study (22.8% and 25%, respectively). The distribution of settings was diverse in both studies (the diversity of settings for this study can be viewed in Table 3).
- The percent of time spent conducting therapy averaged 38.2% in the Beeman & Scott (1991) study and 33.8% in the current study.
- These findings regarding types of information to provide to parents versus adolescents for informed consent were similar to the Beeman & Scott (1991) study with the exception that possible advantages to therapy had a higher mean importance rating that time, place, setting and duration.
- The two studies showed similar results for reasons to seek informed consent and both included satisfying ethical requirements as a top reason for seeking informed consent.
- The Beeman & Scott (1991) study reported a mean of 11.3% of clients that were unable to provide informed consent as opposed to the 17.22% in this study that were unable to consent. In the present study 5.22% of adolescent clients refused to consent as opposed to the Beeman and Scott (1991) study where 11.6% of clients refused to consent.
- The actions taken by practitioners in this study when either of these situations occurred are similar to the Beeman & Scott (1991) study.

CONCLUSIONS

Summary

The overall theme from this study's findings is that practitioners appear to be differentiating between assent and informed consent. The differences in the ages that assent and informed consent are each sought as well as the rise in age for informed consent from 1991 to the present evidence of this theme. Practitioners in this study have indicated that agency policies and state laws, which have a large emphasis on age rather than cognitive capabilities or decision-making capabilities, are the default guidelines used when determining whether to seek assent or informed consent. Assent was a common practice in this sample of training directors in this study and is used to benefit the adolescent's psychotherapy. These two last findings reflect legal considerations as well as ethical considerations.

Seeking informed consent was less common despite respondents indicating that the reasons for not seeking informed consent were not extremely or even very important ones. One conclusion that could be drawn by the differences in the means between the two studies for the reasons is that current training directors do not find the reasons to be as inhibiting. Another explanation could be that training directors in 1991 had only informed consent and not assent as option and therefore gave greater consideration to reasons why they might not than the current sample of training directors for whom assent seeking was more common. Even when informed consent is sought there is a great deal of involvement of parents if the adolescent refuses psychotherapy. However, parental involvement does not mean that parents have unlimited access to information regarding the therapy of their adolescent.

Ultimately, the conclusion can be made that the practice of seeking informed consent for adolescent clients is a practice with a great deal of variability in its application.

Strengths

One of the strengths of this study is that the sample consists of experienced doctoral level practitioners in the position to provide guidance for future psychologists and influence future trends in the field of adolescent psychotherapy. Of these practitioners, most spent much of their time conducting therapy and treating adolescents.

In addition, the respondents were from a national sample and included a greater number of female respondents, thus allowing a greater degree of generalizability and better reflected the demographics of the field of training directors today.

Another strength of the study is that the study assessed the distinction psychologists make between assent and informed consent and had an objective item format with opportunities for participants to expand their answers and make additional comments.

The basic format and analyses were kept similar as possible to the Beeman and Scott (1991) study and therefore allowed greater comparison to that study.

Weaknesses

The most noticeable weakness of the study is the low return rate. Despite systematic efforts to increase return rate, the sample size remained lower than the Beeman & Scott (1991) study but comparable to the Taylor, et al (1984) 27% return rate. This lower return rate reduces generalizability of the study and comparability to the Beeman & Scott (1991) study.

There were dramatic differences in regional return rates compared to the initial regional distributions. The differences ranged from 3.59% less returned to as much as

17.26% less returned. This demonstrates that while there is good representation of national regions in the sample, there were not proportional response rates for each region. The Beeman & Scott (1991) study did not track respondents by geographical region.

It is theorized that at least a partial contributor to this low return rate was the time of year the surveys were sent to training directors at APPIC directory sites. The time of year the survey was sent out corresponded to the time of year when internship applications are due, increasing the workloads of the training directors and thus, their ability to engage in additional endeavors. In addition, the winter holiday season often contributes to absences from sites due to vacations.

