INFORMED CONSENT PRACTICES OF SCHOOL COUNSELLORS WHEN WORKING WITH MINORS IN NEWFOUNDLAND AND LABRADOR

By

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Abstract

The process of obtaining informed consent can be complex when counselling children and adolescents in a school context. The current study explored informed consent practices among school counsellors (n=123) in the province of Newfoundland and Labrador through distributing surveys to school counsellors in the province via the SurveyMonkey platform. Findings indicated that a majority of school counsellors tended to obtain informed consent from the students they were working with regardless of their students' ages. Having said that, variation did exist among the school counsellors in terms of what ages they reported to seek informed consent from students. School counsellors working with children (ages 5-11) appear to be more inclined to also involve parents in the informed consent process, whereas the majority of school counsellors working with early adolescents (ages 12-15) and late adolescents (ages 16-18) were less inclined to do so. As well, school counsellors reported parents having less and less access to their children's counselling information as students became older. Ideas about necessary information to provide through the informed consent process and the level of importance of such pieces of information varied in some cases among participants, suggesting potential variations in informed consent practices. Implications for future research and practice are discussed.

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Table of Contents

Abstract ii

Acknowledgements ii

Table of Contents v

List of Tables vii

List of Appendices x

Chapter 1: Introduction 1

1.1 Problem and Purpose statement 1

1.2 Research Questions 2

1.3 Definitions of Key Terms 4

1.4 Summary 4

Chapter 2: Literature Review 6

2.1 The History of Informed Consent and Children's Rights 7

2.2 The Significance and Limitations of Informed Consent 10

2.3 What Informed Consent Information Should be Provided? 16

2.4 Competency and Minors 22

2.5 Counselling in a School Context 32

2.6 Conclusion 36

Chapter 3: Methodology 37

3.1 Participants 37

3.2 Sampling 37

3.3 Research Design and Data Analysis 38

3.4 Conclusion 40

Chapter 4: Results 41

4.1 *Demographic Profile* 41

4.2 Data Tables 42

4.3 Conclusion 69

Chapter 5: Discussion 70

5.1 Introduction 70

5.2 Informed Consent and Information Sharing Practices 71

5.3 Relevant Informed Consent Information to Parents and Clients 75

5.4 Limitations of Study 78

5.5 Concluding Comments 79

References 81

Appendix 92

List of Tables

Table 1. Sex and Age of Survey Participants

Table 2. Experience, Percentage of Counselling Allocation, and Location of School/s

Table 3. Ages of Student Clients

Table 4. Obtaining Parental Consent When Counselling Children

Table 5. Obtaining Consent From the Child When Counselling Children

Table 6. Obtaining Consent From Parents When Counselling Early Adolescents

Table 7. Obtaining Consent From the Adolescent When Counselling Early Adolescents

Table 8. Obtaining Consent From Parents When Counselling Late Adolescents

Table 9. Obtaining Consent From the Adolescent When Counselling Late Adolescents

Table 10. Parental Access to Counselling Information of Children

Table 11. Parental Access to Counselling Information of Early Adolescents

Table 12. Parental Access to Counselling Information of Late Adolescents

Table 13. Correlation of Counsellor Demographic Variables and Informed Consent Practices of Counsellors Working With Children

Table 14. Correlation of Counsellor Demographic Variables and Informed Consent Practices of Counsellors Working With Early Adolescents

Table 15. Correlation of Counsellor Demographic Variables and Informed Consent Practices of Counsellors Working With Late Adolescents

Table 16. Correlations Between Counsellor Demographics and Parental Access to Information of Counsellors Working With Children, Early Adolescents and Late Adolescents

Table 17. Counsellor Self Reported Theoretical Orientations

Table 18. Chi-Square Between Informed Consent Practices and Counsellors Who Ascribe to the 'Behavioural' Theoretical Model

Table 19. Chi-Square Between Informed Consent Practices and Counsellors Who Ascribe to the 'Cognitive' Theoretical Model

Table 20. Chi-Square Between Informed Consent Practices and Counsellors Who Describe Themselves as 'Eclectic' in Terms of Theoretical Model

Table 21. Chi-Square Between Informed Consent Practices and Counsellors Who Do Not Ascribe to a Theoretical Model

Table 22. Counsellors' Views on the Level of Importance of Information to Parents of Child Clients During the Informed Consent Process

Table 23. Counsellors' Views on the Level of Importance of Information to Parents of Early Adolescent Clients During the Informed Consent Process

Table 24. Counsellors' Views on the Level of Importance of Information to Parents of Late Adolescent Clients During the Informed Consent Process

Table 25. Counsellors' Views on the Level of Importance of Information to Child Clients During the Informed Consent Process

Table 26. Counsellors' Views on the Level of Importance of Information to Early Adolescent Clients During the Informed Consent Process

Table 27. Counsellors' Views on the Level of Importance of Information to Late Adolescent Clients During the Informed Consent Process

List of Appendices

Appendix A – Western District Approval

Appendix B – Nova Central District Approval

Appendix C – Eastern District Approval

Appendix D – Labrador District Approval

Appendix E – Invitation to School Counsellors to Request Participation in Research

Appendix F – Reminder Email to School Counsellors

Appendix G – Informed Consent Form

CHAPTER 1

INTRODUCTION

Problem and Purpose Statement

Counsellors, like most other professionals, are expected to operate under and be informed by a set of ethical guidelines. Consequently, there exists a plethora of ethical considerations that those who choose to embark on counselling careers must take into account. There are, in fact, entire courses devoted to counselling ethics that counsellors-in-training are required to complete before they are deemed qualified to take on counselling roles. These courses are not designed to provide counsellors-in-training with the answers to every single potential ethical dilemma, rather, they are intended to help these future counsellors engage in sound ethical decision-making processes. Often there *are* no clear-cut answers and therefore many counsellors find themselves wondering *what is the right thing to do?*

One of the aforementioned major ethical considerations is informed consent. Informed consent is guided by the premise that "all other things being equal, the right to make decisions about whether or not to receive psychological services, and the nature of those services, belongs to the client" (Truscott & Crook, 2004, p. 55). Counsellors have a responsibility to be candid and straightforward with the people they may potentially begin counselling relationships with so that those people are truly *informed* before deciding whether or not to participate in counselling. Remley and Herlihy (2005) note additional benefits to the informed consent process, stating that "providing clients with

information about how the counselling process works helps demystify counselling and makes clients active partners in defining the counselling relationship" (p. 77-78). There is little debate amongst counsellors that informed consent is a crucial component of the counselling process, but how does the process translate for counsellors working with minor students in a school setting?

At present there has been little research conducted showing how school counsellors in this province view and approach informed consent practices when beginning a counselling relationship with a minor student. The purpose of this study was to examine just that: how school counsellors working within the four English school districts in Newfoundland and Labrador (at the time of writing these districts have amalgamated into one district known as the English district) view and approach informed consent practices when working with minors, defined as those under the age of 19. A quantitative study utilizing a survey developed by Dr. David Beeman and subsequently modified by this author and Dr. Greg Harris was administered electronically to school counsellors in Newfoundland and Labrador. It is hoped that the information gleaned from this study will further highlight current practice and provide more context to help those in the counselling profession as they engage in these types of decision-making processes.

Research Questions

The primary research question in this study was: How do school counsellors in Newfoundland and Labrador view and approach the informed consent process when

counselling minor students? This particular research question, however, can be divided into several more specific questions, including:

1.) What are the current informed consent practices of counsellors (i.e., obtaining informed consent from the client and/or parents) and what are the current practices of counsellors around parental access to client files for counsellors working with children, early adolescents, or late adolescents?
2.) Are counsellor demographic variables (i.e., age, years of experience in counselling position, sex, percentage of time in counselling role, and geographical location of school) related to informed consent practices (i.e., obtaining informed consent from the client and/or parents) for counsellors working with children, early adolescents, and late adolescents?
3.) Are counsellor demographic variables (i.e., age, years of experience in counselling position, sex, percentage of time in counselling role, and geographical location of school) related to practices around parental access to client information for counsellors working with children, early adolescents, and late adolescents?
4.) Do counsellor self reported theoretical orientations relate to informed consent practices (i.e., obtaining informed consent from the client and/or parents) and/or parental access to clients' files for counsellors working with children, early adolescents or late adolescents?
5.) What informed consent dimensions do counsellors view as important when obtaining informed consent from parents?
6.) What informed consent dimensions do counsellors view as important when

obtaining informed consent from clients?

Definition of Key Terms

The key terms in this study were defined as follows:

Informed Consent – Informed consent requires that an individual voluntarily provides consent to participate in counselling and that the individual's choice is made on the basis of sufficient information and competency to make a decision.

Counselling – Counselling is broadly defined and involves therapeutic contact with a student.

Parent – A parent is a biological or adoptive parent or legal guardian of a child, early adolescent, or late adolescent.

Child – Those who are ages five through eleven.

Early Adolescent – Those who are ages twelve through fifteen.

Late Adolescent – Those who are ages sixteen through eighteen.

Assent – Verbal agreement obtained from an individual to engage in counselling services, even though informed consent was not legally required from that individual.

Summary

In summary, the current study aims to add to the limited amount of empirical literature on the topic of informed consent in school counselling contexts - particularly as it relates to school counselling in the province of Newfoundland and Labrador. Informed

consent is an integral component of the counselling process, but there exist many different perspectives on the most appropriate ways to obtain such consent in our schools.

Importantly, informed consent also has implications for other types of ethical issues. Bodenhorn (2006) carried out a survey of Virginia school counsellors, in which they reported issues of confidentiality and parental rights to be amongst the most frequent and challenging ethical dilemmas they experienced in counselling at all grade levels. Ethical dilemmas related to confidentiality and parental rights often go hand in hand with informed consent. For example, if confidentiality and its limitations can be clearly explained during the informed consent process at the onset of counselling, there will be much less confusion related to confidentiality experienced by all stakeholders later on in the counselling process.

CHAPTER 2

LITERATURE REVIEW

Introduction

Imagine the following scenario: As a school counsellor at a K-6 elementary school, you are sitting in your office completing some important paperwork. As soon as the bell rings for recess, you hear a frantic knock on your door. You open the door and find a distraught grade five girl. She looks disheveled and is in tears. "Can I talk to you?" she manages to ask between sobs. As the school's counsellor, what is your next step? Do you decide to talk with the student once and worry about informed consent procedures afterwards? Do you turn the student away until you can contact her parents/guardians? Do you decide to involve her parents/guardians at all? Do you sit the student down while she is so upset and go through your informed consent procedures? As a counsellor, you have many options in this situation. But which option is the 'right' one? Which of the options will ensure that you are acting ethically and also responding to the needs of the student in a caring, empathetic way?

There are no definite answers, and opinions on the appropriate ways to proceed with obtaining informed consent in situations such as these varies amongst professionals. Nevertheless, it is wise to examine both the literature and the ethical guidelines established in particular jurisdictions in an effort to make decisions that will be the most beneficial for everyone involved.

A review of selected literature related to the topic of informed consent is

presented in this chapter.

The History of Informed Consent and Children's Rights

The doctrine of informed consent originated in medicine and stems from the belief that patients hold the right to decide what will happen to their bodies as well as the right to be clearly communicated with regarding their treatments and health (Beahrs & Gutheil, 2001; Braaten & Handelsman, 1997; Crowhurst & Dobson, 1993; Knapp & VandeCreek, 2006; Sales, DeKraai, Hall, & Duvall, 2008; Tymchuk, 1997).

Prior to the widespread acceptance of these basic patient rights, physicians possessed sole authority when it came to making medical decisions for their patients and often chose the options for treatment that *they* thought best or disclosed information that *they* felt was appropriate to disclose (Applebaum, 1997; Braaten & Handelsman, 1997). Changes in patient rights occurred only as society itself underwent a variety of complex changes that eventually led to support for the idea that patients are entitled to be informed about their health, treatment options, risks and benefits of treatment options, as well as alternative treatment options (Applebaum, 1997; Kohrman & Clayton, 1995).

Over time, the medical model of informed consent began to spread its influence into the sphere of mental health. Litigation for informed consent practices related to mental health has basically followed the patterns previously established by medical health care (Braaten & Handelsman, 1997). In addition to the impact of medicine, Goddard, Murray, and Simpson (2008) contend that informed consent emerged as a major concern in the psychological sciences "following the seminal but controversial

work of Stanley Milgram in the 1960s" (p. 177). They note that Milgram's obedience studies underscored the importance of ethical issues, particularly informed consent, in psychological research (Goddard et al., 2008). Another contributing factor to the rise of informed consent procedures in recent years is an undeniable societal shift which has prompted many modern societies to leave behind a paternalistic, autocratic culture in favour of a more participatory and autonomous one (Corrigan, 2003).

Cultural changes have also resulted in increased rights for minors. Historically, there existed an assumption that parents always tend to act in the best interests of their children and courts therefore acknowledged the rights of parents to exercise complete control over their child's welfare and destiny (Hesson, Bakal, & Dobson, 1993). Dating even further back on the historical timeline to the era of Roman law, it was generally accepted that the father was the supreme figure of authority in the family and he held the right to determine whether or not his children should live, die, or be sold into slavery (Halasz, 1996; Lawrence & Kurpuis, 2000). Halasz notes that "this absolute patriarchal power resulted in acceptance of systematic ill-treatment of children: abandonment, physical and sexual abuse, exploitation, neglect, and infanticide" (p. 285). Only in the 18th century did an empathetic ethos begin to surface in Western civilization, giving way to new ideas and attitudes concerning children (Halasz, 1996).

