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Breaching Confidentiality with Adolescent Clients: A Survey of Australian Psychologists about the Considerations that Influence Their Decisions

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Breaching Confidentiality with Adolescent Clients: A Survey of Australian Psychologists about the Considerations that Influence Their Decisions

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Confidentiality is vital for building effective therapeutic alliances with clients, yet determining when to breach confidentiality to prevent harm can be challenging. This is especially true when clients are minors, as the primary concern often entails preventing harm to the young person, as opposed to others. The current study sought to explore the considerations that Australian psychologists take into account when making decisions about breaching confidentiality with adolescents. Two hundred sixty-four psychologists responded to an online survey and rated the importance of 13 considerations. Participants were also able to list additional considerations. Factor analysis indicated that four underlying constructs influence psychologists' decisions: (1) the negative nature of the behaviour; (2) maintaining the therapeutic relationship; (3) the dangerousness of the risk-behaviour; and (4) legal protection. Qualitative analysis of the additional considerations uncovered a range of complex and often competing priorities that are also utilised when making decisions about confidentiality with adolescent clients.

Key words: adolescent; confidentiality; ethics; minors; psychiatry; psychology.

Introduction

The importance of confidentiality for psychological practice is well established (Gustafson & McNamara, 1987; Isaacs & Stone, 1999; Kobocow, McGuire, & Blau, 1983; McCurdy & Murray, 2003; Sealander, Schwiebert, Oren, & Weekley, 1999; Sharkin, 1995). The ethical bases for confidentiality have also been well described and include respect for autonomy, the principle of beneficence, consequentialist arguments and deontological frameworks (Beauchamp & Childress, 2008; Kampf & McSherry, 2006; McMahon, 2006; McSherry, 2001). Ethical codes have provided professional guidance regarding confidentiality for many years (American Psychological Association, 2002; Australian Psychological Society, 2008; British Psychological Society, 2006). These codes emphasise the importance of confidentiality but also note that it is not absolute. Circumstances under which psychologists are permitted or required to disclose confidential information include situations in which the client (or the client's legal guardian) has provided consent, where there is a legal obligation to do so, where there is an immediate risk of harm

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that can only be averted by disclosing information, or when colleagues or supervisors need to be consulted (Australian Psychological Society, 2008).

Despite the availability of guidance about and support for confidentiality, ethical dilemmas concerning confidentiality remain widespread (Bourke & Wessely, 2008; Younggren & Harris, 2008). Research indicates that psychologists are uncertain and confused about when to breach confidentiality (Kampf, McSherry, Thomas, & Abrahams, 2008). It has also been argued that laws concerning confidentiality are overly complex and that more detailed guidelines and better training in ethics are required (Kampf et al., 2008). A key focus of past literature about breaching confidentiality has been the notion of the 'dangerous client' who poses a risk to others. These discussions typically revolve around clients who are adults (Kampf & McSherry, 2006; Kampf et al., 2008; McSherry, 2001, 2008). In these cases a decision about breaching confidentiality generally entails a determination of the degree of risk to others (immediacy and severity) and the public interest in preventing this.

When clients are minors, the considerations relevant to decisions about confidentiality are different from those concerning adults. With young people, concerns about maintaining confidentiality often focus on the risk that young people pose to *themselves* and their ability, or competence, to understand the consequences of their actions. Thus, dilemmas about confidentiality with minors often entail a decision about whether or not to inform parents about risk behaviour. For these reasons, when psychological clients are minors, the complexity regarding confidentiality is increased (Davis & Mickelson, 1994; Gustafson & McNamara, 1987; Isaacs & Stone, 1999; Kaczmarek, 2000; Ledyard, 1998; Myers, 1982; Taylor & Adelman, 1989).

The APS has recently published a detailed set of guidelines for working with young people (Australian Psychological Society, 2009). In relation to confidentiality, these guidelines refer to the Code of Ethics, section A.5.1, in re-stating that there is an obligation to 'safeguard the confidentiality of information obtained' during psychological consultations (p. 185). The guidelines add, in section 5.1.4 relating to limits to confidentiality, 'in those unusual circumstances where failure to disclose a young person's information may result in clear risk to the young person or to others, a psychologist may disclose information necessary to avert risk' (p. 185). The guidelines are also clear about placing the best interests of young people first, noting that when conflicts arise between parents and young people, psychologists should 'consider the young person's best interests as paramount' (p. 182).