Another weakness could be possible bias the respondents versus the nonrespondents. However, based upon what is known about the nonrespondents, no bias was detected on the basis of work settings or theoretical orientation. The respondents represented the full range of the sampled primary work settings and theoretical orientations. Theoretically, nonrespondents had little or no direct frequent contact with adolescents. Such would be the case with college counseling centers whose primary adolescent contact would be with adolescents already at the high end of the definition of adolescent for the purposes of this study (17 year s of age).

The survey, in its attempt to be thorough to assess distinctions between assent and informed consent, was complex in its dual column format and had additional length from the Beeman & Scott (1991) study. This may have also contributed to the low return rate as the survey may taken more time than the potential respondent wished to spend on it. In addition, those who did respond may have provided less thoughtful and less differentiated responses

by the end of the questionnaire due to fatigue or disinterest. The order of the questions was not varied so order effects could not be examined.

Race, ethnicity, and age (apart from the date the practitioner received her/his degree) were three domains not addressed in this study. There is no reason, however, to necessarily believe these demographic variables would have a direct and significant relationship to any of the ethical considerations that were the focus of this study.

Future Research

It is recommended that future research continue to include national samples, but also seek to include other types of mental health professionals and sites that treat adolescents such as private practitioners. It would be suggested that a method for tracking the sites' type and theoretical orientation from the beginning rather than determining the distribution at the end of the study should be developed. Race, ethnicity, and age of the respondent could be included in future studies if the researcher is interested in testing the affects of these variables.

The main purpose of this study was to replicate and extend a previous study so the questionnaire was primarily left the same with assent questions added in. Future research could consider the use of branching tree structure or between subject designs. The questionnaire could be arranged differently in order to separate the columns to make it easier to understand. The order of questions as well as the options within each question should be varied to address the possibility of order effects. Vignettes manipulating assorted variables such as age, cognitive competencies of the adolescent, or refusal versus inability to consent could be another approach.

In addition, the unique and valuable perspectives of adolescents as they struggle for autonomy would be essential, not only to add to the literature but also to a more complete understanding of procedures in psychotherapy with adolescents.

It seems apparent that despite not seeking informed consent, practitioners do value the adolescents' rights to autonomy and to influence the progression of their own psychotherapy. In this study, it was shown to be a common practice to seek assent as one way to show adolescents that respect.

By gaining adolescents' perspectives on psychotherapy's informed consent practices and the subsequent responses of practitioners, the field of knowledge can be embellished with additional ways, generated by adolescents, to respect their autonomy in a changing world where the law does not seem to be keeping up with the additional responsibilities and opportunities being afforded to adolescents. Adolescents' perspectives, as opposed to those of adults, can also help determine if the practitioners' intentions for using assent or informed consent are having the desired effects. Thus, this knowledge can then be used to make the psychotherapy experience more available, meaningful, and useful to adolescents.

APPENDIX

MATERIALS

Postcard 1

Iowa State University
Psychology Department
Dr. Norman A. Scott
Summer Brunscheen
W112 Lagomarcino Hall
Ames, Iowa 50011

IOWA STATE UNVERSITY
ADOLESCENT INFORMED CONSENT SURVEY

Dear Colleague,

Approximately one week from now, you will be receiving a survey seeking your attitudes and practices regarding the informed consent process with adolescent minor clients. This study is part of thesis research and aims to increase the knowledge about practices of informed consent procedures with adolescents by practitioners. As a training director working with adolescents you are in a special position to provide this knowledge. You responses to this survey are very valuable and we thank you in advance for your participation.

Sincerely,

Summer K. Brunscheen
Graduate Student

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

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

October 9, 2000

Dear Psychologist Colleague:

We are requesting your participation in a study of assent and informed consent practices regarding psychotherapy with adolescents. Your agency has been selected from the Association of Psychology Postdoctoral and Internship Centers (APPIC) directory as a site that provides services to adolescents. We are aware that you, as the chief psychologist/training director, may not necessarily treat adolescents. Therefore, we request you forward this survey to an appropriate staff member if, as a part of your activities, you do not provide adolescent services. This research is being conducted at Iowa State University and has been approved by the University's Human Subjects Review Board.