With the growing interest in civil rights during the 1960s and 1970s came a movement to allow minors to have a voice in the decisions that would affect them and to offer to them the same legal rights that were being extended to adults (Halasz, 1996). Then, in 1989, the UN put forth the Convention on the Rights of the Child, which was:

> . . .the first legally binding international instrument to incorporate the full range of

> human rights – civil, cultural, economic, political and social rights. In 1989, world leaders decided that children needed a special convention just for them because people under 18 years old often need special care and protection that adults do not. The world leaders also wanted to make sure that the world recognized that children have human rights too (United Nations International Children's Emergency Fund [UNICEF], 2015, para #4).

The Convention highlights the basic human rights of children everywhere, the four key principles of the Convention being: "non-discrimination; devotion to the best interests of the child; the right to life, survival, and development; and respect for the views of the child" (UNICEF, 2015, para #5).

Only in the past couple of decades have Canadian courts begun to address children's rights in the context of the Canadian Charter of Rights and Freedoms, which is considered the supreme law of Canada (Hesson et al., 1993). Hesson et al. assert that there are two sections of the Charter that are particularly pertinent to the rights of children:

> Section 15 prohibits any individual from being denied equal protection and equal benefit of the law without discrimination based on race, ethnic origin, colour, religion, sex, age, or mental or physical disability. Section 7 guarantees life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of 'fundamental justice' (1993, p. 318).

Evidently, there has been an observable societal progression related to children's

rights in the past century. Judicial law has played a vital role in this progression, helping transform a patriarchal and controlling society where minors have very few rights into a society where minors are viewed as more than property and are afforded the basic human rights that adults get to enjoy.

The Significance and Limitations of Informed Consent

'An ounce of prevention is worth a pound of cure'. This old adage rings particularly true for many as they consider the idea of informed consent. It is better to be proactive than reactive, better to be safe than sorry, and better to guarantee that clear information is relayed to potential clients *before* any important decisions are made – rather than *after*. Ethically and legally, counsellors have a responsibility to safeguard the rights of the clients they work with. One condition of this overarching task involves ensuring that clients make informed decisions about entering into a counselling relationship (Paez & Britton, 2004). The significance of offering clear and concise explanations in an effort to help people become *informed* before making major decisions cannot be overemphasized. Of course, the process of obtaining informed consent involves far more than someone offering up a simple yes or no to the proposition of accessing counselling services. Informed consent is a concept of great complexity that relates to the rights and responsibilities of clients. Schulz, Sheppard, Lehr, and Shepard (2006) acknowledge that legally, consent is a contractual relationship and the consent agreement is based upon a 'fiduciary' relationship. This implies that counsellors should act only in ways that are beneficial to their clients. Out of this principle emerges the idea that "the

choice to enter or continue therapy must be made knowingly, intelligently, and voluntarily" (Beeman & Scott, 1991, p. 230). Offering clients opportunities to make voluntary, informed decisions about whether or not to participate in counselling demonstrates respect for personhood and highlights the fact that counselling is collaborative in nature (Fisher & Oransky, 2008).

The rationale behind informed consent involves the ethical principles of nonmaleficence (i.e., to do no harm) and autonomy (Handelsman, Kemper, Kesson-Craig, McLain, & Johnsrud, 1986). According to Glosoff and Pate (2002): "autonomy refers to respecting the freedom of clients to choose their own directions and make their own choices within the counselling relationship" (p. 21). Since counselling relationships are intended to be built upon a foundation of trust and respect, counsellors must recognize the autonomy of their clients as well as clients' rights to self-determination (Batten, 1996; Crowhurst & Dobson, 1993; Glosoff & Pate, 2002; Goddard et al., 2008; Gustafson, McNamara, & Jensen, 1994; Henkelman & Everall, 2001; Huey, 1996; Knapp & VandeCreek, 2006; Martindale, Chambers, & Thompson, 2009; Sales et al., 2008; Tymchuk, 1997). When counsellors *do* respect the autonomy of their clients and astutely attend to the process of obtaining informed consent, the therapeutic alliance will be strengthened (Beahrs & Gutheil, 2001; Fisher & Oransky, 2008). This may very well affect the outcome of counselling; a positive correlation has been shown to exist between the quality of the therapeutic alliance and treatment outcome (Martin, Garske, & Davis, 2000). The principle of informed consent has become widely accepted and the practice widely employed in an effort to honour this individual autonomy - a value that is now a central part of western civilization (Lidz, 2006). The value itself stems from the belief

that all capable humans have a right to have their voices heard when it comes to decisions that will impact them. This has also been made clear in the Canadian Code of Ethics for Psychologists, which states the primary and overarching ethical principle as being: Respect for the Dignity of Persons. The principle suggests that each and every person has the right to be valued as a person and not treated either as an object or a means to an end (CPA, 2001). Informed consent is a substantial piece of the puzzle; it can be argued that if professionals refrain from engaging clients in the informed consent process they are demonstrating a disregard for the dignity of individuals.

Informed consent is also significant because it can aid in the demystification of the therapeutic process, which can in turn reduce client anxiety (Fisher & Oransky, 2008). Additionally, it often provides clients with a sense of ownership and enhances rapport building between clients and professionals (Fisher & Oransky, 2008). Beahrs and Gutheil (2001) note that the informed consent process helps clients become more active agents on their own behalf, which is key when considering that what clients do for *themselves* correlates more with therapeutic change than anything therapists/counsellors do or say. Cahana and Hurst (2008) take the position that informed consent is so significant because it represents a permission to encroach on another person's private sphere. Knapp and VandeCreek (2006) draw attention to yet another important aspect of informed consent, stating:

> Informed consent procedures are also part of maintaining a 'culture of safety.' The content of the informed consent procedures is intended to anticipate questions that most reasonable patients would have and to prevent future misunderstandings and disappointments. If implemented properly, informed consent procedures

promote open exchanges between psychologists and their patients (p. 100).

Sullivan, Martin, and Handelsman (1993) carried out a study, which showed that "clients may be more favorably disposed to therapists who take the time and effort to provide [informed consent] information" (p. 162). In the same vein, a study by Braaten and Handelsman (1993) demonstrated that clients and non-clients alike highly value the information that is conveyed to them throughout the informed consent process. Lyden and Peters (2004) note that empirical studies have shown how perceived loss of control may cause people to suffer declines both mentally and physically. A disregard for individual autonomy and a client's rights to self-determination can therefore yield potentially serious repercussions and impede the counselling process.

Pragmatically speaking, informed consent is also necessary because it exists as a legal doctrine in addition to being an ethical one. Employing proper informed consent procedures can help practitioners avoid legal liability in the future.

Evidently, there are many reasons why informed consent should be and usually is viewed as a crucial aspect of any therapeutic, counselling relationship. However, as one might suspect, it has also not gone without its criticisms. West (2002) questions whether or not truly informed consent is even a possibility:

> How can clients consent to counselling, especially if they have had no previous experience of counselling? How can this possibly be *informed* consent? Even if the client has had some previous experience, say of the CBT therapist down the road or a colleague of mine who describes her practice in the same way as I do, how can I accurately convey to this would-be client what counselling from *me*

would be like? If my would-be client is seeking counselling because of some life crisis, does this not affect his or her ability to give consent? (p. 262).

West (2002) does not, however, approach informed consent from an all-or-nothing stance. He goes on in his article to discuss the importance of sensitive and ongoing consent, also known as 'process consenting.' In doing so his idea of informed consent merges with the ideas of many other researchers who believe that consent should not be simply a one-shot deal that occurs at the very beginning of the counselling relationship, but rather a continuous agreement of mutual interest (Batten, 1996; Braaten & Handelsman, 1997; Daws, 1986; Knapp & VandeCreek, 2006; Lyden & Peters, 2004; Martindale et al., 2009).

Paez and Britton (2004) report that having worked with Master's level students in clinical training they have found a common complaint of theirs to be that providing informed consent information to clients hampers the development of a therapeutic bond. Paez et al. go on to discuss the rigid and legalistic approach many new students-in-training take when it comes to informed consent procedures. It is unclear as to whether or not these views toward the informed consent process tend to change over time, as students gain more experience and as their comfort levels increase. Yet, the fact remains that many counsellors and therapists share concerns that the provision of informed consent information to clients can come across as intimidating, daunting, and even threatening at times - thus affecting the therapeutic alliance negatively (Braaten & Handelsman, 1997). Similarly, Beahrs and Gutheil (2001) note that two of the perils associated with the provision of informed consent information to clients include an

unpredictability of outcomes and a possibility that clients may begin to replace positive expectancy with negative suggestion.

Tymchuk (1997) suggests that many practitioners see consent as a compulsory burden rather than a constructive adjunct to good practice. Part of this apprehension surrounding informed consent stems from the lack of empirically-established criteria for determining: the quality of clients' decision-making processes, the adequacy of clients' understanding, the level of rationality of clients' choices, and the appointment of a proxy decision-maker if clients are incompetent to decide for themselves (Tymchuk, 1997). Oftentimes clients are not necessarily able to fully understand what it is they are agreeing to, especially those clients who have lower levels of reading comprehension than the written information that is presented to them, those who are unable to process information rapidly, or those who have difficulty when it comes to remembering things (Tymchuk, 1997). Tymchuk (1997) also asserts that it may be unfair to use the 'reasonable person' standard, which claims that any information that a reasonable person would want to know is what should be communicated to clients through informed consent processes. He believes that the standard implies that we have a special knowledge of what a 'reasonable person' would understand in any given context and that there must then be some normative data against which to compare, though there is presently no standardized method available to make this comparison (Tymchuk, 1997).

Despite its apparent limitations, informed consent is considered to be a vital piece of what constitutes 'best practice' in counselling. To follow the chief principle laid out by the Canadian Psychological Association, Respect for the Dignity of Persons, counsellors must respect the right of individuals to *choose* and work continuously with

their clients to ensure that the implications of these choices are made as clear as possible.

What Informed Consent Information Should be Provided?

Much of the literature on informed consent details three components or elements that must be present in order to meet the often stringent requirements of informed consent. These elements are: knowledge, voluntariness, and competence/rationality (Batten, 1996; Beeman & Scott, 1991; Cahana & Hurst, 2008; Croxton, Churchill, & Fellin, 1988; Henkelman & Everall, 2001; Lyden & Peters, 2004; Saks & Jeste, 2006; Sales, et al., 2008). The condition of *knowledge* deals with the type of information that counsellors should provide to their clients (Sales et al., 2008). *Voluntariness* addresses the idea that clients must make their consent decisions with the benefit of free choice and without the involvement of any coercion or manipulation. *Competence* and *rationality* refer to the need for individuals to be aware of their environments and have the capacity to reason about proposed treatments, weighing pros and cons and absorbing all of the relevant information provided to them (Lyden & Peters, 2004).

Several years ago, Meisel, Roth, and Lidz (1977) proposed a model of informed consent by using two specific formulae:

$$I + C = U$$

$$V + U = D$$

where: *(I) = adequate information, (C) = a competent individual, (U) = understanding (V) = a voluntary individual, and (D) = a free and rational decision.* "That is, adequate information given to a competent individual will yield understanding, and a voluntary

individual who understands will make a free and rational decision" (Lidz, 2006, p. 536). What relevant and adequate information *(I)*, then, should be communicated to prospective clients in an effort to ensure that the requisite *knowledge* piece of the informed consent puzzle has been satisfied?

The answer to this question varies depending upon the persons being asked. Kohrman and Clayton (1995) discuss informed consent as it relates to pediatric practice, but much of the information they view as crucial to the decision-making processes of their potential patients can also be applied in a more therapeutic context. They note,

> patients should have explanations, in understandable language, of the nature of the ailment or condition; the nature of proposed diagnostic steps and/or treatment(s) and the probability of their success; the existence and nature of the risks involved; and the existence, potential benefits, and risks of recommended alternative treatments (including the choice of no treatment) (p. 315).

Indeed, a great deal of the literature on informed consent processes in therapeutic and counselling contexts takes a similar stance that would-be clients should be provided with information and *knowledge* about some or all of the following: credentials of therapist or counsellor, nature of the therapy or counselling, goals, confidentiality and its limitations, fees, techniques, record-keeping procedures, probable benefits and risks, alternative approaches, and the right to refuse services (Applebaum, 1997; Batten, 1996; Crowhurst & Dobson, 1993; Croxton et al., 1988; Fisher & Oransky, 2008; Glosoff & Pate, 2002; Henkelman & Everall, 2001; Knapp & VandeCreek, 2006; Lawrence & Kurpuis, 2000; Ledyard, 1998; Paez & Britton, 2004; Sales et al., 2008; Sperry, 2007;

Tymchuk, 1997).

Standard I.23 in the Companion Manual to the Canadian Code of Ethics for Psychologists states that in adherence to the overarching Principle of Respect for the Dignity of Persons, psychologists must:

> Provide, in obtaining informed consent, as much information as reasonable or prudent persons would want to know before making a decision or consenting to the activity. The psychologist would relay this information in language that the persons understand (including providing translation into another language, if necessary) and would take whatever reasonable steps are needed to ensure that the information was, in fact, understood (CPA, 2001, p. 51).

Standard I.24 goes on to add that psychologists should:

> Ensure, in the process of obtaining informed consent, that at least the following points are understood: purpose and nature of the activity; mutual responsibilities; confidentiality protections and limitations; likely benefits and risks; alternatives; the likely consequences of non-action; the option to refuse or withdraw at any time, without prejudice; over what period of time the consent applies; and, how to rescind consent if desired (CPA, 2001, p. 51).

In 1991, Jensen, McNamara, and Gustafson carried out a study in which they compared clinician and consumer attitudes towards informed consent. The study revealed that both groups had similar informed consent preferences (Jensen et al., 1991). The most important information, according to their ratings, was information about confidentiality and its limits, fee structuring, therapeutic benefits and iatrogenic risks

(Jensen et al., 1991). Consumers rated risks as having a higher priority than did clinicians, while both groups placed a lesser amount of emphasis on discussions around stigma risks and scheduling (Jensen et al., 1991). The results of the study indicated that both of the groups highly valued a variety of informed consent information (Jensen et al., 1991).

