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# EXPERIENCES OF ETHICAL TENSION WHEN USING A HARM REDUCTION APPROACH WITH HIGH-RISK YOUTH

BY

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## Approval of Thesis

The undersigned certify that they have read the thesis entitled

**"Experiences of Ethical Tension when Using a Harm Reduction Approach with High-Risk Youth"**

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The thesis examination committee certifies that the thesis and the oral examination is approved

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## Dedication

I would like to dedicate this thesis to all of the youth that I have met and worked with over the past several years. Your voices, fight, resiliencies, and spirit, in the face of extreme tragedies, have repeatedly inspired and moved me.

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**Abstract**

Little is known about the ethical experiences of psychologists who work with high-risk youth and implement a harm reduction approach. This study uses an interpretative phenomenological analysis methodology (IPA) to explore the experiences of psychologists who are faced with ethical tensions as a result of their work with high-risk youth and the use of a harm reduction approach. A small, purposefully selected sample consisting of two psychologists-in-training and a registered psychologist were interviewed. Data analysis of the ethical tensions experienced revealed three overarching themes: *questioning*, *acting* and *holding*. An experience of *questioning* ensued for each participant when that person was initially faced with an ethical tension. The experiences of *acting* and *holding* were in reference to how the psychologists managed the tensions. Data analysis also revealed a subtheme of *sitting with tension*. It was noted that participants had learned to coexist with ethical tensions when working with a harm reduction approach given the prevalence of ethical tensions that arise when working with high-risk youth. Implications for practice, suggestions for further research, and limitations of the research are discussed.

Keywords: counselling, ethical tensions, harm reduction, high-risk youth, interpretative phenomenological analysis

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# Experiences of Ethical Tension when Using a Harm Reduction Approach with High-Risk Youth

## Chapter 1: Introduction

Counsellors who work with adolescents are faced with unique and challenging ethical tensions. For these professionals, ethical tensions related to matters of competence (Dailor & Jacob, 2011; Kolay Akfert, 2012; Koocher, 2008), informed consent (Koocher, 2008), and confidentiality (Bodenhorn, 2006; Duncan, Williams & Knowles, 2012; Rae, Sullivan, Razo & Garcia de Alba, 2009; Sullivan, Ramirez, Rae, Razo & George, 2002) are the most prominent.

A particularly challenging tension is confidentiality. Confidentiality is the most common ethical dilemma faced by mental health professionals (Fisher, 2008; Wierzbicki, Siderits & Kuchan, 2012). It becomes further complicated with adolescents. Since adolescents are considered vulnerable persons, and are legally dependent on guardians, counsellors must first obtain the approval of the guardian in order to provide counselling services (College of Alberta Psychologists [CAP], 2010, Canadian Psychological Association [CPA], 2000). Guardians have the legal authority to approve counselling and, thus, also have legal access to what is disclosed during counselling (CAP, 2010; Knapp & VandeCreek, 2006). The impact of these legal parameters is that a counsellor may not be able to guarantee confidentiality to his or her client.

Guardian access to information shared in counselling may have detrimental effects on how adolescents access and use counselling services (Boulton et al., 2007; Fox & Butler, 2007; Gustafson & McNamara, 1987; Jenkins, 2010; Lehrer, Pantell, Tebb & Shafer, 2007). Whether practitioners can provide confidentiality may be a significant

detail for adolescents considering to access counselling (Eyrich-Garg, 2008; Fox & Butler, 2007; Jenkins, 2010; Kearney, 1998; Lehrer et al., 2007). Some youth may wish to consult with a psychologist, but may desire to keep their consultations and counselling sessions private from their guardians.

For high-risk youth, the issue of confidentiality becomes more significant. These youth engage in high-risk behaviour more often, and are more likely to be involved in gangs, be sexually exploited, and have more profound addictions (Smyth & Eaton-Erickson, 2009). These youth are also more difficult to engage, due to their lack of trust in adults and persons of authority (Smyth & Eaton-Erickson, 2009; Kearney, 1998). Counsellors who work with this demographic may find themselves in situations where they must breach confidentiality more often. Problematically, some counsellors fear that breaching confidentiality may rupture the working alliance between the adolescent and counsellor, and could deter that young person from seeking counselling services in the future (Kearney, 1998; Rae et al., 2009; Sullivan et al., 2007; Taffel 2005).

The purpose of this study is to explore the lived experiences of psychologists who face ethical tensions as a result of working with high-risk youth and the use of a harm reduction approach. The aims of the study are to understand the professional and personal experiences of these practitioners, and how these experiences are managed. An interpretative phenomenological analysis (IPA) methodology was used to explore this topic.

## My Story

The idea of this research topic was developed many years ago and has continued to grow over the course of my career. During my career, I have volunteered with a

restorative justice committee, worked in group homes, and have been employed with a law firm that handled youth criminal matters almost exclusively. In these settings, I worked with very high-risk youth. My clients have come from a variety of backgrounds. They have been culturally and ethnically diverse. Most have had severe addictions, faced homelessness, have been sexually exploited, involved with gangs, suffered from severe mental illness, and had significant criminal involvement. The nature of my volunteering and employment has been to mentor and support these youth, provide outreach services, and assist in legal proceedings.