Informed consent for psychotherapy with adolescents is a controversial issue that has been receiving increasing attention. We are interested in examining the degree to which adolescents are presently given the opportunity to consent to therapy, with or without parental knowledge. We are especially interested in practicing psychologists' attitudes towards assent and informed consent procedures. You, as a therapist for adolescents, are in a unique position to help provide an understanding of practices and attitudes in this domain. It is because this issue is so controversial that an accurate assessment of the attitudes and practices is vital. Your cooperation with this research is crucial in helping increase knowledge of informed consent procedures and practices.

Completion of this anonymous survey should take at most one half-hour. We recognize the time commitments you already have, but hope you will take the opportunity to participate in this study. Your knowledge, opinions, and ideas are critical to a better understanding this complex area. Thus, your cooperation is needed, valued, and will be greatly appreciated.

No individual data obtained from this survey will be reported. Summaries will report group data only. All responses will be kept confidential and anonymous.

After completing the survey, please mail it in the postage-paid envelope provided. We would appreciate a response no later than October 30, 2000. If you would like a summary of the results of this research and/or would like to be entered in the drawing for one of two $50 gift certificates to the **Amazon.com** website (drawn randomly and without replacement), please check the appropriate boxes on the postcard and fill in your address. The odds of being accorded a prize are 2/343 if all selected sites participate in this research. The drawing will be held during the first week of December, and winners will be notified via U.S. mail.

Please return the postcard separately so that the anonymity of your questionnaire responses will be assured. By returning the enclosed survey, informed consent for participation in this research project is assumed. If you do not wish to participate and wish to avoid a follow-up, you may fill out the enclosed postcard with your address and check the option stating you are not interested in participating. This will ensure no further contact.

Thank you for your time and cooperation.
Sincerely,

Summer K. Brunscheen	Norman A. Scott, Ph.D.
Graduate Student	Associate Professor of Psychology

Informed Consent of Psychotherapy with Adolescents

This is an anonymous survey. Please complete the following items by: 1) placing an (X) in the appropriate blank; or 2) placing the chosen scale value in the appropriate blank; or 3) filling in the blank.

When finished, please return the survey in the postage-paid envelope provided for your convenience. No individual data obtained from this survey will be reported; summaries will report group data only. All responses will be kept confidential. ***By returning the enclosed survey, informed consent for participation in this research project is assumed.***

For the purpose of this survey, the following definitions will be used:

Adolescent: An adolescent is an individual whose age is 12-17 years.

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

Informed consent: Informed consent requires that an individual voluntarily give permission for a treatment and that the choice is made on the basis of sufficient information and formally assessed competency to make a decision.

Assent: Assent is asking a minor client to verbally agree or disagree to voluntarily enter into or continue treatment. It requires the minor to understand what treatment is being assented to and to understand that their permission is being sought independently of parent/guardian opinion or permission. Formal assessment of competency of the adolescent is not required.

1. In the setting in which you practice are there institutional/agency policies or state laws pertaining to informed consent for adolescents that guide your decisions to obtain informed consent or assent from adolescent clients? (Please check all that apply.)
   _____Institutional/Agency Policies _____ State Laws _____ Other (specify)_____

2. Whom do you generally gain informed consent from when working with adolescents: (Please check all that apply)
   a. _____ Parent/Guardians
   b. _____ Adolescent
   c. _____ Both Parent/Guardian **and** Adolescent

3. When working with adolescents if you seek informed consent from the Parent/Guardian, do you in addition seek assent from the adolescent? _____ Yes _____No

4. Which of the following the additional elements you would use to determine the necessity of obtaining an adolescent client's informed consent beyond seeking assent? Please check all that apply.
   _____ a. Cognitive capabilities to read and understand the informed consent statement
   _____ b. Cognitive capabilities to understand the costs and benefits of therapy
   _____ c. The degree of emancipation from the parent(s).
   _____ d. The ability to make informed decisions without undue influence.
   _____ Other (specify) _____

5. For what percentage of your adolescent clients do you seek assent? ____Informed consent?_____

6. In your opinion, has the practice of obtaining informed consent from adolescents increased in the past ten years? _____ Yes _____ No