Braaten, Otto, and Handelsman (1993) later carried out a similar study with 108 college students in which they attempted to assess the types of information people want to know about psychotherapy prior to making a decision to participate. The results of their study also showed that participants have a desire to know a variety of information, including the personal characteristics of the therapist and the therapist's experience and credentials (Braaten et al., 1993). After reviewing the literature and recognizing that there had been no previous studies conducted with *current* clients regarding their informed consent preferences, Braaten and Handelsman expanded upon their 1993 study. They surveyed three groups of participants: those who were accessing counselling services, those with previous counselling experience, and those with no counselling experience (Braaten & Handelsman, 1997). The results of their study showed that both clients and non-clients value the information that is conveyed during the informed consent process (Braaten & Handelsman, 1997). Some of the most highly rated items included: information about inappropriate therapeutic techniques, confidentiality, and risks of alternative treatments (Braaten & Handelsman, 1997).

Beeman and Scott (1991) conducted a study in 1991, which involved surveying 255 psychologists about their attitudes toward the provision of informed consent information to adolescents. Results showed that when it comes to the provision of

informed consent information only about 54% of the respondents rated high the importance of discussing the limits of confidentiality (Beeman & Scott, 1991). Yet, the only four pieces of informed consent information that were rated by anyone as being 'very important' were the limits to confidentiality, the intended outcome of therapy, the nature of the sessions, and the time, place, setting, and duration of the sessions (Beeman & Scott, 1991). Findings also showed a consistently high ranking of importance to the provision of the limits to confidentiality to both adolescents and their parents (Beeman & Scott, 1991).

The discussion of what information should be conveyed during the informed consent process is an important one to have - a fact proven by the late 1980s legal case of *Osheroff v. Chestnut Lodge.* The plaintiff in the case had undergone long-term, intensive inpatient psychoanalytic treatment for his severe depression, but the treatment was unsuccessful for him (Applebaum, 1997; Beahrs & Gutheil, 2001; Fisher & Oransky, 2008). After leaving the esteemed facility and discontinuing therapy, Osheroff began taking a course of antidepressant medications and he responded well to this treatment (Applebaum, 1997; Beahrs & Gutheil, 2001; Fisher & Oransky, 2008). He alleged that if he had been aware of this option at the onset of therapy he could have avoided a year of misery and heavy financial burden (Beahrs & Gutheil, 2001). Osheroff felt that he should have been informed that the use of antidepressant medications was an option or an alternative for him, especially when it became clear that he was failing to respond to the treatment Chestnut Lodge was providing (Applebaum, 1997). This case was ultimately settled out of court and therefore no legal precedent was established, but because it was so highly publicized it also shifted public attention to informed consent in therapy and the

duty of therapists to present clear information to their clients, including a discussion of feasible treatment alternatives (Beahrs & Gutheil, 2001; Fisher & Oransky, 2008).

A series of research studies in the United States examined the informed consent practices of therapists. It is interesting to note that the results of these studies highlight variations in the opinions and practices of therapists in relation to their theoretical orientations (Goddard et al., 2008). A study by Somberg, Stone, and Claiborn (1993) showed that therapists who labeled themselves as cognitive-behavioural therapists were more likely to inform their clients about the projected length of treatment and discuss alternative treatment options than were eclectic and psychodynamic therapists. A study by Dsubanko-Obermayr and Baumann (1998) found that those who referred to themselves as behavioural therapists were more inclined to discuss with their clients the goals and methods of treatment and utilize written consent procedures as a part of their informed consent process. The same study showed that psychodynamic therapists rated the disclosure of financial arrangements as being important (Dsubanko-Obermayr & Baumann, 1998). Croarkin, Berg, and Spira (2003) found that psychodynamic therapists gave lower importance ratings to the following: the value of informed consent in therapy, the perceived benefits of informed consent for clients, and the use of written informed consent procedures.

The provision of specific information to clients is imperative to the satisfaction of the *knowledge* component of the informed consent process as its goal is to aid people in making better, educated decisions for themselves. The aforementioned studies make it unmistakably clear that the communication of this informed consent information tends to be highly valuable to clients and counsellors alike.

Competency and Minors

One of the grey areas associated with the informed consent process centers around the issue of competency. This is particularly true when working with those people in society who are considered to be vulnerable (e.g., minors, seniors, those who have low levels of cognitive functioning). Counsellors may often find themselves wondering*: are my clients able to give viable consent?* Or, *do they have the means by which to make carefully considered, rational decisions?* Indeed, Saks and Jeste (2006) propose that an incompetently made choice is not really an autonomous choice. They state,

> If one does not understand the relevant information in the sense of comprehending its meaning, one will not know what is at stake in one's decision. If one can not form adequate beliefs about the information, one will not know how one's decision will take effect in the world. If one cannot reason, one's inferences from premises will be faulty and may lead to an outcome that does not reflect one's values and goals. And if one can not evidence a choice, no one can honor that choice (Saks & Jeste, 2006, p. 416).

Koocher (2008) defines competence as "…the quality of having adequate or better ability to perform some task physically, intellectually, emotionally, or otherwise" (p. 602). Henkelman and Everall (2001) refer to competence as the ability to make a choice about whether or not to participate in treatment, withdraw from treatment, and/or continue treatment, and to make these decisions clearly and in an understandable way. In the legal system adults are usually presumed to be competent (unless shown to be

incompetent), whereas those who have not reached the legal age of majority are generally presumed to be incompetent under the law (Croxton et al., 1988; Koocher, 2008; Lyden & Peters, 2004; Sales et al., 2008). Consequently, when minor clients do not have the legal capacity to give consent, proxy consent must come from those who are competent to provide consent on the client's behalf – typically a parent or guardian (Koocher, 2008; Knapp & VandeCreek, 2006). Isaacs and Stone (1999) claim that the younger the client in question is, the more control parents have over decisions concerning their child. Additionally, the less competent minors are to provide informed consent on their own behalf, the more dependent they are upon adults, typically parents or guardians, to protect their rights (Isaacs & Stone, 1999). Parents or legal guardians of minors, with some exceptions, legally have the right to control the professional services that are provided to their children and also to be involved in planning those services (Glosoff & Pate, 2002). Henkelman and Everall (2001) point out that while informed consent is meant to be voluntary, many children have been taught to respect and obey adults and as such may have difficulty questioning any requests made by an adult. These uncertainties surrounding the nature of informed consent have left many psychotherapists and counsellors to wonder whether or not there is a specific age or measurable cognitive capacity that can be used to determine the point at which minor clients are able to play bigger roles in the decision-making processes that affect them (Halasz, 1996). The law tends to make distinctions based on specific ages, while counsellors typically focus on maturation levels (Isaacs & Stone, 1999). There is currently no precise, specific age at which minors are deemed to be legally competent, and it is important to note that the age of majority is not always equivalent to the age of consent (Schulz et al., 2006). The

existence of a 'mature minor' rule has left some room for flexibility:

> the common law has adopted the 'mature minor' rule, in which the court decides on a case-by-case basis whether a child has the *capacity* to consent (i.e., is capable of understanding the nature and consequences of a treatment decision). Children who demonstrate this capacity are deemed 'mature minors," and are accorded full rights of self-determination over health services. Thus, if it can be determined that a minor in fact understands the proposed interventions, can properly weigh the risks and benefits of various procedures, understands other courses of action and their implications, and is not prohibited from consenting by legislation, a health practitioner may accept the consent of that minor client as legally valid (Hesson, Bakal, & Dobson, 1993, p. 320).

The Canadian Counselling and Psychotherapy Association (2001) also recognizes the 'mature minor' rule:

> The parents and guardians of younger children have the legal authority to give consent on their behalf. However, the parental right to give consent diminishes and may even terminate as the child grows older and acquires sufficient understanding and intelligence to fully comprehend the conditions for informed consent. Counsellors should be vigilant to keep themselves informed of their statutory obligations with respect to the rights of children, including their right to privacy and self-determination commensurate with their ability to do so and with regard to their best interests (p. 11).

A 1986 court case, *J.S.C. and C.H.C. v. Wren,* aided in the clarification of this

position for medical and health practitioners (Hesson et al., 1993). A sixteen-year-old girl became pregnant and made the decision to have an abortion against her parents' wishes (Hesson et al., 1993). The parents in the case sought an injunction against the physician who was going to perform the abortion on the grounds that their minor daughter was incompetent to provide informed consent for the procedure (Hesson et al., 1993). The judge, however, found that the girl demonstrated sufficient intelligence and understanding; she was aware of the consequences of her decision and was deemed a 'mature minor' - the suit was therefore dismissed (Hesson et al., 1993). In the United Kingdom, the 'Gillick' case set a legal precedent in that it established the position that if a young person under the age of 16 is able to understand the nature of the issues and the consequences involved, that young person is considered competent and has a legal right to make an autonomous decision (Lehr, Lehr, & Sumarah, 2007).

While the 'mature minor' rule offers flexibility, a caveat is that it also has the ability to instill a significant amount of uncertainty, especially for the mental health professionals who work with minors. After all, the onus is placed upon the service provider to determine competency. Yet, there is substantial disagreement when it comes to defining a set of specific criteria in order to determine the competence of minors to participate in decision-making (Taylor, Adelman, & Kaser-Boyd, 1984).

In addition to the 'mature minor' rule, certain minors can be deemed 'emancipated' and treated as adults for all intents and purposes if they are: "1) self-supporting and/or not living at home; 2.) married; 3.) pregnant or a parent; 4.) in the military; or 5.) declared to be emancipated by a court" (Kohrman & Clayton, 1995, p. 316).

Oftentimes, children who have been referred for psychological treatment may be seen as 'doubly incompetent'; meaning that their age and their psychological 'problem' are both factors contributing to their incompetence (Kaser-Boyd, Adelman, Taylor, & Nelson, 1986). This suggests that therapists/counsellors need to pay special attention to their informed consent practices when working with minor populations. Grisso and Vierling (1978) have identified several mental processes that are critical in determining competence: attention to the task, ability to delay responses to reflect on the issues, ability to weigh treatment alternatives and sets of risks simultaneously, ability to hypothesize about not yet existent risks and alternatives, and ability to utilize inductive and deductive reasoning.

The developmental theories of Jean Piaget suggest that children who have reached the stage of formal operations are more likely to be capable of engaging in the sort of abstract thinking that is required by the informed consent process (Kaser-Boyd et al., 1986). Piagetian theory posits that the stage of formal operations begins at around age 11 and consolidates at about age 14 or 15 (Kaser-Boyd et al., 1986). A study by Weithorn and Campbell (1982) focused on the competency of minors to make informed treatment decisions. Results of the study showed that while children at the age of nine had a reduced ability to understand and reason with treatment information as compared with adults, they did tend to make similar treatment choices in the end (Weithorn & Campbell, 1982). No differences, however, were found between 14-year-olds and adults with regard to the selection of a reasonable outcome, ability to rationalize reasons, or ability to understand and identify risks (Weithorn & Campbell, 1982). Shedding even more light on the issue of minors' competency to provide informed consent for therapy, Kaser-

Boyd, Adelman, and Taylor (1985) carried out a study that examined minors' abilities to identify the risks and benefits of therapy. Results of this study showed that minors who had no previous therapy experience and who were as young as 10 were able to generate risks and benefits related to their individual circumstances and developmental needs (Kaser-Boyd et al., 1985). A complementary 1986 study by Kaser-Boyd et al. assessed children's abilities to process specific information about the risks and benefits of psychological treatment. The results of this study showed no significant age differences between children with respect to their abilities to identify and weigh the potential risks and benefits of therapy (Kaser-Boyd et al., 1986). Kaser-Boyd et al. (1986) argue that because so many of the young minors participating in the study were able to meet the study's criteria for competence, setting specific age limits for participation in treatment decisions may be arbitrary. Additionally, the results suggest that young clients may be more capable of being involved in therapy decisions than was previously believed (Kaser-Boyd et al., 1986).

A line of distinction has been drawn between the different *aspects* of maturity by Steinberg, Cauffman, Woolard, Graham, and Banich (2009), who argue that the varying aspects need to be considered separately. They claim that while many adolescents perform comparably to adults on cognitive measures of logical reasoning about moral, social, and interpersonal issues – adolescents and adults are not equally mature when it comes to psychosocial capacities such as impulse control and resistance to peer pressure. Risky behaviour is more common during late adolescence and even early adulthood than after, so although adolescents may demonstrate high levels of maturity in some respects by the age of 15 they usually show continued immaturity in other areas beyond that point

in development (Steinberg, 2007). Steinberg et al., (2009) do acknowledge, however, that in terms of reasoned decision making where emotional and social influences can be minimized and where there are consultants who can provide unbiased information about costs, benefits, and alternative courses of action, the decision-making capabilities of many adolescents do tend to be comparable to the decision-making capabilities of adults.

So, how do practitioners go about assessing competency? Henkelman and Everall (2001) suggest that the level of competency of a client can be determined by an extended discussion in which both the intent and processes of counselling are examined. They advise asking questions such as 'what is your understanding of the issue that brought you here?' and 'what do you hope to gain from counselling?' (Henkelman & Everall, 2001). Saks and Jeste (2006) claim that "assessments of competency are inevitably both empirical and normative" (p. 413). They use an analogy of assessing a person's ability to build a house in order to demonstrate this fact. The empirical aspect of the assessment might involve looking at other instances of house-building to determine what works and what does not work (Saks & Jeste, 2006). The normative piece, on the other hand, provides the house-builder with a set of standards for judging the decisions they make – it allows them to make comparisons to determine what constitutes 'good' (Saks & Jeste, 2006). If the builder paints the entire house with a toothbrush, he is not demonstrating an adequate ability to paint the house (Saks & Jeste, 2006). Lidz (2006) posits, "if it is true that if information is presented to a competent person s/he will understand it, the corollary is that if information is presented adequately people who are incapable of understanding that information must be of questionable competency" (p. 537). In 1980 the Canadian Psychiatric Association proposed four questions of clinicians in an effort to

aid in the assessment of competence to provide consent for treatment:

1) does the patient understand the condition for which treatment is proposed?