It was early in high school that I first became familiar with the harm reduction model. In brief, this approach aims to reduce the harms and risks associated with a high-risk behaviour, not necessarily disrupt the behaviour itself (International Harm Reduction Association [IHRA], 2010). Advocates of harm reduction understand that for some high-risk individuals, complete disruption of the high-risk activity is unrealistic and as such, regardless of a person's ability or willingness to discontinue the high-risk behaviour, those individuals must still have their basic human rights met (IHRA, 2010). It was not until my employment, that I began incorporating harm reduction into my practice. This approach aligns with my personal and professional values and beliefs. Many of my clients were so entrenched in their high-risk lifestyles, that sudden and complete abstinence, was not realistic for them. Instead, much of my work was tailored around safety planning and reducing the risks associated with some behaviours. During my employment at a law office, I was also awarded solicitor-client privilege. This meant that unless my clients disclosed plans to cause serious and immediate harms to self or others, all information provided was private.

Throughout my employment, I experienced personal and professional angst in worrying about my clients. Though I realized that harm reduction was the best option available; I occasionally found it difficult to implement: risk is minimized but clients remain at risk regardless. However, as I mentioned, harm reduction was the best, and at times, only, approach available. Furthermore, solicitor-client privilege meant that I was not to share what my clients disclosed, unless they, or another person, were proving to be in immediate risk. Though I worried about my client's safety, and at times felt personal distress due to my personal beliefs not aligning with my professional obligations, I did not experience professional angst. I knew that I was fulfilling my professional obligations.

During my counselling practicum, I found that I experienced these tensions differently. In the practicum, I was obligated to report the high-risk behaviours that my clients disclosed. This added another layer of angst. I was unsure of the proper protocol. I wanted to help my client and incorporate a harm reduction approach, but I also needed to follow through on my ethical obligations. I felt conflicted about what to report, how much of the disclosure to report, and worried that I had not followed the reporting obligations properly.

I was also concerned about how reporting may affect my client. As clients become aware of all reporting, I worried that my clients would terminate our professional relationship. I also wondered how this experience might influence that client's future decisions to access counselling. Early on in my career, I had observed how much the youth I worked with valued confidentiality, and distrusted most helping professionals. I had learned that the perception held (by those I spoke with) was that helping

professionals were not trustworthy, and the youth feared being reported to authorities for infractions they might disclose.

In discussing these issues with my colleagues (primarily practicum and provisional psychologists) I found that they also, experienced similar angst. I wanted to know more about this experience and how my fellow colleagues managed this angst. I wondered how the experience of these ethical tensions changed as a counsellor gained more experience. I could not find any literature that consoled my ethical obligations as a counsellor, with the use of the harm reduction approach. Out of these wonderings, my thesis was slowly being born.

## Implications and Relevance

Given the complexity and prevalence of tensions relating to clinical competence, informed consent, and confidentiality when working with adolescent populations, there is surprisingly little research that examines the personal and professional experiences of psychologists who find themselves faced with these dilemmas. Confidentiality is recognized as one of the most prevalent ethical tensions that psychologists experience (American Psychological Association [APA], 2003, 2005; Bodenhorn, 2006; Dalen, 2006; Fisher, 2008; Pope & Vetter, 1992; Wierzbicki et al., 2012). The impact of these tensions is sense of confusion amongst mental health professionals (Fisher, 2008; Jenkins, 2010).

Harm reduction is a promising approach (Collins, Clifasefi, Logan et al., 2012; IHRA, 2010) that is gaining popularity throughout the world (Collins, Clifasefi, Logan et al., 2012; IHRA, 2010). Harm reduction may be best suited when working with high-risk youth considering the dangers this population is exposed to (Smyth & Eaton-Erickson,

2009). As high-risk behaviour also tends to be high in volume, the ethical tensions experienced by the treating psychologist may occur quite frequently. Consider a young male, aged 15, seeking counselling to help with an addiction issue. This young person discloses significant drug use, but is adamant that he does not want to seek formal, residential treatment. Instead, he would like to try to manage the addiction with the help of the counsellor. Furthermore, he explicitly states that if the counsellor discloses the drug use, or refers him to residential treatment, the young person will run away. According to the Code of Ethics for Psychologists (CPA, 2000), this young person is placing himself at risk for considerable harm as a result of his addiction, and as such, the treating psychologist should inform the youth's parent(s) or guardian(s). The tenants of harm reduction stress, however, that work should be tailored at helping the individual reduce the risks associated with the harmful behaviour (Collins, Clifasefi, Logan et al., 2012). Several dilemmas can be noted in this situation. The young person may likely need the support of counsellor. Reporting the drug use to the guardian may deter the young person from continuing to work on managing his addiction, or from trusting adults and authority figures in the future. Alternatively though, the guardian rights may be violated if they are not informed of the addiction. The counsellor would not be abiding by his or her ethical obligations if the guardian is not contacted. The counsellor now has an ethical dilemma.

The purpose of this research is not specifically to examine what course of actions counsellors should take in the face of ethical tensions, but instead to examine the experiences of counsellors, regardless of how they chose to handle the ethical dilemma, when using a harm reduction framework. Building this knowledge base will support

novice and seasoned psychologists as they prepare for these tensions. The aims of this research are to (a) investigate how and when these ethical tensions arose, (b) explore the professional and personal significance of these experiences for the psychologists, and (c) explore how psychologists managed these tensions, professionally and personally. The anticipated outcome of this research is the addition of fundamental knowledge that is currently missing from the literature, and the opportunity to extend discussions amongst workers who experience these tensions. The findings of this research will contribute to the field of ethics and potentially, practitioner self-care. With a broader knowledge base, psychologists may advance their skills related to the management of these tensions, the accompanying distress and perhaps reduce burn out.