Young People

Young people differ from adults in their cognitive, emotional and social capabilities (Hazen, Schlozman, & Beresin, 2008), as well as their legal status (Isaacs & Stone, 1999; Lawrence & Kurpius, 2000; McCurdy & Murray, 2003; Mitchell, Disque, & Robertson, 2002; Sealander et al., 1999; Sobocinski, 1990). Nevertheless, past research has suggested that young people are generally able to make competent, adult-like decisions from the age of 14–15 years (Belter & Grisso, 1984; Grisso & Vierling, 1978; Piaget, 1953; Weithorn & Campbell, 1982). More recently, studies using technologies such as magnetic resonance imaging (MRI) have demonstrated that the human brain continues to develop well into the third decade of life (Giedd, 2008). This has implications for understanding young people's cognitive capacities and behaviour (McAnarney, 2008; Spear, 2000; White, 2009), although the precise way in which

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current understanding should be revised is yet to be clearly articulated (Giedd, 2008).

As well as physiological maturation, young people undergo a range of social and emotional changes during adolescence as they grapple with identity formation issues. Experiences that are generally specific to adolescence include, but are not limited to: changes in the child-parent relationship, the increasing influence of peers, greater desires for autonomy and independence, involvement in romantic relationships and engagement in risk-taking behaviours (Smetana, Campione-Barr, & Metzger, 2006). Accidents and injuries (both self-inflicted and unintentional) and behavioural problems, such as substance use and unsafe sexual experimentation account for most of the morbidity and mortality in the adolescent population (Viner & Booy, 2005).

Young People and Confidentiality: Empirical Research

A small body of empirical research has looked at confidentiality with adolescents in psychological practice. Kobocow et al. (1983) measured the effects of different types of assurances about confidentiality on self-disclosure in adolescents and found that the number of disclosures for sensitive questions were higher when confidentiality was explicitly assured. Research in medical settings also demonstrates that young people's desires to disclose sensitive information is hampered when confidentiality is not assured (Society for Adolescent Medicine, 2004).

Collins and Knowles (1995) surveyed adolescents between the ages of 13 and 18 years about confidentiality in the school counselling setting. They found that 98% of these young people agreed that confidentiality within a school counselling setting was either essential or important. Isaacs and Stone (1999) surveyed school counsellors about the circumstances in which they would breach confidentiality with clients who were minors. The majority of counsellors reported that they would breach confidentiality for the following issues: impending suicide, planned retaliation for victimisation (shooting a fellow student), use of crack cocaine, sex with multiple partners when HIV positive, armed robbery, indications of depression, abortion and marijuana use. Davis and Mickelson (1994) also surveyed school counsellors. They found that there was less than 50% agreement on the preferred ethical or correct legal choices in relation to dilemmas about student privacy, confidentiality and parental rights. Thus, although a small body of empirical research exists regarding the importance of confidentiality with adolescents and the types of circumstances in which psychologists may choose to breach confidentiality, little is known about the decision-making process that psychologists employ when making these decisions.

The current study replicated a study of American paediatric psychologists (Sullivan, Ramirez, Rae, Razo, & George, 2002). Participants in the American study ($N = 74$) were presented with 13 items and were asked to rate the importance of each item for their decisions about breaching confidentiality to report adolescent risk-taking behaviour to parents. The items covered a range of considerations including the frequency, intensity and duration of the risk-behaviour, upholding the law, not disrupting the process of therapy and the potential for the risk-taking behaviour to stop without a breach of confidentiality. Factor analysis of these responses provided support for a two-factor model to fit the data. These two factors were termed 'Negative Nature of the Behaviour' and 'Maintaining the Therapeutic Process'. The current study aimed to identify the considerations that Australian psychologists utilise when making decisions about breaching confidentiality with adolescent

clients to report adolescent risk-taking behaviour to parents.