2) does the patient understand the nature and purpose of the treatment?

3) does the patient understand the risks and benefits involved in the treatment?

4) does the patient understand the risks and benefits involved in not having treatment?

Though seemingly simplistic at first glance, it can be difficult to assess whether or not true understanding has been established. However, as guiding questions for the assessment of competence, they may be helpful for practitioners.

With this information in mind, another important question for practitioners to ask themselves is: if a minor is determined to be incompetent, should they then be excluded from all decisions related to their treatment? Taylor, Adelman, and Kaser-Boyd (1984) carried out a study that involved surveying a variety of mental health professionals who provide psychotherapy and counselling services to minors. The results of the study showed that less than half of the respondents tended to ask minors to provide consent in addition to the consent of their parents (Taylor et al., 1984). A majority of the respondents *did*, however, provide minors with some of the following information: time, place, setting, duration of sessions; what the sessions would be like and what would take place; and, the intended outcomes of treatment (Taylor et al., 1984). Therapists who were inclined to ask for minors' consent reported a mean age of 12.3 as the age at which they would request it (Taylor et al., 1984). Interestingly, it was found that the participating therapists who were over the age of 50 tended to provide less information to minors than did their younger therapist colleagues (Taylor et al., 1984).

If it is determined that a minor is not competent to provide informed consent on

his or her own behalf, there is still merit in attempting to involve them in the process. Lawrence and Kurpius (2000) noted that "minors over the age of seven years can give informed assent to be involved in counselling or research. Although this is not legally recognized, it demonstrates respect for the minor and signals that the minor has agreed to participate" (p. 134). Indeed, Hall and Lin (1995) argue that treating children as though they are incompetent and totally dependent on adults can impede their self-growth. Instead, they state that children should be awarded opportunities to exercise responsibility by participating in treatment decisions (Hall & Lin, 1995). Standard I.35 in the Companion Manual to the Canadian Code of Ethics for Psychologists states that psychologists should:

> Seek willing and adequately informed participation from any person of diminished capacity to give informed consent, and proceed without this assent only if the service or research activity is considered to be of direct benefit to that person (CPA, 2001, p. 53).

A research study by Taylor, Adelman, and Kaser-Boyd (1983) in which the perspectives of 32 participants (aged 11 to 19 years) were examined revealed that the majority were interested in participating in decision-making and planning related to their psychoeducational treatment. Moreover, they tended to perceive themselves as competent, follow through on decisions, and they had relatively positive experiences when they were involved (Taylor et al., 1983).

Obtaining assent from an incompetent minor and ending the informed consent process there, however, would not be considered best practice in many circles. Belter

and Grisso (1984) stated that "affording rights of self-determination to minors when they are less capable of understanding would not be in the minor's best interest" (p. 899). Many practitioners concur that it is likely not a good idea to leave parents out of the process and parents' rights and responsibilities for their minor children should be honoured (Herlihy and Corey, 1996; Huey, 1996). Yet, a study by Gibson and Pope (1993) showed that 44% of the counsellors they surveyed have worked with minor clients without the consent of their clients' parents. Croxton, Churchill, and Fellin (1988) agree that parents should be involved in decision-making regarding treatment for their minor children, but they also contend that there are considerable reasons for expanding the rights of minors, not the least of which is that for many minors the protective function of the family is not necessarily being satisfied. Indeed, Batten (1996) recognizes that in putting the primary responsibility of minors with parents/guardians, there exists an assumption that the parents/guardians have the child's best interests at heart, and it can be exceedingly difficult and problematic for professionals to attempt to demonstrate otherwise. Some parents may refuse to acknowledge the realities of the minor's problems, or they may refuse the treatment as a result of their own doubts and fears (Croxton et al., 1988). Other parents may be in conflict with their children and their knowledge of the counselling relationship could serve to exacerbate problems (Croxton et al., 1988). This is not to suggest that parental inclusion in the informed consent process is necessarily detrimental, but they are important considerations nevertheless. When minors are deemed competent to make well-reasoned decisions, those rights should be afforded to them. Furthermore, minors at any level should be permitted to have a voice in the decisions that affect them in an effort to show respect for their autonomy and

dignity as persons.

Counselling in a School Context

School counsellors face unique dilemmas related to informed consent. While some school boards adopt strict policies around informed consent for counselling, others are more laissez-faire and leave counselling decisions to the discretion of the counsellors. On top of that, many school counsellors are trying to balance all at once their legal and ethical responsibilities to a variety of stakeholders: students, students' parents, teachers, administrators, regulatory bodies, and the school districts in which they work (Glosoff & Pate, 2002). A 2006 study carried out in Australia by Thielking and Jimerson revealed a number of similarities and differences between the perspectives of teachers, principals, and school psychologists regarding the roles and responsibilities of school psychologists. The plethora of perspectives existing in schools often leaves the counsellors/psychologists who work within them to question: *who are my clients? What rights do teachers and administrators have? How do I balance the rights of my students with the rights of their parents? Am I required to obtain consent from parents before seeing their minor child?*

Not surprisingly, there are mixed opinions when it comes to discussions of whether or not school counsellors should be required to obtain parental consent for counselling minors. Results of a survey of school counsellors in Virginia showed that issues related to confidentiality and the rights of parents were among the most challenging and common ethical dilemmas they faced (Bodenhorn, 2006). One opinion on the matter is that counsellors should refer to the educational mandate of 'in loco

parentis.' In loco parentis is a piece of Victorian case law that has been subsequently adapted to suggest that educators are to act towards their students as caring parents would (Jenkins, 2004). This would mean that if an educator at the school level decides that counselling is in the best interest of a particular student, no further parental consent should be necessary for the student to avail of counselling services at school. Indeed, Remley and Herlihy (2001) contend that school counsellors do not necessarily need parental permission before they can provide counselling services to students. Others, however, posit that counselling is a service which goes above and beyond the regular expectations of the school day and therefore a minor's parents should invariably be included in the process to the highest extent possible. Many add that involving parents and approaching them as allies in the counselling process is usually in the best interest of the student (Glosoff & Pate, 2002). Still others feel that the legal rights of parents cannot be hastily dismissed and that parents should be involved if a minor is deemed incompetent, but once a minor can appropriately fall under the category of a 'mature minor' s/he should be provided with the autonomy to make her/his own decision about whether or not to enter into a counselling relationship. Huss, Bryant, and Mulet (2008) suggest that in an effort to establish an ethical and collaborative working environment, school counsellors should create management agreements between themselves, school administration, parents, and students so that clearly defined, agreed-upon conditions can be determined. Bergin, Hatch, and Hermann (2004) have proposed that schools inform parents at the beginning of the year that there are individual counselling services offered at the school, and that if they do not want their child to avail of these services they should notify the school in writing.

Lehr et al. (2007) call attention to the fact that while the mature minor concept has been readily applied to health decisions, there seems to be more of a reluctance when it comes to applying the same principle in educational settings. Many school districts and schools have instated policies that cast a blanket over all minors and require counsellors to obtain parental consent and/or make disclosures to parents. This can beget confusion for counsellors who have been taught that there are certain minors who should legally be considered 'mature' and who are capable of providing their own informed consent. A research study carried out by Lehr et al. (2007) involved conducting interviews with counsellors who work in Nova Scotia, Canada schools regarding issues of confidentiality and informed consent. Some of the questions the counsellors were asked include: *how do you inform students about the confidentiality of their sessions with you?; What processes do you go through to share information with other professionals and parents?;* and *At what age do you feel confident that a student can provide informed consent?* (Lehr et al., 2007). One counsellor reported visiting classes at the beginning of the year to explain the role of a counsellor as well as confidentiality, and then reiterating the parameters of confidentiality when individual students come for counselling (Lehr et al., 2007). With regards to sharing information with other professionals, one of the participants mentioned getting permission from the student to share a general memo with the student's teacher stating that the student has some personal concerns but not giving specifics. That same participant noted that some teachers tend to feel they deserve more information than what has been offered to them (Lehr et al., 2007). It was typical for counsellors involved in the study to work with their students to try and get parents involved to the highest degree possible when it was in the best interest of the student (Lehr et al., 2007). There were

several inconsistencies amongst participants on topics pertaining to the appropriate age for students to provide their own informed consent (Lehr et al., 2007). While most of the counsellors stated that the age should be set at 16, some said 14, others thought that all high school students should be able to provide their own consent, and some cited ages of 17, 18, and 19 as appropriate ages for students to provide their own informed consent (Lehr et al., 2007). Counsellors involved in the study noted that they tended to feel conflicted about issues related to the autonomy of minors and the perceived rights of others who are considered to be responsible for those minors (Lehr et al., 2007). Many of the school counsellors said they often feel isolated, misunderstood, and alone in their profession (Lehr et al., 2007).

As one might suspect, there are some notable discrepancies between counselling practices at the different school levels. A study by Hardesty and Dillard (1994) found that elementary school counsellors more frequently engaged in consultation with teachers than did their middle and secondary school counterparts. Wagner (1981) concluded from her study that elementary school counsellors tend to be more lenient when it comes to providing confidential information to parents, and parents of elementary school students are more likely to ask about the things being discussed in counselling sessions. However, few studies have been carried out to examine the varying practices of school counsellors working with different grade levels of students. A hope for the present study is that it will be able to shed additional light in this area.

Conclusion

Evidently, the issue of informed consent when working with minors is quite complex, and the level of complexity seems only to increase in school contexts. Due to the fact that counselling is a specialized field in the educational arena, informed consent for counselling is often not fully considered by anyone in school systems apart from the counsellors themselves. The common lack of well-defined guidelines results in a profusion of ambiguity and disarray. Counsellor practices related to informed consent tend to be somewhat inconsistent, even amongst schools that fall within the same school district.

Lyden and Peters (2004) assert that the current literature pertaining to competency to provide consent for various medical and psychological procedures needs to be developed and refined. The literature related to the practices of school counsellors working with different age populations in particular, is lacking. The current study adds to this area of research. With the background literature presented, the author will now discuss the methodology of the current study.

CHAPTER 3

METHODOLOGY

This study utilized a survey method to examine how school counsellors working within the province of Newfoundland and Labrador obtain informed consent for counselling minors at differing age levels. The survey used in this research was developed by Dr. David Beeman (1991) and subsequently modified by this author and Dr. Greg Harris. Permission to use and adapt this survey was granted by Dr. David Beeman. This chapter presents information on participants, sampling approach, research design, and the methods used for data collection and analysis.

Participants

In total, 195 school counsellors in the province of Newfoundland and Labrador were invited to participate in this study. Participation involved reviewing an electronic informed consent form, providing consent, and then following a link at the end of the informed consent form to complete the online survey. One-hundred and twenty-three school counsellors completed the electronic survey, resulting in a response rate of 63.08%.

Sampling

Participants in this study were school counsellors from the four English-speaking school districts in Newfoundland and Labrador. These districts were the Eastern, Nova

Central, Western, and Labrador school districts.[1] Ethics approval to carry out the research was granted from the Interdisciplinary Committee on Ethics in Human Research (ICEHR), and subsequent permission was obtained from the appropriate personnel at each individual school board (see Appendices A, B, C, and D). In the case of the Eastern School District permission was also obtained from the principals of each school with a participating school counsellor. In total, 195 school counsellors were invited to participate in this study.

In the case of the Eastern school district, which required that permission also be obtained from the principal/s of each school, the researcher emailed and telephoned each principal in an effort to obtain written and/or verbal consent before proceeding with sending the electronic invitations to the respective school counsellors. Four out of 117 principals who have school counsellors working at their schools denied permission to have this researcher contact their school's counsellor. Once consent was received from the other school principals, an invitation e-mail was sent to school counsellors inviting them to participate in the study.

Research Design and Data Analysis

The survey utilized in this study was administered electronically via an electronic survey platform system to all school counsellors in the four English-speaking school districts of Newfoundland and Labrador. After the proper permissions were obtained

[1] As of 2013, these districts have been amalgamated into one English district.

from school district personnel and in some cases school principals, school counsellors were contacted via e-mail with an invitation to participate (see Appendix E). In this email counsellors were provided with a link, which allowed them to access the informed consent form (see Appendix G). The informed consent form discussed issues such as confidentiality, the purpose of the study, and the rationale behind the research. Contact information was also provided in the event that participants had any questions that they needed answered. If they agreed to participate after reading the informed consent form they were able to indicate this on the form and then click through to the survey. All participants were informed of the voluntary and anonymous nature of their participation and that their employment would not be affected in any way as a result of either their participation or nonparticipation.

Two weeks after the initial invitation was sent to potential participants, a reminder e-mail was sent to once again request the participation of the school counsellors in the study (see Appendix F). The survey was selected for this research with the hope that it might provide a snapshot of how school counsellors in Newfoundland and Labrador navigate issues of informed consent when working with their minor students. As noted above, it was modified to also examine how informed consent practices vary depending on the particular ages of the minors with whom counsellors are working. Participants were asked to provide demographic information (i.e., sex, age, education, years of experience, percentage of counselling position, grades and courses taught, theoretical orientation) and school information (i.e., location of school/s, type of school/s serviced, approximate amount of time spent counselling students). As an extra incentive to participate, counsellors could e-mail their names and addresses to this researcher to be

entered into a draw for a $25 gift card.