**Defining Key Terms**

**High-risk youth.** For the purposes of this study, I used a combination of McWhirter, McWhirter, McWhirter & McWhirter (2007) and Smyth and Eaton-Erickson's (2009) definitions of high-risk youth. Furthermore, in this study, the term *high-risk* youth, young persons, or adolescents are used interchangeably. These terms refer to youth who use and abuse alcohol and illicit drugs. These youth may also be engaged in a variety of risky behaviours, such as sexual exploitation, criminal involvement, running away, homelessness and gang involvement. I also incorporated McWhirter et al.'s (2007) definition of at risk, as this term refers to situations that are not necessarily current, but are at risk of occurring in the absence of intervention (p. 6). For the purposes of this study, practitioners were asked to recall experiences that only involve youth between the ages of 12-18. This last parameter is included because clients who are younger than 18 years in most instances have to gain parental consent to access

counselling and there is an expectation that an adolescent's guardian will have access to the information shared in counselling.

**Harm reduction.** Harm reduction refers to an approach or strategies that aim to reduce the risks or harms associated with socially harmful or problematic behaviours and activities, such as prostitution, gambling or illicit drug use (Kleinig, 2008; Marlatt, 1996). This definition will be explored in the literature review.

**Ethical problems.** For the purpose of study, the researcher referred to Andrew Jameton's (1984) definition of ethical problems. While dated, the benefit of using Jameton's conceptualization of ethical problems is that the definitions are broad and can encompass a range of experiences that practitioners might find themselves facing.

Jameton (1984) categorizes moral and ethical problems into three different types. According to him, these problems can result in *moral uncertainty*, *moral dilemmas* or *moral distress*. Moral uncertainty refers to instances where a professional is unsure what the moral problem is, or what moral principles or values may apply. Moral dilemmas result in the presence of two or more clear and applicable moral principles that support mutually inconsistent courses of action. Finally, moral distress arises when institutional constraints inhibit one from pursuing the right course of action. In this research study, the term ethical tension, or dilemmas, refers to these ethical problems.

**Psychologists.** For the purpose of this study, psychologists-in-training and registered psychologists were interviewed. Psychologists-in-training are those that are completing, or have completed, a Master's degree in psychology, and are participating in the internship, or residency, portion of their program. All of these individuals are expected to abide by the Canadian Code of Ethics for Psychologists as put forth by the

Canadian Psychological Association, as well as the Standards of Practice (2013) of the College of Alberta Psychologists. To enhance readability the terms psychologists, practitioners, therapist and mental health professionals are used interchangeably. Study participants are referenced accordingly.

## Chapter 2: Literature Review

The purpose of this literature review is to critically examine and synthesize research pertinent to the ethical tensions experienced by psychologists who work with high-risk youth and incorporate a harm reduction approach. A search of existing literature yielded minimal research that examined the interaction of the two variables (working with harm reduction and high-risk youth) and the resulting personal and professional experience of counsellors.

For the purposes of this literature review, several areas related to these topics are examined. First, the experiences of adolescents in counselling will be documented, as well as the barriers for adolescents and high-risk youth who seek counselling. This section will also provide a definition and overview of high-risk youth. Next, the theory and research behind harm reduction with be explored. Finally, some of the ethical complications and tensions that may arise when working with high-risk youth will be examined. Particular attention will be awarded to the matter of confidentiality. The conclusion will summarize the findings on the existing research in this field.

### Adolescents in Counselling

In Western society, the principle of autonomy is highly valued (Powell, 1984). During adolescence, youth undergo a period of physiological maturation, as well as social and emotional changes (Duncan, Williams & Knowles, 2012; Roaten, 2011) as they strive for autonomy (Eyrich-Garg, 2008; Higham, Friedlander, Escudero & Diamond, 2012; Jenkins, 2010; Roaten, 2011). According to Taffel (2005), during this time adolescents may “struggle with handling the stress of normal, everyday teen life” (p. 11). In some cases, psychologists can help adolescents navigate this turbulent time (Taffel,

2005). The purpose of this section is to examine some of the peculiarities of working with the adolescent population within a counselling capacity, and discuss some of the technical issues that arise when adolescents seek counselling, especially unbeknownst to their guardians.

Roaten (2011) stressed that working with adolescent clients is vastly different from conducting therapy with children or adults. She conveyed that adolescence is a period of intense brain development, which strongly influences behaviours, emotions, and cognitions. When working with adolescents, Roaten has advised counsellors to consider how this development, as well as the need for autonomy, can affect the progression of therapy and the formation of a therapeutic alliance. She emphasized the importance of a strong working alliance between a practitioner and his or her adolescent client. This alliance can help facilitate positive outcomes in therapy (Creed & Kendall, 2005; Hawley & Garland, 2008; Shirk, Karver & Brown, 2011).

**Adolescents Accessing Counselling**

Adolescents tend to enter therapy at the request of parents or guardians, or because they are mandated by an outside source (Bartholomew & Carvalho, 2008; Knapp & VandeCreek, 2006; Roaten, 2011). Although adolescence is a period that is marked by a growing desire for autonomy (Eyrich-Garg, 2008; Higham et al., 2012; Jenkins, 2010; Roaten, 2011), youth remain financially and legally dependent on their guardians. In Canada, the provincial regulatory bodies that govern the provision of psychological services dictate how a child or adolescent can access treatment. According to the College of Alberta Psychologists (CAP, 2010), individuals under the age of 18 must obtain parental consent prior to receiving psychological services. Furthermore, the child's

guardians also have the right to access any information that is gathered during treatment (CAP, 2010; Knapp & VandeCreek, 2006).