Method

Participants

A total of 282 people responded to the questionnaire. The target sample was Australian psychologists who had previous experience working with young people. Exclusion criteria included: not currently working in Australia; no previous experience working with young people; and not studying to become or currently qualified as a registered psychologist. Eighteen participants who did not satisfy these criteria were excluded, as were participants who missed more than 10% of the questions. This left a total of 264 participants. Eighty-seven per cent of the participants were female and 13% were male, with a mean age of 39 years ($SD = 11$). A majority of participants were from New South Wales or Victoria. Participants had a mean number of 9.5 years' experience working with young people ($SD = 7.8$). A total of 42% had completed a 4-year-degree plus 2 years of supervision, 49% had completed either a Doctorate of Psychology or a Masters Degree, 7% had completed a PhD and the remaining 3% of participants were still completing their qualifications. Participants worked in a range of settings, with 26% working in schools, 22% in private practice, 11% in the public sector and small numbers working for universities, in family therapy environments, in community settings, for the government, for the justice system, or in a combination of these settings. Eighty-two per cent of the participants were members of the Australian Psychological Society (APS).

Statistics are not available on the demographic profile of Australian psychologists who work with young people and so there is no definitive basis for determining the representativeness of this sample. However, the APS collects data on its membership and the demographics of the study sample are summarised in Table 1 using the same reporting categories as the APS. For comparison, APS (2009) membership statistics are also shown in Table 1.

The age distribution in the current study sample was broadly comparable to the APS membership profile, although the sample's age profile was younger. This difference may be due to the method of data collection (an online questionnaire) but equally may represent the characteristics of those who work with adolescents. Male psychologists were underrepresented in the sample. The reason for this is unknown, but once again may reflect the characteristics of psychologists who work with adolescents. The geographic distribution of the participants closely matched the APS membership profile.

Table 1. Participant demographics and comparison with Australian Psychological Society (APS) membership data.

	Study sample (%)	APS members* (%)
Age category		
<30	23	12
30–39	35	26
40–49	20	24
50–59	16	24
60+	6	14
Sex		
Male	13	28
Female	87	72
State		
New South Wales	29	32
Victoria	29	34
Queensland	15	14
South Australia	6	6
Tasmania	5	2
Western Australia	12	8
Australian Capital Territory	3	3
Northern Territory	1	1

*APS (2009).

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Materials

The online questionnaire developed for the current study was an electronic version of the questionnaire used by Sullivan et al. (2002). The questionnaire was in two parts; Part A used a series of vignettes to explore situations in which psychologists would breach confidentiality with adolescent clients and disclose information to parents. Part B focused on the considerations utilised by psychologists when making these decisions. This paper reports results from Part B. In Part B, a list of 13 considerations was presented that might influence psychologists' decisions regarding confidentiality with adolescent clients. Sullivan et al. identified these 13 considerations from a literature review of factors that may influence ethical decisions about confidentiality and their own clinical experience. The resulting list was then reviewed by their colleagues. Participants were asked to rate how important each consideration was for making decisions about breaking an adolescent's confidentiality and reporting risk-taking behaviours to the parents. They rated each item on a 5-point Likert scale from 1 (the consideration was *extremely unimportant*) to 5 (the consideration was *extremely important*). Participants were then asked if there were 'any other important considerations you take into account when making a decision to break confidentiality and report adolescent risk-taking behaviour to parents'.

Procedure

Following receipt of ethics approval, invitations to participate were distributed via two means. First, potential participants were contacted through the APS newsletter (sent to all APS members fortnightly via email) and also via a notice on the APS website notifying them of the survey and providing a link to the study website. Second, participants were invited via personal emails which included details about the survey and a link to the survey website. This email distribution used the snowballing technique, in which the researchers emailed colleagues who were then asked to forward the email to their colleagues and so on. It was not possible to calculate a response rate for the current study as it is not known how many people received a notification about the survey. An incentive was provided to potential participants in the form of a $100 book/CD voucher prize draw. Participants who wanted to go into the prize draw were asked to provide a name and telephone number at the end of the questionnaire. These details were separated from other questionnaire responses to maintain anonymity.