The original survey utilized by Dr. David Beeman examined the informed consent practices of counsellors and sought to explore what information counsellors deemed important to provide to clients and parents/guardians if the client is a minor. This researcher tailored the survey so that respondents (i.e., all school-based counsellors) were able to respond specifically to questions based on the specific age populations with whom they work. Most questions related to the provision of informed consent information to the minors themselves and then also to the parents/guardians of the minors.

All data was transferred from SurveyMonkey into an SPSS datafile. Following this transfer, data was manually hand checked to ensure an accurate data transfer. Data was analyzed using SPSS to explore measures of central tendency and dispersion. Data analysis also included Spearman correlations that were used to determine the relationship between demographics and informed consent practices for counsellors working with each age category. Chi square or continuity correlations were used for comparing theoretical models with informed consent practices.

Conclusion

This chapter provided a summary of the methodology used in this research by presenting information regarding the methods utilized for data collection and analysis. The procedures that were undertaken to administer the survey measure to the school counsellors were presented. The following chapter will present the findings of the

current study.

CHAPTER 4

RESULTS

A survey focused on informed consent practices among school counselors was administered electronically to 123 participating school counsellors in the province of Newfoundland and Labrador. This chapter presents the findings of the study in an effort to address the research questions posed.

Demographic Profile

Data collected from the first ten questions of the survey was utilized to provide a comparative demographic and background description of all the school counsellors who participated in this study as well as the schools in which they provide counselling services. These questions related to sex, age, educational training, years of experience as a counsellor, percentage of counselling position (i.e., full-time, part-time, etc.) grades and courses taught, theoretical orientation to counselling, location of school/s, type of school/s serviced (e.g., k-6, 1-3, 9-12, etc.), the approximate amount of time spent counselling students, and the ages of students with whom they work. This information helps provide a basic profile of the sample of counsellors surveyed. The sample

consisted primarily of female participants (n = 84, 72.4%) and half of the participants fell into the 41-50 age range (n = 59, 50.9%). (See Table 1).

Table 1

Sex and Age of Survey Participants

Characteristic	N	% of Sample
Sex		
Male	32	27.6
Female	84	72.4
Age		
Under 30	10	8.6
31-40	24	20.7
41-50	59	50.9
51-60	21	18.1
61+	2	1.7

Table 2

Experience, Percentage of Counselling Allocation, and Location of School/s

Characteristic	N	% of Sample
Years of Experience		
0-5	35	30.4
6-10	20	17.4
11-15	18	15.7
16-20	17	14.8
21-25	15	13
26+	10	8.7
Percent of Counselling Position		
Full time counsellor	77	66.4
Part time counsellor + other	37	31.9
Part time counsellor only	2	1.7
Location of School/s		
Urban	43	38.1

Rural	67	59.3
Both	3	2.7

A majority of the sample (46.1%) reported that they were working with children aged 5-11. Thirty five percent (35.7%) of respondents were working with early adolescents (aged 12-15) and 18.3% were working with late adolescents (aged 16-18) at the time of their participation in this study. Many of the participants were working with multiple age groups of students and were able to reflect this appropriately in their responses while completing the survey (see Table 3).

Table 3

Ages of Student Clients

Characteristic	N	% of Sample
Ages of student clients		
Children (5-11)	53	46.1
Early Adolescents (12-15)	41	35.7
Late Adolescents (16-18)	21	18.3

Research Questions

Question #1

What are the current informed consent practices of counsellors (i.e., obtaining informed consent from the client and/or parents) and what are the current practices of counsellors around parental access to client files for counsellors working with children, early adolescents, or late adolescents?

A majority of counsellors (74.6%) working with children indicated that they obtain consent from the child's parents, although a sizeable percentage (25.4%) did report no such consent practices (see Table 4).

Table 4

Obtaining Parental Consent When Counselling Children

When working with children (aged 5-11) do you obtain consent from the children's parents?	Frequency	Valid Percent
Yes	47	74.6
No	16	25.4
Total	63	100

A majority of counsellors surveyed (73.4%) indicated that they obtain informed

consent from the child him or herself, with a smaller percentage (26.6%) reporting no such practices (see Table 5).

Table 5

Obtaining Consent From the Child When Counselling Children

When working with children (aged 5-11) do you obtain consent from the child him or herself?	Frequency	Valid Percent
Yes	47	73.4
No	17	26.6
Total	64	100

The majority of surveyed counsellors (68.9%) who work with early adolescents indicated that they *do not* obtain informed consent from the parents of the early adolescent they are working with (see Table 6).

Table 6

Obtaining Consent From Parents When Counselling Early Adolescents

When working with an early adolescent (aged 12-15) do you obtain informed consent from the parents of the early adolescent?	Frequency	Valid Percent
Yes	19	31.1
No	42	68.9
Total	61	100

Eighty two percent of survey participants working with early adolescents obtain informed consent for counselling from the early adolescent they are working with (see Table 7).

Table 7

Obtaining Consent From the Adolescent When Counselling Early Adolescents

When working with an early adolescent (aged 12-15) do you obtain informed consent from the early adolescent him or herself?	Frequency	Valid Percent
Yes	50	82.0
No	11	18.0
Total	61	100

The vast majority (97.4%) of surveyed counsellors who work with late adolescents indicated that they *do not* obtain informed consent for counselling from the parents of their late adolescent clients (see Table 8).

Table 8

Obtaining Consent From Parents When Counselling Late Adolescents

When working with late adolescents (aged 16-18) do you obtain informed consent from the student's parents?	Frequency	Valid Percent
Yes	1	2.6
No	38	97.4
Total	39	100

The vast majority (90%) of surveyed participants who work with late adolescents said that they obtain informed consent for counselling from their late adolescent clients (see Table 9).

Table 9

Obtaining Consent From the Adolescent When Counselling Late Adolescents

When working with late adolescents do you obtain informed consent from the late adolescent him or herself?	Frequency	Valid Percent
Yes	36	90.0
No	4	10.0
Total	40	100

Ninety percent (90.4%) of survey participants indicated that when working with children, parents have access to information regarding the counselling of their children (see Table 10).

Table 10

Parental Access to Counselling Information of Children

Do parents have access to information regarding the counselling of their child (aged 5-11)?	Frequency	Valid Percent
Yes	47	90.4
No	5	9.6
Total	52	100

Seventy one percent (71.2%) of those working with early adolescents said that

parents have access to information regarding the counselling of their early adolescent (see Table 11).

Table 11

Parental Access to Counselling Information of Early Adolescents

Do parents have access to information regarding the counselling of their early adolescent (aged 12-15)?	Frequency	Valid Percent
Yes	37	71.2
No	15	28.8
Total	52	100

Fifty one percent (51.5%) of surveyed counsellors working with late adolescents said that parents *do not* have access to information involving the counselling of their late adolescent, whereas 48.5% of surveyed counsellors indicated that parents do have access to this counselling information (see Table 12).

Table 12

Parental Access to Counselling Information of Late Adolescents

Do parents have access to information regarding the counselling of their late adolescent (aged 16-18)?	Frequency	Valid Percent
Yes	16	48.5
No	17	51.5
Total	33	100

For counsellors working with children (aged 5-11), 74.6% obtain informed consent from parents and 73.4% obtain informed consent from the children. For counsellors working with early adolescents (aged 12-15), 31.1% obtained informed consent from the parents and 82% obtained informed consent from the early adolescent. For counsellors working with late adolescents (aged 16-18), 2.6% obtain informed consent from the parents and 90% obtain informed consent from the late adolescent.

For counsellors working with children (aged 5-11), 90% allow parents access to information regarding counselling. For counsellors working with early adolescents (aged 12-15), 71.2% allow parents access to information regarding counselling. For counsellors working with late adolescents (aged 16-18), 48.5% allow parents access to information regarding counselling.

Question #2

Are counsellor demographic variables (i.e., age, years of experience in counselling position, sex, percentage of time in counselling role, and geographical location of school) related to informed consent practices (i.e., obtaining informed consent from the client and/or parents) for counsellors working with children, early adolescents, and late adolescents?

Spearman correlations were used to determine the relationship between demographics and informed consent practices for counsellors working with children, early adolescents and late adolescents. For counsellors working with children (aged 5-

11) there were no significant correlations between demographics and informed consent practices (see Table 13). For counsellors working with early adolescents (12-15) there was a small negative correlation (-0.258, P=.045) between percent of time in position and obtaining consent from parents. There were no other significant correlations for other demographic variables (see Table 14). For counsellors working with late adolescents (16-18) there were no significant correlations between demographics and informed consent practices (see Table 15).

Table 13

Correlation of Counsellor Demographic Variables and Informed Consent Practices of Counsellors Working With Children

			Obtaining consent from the parent of the child (aged 5-11)	Obtaining consent from the child (aged 5-11)
Spearman's rho	Sex	Correlation Coefficient	- 0.214	-0.001
		Sig. (2-tailed)	0.092	0.992
		N	63	64
	Age of the respondent	Correlation Coefficient	-0.128	0.062
		Sig. (2-tailed)	0.317	0.626
		N	63	64
	Percent of time in position 2 Levels	Correlation Coefficient	0.052	-0.044
		Sig. (2-tailed)	0.688	0.733
		N	63	64
	Years of experience in role	Correlation Coefficient	-0.013	0.155
		Sig. (2-tailed)	0.921	0.224
		N	62	63
	Geographical location of school	Correlation Coefficient	0.005	-0.135
		Sig. (2-tailed)	0.967	0.301
		N	60	61

** Correlation is significant at the 0.01 level (2-tailed)
* Correlation is significant at the 0.05 level (2-tailed)

Table 14

Correlation of Counsellor Demographic Variables and Informed Consent Practices of Counsellors Working With Early Adolescents

			Obtaining consent from the parent of the early adolescent (aged 12-15)	Obtaining consent from the early adolescent (aged 12 -15)
Spearman's rho	Sex	Correlation Coefficient	-0.240	-0.108
		Sig. (2-tailed)	0.062	0.407
		N	61	61
	Age of the respondent	Correlation Coefficient	-0.107	-0.067
		Sig. (2-tailed)	0.410	0.607
		N	61	61
	Percent of time in position 2 Levels	Correlation Coefficient	-0.258*	-0.071
		Sig. (2-tailed)	0.045	0.589
		N	61	61
	Years of experience in role	Correlation Coefficient	0.122	-0.056
		Sig. (2-tailed)	0.353	0.672
		N	60	60
	Geographical location of school	Correlation Coefficient	-0.063	0.039
		Sig. (2-tailed)	0.645	0.777
		N	56	56

** Correlation is significant at the 0.01 level (2-tailed)

* Correlation is significant at the 0.05 level (2-tailed)

Table 15
Correlation of Counsellor Demographic Variables and Informed Consent Practices of Counsellors Working With Late Adolescents

			Obtaining consent from the parent of the late adolescents (aged 16-18)	Obtaining consent from the late adolescents (aged 16-18)
Spearman's rho	Sex	Correlation Coefficient Sig. (2-tailed) N	-0.115 0.487 39	-0.120 0.469 39
	Age of the respondent	Correlation Coefficient Sig. (2-tailed) N	-0.237 0.147 39	0.181 0.270 39
	Percent of time in position 2 Levels	Correlation Coefficient Sig. (2-tailed) N	-0.229 0.160 39	-0.239 0.143 39
	Years of experience in role	Correlation Coefficient Sig. (2-tailed) N	- - 37	0.164 0.325 38
	Geographical location of school	Correlation Coefficient Sig. (2-tailed) N	- - 37	-0.317 0.056 37

** Correlation is significant at the 0.01 level (2-tailed)
* Correlation is significant at the 0.05 level (2-tailed)

Question #3

Are counsellor demographic variables (i.e., age, years of experience in counselling position, sex, percentage of time in counselling role, and geographical location of school) related to practices around parental access to client information for counsellors working with children, early adolescents, and late adolescents?

Spearman correlations were used to determine the relationship between demographics and parental access to client information for counsellors working with children, early adolescents and late adolescents. There were no significant correlations between counsellor demographic variables and parental access to client files for counsellors working with children, early adolescents, or late adolescents (see Table 16).

Table 16
Correlations Between Counsellor Demographics and Parental Access to Information of Counsellors Working With Children, Early Adolescents and Late Adolescents

			Parent access to information of child (aged 5-11) counselling combined	Parent access to information of early adolescent (aged 12-15) counselling combined	Parent access to information of late adolescent (aged 16-18) counselling combined
Spearman's rho	Sex	Correlation Coefficient	0.051	-0.063	0.020
		Sig. (2-tailed)	0.720	0.657	0.912
		N	52	52	33
	Age of the respondent	Correlation Coefficient	-0.014	-0.002	0.032
		Sig. (2-tailed)	0.923	0.991	0.862
		N	52	52	33
	Percent of time in position 2 Levels	Correlation Coefficient	0.174	0.035	0.038
		Sig. (2-tailed)	0.217	0.803	0.835
		N	52	52	33
	Years of experience in role	Correlation Coefficient	0.088	-0.030	-0.024
		Sig. (2-tailed)	0.539	0.832	0.895
		N	51	51	32
	Geographical location of school	Correlation Coefficient	-0.038	0.243	-0.044
		Sig. (2-tailed)	0.798	0.099	0.816
		N	49	47	31

** Correlation is significant at the 0.01 level (2-tailed)
* Correlation is significant at the 0.05 level (2-tailed)

Question #4

Do counsellor self reported theoretical orientations relate to informed consent practices (i.e., obtaining informed consent from the client and/or parents) and/or parental access to clients' files for counsellors working with children, early adolescents or late adolescents?

Chi square or continuity correlations were used for comparing theoretical models with informed consent practices. Only theoretical models with a sample size of 25 or greater were selected for the comparison.