There are, however, some exceptions to this rule. Some adolescents can be deemed to be mature minors (CAP, 2010). This designation means that an adolescent is considered emancipated from his or her guardian (CAP, 2010). To be considered a mature minor, an adolescent must be at least 15 years of age and must have the intellectual and cognitive capabilities to make his or her own decisions regarding treatment (CAP, 2010). All other children and youth under the age of 15 must obtain parental consent to access psychological services (CAP, 2010).

Some researchers have suggested that when working with adolescents, obtaining parental or guardian informed consent can become a complicated task (Powell, 1984; Koocher, 2003, 2008; Wolbransky, Goldstein, Giallella & Heilbrun, 2013). The Canadian Psychological Association's (CPA, 2000) Code of Ethics for Psychologist, states that obtaining informed consent is an ethical obligation. In short, informed consent requires that the psychologist explain to his or her client, in a language that the client can understand, what will transpire in treatment, what the plan for treatment is, and any limits to confidentiality (CPA, 2000). The purpose is so that the client is informed about treatment and can, in turn, make informed decisions (CPA, 2000). Although adolescents can also give informed consent in counselling, known as *assent*, it is mandatory that guardians do, as adolescents are considered to be a vulnerable population (CPA, 2000).

Informed consent involves addressing confidentiality. By providing informed consent, guardians then have the right to access any information that their child shares in counselling. As some adolescent clients may not want their parents to know what

transpires in therapy (Ascherman & Rubin, 2008; Koocher, 2008; Powell, 1984), obtaining informed consent may become challenging. Furthermore, this obligation may influence whether adolescents seek counselling and how they report high-risk behaviour (Boldt, 2012; Gustafson & McNamara, 1987; Rojas, Sherrit, Harris & Knight, 2008; Tigges, 2003).

Another difficulty that can arise when undertaking the informed consent process is determining the identity of the guardian (Wolbransky et al., 2013). In some instances, it can be a challenge to determine who the legal guardian is: the government, foster parent, biological parent, or extended family member (Wolbransky et al., 2013). In addition, there may be challenges in gaining access or communicating with the guardians. In summary, obtaining informed consent when working with adolescents is a multifaceted issue that may cause stress and uncertainty for many practitioners (Meade & Slesnick, 2002). Practitioners have to meet their ethical obligations, but be mindful of the unique circumstances that arise when working with adolescent clients. Further discussion around the issues of obtaining informed consent will follow later in this review.

**High-Risk Youth**

The adolescent years are associated with an increase in risk-taking behaviour (Rae, Sullivan, Razo & Garcia de Alba, 2009). Some of these behaviours may include unsafe sexual practices, gang activities, violence, and drug and alcohol use (Rae et al., 2009; Smyth & Eaton-Erickson, 2009). There is, however, disagreement regarding how at-risk, or high-risk ought to be defined, and interpretations of this term vary greatly (Smyth & Eaton-Erickson, 2009). In this section, two definitions of high-risk youth are explored, while some of the defining characteristics of this population are simultaneously

documented. These terms are selected because they illustrate some of the characteristics of this population. Furthermore, these terms demonstrate how little continuity there is in the terms and language used to describe the same population. By using these two definitions however, a thorough description of high-risk youth can be achieved.

According to McWhirter, McWhirter, McWhirter & McWhirter, (2007), how these terms are defined largely depends on the context within which they are used. McWhirter et al. (2007) explain that psychologists, use the term *at-risk* to refer to individuals who suffer behavioural, emotional or adjustment problems. Educators and teachers, on the other hand, use the term to refer to students who are at risk of dropping out of school. Finally, physicians use the term to refer to individuals who are at risk of developing health problems. This lack of consensus and interchangeability, as to what this term means, can result in confusion.

To remedy this confusion when discussing risk within the context of working with youth and adolescents, McWhirter et al. (2007) distinguish between *at risk* and *at-risk*. They define *at risk* as being a "cause-effect dynamics that place an individual child or adolescent in danger of future negative outcomes" (p. 6). *At-risk* on, the other hand, lies on a continuum which will be discussed shortly. In brief, this latter term refers to those youth in the highest level of risk, and who are already engaging in harmful behaviours (McWhirter et al., 2007).

There is no clear definition of low, medium, or high risk. To mediate this, McWhirter et al. (2007) propose an at-risk continuum. Their continuum holds five categories: minimal risk, remote risk, high risk, imminent risk, and at-risk (McWhirter et al., 2007, pp. 8-9). Minimal risk refers to youth who are exposed to few psychosocial

stressors, who have healthy support systems, and whose families have a higher socioeconomic status. The term no-risk does not apply to these youth because they may still experience stressors. Remote risk applies to those adolescents where markers of future problems begin to appear. These youth may be from a lower socioeconomic status, lack access to good education and have experienced oppression, economic marginalization or racism. These youth may have been exposed to violence and may be vulnerable for a variety of reasons.

High-risk youth are more likely to come from dysfunctional families, attend poor schools, and experience negative social interaction. Youth from the remote risk category can, however, experience these characteristics as well. The marking characteristic of the high-risk category is that these youth also have negative attitudes, emotions, and behaviours, such as aggression, conduct problems, impulsivity, anxiety, affective problems and hopelessness. Furthermore, these youth often have poor social skills and coping strategies.