7. At what age do you typically request a minor's assent? _____ Informed consent? _____

8. Do parents have free access to information regarding the therapy of their adolescent (apart from information from family therapy sessions)? _____ Yes _____ No

9. In your opinion, has the practice of providing parental access to information regarding the therapy of their adolescent increased over the past decade? _____ Yes _____ No

10. How important do you consider the provision of the following types of information to the parents of an adolescent with whom you are working? Please are the importance of each item using the following scale:
1 = Not important; 2 = Slightly important; 3 = Important; 4 = Very important; 5 = Extremely important
_____ a. Time, place, setting, and duration of sessions
_____ b. The nature of the sessions and what will take place
_____ c. Limits to confidentiality
_____ d. Intended outcome of therapy (goals and objectives)
_____ e. Probability of intended outcome
_____ f. Financial cost
_____ g. Description of therapist's orientation to therapy
_____ h. Training and qualifications of therapist
_____ i. Possible advantages of therapy
_____ j. Possible negative side effects
_____ k. Description of alternatives
_____ l. Other (specify)_____

11. How important do you consider the provision of the following types of information to the adolescents with whom you are working when seeking informed consent or when seeking assent? Please separately rate the importance of each item for both assent and informed consent using the following scale:
1 = Not important; 2 = Slightly important; 3 = Important; 4 = Very important; 5 = Extremely important

Assent	**Consent**	
_____	_____	a. Time, place, setting, and duration of sessions
_____	_____	b. The nature of the sessions and what will take place
_____	_____	c. Limits to confidentiality
_____	_____	d. Intended outcome of therapy (goals and objectives)
_____	_____	e. Probability of intended outcome
_____	_____	f. Financial cost
_____	_____	g. Description of therapist's orientation to therapy
_____	_____	h. Training and qualifications of therapist
_____	_____	i. Possible advantages of therapy
_____	_____	j. Possible negative side effects
_____	_____	k. Description of alternatives
_____	_____	l. Other (specify)_____

12. How important do you consider each of the following reasons for not requesting informed consent from an adolescent? Please rate the importance of each item using the following scale:
1 = Not important; 2 = Slightly important; 3 = Important; 4 = Very important; 5 = Extremely important
_____ a. The usual and customary practice in this setting is not to request adolescent consent
_____ b. Although some minors may be capable, my clients are too young to give a valid consent
_____ c. It is not legally required
_____ d. It is not ethically required
_____ e. The adolescent may refuse needed treatment
_____ f. Informed consent procedures may increase anxieties and exacerbate problems
_____ g. There is too much information for the adolescent to understand
_____ h. The information may reduce self-disclosure
_____ i. It infringes upon the parents' rights
_____ j. Other (specify)_____

Please indicate whether you seek informed consent or assent from an adolescent client.
_____ Informed Consent _____ Assent _____ Neither (Skip to Question 19)

13. How important do you consider each of the following reasons for requesting assent and for informed consent from an adolescent? Please separately rate the importance of each item for both assent and informed consent using the following scale:
1 = Not important; 2 = Slightly important; 3 = Important; 4 = Very important; 5 = Extremely important

Assent	**Consent**	
_____	_____	a. To increase motivation for therapy
_____	_____	b. To help ensure appropriate expectations
_____	_____	c. To enhance the therapeutic relationship
_____	_____	d. To satisfy legal requirements (avoid possible legal liability)
_____	_____	e. To satisfy ethical requirements
_____	_____	f. To select only those who want therapy
_____	_____	g. To enhance feelings of autonomy and control
_____	_____	h. To minimize complication when parents are divorced
_____	_____	i. To accommodate older adolescents who are viewed as adults
_____	_____	j. Other (specify)_____

14. Some people cannot provide a valid consent/assent because of an insufficient understanding of the information provided to them. Please estimate the approximate percentage of adolescents with whom you have had contact who are unable to provide a valid assent: _____ ; informed consent: _____.

