Demands for Privacy Among Adolescents in Multimodal Alcohol and Other Drug Abuse Treatment

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Adolescent clients' perceptions of the limits of confidentiality, as well as their privacy demands within the counseling relationship, were assessed. A total of 30 adolescents involved in individual, group, and family counseling for alcohol and other drug abuse served as participants. Participants were asked to respond to vignettes of confidentiality issues in terms of what they believed the counselor should do and what they would prefer the counselor to do. Results suggested that adolescents generally want higher levels of confidentiality than they expect to receive. This group of adolescent clients, however, made clear distinctions in their privacy expectations and demands according to specific situations.

The client's willingness to disclose personally sensitive information is considered vital to successful process and outcome in counseling (Egan, 1990; Yalom, 1985). Although the self-disclosure process seems to be a function of many variables, the expectation that what is communicated in the counseling relationship will remain private or confidential seems to be crucial to both the client's willingness and ability to self-disclose (Lane, 1979; Rothmeier & Dixon, 1980; Strong & Schmidt, 1970; Woods & McNamara, 1980). Mental health professionals have assumed that clients expect confidentiality in their therapeutic relationships (Jagim, Wittman, & Knoll, 1978; McGuire, Graves, & Blau, 1985), and empirical evidence has supported the proposition that both child and adult clients value privacy in counseling relationships and are negatively affected by threats of unauthorized disclosures (Kobocow, McGuire, & Blau, 1983; McGuire, Toal, & Blau, 1985; Messenger & McGuire, 1981; Miller & Thelen, 1986; Schmid, Appelbaum, Roth, & Lidz, 1983).

Although there has been much written in the literature supporting and clarifying the nature and extent of privacy rights with adult counseling clients, the issues are less clear for minor clients. Glenn (1980) has noted that the application of codes of ethics to children "does more to create ambiguity than to answer questions" (p. 613). Traditionally, rights to informed consent, confidentiality, and treatment itself have been denied or significantly curtailed to minors without parental consent (Glenn, 1980; "Parental Consent," 1975; Rosenberg & Katz, 1972; Ross, 1966). Current professional, legal, and ethical standards, as well as responsible clinical practice, however, support equal rights to competent minors (American Association for Counseling and Development [AACD, now the American Counseling Association], 1981; American Psychological Association, 1990; Brewer & Faitak, 1989; McGuire, 1974; Sheeley & Herlihy, 1987; Taylor & Adelman, 1986, 1989; Weinapple & Perr, 1981). In addition, research has determined that minor clients, especially adolescents, understand many treatment issues (Grisso & Vierling, 1978; Kaser-Boyd, Adelman, & Taylor, 1985), recognize when their rights have been violated (Belter & Grisso, 1984), and are quite sensitive to the demand for privacy in their therapeutic relationships (Messenger & McGuire, 1981).

It is perhaps ironic that the areas of practice in which confidentiality-privilege issues are the most difficult (e.g., group, family therapy) represent common treatment modalities for minor clients (Baruth & Huber, 1984; Hare-Mustin, 1980; Lakin, 1986; Margolin, 1982). Adolescents in alcohol and other drug abuse treatment are frequently involved in multimodal therapeutic approaches including individual, group, and family-counseling formats. The nature of these treatment modalities and the status of adolescent clients as minors raise many questions regarding their perspective on rights to confidentiality and the reality of privacy within their varied counseling relationships. For example, do they expect or desire communication to occur from their individual or group treatment to family sessions? Prior research has infrequently addressed the role of privacy issues for adolescent clients and has rarely attempted to assess directly their perceptions of confidentiality within their own treatment. In this research, adolescent clients' understanding regarding the nature and limits of confidentiality, as well as their privacy demands, were assessed.

Previous studies (e.g., Beeman & Scott, 1991; Kobocow et al., 1983; Messenger & McGuire, 1981) have suggested that adolescents in counseling are particularly sensitive to privacy issues and at times might desire or demand a greater degree of privacy than is consistent with current professional or legal standards. This investigation specifically attempted to assess the adolescent clients' differential expectations for privacy in a variety of treatment modalities (i.e., individual, group, family) and across a variety of situations in which confidentiality issues might be confusing (e.g., disclosure of drug use, disclosure of potential harm to self or others, court-ordered treatment). Related investigations focusing on ethical conflict decision making by professionals (e.g., Bernard, Murphy, & Little, 1987; Wilkins, McGuire, Abbott, & Blau, 1990) suggest that adolescent clients might have significantly different attitudes regarding what a counselor "should" do in response to certain information disclosed in counseling versus what they "want" or "would prefer" the counselor to do. Thus, in many treatment situations, minor clients might expect their counselor to be obligated to communicate information obtained in an individual or group session to parents, teachers, other therapists, and so on, but might strongly prefer that the counselor maintain complete privacy.