There was a significant correlation between counsellors who ascribe to the behavioural theoretical model and obtaining informed consent from child clients by counsellors working with children ($X2 = 4.985$, $p = 0.026$). There was also a significant correlation between counsellors who do not subscribe to a theoretical model obtaining informed consent from the child clients they work with ($X2 = 4.105$, $p = 0.043$). No other significant relationships were observed in the data (see Tables 17, 18, 19, 20, and 21).

Table 17
Counsellor Self Reported Theoretical Orientations

Theoretical Models	Frequency	Valid Percent
Adlerian	3	1.7
Existential	4	2.3
Reality	12	6.8
Behavioural	27	15.3
Gestalt	3	1.7
Cognitive	39	22.0
Humanistic	10	5.6
Psychoanalytic	2	1.1
Systems/Family	6	3.4
Transactional Analysis	1	0.6
Eclectic	42	23.7
Do not subscribe to a theoretical model	28	15.8

Table 18

Chi-Square Between Informed Consent Practices and Counsellors Who Ascribe to the 'Behavioural' Theoretical Model

	Yes	No	Pearson Chi-Square	Continuity correlation	Asymp. Sig (2-sided)
Informed consent from child?	47	17	4.985		0.026
Informed consent from parent of child?	47	16		1.405	0.236
Informed consent information given to parent of child?	47	5		0.018	0.893
Informed consent from early adolescent?	50	11		0.883	0.347
Informed consent from parent of early adolescent?	19	42	1.735		0.188
Informed consent information given to parent of early adolescent?	37	15		0.060	0.806
Informed consent from late adolescent?	36	4		0.000	1.000
Informed consent from parent of late adolescent?	1	38		0.547	0.459
Informed consent information given to parent of late adolescent?	16	17		0.095	0.758

Table 19

Chi-Square Between Informed Consent Practices and Counsellors Who Ascribe to the 'Cognitive' Theoretical Model

	Yes	No	Pearson Chi-Square	Continuity correlation	Asymp. Sig (2-sided)
Informed consent from child?	47	17	0.646		0.421
Informed consent from parent of child?	47	16		0.485	0.486
Informed consent information given to parent of child?	47	5		0.343	0.558
Informed consent from early adolescent?	50	11		0.000	1.000
Informed consent from parent of early adolescent?	19	42		1.411	0.235
Informed consent information given to parent of early adolescent?	37	15	2.564		0.109
Informed consent from late adolescent?	36	4		0.000	1.000
Informed consent from parent of late adolescent?	1	38		0.058	0.810
Informed consent information given to parent of late adolescent?	16	17	0.308		0.579

Table 20

Chi-Square Between Informed Consent Practices and Counsellors Who Describe Themselves as 'Eclectic' in Terms of Theoretical Model

	Yes	No	Pearson Chi-Square	Continuity correlation	Asymp. Sig (2-sided)
Informed consent from child?	47	17	0.004		0.949
Informed consent from parent of child?	47	16	0.256		0.613
Informed consent information given to parent of child?	47	5		0.052	0.820
Informed consent from early adolescent?	50	11		0.466	0.495
Informed consent from parent of early adolescent?	19	42	0.465		0.495
Informed consent information given to parent of early adolescent?	37	15	0.046		0.830
Informed consent from late adolescent?	36	4		0.000	1.000
Informed consent from parent of late adolescent?	1	38		0.128	0.720
Informed consent information given to parent of late adolescent?	16	17	0.017		0.895

Table 21

Chi-Square Between Informed Consent Practices and Counsellors Who Do Not Ascribe to a Theoretical Model

	Yes	No	Pearson Chi-Square	Continuity correlation	Asymp. Sig (2-sided)
Informed consent from child?	47	17	4.105		0.043
Informed consent from parent of child?	47	16		0.471	0.492
Informed consent information given to parent of child?	47	5		0.074	0.786
Informed consent from early adolescent?	50	11		0.025	0.874
Informed consent from parent of early adolescent?	19	42	0.727		0.394
Informed consent information given to parent of early adolescent?	37	15		0.781	0.377
Informed consent from late adolescent?	36	4		0.000	1.000
Informed consent from parent of late adolescent?	1	38		0.000	1.000
Informed consent information given to parent of late adolescent?	16	17		0.790	0.374

Question #5

What informed consent dimensions do counsellors view as important when obtaining informed consent from parents?

When working with children, 40.7% of counsellors viewed going over the limits to confidentiality with parents/guardians as extremely important. Sharing probability of intended outcome with parents/guardians of child clients was noted as being important by 48.1% of respondents. When working with early adolescents, surveyed counsellors viewed limits to confidentiality (54.7% extremely important) as an important aspect of obtaining informed consent from parents. When working with late adolescents, counsellors also viewed limits to confidentiality (54.5% extremely important) as an important aspect of obtaining informed consent from parents (see Table 22, 23, and 24).

Table 22

Counsellors' Views on the Level of Importance of Information to Parents of Child Clients During the Informed Consent Process

	Not Important	Slightly Important	Important	Very Important	Extremely Important	Total
Time, place and setting of sessions	11 20.0%	19 34.5%	19 34.5%	3 5.5%	3 5.5%	55
The nature of the sessions and what will take place	1 1.8%	9 16.4%	25 45.5%	11 20.0%	9 16.4%	55
Limits to confidentiality	1 1.9%	0 0.0%	14 25.9%	17 31.5%	22 40.7%	54
Intended outcome of counselling	0 0.0%	1 1.9%	24 44.4%	15 27.8	14 25.9%	54
Probability of intended outcome	2 3.7%	8 14.8%	26 48.1%	12 22.2%	6 11.1%	54
Description of counsellor's orientation to counselling	28 51.9%	13 24.1%	9 16.7%	3 5.6	1 1.9%	54
Training and qualifications of counsellor	9 16.7%	15 27.8%	16 29.6%	7 13.0%	7 13.0%	54
Possible advantages of counselling	1 1.9%	2 3.7%	23 42.6%	17 31.5%	11 20.4%	54
Possible negative side effects of counselling	4 7.4%	11 20.4%	23 42.6%	11 20.4%	5 9.3%	54
Description of alternatives	5 9.4%	11 20.8%	20 37.7%	13 24.5%	4 7.5%	53
Option to refuse/withdraw counselling	2 3.8%	4 7.5%	22 41.5%	15 28.3%	10 18.9%	53

Number reflects frequency and percent reflects valid percentage of respondents

Table 23

Counsellors' Views on the Level of Importance of Information to Parents of Early Adolescent Clients During the Informed Consent Process

	Not Important	Slightly Important	Important	Very Important	Extremely Important	Total
Time, place and setting of sessions	15 28.3%	17 32.1%	16 30.2%	3 5.7%	2 3.8%	53
The nature of the sessions and what will take place	4 7.5%	9 17.0%	28 52.8%	7 13.2%	5 9.4%	53
Limits to confidentiality	1 1.9%	2 3.8%	9 17.0%	12 22.6%	29 54.7%	53
Intended outcome of counselling	3 5.7%	2 3.8%	27 50.9%	14 26.4%	7 13.2%	53
Probability of intended outcome	5 9.4%	10 18.9%	25 47.2%	9 17.0%	4 7.5%	53
Description of counsellor's orientation to counselling	25 47.2%	16 30.2%	9 17.0%	3 5.7%	0 0.0%	53
Training and qualifications of counsellor	9 17.0%	15 28.3%	19 35.8%	8 15.1%	2 3.8%	53
Possible advantages of counselling	2 3.8%	7 13.2%	18 34.0%	18 34.0%	8 15.1%	53
Possible negative side effects of counselling	2 3.8%	11 21.2%	26 50%	9 17.3%	4 7.7%	52
Description of alternatives	3 5.8%	13 25.0%	18 34.6%	12 23.1%	6 11.5%	52
Option to refuse/withdraw counselling	5 9.4%	3 5.7%	19 35.8%	16 30.2%	10 18.9%	53

Number reflects frequency and percent reflects valid percentage of respondents

Table 24

Counsellors' Views on the Level of Importance of Information to Parents of Late Adolescent Clients During the Informed Consent Process

	Not Important	Slightly Important	Important	Very Important	Extremely Important	Total
Time, place and setting of sessions	15 45.5%	11 33.3%	3 9.1%	4 12.1%	0 0.0%	33
The nature of the sessions and what will take place	9 27.3%	11 33.3%	9 27.3%	3 9.1%	1 3.0%	33
Limits to confidentiality	1 3.0%	0 0.0%	4 12.1%	10 30.3%	18 54.5%	33
Intended outcome of counselling	4 12.5%	6 18.8%	14 43.8%	5 15.6%	3 9.4%	32
Probability of intended outcome	8 25.0%	8 25.0%	11 34.4%	4 12.5%	1 3.1%	32
Description of counsellor's orientation to counselling	15 46.9%	9 28.1%	8 25.0%	0 0.0%	0 0.0%	32
Training and qualifications of counsellor	5 16.1%	7 22.6%	13 41.9%	4 12.9%	2 6.5%	31
Possible advantages of counselling	3 9.4%	3 9.4%	8 25.0%	11 34.4%	7 21.9%	32
Possible negative side effects of counselling	4 12.5%	7 21.9%	13 40.6%	6 18.8%	2 6.3%	32
Description of alternatives	4 12.1%	4 12.1%	14 42.4%	6 18.2%	5 15.2%	33
Option to refuse/withdraw counselling	6 18.2%	2 6.1%	10 30.3%	7 21.2%	8 24.2%	33

Number reflects frequency and percent reflects valid percentage of respondents

Question #6

What informed consent dimensions do counsellors view as important when obtaining informed consent from clients?

When working with children, counsellors viewed limits to confidentiality (44.4%, extremely important) as an important component of obtaining informed consent from the client. When working with early adolescents, counsellors viewed limits to confidentiality (69.2%, extremely important) as an important dimension of obtaining informed consent from the client. When working with late adolescents, counsellors viewed limits to confidentiality (79.4%, extremely important) and option to refuse or withdraw counselling (46.9%, extremely important) as important dimensions when obtaining informed consent from clients (see Tables 25, 26, and 27).

Table 25

Counsellors' Views on the Level of Importance of Information to Child Clients During the Informed Consent Process

	Not Important	Slightly Important	Important	Very Important	Extremely Important	Total
Time, place and setting of sessions	4 7.4%	9 16.7%	21 38.9%	16 29.6%	4 7.4%	54
The nature of the sessions and what will take place	1 1.9%	2 3.7%	24 44.4%	18 33.3%	9 16.7%	54
Limits to confidentiality	1 1.9%	1 1.9%	14 25.9%	14 25.9%	24 44.4%	54
Intended outcome of counselling	1 1.9%	6 11.1%	23 42.6%	15 27.8%	9 16.7%	54
Probability of intended outcome	8 15.1%	9 17.0%	20 37.7%	12 22.6%	9 17.0%	53
Description of counsellor's orientation to counselling	36 69.2%	8 15.4%	8 15.4%	0 0.0%	0 0.0%	52
Training and qualifications of counsellor	27 50.9%	9 17.0%	10 18.9%	4 7.5%	3 5.7%	53
Possible advantages of counselling	1 1.9%	6 11.3%	20 37.7%	18 34.0%	8 15.1%	53
Possible negative side effects of counselling	11 20.8%	14 26.4%	17 32.1%	6 11.3%	5 9.4%	53
Description of alternatives	13 25.0%	12 23.1%	18 34.6%	8 15.4%	1 1.9%	52
Option to refuse/withdraw counselling	5 9.6%	4 7.7%	19 36.5%	13 25.0%	11 21.2%	52

Number reflects frequency and percent reflects valid percentage of respondents

Table 26

Counsellors' Views on the Level of Importance of Information to Early Adolescent Clients During the Informed Consent Process

	Not Important	Slightly Important	Important	Very Important	Extremely Important	Total
Time, place and setting of sessions	3 5.7%	8 15.1%	23 43.4%	9 17.0%	10 18.9%	53
The nature of the sessions and what will take place	0 0.0%	3 5.7%	20 37.7%	17 32.1%	13 24.5%	53
Limits to confidentiality	0 0.0%	0 0.0%	8 15.4%	8 15.4%	36 69.2%	52
Intended outcome of counselling	0 0.0%	2 3.8%	21 39.6%	22 41.5%	8 15.1%	53
Probability of intended outcome	0 0.0%	12 22.6%	24 45.3%	10 18.9%	7 13.2%	53
Description of counsellor's orientation to counselling	31 58.5%	11 20.8%	7 13.2%	3 5.7%	1 1.9%	53
Training and qualifications of counsellor	22 41.5%	11 20.8%	12 22.6%	5 9.4%	3 5.7%	53
Possible advantages of counselling	1 1.9%	7 13.2%	21 39.6%	17 32.1%	7 13.2%	53
Possible negative side effects of counselling	4 7.5%	16 30.2%	21 39.6%	6 11.3%	6 11.3%	53
Description of alternatives	2 3.8%	13 25.0%	21 40.4%	12 23.1%	4 7.7%	52
Option to refuse/withdraw counselling	1 1.9%	4 7.5%	15 28.3%	16 30.2%	17 32.1%	53

Number reflects frequency and percent reflects valid percentage of respondents

Table 27

Counsellors' Views on the Level of Importance of Information to Late Adolescent Clients During the Informed Consent Process

	Not Important	Slightly Important	Important	Very Important	Extremely Important	Total
Time, place and setting of sessions	1 2.9%	4 11.8%	15 44.1%	8 23.5%	6 17.6%	34
The nature of the sessions and what will take place	1 2.9%	2 5.9%	13 38.2%	10 29.4%	8 23.5%	34
Limits to confidentiality	0 0.0%	0 0.0%	4 11.8%	3 8.8%	27 79.4%	34
Intended outcome of counselling	0 0.0%	1 3.0%	10 30.3%	11 33.3%	11 33.3%	33
Probability of intended outcome	0 0.0%	7 21.2%	15 45.5%	6 18.2%	5 15.2%	33
Description of counsellor's orientation to counselling	9 26.5%	12 35.3%	10 29.4%	1 2.9%	2 5.9%	34
Training and qualifications of counsellor	8 23.5%	9 26.5%	10 29.4%	5 14.7%	2 5.9%	34
Possible advantages of counselling	1 2.9%	3 8.8%	14 41.2%	8 23.5%	8 23.5%	34
Possible negative side effects of counselling	4 12.5%	8 25.0%	12 37.5%	5 15.6%	3 9.4%	32
Description of alternatives	1 2.9%	6 17.6%	14 41.2%	7 20.6%	6 17.6%	34
Option to refuse/withdraw counselling	2 6.3%	2 6.3%	9 28.1%	4 12.5%	15 46.9%	32

Number reflects frequency and percent reflects valid percentage of respondents

Conclusion

This chapter presented the results observed in the current study including demographic variables, data on informed consent practices, and data on counsellors' views of the importance of various informed consent practices. The author presented data in response to the research questions that were posed in chapter one. In summary, a majority of participants indicated that they are more likely to involve parents in the informed consent process if their clients are children or early adolescents and are less likely to involve parents when working with late adolescents. Most of the counsellors surveyed obtain informed consent from their clients (i.e., regardless of age) but the frequency increases with client age. Reviewing the limitations to confidentiality repeatedly came up as an area of importance in the informed consent process. Results will be discussed further in the next chapter.