Quantitative responses were imported directly into SPSS for analysis. Basic descriptive statistics were calculated for the 13 considerations that respondents rated on a 5-point Likert scale. Exploratory factor analysis was then carried out using maximum likelihood estimation and oblimin rotation in order to explore a factor model for the 13 considerations that had been rated. Qualitative responses were analysed using interpretive content analysis (Hansen, 2006). This entailed searching the responses for considerations that were different from those already provided within the predetermined list of 13 considerations in the questionnaire until an exhaustive list was obtained. This list was then categorised, and re-categorised until a final mutually exclusive list was compiled. Qualitative analysis was conducted independently by RD and AK and then compared and discussed until consensus was reached.

Results

Table 2 presents the means and standard deviations of participants' responses to the 13 considerations they rated on a 5-point Likert scale. Table 2 also includes comparison data from the previous study by Sullivan et al. (2002).

Table 2. Australian and American psychologists' ratings of the relative importance of 13 considerations for decisions about confidentiality with adolescent clients (on a 5-point Likert scale where 1 indicated 'extremely unimportant' and 5 indicated 'extremely important').

Consideration	Australian psychologists*		American psychologists**	
	M	*SD*	*M*	*SD*
Intensity of the risk-taking behaviour	4.64	0.56	4.61	0.82
Apparent seriousness of risk-taking behaviour	4.62	0.63	4.61	0.82
Protecting the adolescent	4.53	0.79	4.66	0.76
Frequency of the risk-taking behaviour	4.39	0.81	4.42	0.81
Duration of the risk-taking behaviour	4.32	0.80	4.42	0.88
Confidence that the risk-taking behaviour has actually occurred	3.86	1.00	4.37	0.81
Potential for the risk-taking behaviour to stop without telling parents	3.86	1.00	3.92	1.00
Upholding the law	3.44	1.13	3.59	1.32
The negative effects of reporting on the family	3.31	1.13	3.39	1.23
Not disrupting the process of therapy	3.25	0.97	3.31	1.18
Likelihood that the family will continue treatment after breaking confidentiality	3.15	1.16	3.08	1.20
Avoiding legal problems for the adolescent	2.91	1.04	3.05	1.23
Gender of the client	1.68	0.99	1.86	1.13

$^{*}N = 264$, $^{**}N = 74$.

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The most important consideration for Australian participants' decisions about confidentiality with adolescents was the *intensity of the risk-taking behaviour*, followed closely by the *apparent seriousness of the behaviour* and a *desire to protect the adolescent*. On average these items were rated as important to extremely important. The least important consideration for participants' decisions about confidentiality was the *gender of the client* which, on average, was rated unimportant to extremely unimportant. As can be seen in Table 2 the Australian participants' ratings were practically identical to those of the sample from the United States reported by Sullivan et al. (2002). Independent samples' *t*-tests showed that Australian and American ratings differed significantly on only one item; *confidence that the risk-taking behaviour has actually occurred*, which was slightly less important to Australian participants, and significant even when the Bonferroni adjustment for multiple comparisons was made ($t(336) = 4.03$, $p < .001$). The rank ordering of importance of the 13 considerations was identical across the two samples with the sole exception that the American participants rated *protecting the adolescent* as most important (this was rated as third most important by the Australian participants), and this by a negligible margin.

To compare the structure of Australian participants' responses with those of Sullivan et al. (2002), the factor model implied by Sullivan et al.'s exploratory factor analysis was applied to our data using a confirmatory factor analysis, omitting variables which did not load on either factor in Sullivan et al.'s original analysis. This was done using AMOS version 18. This indicated that the model was not a good fit with our data (GFI = .93, AGFI = .88, PGFI = .54, RMSEA = .09).

Since Sullivan et al.'s (2002) model did not fit our data, an exploratory factor analysis of the 13 items was conducted, beginning with a principal components analysis (PCA) using Varimax rotation.