The next category is imminent risk. These youth often participate in "gateway" problem behaviours (McWhirter et al., 2007, p. 9). They are more likely to engage in distressing behaviours that are deviant and self-destructive. In addition, they may exhibit aggressive behaviours within the home, which could be indicative of later criminal involvement. They may also begin smoking tobacco, which may be a gateway to later drug use, or could receive a minor theft charge, which may lead to later, more serious crimes.

The final category on McWhirter et al.'s (2007) continuum is the at-risk category. In this category, adolescents have already "passed beyond risk because they are already

engaged in the problems that define the category" (McWhirter et al., 2007, pp. 9). These youth are already using illicit substances and perhaps finding themselves addicted. They are also more heavily criminally involved. They may be engaging in one behavior (e.g., prostitution or theft) to satisfy an alternate behavior (e.g., drug use).

The second definition of high-risk examined in this review is one that has been conceptualized by Smyth and Eaton-Erickson (2009). These authors accept that while many adolescents engage in some risky behaviour, a distinct group known as *high-risk youth* engage in those behaviours on a regular basis (Smyth & Eaton-Erickson, 2009). They argue that these youth are not simply *at-risk* for negative future outcomes, but are already in the midst of these outcomes (Smyth & Eaton-Erickson, 2009). They describe high-risk as youth between the ages of 14 to 22 who are already deeply involved in high-risk behaviours, or activities such as sexual exploitation, alcohol and drug use, and gang-involvement. High-risk youth are often difficult to engage, are disconnected from positive supports or mainstream society, lack a family or healthy support system, struggle with authority and trusting adults, suffer from a variety of mental health concerns, and are frequently involved in the child welfare and/or justice systems (Smyth & Eaton-Erickson, 2009).

In addition to the aforementioned characteristics, these youth also struggle to build positive meaningful relationships, especially with social workers and other professional adults (Smyth & Eaton-Erickson, 2009). This difficulty results from youth having had negative experiences within the systems, a lack of support during life transitions, and not feeling heard by the various systems in their lives (Smyth & Eaton-Erickson, 2009). These youth often feel excluded from participating in the decision-

making and planning of their lives, and often regard social workers and other service providers as having hidden agendas (Smyth & Eaton-Erickson, 2009).

**Summary.** For the purposes of this study, a combination of McWhirter et al.'s (2007) definition of at-risk youth and Smyth and Eaton-Erickson's (2009) definition of high-risk youth is employed. Though the terms vary, the groups display similar characteristics. Furthermore, in this study, the term *high-risk* youth or adolescents will be solely used. This will include youth who use and abuse alcohol and illicit drugs. These youth may also be engaged in a variety of risky behaviours, such as sexual exploitation, criminal involvement, running away, homelessness and gang involvement. The work will also incorporate McWhirter et al.'s (2007) definition of at risk. This is included because this term refers to situations that are not necessarily current, but are at risk of occurring in the absence of intervention (p. 6). For instance, this would include an adolescent female who is not being sexually exploited, but due to her drug use and association with older males known to exploit young females, is at risk for being exploited.

## Harm Reduction

Harm reduction originated in the Netherlands as a grassroots response to the escalating drug use that was occurring during the 1960's (Collins, Clifasefi, Logan et al., 2012). The concept of harm reduction, however, did not gain prominence until the 1980's (Keane, 2003), when the Dutch government enacted the first harm reduction laws (Collins, Clifasefi, Logan et al., 2012). These laws were influenced by two important factors. The first factor, and arguably one of the most significant, was the HIV epidemic (Collins, Clifasefi, Logan et al., 2012; McCoun, 1998). At that time, there was a growing concern about the increase in HIV reports. This increase in reports was attributed to the

practice of the sharing of needles among intravenous drug users, as well as the prevalence of unprotected sex amongst HIV-infected individuals (McCoun, 1998).

A second influential factor in the emergence of harm reduction was the development of new behavioural therapies for drug addiction (McCoun, 1998). Up until this point, the main goal in substance abuse therapy had been abstinence; a goal that was met with limited success (Bennet & Assefi, 2005; Hunt, 2012; Kelly, 2012; Stitzer et al., 2007). The school of thought in this area, however, was slowly shifting. New therapies were emerging, which demonstrated that some substance users were able to limit or moderate drug use, and thereby reduce the risks associated with that use (MacCoun, 1998). These discoveries, as well as the aforementioned concern with the increasing HIV epidemic, prompted theorists at that time to think of a new approach, which reached beyond the all-or-nothing goal of abstinence. These thoughts led to the new and innovative approach of harm reduction, which was tailored at first to work with individuals with substance abuse issues, though was eventually expanded to include other presenting issues.

Since the 1980's, harm reduction has gained increasing recognition and favour throughout the world (Bridge, Hunter, Atun & Lazarus, 2012; Harm Reduction International [HRI], 2012). There has been an increase in funds provided to harm reduction programs throughout the world, but especially in the United States (Bridge et al., 2012). The HRI (2012) further explains that there has been a substantial increase in the number of countries that address harm reduction in national policies and strategic plans. Western Europe, where this approach originated, remains, by far, the leader in harm reduction programs and policies (HRI, 2012). Though the trends in the adoption of

harm reduction are overwhelmingly positive, some challenges do linger. Despite the fact that harm reduction programs have increased significantly throughout the world, there remains an uneven distribution of these programs, particularly in low to middle-income countries (HRI, 2012, p. 12). In addition, there is still some hesitancy in applying a harm reduction approach with some populations (Kelly, 2012).