15. Please rate each course of action listed below, indicating how likely you are to follow that course of action when the adolescent is unable to give valid assent. Please use the following scale:
1 = Definitely not; 2 = Unlikely; 3 = Uncertain; 4 = Probable; 5 = Definitely would
_____ a. Do not treat the adolescent
_____ b. Contract with the adolescent to attend treatment for a trial period
_____ c. Proceed with parental consent
_____ d. Enlist parents' help in securing the adolescent's consent
_____ e. Conduct family therapy without the adolescent's consent
_____ f. Do not treat and refer the adolescent elsewhere
_____ g. Other (specify)_____

16. Please rate each course of action listed below, indicating how likely you are to follow that course of action when the adolescent is unable to give valid consent. Please use the following scale:
1 = Definitely not; 2 = Unlikely; 3 = Uncertain; 4 = Probable; 5 = Definitely would

_____ a. Do not treat the adolescent
_____ b. Contract with the adolescent to attend treatment for a trial period
_____ c. Proceed with parental consent
_____ d. Enlist parents' help in securing the adolescent's consent
_____ e. Conduct family therapy without the adolescent's consent
_____ f. Do not treat and refer the adolescent elsewhere
_____ g. Other (specify)_____

17. What is the approximate percentage of adolescents with whom you have had contact who refuse to give assent when asked: _____ ; who refuse to give informed consent when asked: _____?

18. When an adolescent refuses to provide assent/informed consent, how likely are you to each of the following? Please rate each alternative course of action separately for both assent and informed consent using the following scale:
1 = Definitely not; 2 = Unlikely; 3 = Uncertain; 4 = Probable; 5 = Definitely would

Assent	**Consent**	
_____	_____	a. Do not treat the adolescent
_____	_____	b. Contract with the adolescent to attend treatment for a trial period
_____	_____	c. Proceed with parental consent
_____	_____	d. Enlist parents' help in securing the adolescent's consent
_____	_____	e. Conduct family therapy without the adolescent's consent
_____	_____	f. Do not treat and refer the adolescent elsewhere
_____	_____	g. Try to work through the resistance
_____	_____	h. Other (specify)_____

19. Whom do you consider to be your primary client when providing counseling to adolescents?
Please check one: _____ Adolescent _____ Parent _____Both _____ Agency/Institution

Please tell us about yourself and your practice:

20. Sex: _____ a. Male _____ b. Female

21. Highest degree achieved:
_____ a. Ph.D. _____ b. Psy.D/Ed.D. ___ c. M.A./M.S. _____ d. Other (specify)_____

22. Year highest degree obtained: _____

23. Area of highest degree:
_____ a. Clinical Psychology _____ b. Counseling Psychology
_____ c. School Psychology _____ d. Other (specify) _____

24. Please select your primary theoretical orientation by placing a "1" in the appropriate blank.

_____ a. Adlerian	_____ e. Gestalt
_____ b. Behavioral/Cognitive	_____ f. Systems/Family
_____ c. Existential/Humanistic	_____ g. Psychoanalytic
_____ d. Eclectic	_____ h. Other (specify) _____

25. Check the primary setting in which you practice:

_____ a. Child/Adolescent Non-Hospital Facility	_____ e. Private Practice
_____ b. Children's Hospital	_____ f. Psychiatric Hospital
_____ c. Community Mental Health Center	_____ g. Student Counseling Center
_____ d. General Hospital	_____ h. Other (specify) _____

26. In what state do you practice? _____

27. Estimate the approximate percentage of time in this agency you spend conducting therapy: _____

28. Estimate the number of clients you have seen for therapy in the last year: _____

29. Estimate the number of clients you have seen for assessments in the last year: _____

30. Estimate the number of clients you have seen for both therapy & assessment in the last year: ____

31. Approximately how many of these clients were adolescents? _____

---

32. If you have informed consent or assent forms or descriptions of these concepts, which you provide to adolescents or to parents; we would be interested in receiving them. Please feel free to enclose them in the additional postage-paid return envelope. **Please send them separately from the questionnaire to ensure your anonymity.**

33. We are interested in the choices people make regarding the use of assent as well as informed consent practices for the provision of psychological services to minors. We would be interested in any comments regarding your practices in this area. A response to this question is not necessary for the completion of this survey, but feel free to offer comments below or on the reverse side of this page.