The Kaiser-Meyer-Olkin's measure of sampling adequacy indicated a reasonable amount of shared variance between the variables (KMO = .76). Bartlett's test of sphericity was significant ($\chi^2(78) = 752.00$, $p < .01$). The maximum correlation between items was .66 indicating collinearity problems would be unlikely. Taken together, these statistics indicated the data were suitable for factor analysis.

Results confirmed that a four-factor model was appropriate for these data with four eigenvalues > 1, a scree plot suggestive of four factors, Horn's (1965) parallel analysis indicating a four factor model and the goodness-of-fit test indicating an excellent fit ($\chi^2(17) = 10.25$, $p = .89$). Oblimin rotation produced a slightly cleaner structure than varimax. Two of the items (*confidence that the risk-taking behaviour has actually occurred* and *gender of the client*) did not load significantly on any of the factors and so were removed, and the remaining items reanalysed. The overall pattern of loadings remained unchanged after the deletion of the two items. This solution is presented in Table 3.

Together, these four factors explained 47.38% of the variance. After considering which items loaded onto each of the four factors, Factor 1 was labelled 'Negative Nature of the Behaviour', Factor 2 was labelled 'Maintaining the Therapeutic Process', Factor 3 was labelled 'Dangerousness of the Risk-Behaviour' and Factor 4 was tentatively labelled 'Legal Protection'. This factor has only two items significantly loading on it; however, it suggests that legal considerations may form a distinct dimension of the therapist's deliberations.

Participants were also able to list additional important considerations that were not included in the list of 13 provided in the questionnaire. A total of 167 participants each provided a written response and 17 distinct considerations were identified that were different from the list of 13 pre-determined considerations provided within the questionnaire. Table 4 presents these additional considerations.

Table 3. Factor solutions for understanding Australian psychologists' decisions about confidentiality with adolescents, compared with American psychologists' decisions.

	Australian psychologists* factor				American psychologists** factor	
Item	1	2	3	4	1	2
Negative effects of reporting on the family	.00	**.43**	.07	.07	.02	**.73**
Avoiding legal problems for the adolescent	.02	**.36**	−.02	.31	.28	.38
Not disrupting the process of therapy	−.01	**.74**	−.04	−.08	−.05	**.93**
Potential for the risk-taking behaviour to stop without telling parents	.18	**.55**	.02	−.33	.36	**.46**
Likelihood that family will continue treatment after breaking confidentiality	−.02	**.75**	−.03	.05	.10	**.61**
Frequency of the risk-taking behaviour	**.83**	.03	−.01	.03	**.70**	.22
Duration of the risk-taking behaviour	**.76**	.05	−.04	.16	**.78**	.10
Intensity of the risk-taking behaviour	**.58**	−.04	**.42**	−.12	**.86**	−.01
Apparent seriousness of the behaviour	.05	−.04	**.69**	−.07	**.79**	.18
Protecting the adolescent	−.04	.16	**.47**	**.39**	**.40**	−.06
Upholding the law	.16	−.04	.01	**.43**	.03	−.18
Eigenvalue	3.22	1.82	1.22	1.00	3.84	2.25
% variance explained	24.63	12.68	5.38	4.69	22.24	17.96

Note: Items in bold indicate loading of the item on the specified factor. $^*N = 264$, $^{**}N = 74$.

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Table 4. Additional considerations used by Australian psychologists when contemplating a breach of confidentiality with adolescent clients.

Consideration	N	%*
How would the family respond if told about their child's risk behaviour?	43	27.8
Will the adolescent talk to his/her parents if I do not breach confidentiality?	25	15.0
Does the adolescent understand why a breach is necessary?	17	10.2
How competent is the young person?	16	9.6
What protective factors does the young person have in his/her life?	11	6.6
How old is the young person?	12	7.2
What is in the best interests of the young person?	9	5.4
Did I provide an initial explanation about limits to confidentiality?	9	5.4
What is the policy of my workplace?	8	4.8
What sort of rapport do I have with the young person?	7	4.2
What potential harm could come to the young person if I do breach confidentiality?	4	2.4
What is the level of previous parental knowledge about the child's behaviour?	4	2.4
What is my duty of care to each individual involved	3	1.8
Is family therapy an option?	2	1.2
Is there a family history of risk behaviour and/or suicide?	2	1.2
What is the previous history of the young person?	2	1.2
Is this a well thought-out decision?	1	0.6

$N = 167$.
*Respondents often described multiple considerations in their written responses.