On a national scale, harm reduction goals were first officially announced in Canada in the late 1980's (Hathaway & Tousaw, 2008). In response to public demand for more effective approaches, in 1987 the National Drug Strategy incorporated a harm reduction approach (Hathaway & Tousaw, 2008). The goal was to reduce the harm that individuals, families, and communities, suffer because of drug abuse (Hathaway & Tousaw, 2008). Accompanying this goal was the realization that law enforcement was ineffective in dealing with, what was beginning to be understood, as a health-related issue. The strategy recommended that greater attention and funding be allocated to rehabilitation programmes. Despite these recommendations, it took nearly 20 years for harm reduction programs to come into effect. In 2003 the first fully committed harm reduction agency was created. This agency was a safe-injection facility, for persons using intravenous drugs in the city of Vancouver, British Columbia. Today, harm reduction approaches, such as needle exchange and safe crack-use programs, exist across the country, though with varying levels of success (HRI, 2012).

**Harm Reduction Theory**

Harm reduction is a promising but controversial approach, or set of strategies, that aims to reduce the risks or harms that are associated with socially harmful or problematic behaviours and activities, such as prostitution, gambling, or illicit drug use (Collins,

Clifasefi, Logan et al., 2012; Kleinig, 2008; Marlatt, 1996). Harm reduction arose primarily out of substance abuse treatment (McCoun, 1998). The International Harm Reduction Association (IHRA, 2010), which is now known as HRI, provides a clear and comprehensive definition for harm reduction, insofar as it concerns drug use:

> Harm reduction refers to policies, programmes, and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs...Harm reduction complements approaches that seek to prevent or reduce the overall level of drug consumption. It is based on the recognition that many people throughout the world continue to use psychoactive drugs despite even the strongest efforts to prevent the initiation or continued use of drugs. (p. 1)

Merkinaite, Grun and Frimpong (2010) have suggested that harm reduction is moving away from only being a treatment approach, and is moving toward being a comprehensive human rights and health services approach. In keeping with this perception, the IHRA posits that regardless of an individual's ability or willingness to discontinue drug or alcohol use, they still need to have their basic human rights honored and met. Those individuals must be granted continued access to good treatment that is aimed at minimizing the risk that drug use inherently bears (IHRA, 2010).

Harm reduction has some important characteristics that set it apart from other substance abuse treatment models. The most distinguishing feature of harm reduction is that this approach moves away from the all-or-nothing, abstinence-based, model of

treatment (Collins, Clifasefi, Logan et al., 2012; Larney, Corcoran, Wodak & Dolan, 2006). Instead, it ventures to work towards a reduction in harm (Collins, Clifasefi, Logan et al., 2012; Larney et al., 2006). This endeavour stems from the fundamental tenet of this approach, which is that in modifying the behaviours of individuals who are at-risk, as well as the conditions in which they are at-risk, the most serious risks to health and safety that these individuals and the public face, can be reduced (HRI, 2012; MacCoun, 1998).

A second characteristic, which distinguishes harm reduction from other treatment approaches, is the position of abstinence within this approach. While advocates and practitioners of harm reduction regard abstinence as ideal, they do not believe that it is the solitary goal in treatment (Collins, Clifasefi, Logan et al., 2012; Larney et al., 2006). According to the World Health Organization (WHO), abstinence is one goal, of many, on the spectrum of drug and alcohol treatment (Larney et al., 2006). Collins, Clifasefi, Logan, et al. (2012) explain the purposeful position of abstinence within harm reduction. They argue that due to a variety of factors, some individuals who engage in high-risk behaviours can find complete abstinence to be difficult to achieve. As a result, these persons will likely continue to engage in harm producing behaviours (Collins, Clifasefi, Logan et al., 2012). According to harm reduction principles however, there remains a strong necessity to maintain a level of safety and a reasonable quality of life for these individuals, as well as those around them (Collins, Clifasefi, Logan et al., 2012). In summary, harm reduction proponents understand that while abstinence may not always be realistic, they still advocate for it. However, it is not a mandatory condition for receiving treatment, services, or support.

A third important characteristic of harm reduction is that it can be applied to a number of problematic or dangerous behaviours, and is not limited to drug use. Harm reduction policies and strategies have included the use of seat belts in cars, the use of nicotine patches, needle and syringe programs, prescribed heroin programs, and education on the safe use of substances or safe sex (Kleinig, 2008). Harm reduction approaches also include alternatives to drinking and driving programs, and housing-first models to address homelessness (Collins, Clifasefi, Logan et al., 2012; Collins, Clifasefi, Dana et al., 2012).

**Strengths and criticisms.** Harm reduction, like any other school of thought has its strengths and limitations. Its strengths relate primarily to how inherently adaptable this approach is (Collins, Clifasefi, Logan et al., 2012). Its weaknesses, on the other hand, are socially, politically and philosophically based (Hathaway, 2001). There are several advantages to adopting a harm reduction model. Perhaps one of the most salient strengths of this approach is that harm reduction is closely aligned with human rights (Collins, Clifasefi, Logan et al., 2012; Hathaway & Tousaw, 2008; Pauly, 2008). According to the philosophy of harm reduction, disenfranchised populations, whether these include the homeless, those using illicit drugs, or those involved in the sex trade, still need to have their basic human rights met (Collins, Clifasefi, Logan et al., 2012). These populations still ought to receive equal access to health care and housing (Collins, Clifasefi, Logan et al., 2012). The philosophy of harm reduction recognizes the humanity of these persons and strives to honor their inherent rights, by creating conditions that honor those rights, keep the individual and public safe, and offer assistance to those individuals in changing their circumstances.