Three predictions based on previous research were examined: First, responses by adolescent client participants would demonstrate a significant demand for privacy within their counseling relationships. Second, participants would choose "qualified" or "limited" privacy in situations in which they were asked what a counselor should do, but would favor "absolute" privacy when asked how they would prefer the counselor to behave. Third, participants would indicate significant differences in their demands for privacy depending on the specific situation.

METHOD

Participants

A total of 30 adolescent clients undergoing treatment for alcohol and other drug abuse participated in the study. Of these participants, 24 were in outpatient treatment programs, and 6 were in inpatient treatment. Eight participants were young women or girls, and 22 were young men or boys. This sex distribution seems to reflect the typical male-to-female ratio of adolescent clients in alcohol and other drug abuse outpatient treatment programs (Butynski, Canova, & Reda, 1989). Participants were mostly White and middle class. The research sample of 30 volunteer adolescent clients was drawn from a pool of 37 potential participants at four Central Florida treatment facilities at the time of the study. Each client's treatment program included individual, group, and family therapy modalities. Informed consent to participate in the study was obtained from both adolescents and their parent(s) or guardian(s).

Materials

Materials for the study included a demographic data sheet, prequestionnaire, and experimental questionnaires. The demographic data sheet was designed to obtain basic information from the parents or guardians about their adolescent: age, sex, grade, length of time in treatment, and current diagnosis. This sheet also assessed parents' perceptions of whether confidentiality had been previously explained and their understanding of their own and their child's rights to privacy in counseling. The prequestionnaire was completed by each adolescent client participant. It contained five open-ended questions designed to assess their understanding of confidentiality—specifically, please define confidentiality as you understand it; why do you think it is important; has anybody ever explained confidentiality to you; are there times when you believe something should not be kept confidential; and at what age do you feel your rights to confidentiality should begin.

Experimental questionnaires were constructed to depict individual, group, or family-counseling vignettes. Alternate forms of the vignettes for male and female participants were used to enhance the relevance of the questionnaires for the participants. Male-version vignettes depicted the counselor as a man, whereas female vignettes depicted and referred to the counselor as a woman. Each questionnaire consisted of 10 vignettes reflecting common confidentiality issues encountered in counseling (*Reader note.* A copy of the experimental questionnaires and response options can be obtained from the first author): harm to self, harm to others, supervision of therapist, court-ordered release of information, access to files, release of information to parents, drug use disclosure (pot), drug use disclosure (crack), sexual behavior disclosure, and confidentiality limits discussed. For example, a harm-to-self vignette was the following: "Suppose that you had recently felt very depressed and had considered taking your own life. You have told your counselor how you feel, and your counselor is concerned." Each questionnaire began with a definition of confidentiality to ensure that all participants had at least a basic understanding of the concept of privacy within the counseling situation.

For each of the 10 vignettes, three outcomes were presented representing various degrees of privacy: no privacy ("Your counselor should take whatever action she feels is necessary in order to protect you"), qualified or partial privacy ("Your counselor should tell only your parents"), and absolute privacy ("Your counselor should encourage you to tell your parents [or take whatever other action she feels is appropriate], but should tell no one unless you agree"). The participants were asked to choose one of the three outcomes to represent what they believed their counselor should do in the situation and one to represent how they would prefer their counselor to act. Individual, group, and family versions of the questionnaires contained identical situations, but were cast within the context of the different treatment modalities. The 10 vignettes were presented for each of the three modalities.

Procedure

Upon approval by each facility, the parent(s) of each prospective participant was(were) contacted by the researcher and presented with the parent informed consent form. This occurred at a group meeting with the adolescent present. Parents who completed this form were then given the demographic data sheet to complete. Each adolescent client whose parent(s) had approved his or her participation was given the participant informed consent form. Participants then completed the prequestionnaire and finally the sex-appropriate version of one of the experimental questionnaires (i.e., individual, group, or family). A total of 11 participants completed the individual version, 10 completed the group version, and 9 completed the family version of the experimental questionnaire. Following completion of the experimental questionnaires by all participants at each treatment facility, the experimenter held an informal discussion and question-answer session with participants, interested nonparticipants, and facility staff regarding the issue of confidentiality in counseling treatment.