Thank you very much for your participation.

Postcard 2

Iowa State University
Psychology Department
W112 Lagomarcino Hall
Ames, Iowa 50011

Dr. Norman A. Scott
Summer Brunscheen
Iowa State University
Psychology Department
W112 Lagomarcino Hall
Ames, IA 50011

_____ Yes, I am interested in receiving a summary of the results of this study on informed consent practices with adolescent minor clients.

_____ Yes, I am interested in being entered in the drawing of two $50 gift certificates to the Amazon.com web-bookstore.

_____ I am not interested in participating in this study.

My address is:

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

Reminder Postcard

Iowa State University
Psychology Department
Dr. Norman A. Scott
Summer Brunscheen
W112 Lagomarcino Hall
Ames, Iowa 50011

IOWA STATE UNVERSITY
ADOLESCENT INFORMED CONSENT SURVEY

We have not heard from you and need your response! Approximately two weeks ago you received a questionnaire asking about psychologists' attitudes and practices in obtaining adolescent informed consent/assent for participation in counseling. Your unique perspective as a training director or adolescent therapist in an APPIC internship agency is vital to this study. Your cooperation in completing and returning the questionnaire is crucial to the success of the study, is necessary to better understand this complex area of practice, and will be greatly appreciated. We thank you if you have already returned the questionnaire. If you have no already done so, please take a moment to complete it and return it in the postage paid envelope. Your response will ensure eligibility in the drawing for one of two $50.00 gift certificates to the Amazon.com website, as described in the cover letter accompanying the questionnaire.

We look forward to your response and thank you for your time in completing this task.

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

Summer K. Brunscheen
Graduate Student

Department of Psychology
Iowa State University

W112 Lagomarcino Hall - Ames, IA 50011-3180
Phone: 515-294-1743 Fax: 515-294-6424

FAX TRANSMITTAL

To: From: Dr. Norman A. Scott

Fax: Pages: 1

Phone: RE: Study Participation

[X] Urgent [X] For Review [X] Please Reply

Comments: Psychologist Colleague,

Approximately two weeks ago you received a second request and a second survey packet asking about psychologists' attitudes and practices in obtaining adolescent informed consent for counseling.

We have not heard from you and are seeking a response from you as soon as possible. Your unique perspective as a training director or adolescent therapist in an APPIC internship agency is vital to this study. Your response is necessary to better understand this complex area of practice, is crucial to the success of this study, and is greatly appreciated. We thank you if you have already returned the questionnaire.

If you have not already done so, please take a moment to complete it and return it in the postage paid envelope provided. Thank you very much.

Special note: If your site rarely or never treats adolescents (12-17 years) nor provides supervision for those who do, please check the following box and fax back this sheet at your earliest convenience to Dr. Norman A. Scott at Iowa State University Psychology Department at (515) 294-6424.

[ ] My site is not an appropriate site for inclusion in this study.

If it is more convenient, send an e-mail "Not appropriate for study" to sbrunsch@iastate.edu

A response to this question will be helpful for determining appropriateness for inclusion in this study as we wish to obtain responses from those settings that currently provide services for adolescents.

We look forward to your response and thank you for your time in completing this task.

Happy Holidays,

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

Summer K. Brunscheen
Graduate Student

Iowa State University
Department of Psychology
W112 Lagomarcino Hall
Ames, Iowa 50011

February 6, 2001

Winner Name
Street Address
City, State Zip Code

Winner:

Thank you for your participation in our study of informed consent/assent regarding the mental health treatment of adolescents. Upon conclusion of our data collection we conducted the drawing for two $50 gift certificates from the seventy-eight respondents who indicated they wanted to be included in the drawing. You were one of the winners. Enclosed with this letter of appreciation is your $50 gift certificate to the Amazon.com on-line bookstore. The claim code in the upper right hand corner will enable you to use this gift certificate on any purchase from Amazon.com from now until January 22, 2002. Instructions on its use can be found on the back of the certificate.

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

Sincerely,

Summer K. Brunscheen
Graduate Student

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

SKB/NAS: skb

Encl.: Gift Certificate

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