Another benefit of harm reduction is that it can be tailored to the specific needs of the individual and community to which it is applied (Collins, Clifasefi, Logan et al., 2012). Collins, Clifasefi, Logan et al. (2012) have stated that because of this adaptable feature of harm reduction, it is a culturally competent approach. Harm reduction has been demonstrated to not only be effective in working with varying presenting issues and age groups, but has also shown promise when working with different multicultural groups. Harm reduction arose out of Western Europe where it has been widely popular and it has expanded throughout the world, even as far as Latin America (Gorgulho & Da Ros, 2006; IHRA, 2012). It has also been accepted by some within the Islamic religion (Kamarulzaman & Saifuddeen, 2010). Due to this acceptance, harm reduction programs have increased significantly in number in the Northern Africa and the Middle East (HRI, 2012; Todd et al., 2012).

Harm reduction programs have seen many successes (Collins, Clifasefi, Logan et al., 2012; IHRA, 2010). Research has shown that providing homeless individuals with safe and stable housing leads to a decrease in their alcohol consumption (Collins, Clifasefi, Dana et al., 2012). When compared with no-opioid replacement programs, methadone replacement programs have also shown promise and success (Mattick, Breen, Kimber & Davoli, 2009). Mattick, Breen, Kimber and Davoli discovered that individuals who participated in the methadone replacement programs were more likely to enter and remain in treatment, reduce their use of opioids, have less criminal activity, and have lower mortality rates (2009). Finally, perhaps the most well-known of harm reduction programs, safe injection sites, have shown success and have led to decreases in public drug use, safer conditions under which drugs are used, decreases in needle sharing, more

referrals to treatment, and quicker medical attention to overdoses (Wood, Tyndall, Montaner & Kerr, 2006; Wood, Tyndall, Qui et al., 2006). As a final note, harm reduction programs are also cost-effective and easy to implement (IHRA, 2010)

Despite its strengths and benefits, harm reduction is not without its critics. Hathaway (2001) presented some of the more salient concerns directed toward this approach. The most prevalent criticisms of harm reduction are politically, socially, and philosophically based. Many government agencies, according to Hathaway, reject harm-reduction, saying that it directly contradicts laws and policies. For instance, harm reduction programs that focus on creating conditions in which persons can inject drugs safely, threaten the North American "war on drugs" policy (Hathaway, 2001). Furthermore, within Canada, because drug use is illegal (Controlled Drugs and Substances Act, 1996, c 19), safe-injection sites run contrary to laws and regulations that prohibit the use of drugs (Hathaway, 2001). It is important to note, that contrary to these challenges, the political attitudes toward harm reduction programs have been gradually changing (Collins, Clifasefi, Logan et al., 2012). One example is that in the United States, the most recent government removed the ban on syringe and needle exchange programs (Collins, Clifasefi, Logan et al., 2012). Small victories, such as these, have been associated with the increase in the number of harm reduction programs both domestically and internationally (HRI, 2012).

Criticism of harm reduction is not limited to the political sphere. A social and philosophical perspective argues that by assisting people to reduce some of the dangers associated with illicit drug use, the negative behaviour may inadvertently be reinforced (Carter, Miller & Call, 2012; Hathaway, 2001). Many critics of harm reduction believe

that this model condones and encourages drug use by helping people use "safely" (Carter et al., 2012). In response to this criticism, the WHO has argued against the claim that harm reduction programs condone drug use, and reiterated that abstinence falls within the hierarchy of harm reduction goals (Larney et al, 2006). Collins, Clifasefi, Logan et al. (2012) also support the assertion that harm reduction does not threaten abstinence-based ideals. They argue that within harm reduction programs, abstinence is not only ideal, but desired; however, they do not isolate it as the only goal of treatment. Collins, Clifasefi, Logan et al. (2012) have further added recognition needs to be given to the fact that people will continue to use drugs, despite laws and regulations that prohibit them from doing so. Harm reduction advocates stress that while abstinence is strived for, reducing harm among drug users is most imperative (Collins, Clifasefi, Logan et al., 2012; Larney et al., 2006).

**Harm Reduction Psychotherapy**

Harm reduction is both a philosophical approach and a set of interventions for practitioners to draw upon in their therapeutic work with clients (Ritter & Cameron, 2006). This next section illustrates and examines some of these interventions and will explore the position of the working alliance within harm reduction psychotherapy.

A prominent figure in harm reduction psychotherapy, Andrew Tatarsky, argues that a variety of psychotherapeutic approaches can incorporate harm reduction principles (2002). Noted at a time when harm reduction was positioned mostly within substance abuse treatment, Tatarsky stated that this approach is, "a general category of psychological interventions that may vary in theoretical perspective and clinical approach, but share in the commitment to the reduction of the harm associated with

active substance use...” (2002, p. 23). Tatarsky has further insisted that when trying to understand substance abuse, psychotherapists must consider how the biological, psychological, and social factors have contributed to the genesis of the problem. Practitioners then have to tailor their treatments to target each of these relevant factors. How clinicians do this, claimed Tatarsky, depends upon the clinician and his or her client.

Tatarsky (2002) has maintained that the intervention chosen by the therapist is largely dependent on what works for that client and on the practitioner’s therapeutic model of choice. Regardless of interventions used, Ritter and Cameron (2006) suggested that harm reduction interventions be brief, sometimes as short as 15 minutes. This is necessary due to the short amount of time that clinicians may have with clients and the immediate need to reduce the risk-causing behaviours (Ritter & Cameron, 2006). Some of the common therapeutic approaches that can be used in conjunction with harm reduction include, motivational interviewing, brief solution-focused therapy, single-session therapy, and cognitive behavioural therapy (Ritter & Cameron, 2006).