RESULTS

The first hypothesis predicted that adolescent clients would indicate a significant demand for confidentiality within their counseling relationships. This hypothesis was tested by examining the relative frequencies of should choices among no confidentiality, limited confidentiality, and absolute confidentiality across experimental questionnaire vignettes. A chi-square goodness-of-fit test revealed significantly more frequent responses to ethical choice limited and absolute confidentiality options, $f = 250$, than to the no confidentiality option, $f = 50$, on the should dimension of the experimental questionnaire, $\chi^2(1, N = 30) = 132.003$, $p < .001$. Analyses for each of the 10 vignettes separately revealed similar significant differences (all $ps < .0006$) for all vignettes with the exception of Vignette #1 [harm to self situation, $\chi^2(1, N = 30) = .033$, $p = .86$] and Vignette #4 [court-ordered release of information, $\chi^2(1, N = 30) = .833$, $p = .36$].

Hypothesis 2, which predicted significant differences in levels of demanded privacy between should and would prefer questions, and Hypothesis 3, which predicted differences in expectations for privacy across vignettes, were tested with an ANOVA. A four-way mixed ANOVA with two between-group factors (Sex and Treatment Modality [3 levels]) and two within-group factors (Vignettes [10 levels] and Should and Would Prefer Choices [2 levels]) was conducted. In the initial analysis, neither sex nor group modality yielded significant main effects nor significant interactions with the other factors. Thus, sex and treatment modality were dropped from the design, and further analysis was conducted as a two-factor repeated-measures ANOVA with a pooled $n = 30$ comparison. In this analysis, the main effect for choices was significant, $F(1, 24) = 55.50$, $p < .0001$. Prefer choice scores ($M = 2.58$) were significantly higher than were should choice scores ($M = 2.11$). There was also a significant main effect for vignettes, $F(9, 261) = 11.67$, $p < .0001$. Clusters of nondiffering vignettes were empirically identified based on post-hoc statistical comparisons between vignette pairs. Post-hoc comparisons revealed that mean confidentiality scores for Vignette Cluster A (numbers 1, 3, 5, 6,

and 8) were significantly lower than were mean confidentiality scores for Vignette Cluster B (numbers 2, 7, 9 and 10), $F(1, 29) = 37.87$, $p < .0001$. Confidentiality scores were not different between vignette situations within these two clusters. Additionally, the mean confidentiality score for Vignette #4 was significantly lower than were the confidentiality scores for both Cluster A, $F(1, 29) = 42.99$, $p < .0001$, and Cluster B, $F(1, 29) = 113.36$, $p < .0001$. Means and standard deviations for should and would prefer scores by vignette are presented in Table 1.

A significant interaction was demonstrated between vignette items and should versus prefer confidentiality choice scores, $F(9, 261) = 4.34$, $p = .0001$. Although mean preferred scores were significantly higher than were mean should scores for eight of the vignettes—1, 2, 4, 6, 7, 8, 9, and 10 [$Fs(1, 29) = 6.37$ to 34.04, $ps < .02$]— no significant differences were noted for Vignettes 3 and 5 [$F(1, 29) = 4.17$, $p > .05$; $F(1, 29) = .42$, $p > .50$].

DISCUSSION

Support for all of the principal hypotheses was demonstrated. Additionally, responses to the individual, group, and family therapy versions of the experimental questionnaire did not support the conclusion that adolescent clients have different expectations or demands for privacy among these treatment modalities nor were there any differences in privacy demands between male and female respondents.