Sullivan et al. (2002) did not ask participants if there were any additional important considerations and so comparison is not possible for this section of the questionnaire.

The most frequently cited additional consideration entailed thinking about how the family would respond if informed about their child's risk-taking behaviour. Other considerations included taking into account whether or not the adolescent was likely to inform his/her parents without a breach and also the competence, age, previous history, protective factors and best interests of the young person.

Discussion

The current study surveyed Australian psychologists about the considerations they utilise when making decisions about breaching confidentiality with adolescents. The study replicated a previous study of American psychologists who worked with minors. When asked to rate the importance of 13 considerations for determining whether to inform parents about risk-behaviours in their children, participants indicated that their most important consideration was the *intensity of the risk-behaviour*. This was closely followed by the *seriousness of the risk-behaviour, a desire to protect the adolescent, the frequency of the risk-behaviour* and *the duration of the risk-behaviour*. The least important consideration was the *gender of the client*. These responses were extremely similar to those of Sullivan et al.'s American study (2002). The order in which the 13 considerations were ranked was also almost identical between Australian and American psychologists, with the only difference being placement of *protecting the adolescent*, which was rated as slightly more important by American psychologists. Given the time difference in administration of the two surveys, and the sample size differences, these results suggest a strong and continuing correspondence between the two samples of psychologists.

Factor analysis of ratings for the 13 considerations produced four meaningful factors. These represent the underlying constructs that Australian psychologists take into account when making decisions about breaching confidentiality with adolescent clients. The four factors were:

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(1) the negative nature of the behaviour; (2) maintaining the therapeutic relationship; (3) dangerousness of the risk-behaviour; and (4) legal protection.

The first factor, *negative nature of the behaviour*, encompasses a consideration about how severe the risk-taking behaviour is (i.e., how frequent and how intense) and the potential for negative consequences. Thus, a key consideration for Australian psychologists when making decisions about breaching confidentiality with adolescents is how serious the potential for harm is if a breach of confidentiality does not occur. This first factor closely reflects the first factor identified by Sullivan et al. (2002) which they also termed negative nature of the behaviour. Sullivan et al. noted that in order for psychologists to consider the severity of the risk-taking behaviour, a thorough psychosocial history is required. These Australian findings add strength to this assertion, highlighting the fact that when psychologists are faced with difficult ethical dilemmas about breaching confidentiality with adolescents, detailed information about the nature of the behaviour and how this fits within the young person's wider psychosocial context is vital. Ethical and professional practice guidelines would necessitate recording of this information also.

The second factor, *maintaining the therapeutic relationship*, relates to the importance of continuing therapy with the young person, as well as the broader risks of breaching confidentiality such as effects on the family and potential legal problems for the adolescent. Thus, when Australian psychologists contemplate breaching confidentiality with adolescent clients, another key consideration is the impact that a breach would have on the therapeutic relationship. This involves thinking through the negative impacts that a breach of confidentiality may have for the family, the likelihood that the family will continue therapy if a breach of confidentiality occurs and the potential for the problematic risk behaviour to stop *without* a breach of confidentiality. Reflecting on the possibility of legal problems is also part of this consideration. This factor, once again, closely mirrors the second factor identified by Sullivan et al. (2002), also termed maintaining the therapeutic relationship. Sullivan et al. highlight the importance of attempting to maintain the therapeutic relationship even when a breach of confidentiality is necessary. They stated this requires open and honest communication from the beginning of therapy, in order to minimise the possibility of the breach having a lasting negative impact on the young person; particularly in relation to interactions with other health professionals in the future. The current study lends support to this assertion, highlighting that decisions about breaching confidentiality with adolescents, and the process by which breaches occur, have important implications for young people's engagement in therapy both now and in the future.