CHAPTER 5

DISCUSSION

Introduction

Informed consent is widely accepted as being an essential component of a client-counsellor relationship in both clinical and school settings. There is extensive literature available that highlights the importance of obtaining consent prior to the onset of, and throughout the course of the helping relationship. The literature is consistent in reporting that informed consent is a cornerstone of effective helping relationships; it facilitates trust and demonstrates respect for personhood, which can often be therapeutic in its own right (Beahrs & Gutheil, 2001; Fisher & Oransky, 2008).

However, truly *informed consent* can mean different things to different people, and so there remains a great deal of ambiguity and inconsistency in practice. This uncertainty is amplified when it involves work with minors; practitioners often find themselves asking *who* needs to know *what*? What is the role of clients' parents? What about minors who seem mature enough to be able to provide their own informed consent? Where does one draw the line between providing enough information and providing *so much* information that it could have a negative effect on the therapeutic relationship?

Many counselling agencies and school districts have not adopted or established policies related to informed consent, which means that there can exist gaping discrepancies between the informed consent practices of counsellors/therapists even

within a single organization or school district. The lack of policy and clear guidelines means that many counsellors have often been left to their own professional judgments. While it is probable that a majority of counsellors are diligent, concerned about ethics, and have an understanding of the importance of obtaining informed consent – the lack of policy in general could potentially impact clients negatively or open the counsellors, organizations, or school districts themselves up to liability. Alternatively though, imposing standard and widespread policies could create situations where counsellors are forced to follow rules that may be less than ideal for their clients. It seems likely that flexibility in any policy would be important.

This exploratory study sought to take a sample of the general population and address the question: *What are the informed consent practices of school counsellors working in schools in the province of Newfoundland and Labrador?* A questionnaire developed by Dr. David Beeman was subsequently modified and administered to one hundred and twenty-three school counsellors across the province in an effort to gage current trends in informed consent practices.

This chapter is organized into four sections: I.) Informed consent and information sharing practices; II.) Relevant informed consent information to parents and clients; III.) Study limitations; and IV.) Conclusion.

Informed Consent and Information Sharing Practices

The importance of informed consent is well researched and cannot be overstated. Properly obtained consent serves to exhibit respect for personhood and autonomy, while also demonstrating a recognition of a client's right to act in his or her own best interest (Batten, 1996; Crowhurst & Dobson, 1993; Glosoff & Pate, 2002; Goddard et al., 2008; Gustafson, McNamara, & Jensen, 1994; Henkelman & Everall, 2001; Huey, 1996; Knapp & VandeCreek, 2006; Martindale et al., 2009; Sales et al., 2008; Tymchuk, 1997). Informed consent has also been shown to enhance the therapeutic alliance, which can, in turn, ultimately yield more positive results for clients (Fisher & Oransky, 2008; Lyden & Peters, 2004).

While few counsellors would argue against the significance of informed consent, there seems to exist some inconsistency in practice. Indeed, some variance in the informed consent practices of counsellors was noted in the results of the current study. However, most of the survey participants who work with children (aged 5-11) indicated that they generally obtain informed consent from both the child and the child's parents, though a slightly higher percentage felt it was necessary to obtain consent from the child's parents. As students' ages increased, there was a higher incidence of counsellors reporting that they obtain consent from their student clients and a lower incidence of counsellors reporting that they obtain consent from their student client's parents. Similarly, as the students' ages increased the percentage of counsellors who allowed parents to have access to counselling information decreased. This falls in line with the results from Wagner's (1981) study, which suggested that counsellors who work with

elementary school students often tend to adopt a more relaxed attitude with regards to providing confidential information to parents than those who work with older students.

The competency of minors to provide their own consent for various treatments has long been called into question, and as such the responses of counsellors to these questions in the current study likely do not come as any surprise. As Isaacs and Stone (1999) have suggested: the younger the age of the client in question, the more control there is extended to parents over decisions concerning their children. Weithorn and Campbell's (1982) research corroborates the idea that younger children have a limited ability to reason and understand treatment information as compared with their adolescent and adult counterparts. Thus, most counsellors feel that children require somebody with adequate competence and the capacity to act in their best interest by providing consent on their behalf, or at least in addition to the consent or assent given by the child.

Worthy of note is the fact that although the majority of respondents in the current study reported obtaining informed consent for counselling from both parents and the children (aged 5-11) themselves, twenty five percent (25.4%) said they *do not* obtain consent from the children's parents and twenty six percent (26.6%) *do not* obtain consent from the children themselves. When working with early adolescents, eighty two percent (82%) of counsellors reported that they obtain consent from the client, and nearly sixty nine percent (68.9%) said they *do not* obtain consent from the early adolescent's parents. Out of the counsellors who worked with students in the late adolescent range (16-18), ninety seven percent (97.4%) reported that they *do not* obtain consent from the late adolescent's parents, while ninety percent (90%) *do* obtain informed consent from the late adolescent him/herself. Though ninety percent is clearly a substantial percentage,

there remains a small percent (10%) of counsellors who are reportedly *not* obtaining informed consent from the late adolescents with whom they work.

Evidently, the informed consent practices of school counsellors who work with minors in Newfoundland and Labrador are varied and not always aligned or consistent. Some discrepancy is to be expected, however, given the limited guidelines and established policies within school districts and many organizations. The lack of policy appears to be a common phenomenon, and one that makes sense when considering the specialization of counselling in many settings, particularly in schools. School counsellors often find themselves operating as 'islands' and having to educate their colleagues about what their roles truly entail. Within a school setting, very few other educational professionals have the training and background to be able to fully understand the role of counsellors, apart from the counsellors themselves. This begs the question, if administrators and policy-makers at the school level and beyond do not fully understand the role of counsellors or what the job of a counsellor involves, are they aware of a potential need for basic guidelines related to informed consent? Counsellors themselves should of course be part of the creation of any such policies, so that relevant ethical counselling principles can be applied and counsellors can draw upon their experiences and expertise to provide input.

Importantly, such guidelines should not be put in place to promote a culture of distrust or fear amongst counsellors. Rather, they should be put in place to protect clients and counsellors alike. The construction of informed consent policies would remove a great deal of ambiguity while adding a sense of security as counsellors could look to the guidelines in moments of uncertainty to ensure they are following proper protocol and

acting fully in the best interest of their clients. Any such policy should of course be guiding in principle and still allow for flexibility and sound clinical judgment on the part of the professional school counsellor. While there will always be a certain amount of professional judgment that has to be exercised when it comes to obtaining informed consent, the more objective it can be the better - for all stakeholders.

Further research related to informed consent practices of counsellors and therapists in a variety of settings and working with a variety of age groups is warranted. The current study focused on the informed consent practices of school counsellors working with minors in Newfoundland and Labrador, but concerns related to informed consent in counselling extend beyond this province and certainly beyond school settings.

Relevant Informed Consent Information to Parents and Clients

When examining the practice of obtaining informed consent, it is also necessary to ask questions about what exactly that means. What information is given, to whom, and in what depth? Again, there seems to be some variations in practice between practitioners. Much of the existing research agrees that there are at least three main elements that should be present in order for someone to be able to give truly informed consent: knowledge, competency, and voluntariness (Batten, 1996; Beeman & Scott, 1991; Cahana & Hurst, 2008; Croxton et al., 1998; Henkelman & Everall, 2001; Lyden & Peters, 2004; Saks & Jeste, 2006; Sales et al., 2008). What type of information satisfies the 'knowledge' component?

There is a plethora of research addressing what types of information should be shared with clients/caregivers in the process of obtaining informed consent. In the companion manual to the Canadian Code of Ethics for Psychologists, the CPA (2001) offers a general guideline, which suggests that as much information should be provided as any 'reasonable' person would want to know before agreeing to participate in the counselling/therapy. Jensen, McNamara, and Gustafson's 1991 study showed that both clinicians and clients felt the most important information that should be shared in the informed consent process was details about confidentiality and its limitations, fee structuring, therapeutic benefits, and iatrogenic risks. This was similar to the results of Braaten and Handelsman's 1997 study, which showed that some of the most highly rated pieces of informed consent information included therapeutic techniques, confidentiality, and the risks of alternative treatments. Beeman and Scott's 1991 study also found that the most highly rated items of importance included the limits to confidentiality, the intended outcome of therapy, the nature of the sessions, and the time, place, duration, and setting of the sessions. It seems that confidentiality and the limits to confidentiality, in particular, were consistently rated among the most important pieces of information to share in the informed consent process.

In the current study, much of the focus was on what information counsellors believe should be provided to minors of different age groups as well as the minors' parents. This has not previously been a common focus in the research literature, but additional study would be justified in an effort to more closely examine how/if the types of information provided during the informed consent process changes depending on the age of clients. Counsellors in the current study did show some variance with regard to

the type of information they deem important to provide to the children, early adolescents, and late adolescents with whom they work – as well as to their respective parents.

The top three pieces of information that counsellors felt should be provided to the parents of children in the informed consent process were: the intended outcome of counselling, the probability of the intended outcome, and the limits to confidentiality. For the parents of early adolescents this changed slightly, with the three most reported important aspects of informed consent to address being: the limits to confidentiality, the intended outcome of counselling, and the nature of the sessions and what will take place. This changed ever so slightly again based on the reports of those working with late adolescents, where the top three most important pieces of informed consent information to be shared with parents were identified as being: the limits to confidentiality, the possible advantages of counselling, and a description of alternatives (with the option to withdraw or refuse counselling following closely in terms of level of importance).

With regards to what information counsellors reported should be provided to the clients themselves at various levels, there were some noted differences. However, for all ages (children, early adolescents, and late adolescents) the top three pieces of information were: the limits to confidentiality, the nature of the sessions and what will take place, and the intended outcome of counselling. The percentages associated with these three pieces of information differed depending upon the age of the clients with whom the counsellors were working.

Notably, although 'limits to confidentiality' was consistently ranked as being "extremely important," the percentage increased steadily with the rise in age of the clients. This suggests that in the creation of a policy related to informed consent, policy-

makers would need to closely consider what, if any age, is too young to address confidentiality and its limits with students in a counselling context.

Further study to examine trends in how the types of information shared in the informed consent process changes based on the age (and other demographic variables) of clients would be beneficial and further enrich the research in this field. This could also help promote a bigger-picture dialogue regarding the rights of clients, parents of minors, and what types of information various stakeholders should understand prior to the commencement of counselling, as well as throughout the ongoing counselling relationship.

Limitations of Study

One limitation of the current study is inherent in the survey method of data collection. The counsellors' interpretations of the questions and the prudence with which the questions were answered could not be controlled. Consequently, this method of data collection imposes limitations that are beyond the control of the researchers and this study. In addition, although the study included a relatively large response rate, several school counsellors in the province opted not to participate (or were not permitted to participate by their respective principals) potentially introducing bias into the study findings.

The current study was exploratory and descriptive, allowing for a survey of common practices associated with informed consent in school counselling practice. This

provides added value to the school counselling literature, but also highlights a limitation in that the study was broad in scope. An interesting follow up study would include qualitative interview data to provide a more in-depth look at the decision making processes of school counsellors around informed consent practices.

One last noteworthy point is that the present study was carried out only in one province, and cannot necessarily be generalized to other provinces or states where counsellors may or may not be working under a different set of guidelines. It would be helpful for this study to be replicated in other geographical areas where similar ambiguities exist.

Concluding Comments

One of the primary ways that practitioners in many fields show dignity and respect for the personhood of their clients is through the process of obtaining informed consent. In the context of a client-counsellor relationship, informed consent is especially pertinent, as it has been shown to help strengthen the therapeutic relationship, which can yield positive results for clients and alter the outcome of counselling in a constructive way. The benefits of obtaining informed consent are indeed two-fold; with proper documentation and adequate information provided, obtaining informed consent can also serve to protect practitioners against potential liability, which is especially important in this litigious day and age. Counsellors need to ensure they are acting as ethically as possible for the benefit of all stakeholders, and informed consent is a fundamental component of ethics in counselling.