The adolescent client participants indicated a significant degree of valuing or demand for privacy in their counseling relationships. They consistently chose those outcomes reflecting limited or absolute confidentiality over no confidentiality. These findings are consistent with previous research with adult inpatient and outpatient clients (McGuire et al., 1985; Schmid et al., 1983). The adolescents' tendency to choose outcomes representing at least limited confidentiality suggests that they not only understand and value their right to confidentiality but also that they recognize and accept limitations to this right. Analyses of individual vignette items revealed, as predicted, significant differences in expectations for privacy. On two vignettes (#1, harm to self, and #4, release of records to court), however, participants did not choose limited or absolute confidentiality over no confidentiality. The adolescents in this study seemed to understand and accept the potential necessity of breaching confidentiality when a life is threatened and to recognize the reality of the legal right of the court to access information in some instances. Of the adolescents in this sample, 40% had been court ordered into treatment and were probably familiar with the demand of the court for feedback regarding their treatment. These findings are also consistent with the idea that by the time someone is an adolescent, an understanding of confidentiality has evolved that approaches that of an adult (Belter & Grisso, 1984; Messenger & McGuire, 1981).

Results supported the conclusion that not only do adolescent clients understand and value confidentiality within their counseling relationships but also that if given a choice, they would generally prefer more privacy. Thus, overall, participants indicated significantly higher preferred demands for confidentiality as opposed to how they believed their counselor should behave. These findings complement research investigating ethical decision making (e.g., Bernard et al., 1987; Smith, McGuire, Abbott, & Blau, 1991) that has consistently demonstrated a distinction between what counselors believe they should do versus how they would probably behave in responding to an ethical dilemma. These results suggest that adolescent clients often want more privacy protection in their counseling relationships than they believe they will be afforded. Although little prior research has delineated this phenomenon (Kobocow et al., 1983; Messenger et al., 1981), counselor folklore has suggested that adolescent clients are often particularly sensitive to privacy issues. This is probably related to such developmental issues as autonomy and independence striving as the adolescent attempts to claim his or her rights as an adult.

Also consistent with previous research, these findings document that ethical issues and preferences, particularly with respect to privacy rights, are complex and diverse. As noted previously, these adolescents appreciated the difference between a potentially life-threatening situation or court involvement and other privacy situations. Additionally, although responses to all items demonstrated an increased demand for confidentiality in the would prefer condition, items dealing with common-case handling practices (supervision, clerical handling of files) did not reflect significant differences in should versus would prefer choices. This

TABLE 1

Mean Confidentiality Scores by Vignette Items

Vignette Item	Should		Prefer		Total Confidentiality	
	M	*SD*	*M*	*SD*	*M*	*SD*
1. Harm to self	1.67	0.80	2.57	0.82	2.12	0.69
2. Harm to others	2.27	0.58	2.83	0.46	2.55	0.44
3. Supervision	2.20	0.41	2.43	0.50	2.32	0.33
4. Release-court	1.40	0.50	2.00	0.59	1.70	0.43
5. Access to files	2.40	0.67	2.50	0.78	2.45	0.59
6. Release-parents	2.20	0.61	2.50	0.68	2.35	0.56
7. Drug use (cannabis)	2.27	0.45	2.77	0.43	2.52	0.33
8. Drug use (cocaine)	1.93	0.52	2.40	0.72	2.17	0.56
9. Sexual behavior	2.50	0.57	2.93	0.37	2.72	0.41
10. Confidentiality limits	2.30	0.60	2.90	0.40	2.60	0.40

Note. Maximum range of mean scores is from 1 (no confidentiality) to 3 (absolute confidentiality).

finding is consistent with previous research and suggests that adolescent clients are not overly concerned with this type of privacy intrusion and do not demand a higher level of privacy in these areas than would be expected from adults clients (McGuire et al., 1985; Schmid et al., 1983).

Finally, in this regard, significant differences were found among three groupings of vignette items. Vignette Item 4 had the lowest confidentiality score (M = 1.68), suggesting that participants expected the least degree of privacy in situations involving court access to treatment records. As noted earlier, this finding is consistent with the reality-based experience of many of these adolescents. A second group of vignettes (Items 1, 3, 5, 6, and 8) had a mean confidentiality score that was significantly higher (M = 2.25) than was that for Item 4. Item content for this group consisted of the following topics: harm to self, supervision, clerical access to files, general release to parents, and crack cocaine use. Although the content of these items is not homogeneous, two issues seem apparent. On the one hand, harm to self and cocaine use may have been viewed as highly dangerous and potentially fatal situations, such that only limited confidentiality would be reasonable to expect. On the other hand, peer supervision, clerical access to files, and release to parents of general information concerning counseling may have been viewed as routine, nonthreatening, and, thus, relatively unimportant in terms of demands for strict confidentiality. In each of the vignette situations that constituted this second group, however, the adolescents' mean confidentiality score (M = 2.25) indicated an expectation or preference for more control over privacy than for the court-ordered (Item 4) vignette. A final group of vignettes (Items 2, 7, 9, and 10) had a mean confidentiality score (M = 2.57) that was significantly higher than was either of the previous vignette groupings. This mean score reflects a demand for almost absolute privacy. The content of this third group consisted of the following topics: non-life-threatening harm to others, cannabis use, being sexually active, and disclosure of any limits to confidentiality. Thus, the adolescent clients in this study saw the first three of these issues as extremely important kinds of disclosures for them and did not see these as legitimate areas requiring any breach of confidentiality. With respect to the last content area, participants were indicating that it was of extreme importance to them for their counselor to specify any restrictions or limitations to privacy within their relationship. Future research needs to be directed toward elucidating the reasons behind the apparent situationally specific nature of privacy demands and expectations of adolescent clients.