The third factor, *dangerousness of the risk-behaviour*, encompasses consideration of the intensity and seriousness of the behaviour, combined with a desire to protect the adolescent. It provides an additional layer to Sullivan et al.'s (2002) findings, which only included two meaningful factors. This factor, although somewhat similar to the first factor (negative nature of the behaviour), seems to reflect consideration about the welfare of the young person. That is, their broader best interests and a professional obligation to protect them from harm. The first factor differs from this third factor in that it does not incorporate a specific consideration about protecting the adolescent. This factor accounted for relatively little variance, yet the items comprising this factor had high importance ratings and low standard deviations. It is therefore likely that restriction of range explains the small size of this factor and not its psychological importance.

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The fourth factor, legal protection, again adds to the two-factor solution presented by Sullivan et al. (2002). It reflects a concern about upholding the law and combines a consideration about young people's safety with the broader legal context. It seems that this factor may relate to legal consequences for the psychologist (as opposed to the young person), as it does not include a *desire to avoid legal problems for the adolescent* (one of the 13 considerations that does not load onto this factor). Thus, it appears that this additional fourth factor reflects a fear about upholding professional legal obligations to keep young people safe and perhaps the possibility of adverse legal consequences if professionals fail to do this.

Qualitative analysis of the list of additional considerations provided by participants identified 17 new considerations that Australian psychologists take into account when making decisions about breaching confidentiality with adolescent clients. These were not contained within the predetermined list of 13 considerations provided in both the Australian and American questionnaire. The original American study by Sullivan et al. (2002) did not include a question that asked participants to list additional considerations. This extensive list of additional considerations provided by Australian participants therefore represents a significant finding that extends the original American study. It highlights the wide range of considerations that are utilised by psychologists when attempting to make decisions about confidentiality with adolescents, over and above those that professionals might assume would be key considerations. It also draws attention to the high degree of complexity associated with such decisions.

The most common additional consideration identified by Australian participants was a consideration about how the family might respond if told about their child's risk behaviour. This is important because it represents a consequentialist approach to decision-making, that is, the course of action chosen is at least partly dependent on the likely consequences of that action. Some of the other additional considerations also related to the family context, including the level of previous parental knowledge about the young person's risk behaviour, whether family therapy might be an option and the previous family history of risk-behaviour and suicide.

Another group of additional considerations focused on specific characteristics of the adolescent. For example, the young person's age, competence, protective factors, best interests, previous history and likelihood of talking to his/her parents *without* a breach of confidentiality. Yet another group of additional considerations related to the process of therapy and decision-making. These included considering whether an initial explanation about confidentiality had been provided, thinking about whether the adolescent understood the need for a breach of confidentiality and reflecting on whether the decision was a well-considered one.

Together, the four factors identified through quantitative analysis and the list of additional considerations identified through qualitative analysis provide a detailed and complex picture of the range of issues that professionals might reflect upon when contemplating a breach of confidentiality with adolescent clients. Not only are they many and varied, but they have the potential to compete with one another at times. Thus, weighing up the degree of harm associated with a risk behaviour may prompt different action from consideration of the impact of a breach of confidentiality on therapy. Similarly, thinking about a young person's age and competence may imply a different path from consideration of how the family might respond if informed of the risk behaviour. This highlights the ethical complexity associated with decisions about

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confidentiality with adolescents; emphasising the challenging nature of such decisions and stressing the importance of support, training and guidance for professionals working in this area.

Conclusions

Determining whether or not to breach confidentiality with a client in order to prevent harm can be highly challenging. This is especially true when clients are minors as their capacity for autonomous and competent decision-making differs from that of adults and the potential for self-harm (both intentional and unintentional) is significant. The current survey of Australian psychologists indicates that when making decisions about confidentiality with young people, a wide variety of considerations are contemplated and reflected upon, many of which might compete with one another. There is a need to ensure that current and future health professionals are trained in the *process* of ethical decision-making and the range of considerations that might be involved in such processes, particularly when clients are minors. It will also be important to provide training on how to enact breaches of confidentiality when necessary, while at the same time sustaining the therapeutic alliance.

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