While there will always be some degree of ambiguity and a need for professional judgment to be exercised in the practice of obtaining informed consent, as it stands right now many counsellors are having to create their own 'personal policies' and have not been offered guidance on what is expected around this or on how to handle some of the grey areas they experience. This is especially true in school systems, where counsellors are often the only professionals who fully understand the role of a school counsellor and what is involved in school counselling - professional dialogue and consultation therefore is often minimal at best. Most counsellor training programs have courses dedicated to the study of ethical principles, but in many cases informed consent decisions are being made completely at the discretion of an individual counsellor. Additional focus on informed consent practices in counselling training programs may serve to increase general awareness and enhance the dialogue around informed consent. As it stands, the thoughts and perceptions of individuals in terms of 'the right thing to do' can be quite varied, and it is unlikely that many organizations/school systems would like to leave decisions around such an important practice entirely in the hands of a single individual, without a thorough and thoughtful analysis of *best* practice. To create such policies, further analysis of informed consent practices by those who work with minors of different ages might prove to be beneficial. Furthermore, results from the current study, which highlight common practices and core pieces of information presented during informed consent practices, can help inform policy development.

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APPENDIX A

Western District Approval

WESTERN SCHOOL DISTRICT
Conditions of Approval for Research Projects

Your request to conduct research in our district is approved subject to the conditions / requirements listed below:

- ☐ A list of selected schools will be forwarded to my office before the research can begin.
- ☑ Final approval to conduct this study will rest with the principal of each targeted school and the targeted group of teachers/students where applicable.
- ☑ Conducting the research will in no way negatively impact instructional time for students and teachers.
- ☑ Conducting this research must not put any burden of responsibility on our school administrators or other staff unless they specifically agree to it.
- ☑ Participation in the study will be voluntary and participants will be able to opt out at any time without prejudice. This must be clearly communicated to the participants at the outset.
- ☐ For students under 16 years of age, the researcher must secure parental consent and confirm such consent with the principal before the research proceeds. Students 16 years of age and older must provide their own consent. Regardless of age, youth must be clearly informed from the outset that they may refuse to participate, even if their parents consented to their participation.
- ☑ Anonymity of participants must be ensured.
- * ☑ Before the research project can begin, it must receive final approval from your university's Research Ethics Committee and a copy of this approval must be sent to the Assistant Director of Education (Programs) at the Western School District. * Already received. (JT)
- ☐ A copy of the research findings and resulting papers/reports must be directed to the Assistant Director of Education (Programs) at the Western School District Office.
- ☑ Research results must be made available to the schools involved and the individual participants who request them.
- ☑ The Western School District takes no responsibility in conducting this research, and will not be held liable for any negative impacts relating to this research effort.

Signature of Approval: _____ March 18, 2011
Jeff Thompson — Date
Assistant Director of Education (Programs)

Signature of Compliance: Laura Palmer April 1, 2011
Researcher — Date

A signed copy of this form MUST be returned to the address below before research can begin:

Attention: Assistant Director of Education (Programs)
Western School District
P.O. Box 368
Corner Brook, NL A2H 6G9
jeff.thompson@wnlsd.ca
Fax: (709) 639-1733

APPENDIX B

Nova Central District Approval

From: Laura Palmer [mailto:lrlpalmer@hotmail.com] **Sent:** February-28-11 2:36 PM **To:** Cindy Fleet; Charlie McCormack; Ed Walsh **Subject:** Graduate Research at Memorial

Good day,
My name is Laura Palmer and I am a graduate student completing my masters of education in counselling psychology through MUN. Currently, I am working on a research thesis that centers around the practices of guidance counsellors in Newfoundland & Labrador when it comes to obtaining informed consent for counselling minors. I have just obtained approval from the ethics committee at Memorial (ICEHR) to carry out this research.
I am hoping to send out a short survey to all of the guidance counsellors in the 4 English-speaking school districts in Newfoundland and Labrador. I know that the different districts have varying policies on research, and was wondering what the policy of your district is and if you can point me in the right direction to get started on obtaining the appropriate permissions.
Thank-you so much for your time,
Laura Palmer

From: charliem@ncsd.ca To: lrlpalmer@hotmail.com Subject: RE: Graduate Research at Memorial Date: Tue, 1 Mar 2011 14:29:50 +0000

Hi Laura,

I have attached a letter indicating the requirements to do research in Nova Central School District. When you have the necessary documentation please forward them to me and I will approve your research project for this District.

Best wishes,

Charlie McCormack

Charlie McCormack
Assistant Director of Education – Programs
203 Elizabeth Drive
Gander, NL A1V 1H6
Phone: (709) 256-2547
Fax: (709) 651-3044
Email: charliem@ncsd.ca
Web: www.ncsd.ca

From: Laura Palmer [mailto:lrlpalmer@hotmail.com] **Sent:** March-04-11 8:39 PM **To:** Charlie McCormack **Subject:** Graduate Research at Memorial

Hello,

Thanks so much for your swift reply to my request for information about obtaining the appropriate permissions for my research.

I have attached to this e-mail my approval letter from Memorial's ethics committee (ICEHR) as well as a brief summary of the research for your perusal.

Thanks again,

Laura Palmer

From: charliem@ncsd.ca To: lrlpalmer@hotmail.com CC: charliem@ncsd.ca Subject: RE: Graduate Research at Memorial Date: Mon, 7 Mar 2011 12:21:22 +0000

Hi Laura,

Thanks for the additional material. You now have approval to conduct your research in the Nova Central School District.

I look forward to reading your final report.

Charlie

Charlie McCormack
Assistant Director of Education – Programs
203 Elizabeth Drive
Gander, NL A1V 1H6
Phone: (709) 256-2547
Fax: (709) 651-3044
Email: charliem@ncsd.ca
Web: www.ncsd.ca

APPENDIX C

Eastern District Approval

Office of the Assistant Director
Rural Education and Corporate Services
Dr. Albert Trask

Telephone: 709-758-2341

Chairperson: Milton Peach
C.E.O./Director of Education: Ford Rice

March 29, 2011

Ms. Laura Palmer
P.O. Box 127
Birchy Bay, NL
A0G 1E0

Dear Ms. Palmer:

RE: Research Request – "Informed consent practices of guidance counselors when working with minors in Newfoundland and Labrador."

Thank you for your email correspondence dated February 21, 2011 requesting approval to conduct research within the Eastern School District.

Please be advised that permission has been granted to conduct your research study.

It is the expectation of the Eastern School District that the requirements our research policy be strictly adhered to during the conduct of the research.

Thank you for involving Eastern School District in what appears to be a very worthwhile study. Our District looks forward to receiving a copy of the results of your study.

Please feel free to contact this office should you have further questions.

Sincerely,

Albert Trask

Dr. Albert Trask
Assistant Director
Rural Education and Corporate Services

/jh

Suite 601, Atlantic Place, 215 Water Street
Box 64-66, St. John's, NL A1C 6C9

Telephone: 709-758-2341
Facsimile: 709-758-2387

APPENDIX D

Labrador District Approval

RESEARCHER AGREEMENT[1]

AGREEMENT

This agreement is made between Laura Palmer (name of researcher), referred to below as the researcher, and

Labrador School Board, referred to below as the School Board.

The researcher has requested access to the following records that contain Personal Information and are in the custody or under the control of the institution:

Describe records in detail here. I do not require access to any records for this research, I only require permission to send surveys to the guidance counsellors in your school district.

The researcher understands and promises to abide by the following terms and conditions:

1. The researcher will not use the information in the records for any purpose other than the following research purpose unless the researcher has the School Board's written authorization to do so:

Describe purposes in detail here. The purpose of this research is to examine the informed consent practices of guidance counsellors in the 4 English-speaking school districts in Newfoundland & Labrador.

2. The researcher will give access to Personal Information in a form in which the individual to whom it relates can be identified only to the following persons:

Identify persons with access here. All guidance counsellors participating in this research will be anonymous - even to the researcher.

3. Before disclosing Personal Information to persons mentioned above, the researcher will enter into an agreement with those persons to ensure that they will not disclose it to any other person and will make a copy of each such agreement available to the School Board on request.

4. The researcher will keep the information in a physically secure location to which access is given only to the researcher and to the persons mentioned above.

5. The researcher will destroy all individual identifiers in the information by
There will be no individual identifiers (date)

6. The researcher will not contact any individual to whom Personal Information relates directly or indirectly without the prior written authority of the institution.

7. The researcher will ensure that no Personal Information will be used or disclosed in a form in which the individual to whom it relates can be identified without the written authority of the School Board.

[1] *This agreement template is based on a form specified in Ontario's Freedom of Information and Protection of Privacy Act. It has been reviewed for consistency with Section 41 of ATIPPA*

8. The researcher will notify the School Board in writing immediately upon becoming aware that any of the conditions set out in this agreement have been breached.

Signed at Laura Palmer this 20th day of March, 2011.

Researcher	Representative of School Board
Name: Laura Palmer	Name:
Address: P.O Box 127	Position: Director.
Address: Birchy Bay, NL A0G 1E0	Institution:
Telephone: (709) 743-7124	Telephone:
Signature Laura Palmer	Signature:

APPENDIX E

Invitation to School Counsellors to Request Participation in Research

May 12, 2011

Dear Guidance Counsellor:

My name is Laura Palmer and I am a graduate student from Memorial University working on my thesis for my M.Ed counselling psychology degree. I am writing to request your participation in a study regarding the informed consent practices of Guidance Counsellors who work with minors in the Newfoundland & Labrador school system.

Completion of this survey should take approximately 10 minutes. We recognize and appreciate the time commitments you already have, but we hope you will take the opportunity to participate in this study. Your knowledge, opinions, and ideas are both highly valued and critical to better understanding informed consent practices in our province.

•

• As a thank-you for completing the survey, please send an e-mail with your name to the following e-mail address: lrlpalmer@hotmail.com. This will enter you into a draw for a $25 WalMart gift card. This e-mail will in no way be connected with your survey responses.

To participate in the study, please follow the link below. Upon clicking the link you will be taken to an informed consent form, which will provide further information on the study.

LINK TO INFORMED CONSENT FORM

If you have any questions about the study or aspects of the study, please do not hesitate to contact us:

Laura Palmer – M.Ed Candidate
lrlpalmer@hotmail.com
(709) 489-0558

Greg Harris – Ph.D., R.Psych.
gharris@mun.ca
(709) 737-6925

Thank-you so much for considering this request.

APPENDIX F

Reminder Email to School Counsellors

Dear School Counsellor,

Approximately 3 weeks ago you received an invitation to participate in a research study regarding informed consent practices for counselling minors in the Newfoundland & Labrador school system. This study involved completing a questionnaire that asked you questions about your specific practices when it comes to obtaining informed consent. If you have already completed and returned the questionnaire, please accept our thanks for your participation. The purpose of this letter is to remind you of this study.
The questionnaire will take you approximately 10 minutes to complete. I have provided the link to the questionnaire below:

https://www.surveymonkey.com/s/COUNSELLINGSURVEY

If you are interested in being entered into a draw for a $25 Wal-Mart giftcard please send your name to lrlpalmer@hotmail.com upon completion of the survey (this will not in any way be linked to your individual survey responses). If you would like more information on the study please contact:

Laura Palmer (graduate student) lrlpalmer@hotmail.com 709-743-7124

or

Dr. Greg Harris (supervisor) gharris@mun.ca 709-864-6925

Please note that completed questionnaires will be accepted for approximately 3 more weeks. Thank-you for your consideration of this study.

Sincerely,

Laura Palmer, M.Ed (candidate) Greg Harris, M.Sc, Ph.D., R.Psych

APPENDIX G

Informed Consent Form

Informed Consent Form for Participants

Research Project Title: Informed Consent Practices of Guidance Counsellors When Working with Minors in Newfoundland & Labrador

The purpose of this study is to learn about the informed consent practices of guidance counsellors who work with minors in the four English school districts in Newfoundland & Labrador. Thus, if you agree to participate in the study, you will be asked questions about your informed consent practices when working with students/clients. The current study is in no way evaluative; but your participation is crucial in helping increase knowledge of informed consent procedures and practices in Newfoundland & Labrador.

In order to participate you must be a Guidance Counsellor working in one of the four English school districts in Newfoundland & Labrador. In addition, you must be at least 19 years of age to participate in the study.

Your participation in the study will involve reading the informed consent form and completing the questionnaire. All of your responses on the questionnaire will be completely **anonymous** and **confidential.** The questionnaire will take approximately 10 minutes to complete and includes questions related to your informed consent practices. **Your participation in this study is completely voluntary, and if at any time during the completion of the questionnaire you feel uncomfortable, you are free to stop.**

It is also important for you to know that this questionnaire was developed through SurveyMonkey, which is an on-line survey company located in the United States and as such is subject to U.S. laws. SurveyMonkey's secure communications option will be used for this survey, which supports the encryption of responses. There will be no identifying information on the questionnaire. No one, including the researchers, will be able to link your data with you personally and no individual data from the questionnaire will be reported. Summaries will report group data only. Please note that your employment will not be affected by your decision to either participate or not participate in this study. There will be a draw for a $25 WalMart gift card for participants following the completion of the data collection. If you are interested in having your name entered into this draw, please send your name to this e-mail address: lrlpalmer@hotmail.com. Again, in no way will this e-mail be connected to your actual survey responses.

Submitting the survey electronically indicates that you have read and understood to your satisfaction the information regarding participation in the research project and have agreed to participate. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities.

You are free to withdraw from the study at any time. Please do not hesitate to ask for clarification or new information throughout your participation. Your agreement to participate also provides permission for the researchers to use the data in presentations, published articles, and in any other future publications. If you have further questions related to this research, please contact:

Laura Palmer (709-489-0558 or lrlpalmer@hotmail.com)

Greg Harris (709-737-6925 or gharris@mun.ca)

Please feel free to print a copy of this informed consent form for your reference and records.

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research (such as the way you have been treated or your rights as a participant), you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at (709) 864-2861.

If you have read the above information and wish to participate in the study, click the following link to be taken to the electronic questionnaire: (*please note that clicking the link signifies your agreement to participate):*

SURVEY LINK