CONCLUSION

The results of this study provide strong support for the proposition that adolescent clients value, expect, and want privacy in their counseling relationships. They perceive confidentiality as being related in an important way to their willingness to self-disclose and seem to understand and accept that there are frequently limitations to absolute privacy in counseling. Results, however, suggest that if given a choice, adolescent clients would typically prefer more privacy than they believe they will be afforded.

Results also support the importance of explaining the nature and limitations of confidentiality to both the minor and his or her parents prior to treatment. What is interesting is that many of the parents of the adolescent participants (40%) indicated that no one had ever discussed the concept of confidentiality with them. Unfortunately, both the legal and ethical right to privacy for a minor in a professional counseling situation remains unclear (Taylor & Adelman, 1989). Debate continues regarding the importance of such factors and questions as "working in the child's best interests," "Who pays for counseling?" "legality of behavior based solely on age," "Who is the client, the minor, or parent?" "Who are the persons clearly concerned with the case?" and so forth. Each of these issues has the potential of bringing the counselor into direct conflict with his or her primary obligation to "respect the integrity and promote the welfare of the client" (AACD, 1981, B-1; see also APA, 1990, Principle 6).

Some may argue that prior discussion of confidentiality and its limitations will adversely affect the adolescent client's willingness to self-disclose important matters relevant to his or her treatment. These findings, however, support the view that clarifying the nature and limits of privacy to both adolescent and parent promotes the formation of a positive trusting alliance between the adolescent and the counselor (Brewer & Faitak, 1989; Taylor & Adelman, 1989).

REFERENCES

American Association for Counseling and Development. (1981). *Ethical standards* (rev. ed.). Alexandria, VA: Author.

American Psychological Association. (1990). Ethical principles of psychologists (rev. ed.). *American Psychologist, 45,* 390–395.

Baruth, L. G., & Huber, C. H. (1984). *An introduction to marital theory and therapy.* Monterey, CA: Brooks/Cole.

Belter, R. W., & Grisso, T. (1984). Children's recognition of rights violations in counseling. *Professional Psychology: Research and Practice, 15,* 899–910.

Beeman, D. G., & Scott, N. A. (1991). Therapist's attitudes toward psychotherapy informed consent with adolescents. *Professional Psychology: Research and Practice, 22,* 230–234.

Bernard, J. L., Murphy, M., & Little, M. (1987). The failure of clinical psychologists to apply understood ethical principles. *Professional Psychology: Research and Practice, 18,* 489–491.

Brewer, T., & Faitak, M. T. (1989). Ethical guidelines for the inpatient psychiatric care of children. *Professional Psychology: Research and Practice, 20,* 142–147.

Butynski, W., Canova, D., & Reda, J. (1989). *State resources and services related to alcohol and other drug abuse problems—fiscal year 1989: An analysis of state alcohol and drug abuse profile data* (Florida data). Rockville, MD: U.S. Department of Health and Human Services.

Egan, G. (1990). *The skilled helper* (rev. ed.). Belmont, CA: Brooks/Cole.

Glenn, C. M. (1980). Ethical issues in the practice of child psychotherapy. *Professional Psychology, 11,* 613–619.

Grisso, T., & Vierling, L. (1978). Minor's consent to treatment: A developmental perspective. *Professional Psychology, 9,* 412–427.

Hare-Mustin, R. T. (1980). Family therapy may be dangerous for your health. *Professional Psychology, 11,* 935–938.

Jagim, R. D., Wittman, W. D., & Knoll, J. O. (1978). Mental health professionals' attitudes toward confidentiality, privilege, and third-party disclosure. *Professional Psychology, 9,* 458–466.

Kaser-Boyd, N., Adelman, H. S., & Taylor, L. (1985). Minors' ability to identify risks and benefits of therapy. *Professional Psychology: Research and Practice, 16,* 411–417.

Kobocow, B., McGuire, J., & Blau, B. (1983). Minor's ability to identify risks and benefits of therapy. *Professional Psychology: Research and Practice, 16,* 411–417.

Lakin, M. (1986). Ethical challenges of group and dyadic psychotherapies: A comparative approach. *Professional Psychology: Research and Practice, 17,* 454–461.

Lane, P. J. (1979). *Effects of complete and limited confidentiality on self-disclosure* (Doctoral dissertation, Florida State University, Tallahassee). *Dissertation Abstracts International, 40*(6-B), 2845.

Margolin, G. (1982). Ethical and legal considerations in marital and family therapy. *American Psychologist, 37,* 788–801.

McGuire, J. M. (1974). Confidentiality and the child in psychotherapy. *Professional Psychology, 5,* 374–379.

McGuire, J. M., Graves, S., & Blau, B. I. (1985). Depth of self-disclosure as a function of assured confidentiality and videotape recording. *Journal of Counseling and Development, 64,* 259–263.

McGuire, J. M., Toal, P., & Blau, B. I. (1985). The adult client's conception of confidentiality in the therapeutic relationship. *Professional Psychology: Research and Practice, 16,* 375–384.

Messenger, C. B., & McGuire, J. M. (1981). The child's conception of confidentiality in the therapeutic relationship. *Psychotherapy: Theory, Research and Practice, 18,* 129.

Miller, D. J., & Thelen, M. H. (1986). Knowledge and beliefs about confidentiality in psychotherapy. *Professional Psychology: Research and Practice, 17,* 15–19.

Parental consent requirements and privacy rights of minors: The contraceptive controversy. (1975). *Harvard Law Review, 88,* 1001–1020.

Rosenberg, A. H., & Katz, A. S. (1972). Legal issues of consent in the psychiatric treatment of minors. *Mental Health Digest,* pp. 54–56.

Ross, A. O. (1966). Confidentiality in child therapy: A reevaluation. *Mental Hygiene, 50,* 360–366.

Rothmeier, R. C., & Dixon, D. N. (1980). Trustworthiness and influence: A reexamination in an extended counseling analogue. *Journal of Counseling Psychology, 27,* 315–319.

Schmid, D., Appelbaum, P. S., Roth, L. H., & Lidz, C. (1983). Confidentiality in psychiatry: A study of the patient's view. *Hospital and Community Psychiatry, 34,* 353–355.

Sheeley, V. L., & Herlihy, B. (1987). Privileged communication in school counseling: Status update. *The School Counselor, 34,* 268–272.

Smith, T., McGuire, J., Abbott, D., & Blau, B. (1991). Clinical ethical decision making: An investigation of the rationales used to justify doing less than one believes one should. *Professional Psychology: Research and Practice, 22,* 235–239.

Strong, S., & Schmidt, L. (1970). Trustworthiness and influence in counseling. *Journal of Counseling Psychology, 17,* 197–204.

Taylor, L., & Adelman, H. S. (1986). Facilitating children's participation in decisions that affect them: From concept to practice. *Journal of Clinical Child Psychology, 15,* 346–351.

Taylor, L., & Adelman, H. S. (1989). Reframing the confidentiality dilemma to work in children's best interests. *Professional Psychology: Research and Practice, 20,* 84–89.

Weinapple, M., & Perr, I. N. (1981). The right of a minor to confidentiality: An aftermath of Bartley vs. Kremens. *Bulletin of the American Academy of Psychiatry and the Law, 9,* 247–254.

Wilkins, M. A., McGuire, J. M., Abbott, D. W., & Blau, B. I. (1990). Willingness to apply understood ethical principles. *Journal of Clinical Psychology, 46,* 539–547.

Woods, K., & McNamara, R. (1980). Confidentiality: Its effect on interviewee behavior. *Professional Psychology, 11,* 714–721.

Yalom, I. D. (1985). *The theory and practice of group psychotherapy* (rev. ed.). New York: Basic Books.

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