There are a number of harm reduction programs in existence. These include safe needle exchange programs, methadone clinics, smoking cessation programs, and family planning (Denning, 2000). These programs aim to reduce the harms associated with a behaviour. For instance, insofar as alcohol is concerned evidence shows that increased alcohol consumption leads to increased violence, injury, and public disorder (Ritter & Cameron, 2006). In this scenario, Ritter and Cameron explain that common harm reduction interventions would seek to modify the drinking environment in order to reduce the risks associated with alcohol consumption. Harm reduction programs aimed at

intravenous drug users, on the other hand, aspire to reduce the risks associated with the sharing of needles and the risks of overdoses. Interventions include safe injection sites and education on blood-borne diseases (Ritter & Cameron, 2006).

**The therapeutic alliance in harm reduction psychotherapy.** As already discussed, a harm reduction framework can be included in a variety of therapeutic models (Marlatt, Blume & Parks, 2001; Ritter & Cameron; 2006; Tatarsky, 2002; Tatarsky & Kellogg, 2012). Regardless of the model used, the importance of a strong alliance between the client and counsellor is essential when incorporating harm reduction approaches (Marlatt et al., 2001; Tatarsky, 2002; Tatarsky & Kellogg, 2012). When discussing the working alliance it is important to note that some of the factors that contribute to a strong alliance are embedded within the philosophy of harm reduction itself. Factors such as compassion, acceptance, respect, choice, and a non-judgemental approach, are hallmarks of this framework, (Denning, 2000; Marlatt et al., 2001; Tatarsky & Kellogg, 2012).

Marlatt, Blume and Parks (2001) stated that the most important principle of harm reduction therapy is compassion. In contrast to the some traditional approaches, harm reduction therapy offers services, "without punishing people with stigmatic labels (e.g., "alcoholic" or "drug addict"), or presenting roadblocks or hoops to jump through to obtain services" (Marlatt et al., 2001, p. 14). The harm reduction therapist is compassionate and non-judgemental (Marlatt et al., 2001). The therapist offers services and treatment to clients without requiring that clients meet certain conditions, such as sobriety (Marlatt et al., 2001). This can potentially relieve some stress for clients who

may have avoided seeking counselling or treatment due to the aforementioned condition of sobriety.

Aside from compassion, there are a number of other principles found within harm reduction therapy that play a role within the working alliance. Denning (2000, p. 24) stressed that, "harm reduction is a philosophy of inclusion, respect, collaboration, and choice." Harm reduction therapists understand that reducing alcohol or drug use can happen in incremental steps, and they support clients during this process, even if clients experience periods of relapse (Marlatt et al., 2001). In other words, harm reduction therapists do not judge, nor withdraw services, if clients relapse.

A final principle is that harm reduction therapists meet the client where they are (Marlatt et al., 2001; Tatarsky, 2002). This means that the therapist tailors the therapy to meet the client's needs and stage of change. Tatarsky and Kellogg (2012) have instructed clinicians to make the harm reduction position explicit at the beginning of therapy. The client, in collaboration with their therapist, creates safe and manageable goals for therapy (Marlatt et al., 2001; Tatarsky, 2002; Tatarsky & Kellogg, 2012). This principle, according to Denning (2000), forms the basis of all harm reduction therapy. Therapists do not force abstinence upon their clients (Tatarsky, 2002). Clinicians must accept client ambivalence and tailor the therapy goals to that individual client (Tatarsky & Kellogg, 2012). They must pay special attention to feelings of anxiety in their clients, and deal with these gently and supportively (Tatarsky & Kellogg, 2012).

**Harm Reduction with Adolescents**

The use of harm reduction strategies with adolescent populations is controversial (Kelly, 2012). In the province of Alberta, individuals under the age of 18 are considered

to be minors (CAP, 2010) and the consumption of alcohol by those under that age is prohibited. Furthermore, the use of any illicit substances by adolescents or adults is also prohibited (Poulin, 2006). Harm reduction strives to reduce the harm associated with certain behaviours, not necessarily reduce that behaviour itself (Collins, Clifasefi, Logan et al., 2012). Herein is where the problem arises. Given that harm reduction focuses on the reduction of harm, and not the termination of the problematic behavior itself, it does not uphold the law, which proclaims that it is illegal for those under the age of 18 to consume alcohol or illicit drugs. Furthermore, adolescents are regarded as vulnerable populations, and if they disclose risky behaviours that can result in imminent harm, psychologists are obligated to report this disclosure (CAP, 2010), thereby potentially leading to a rupture in alliance.

Kelly (2012) has argued that the harm reduction approach can be used when working with adolescents. The knowledge that adolescent drinking is a common phenomenon, and the failure of abstinence-based programs to dissuade adolescents from consuming alcohol, is concerning (Kelly, 2012; Marlatt, Blume & Parks, 2001; Poulin, 2006). Kelly has argued that there has been little research upholding the benefits of abstinence-based programs with adolescents. Furthermore, he stated that many parents incorporate harm reduction principles themselves. Some parents allow their adolescent children to consume alcohol in the home, hoping that by doing so in a controlled and safe environment, their adolescent can learn how to consume alcohol responsibly (Kelly, 2012). Due to this practice by some parents, Kelly advocates for further exploration and consideration of a harm reduction approach when working with adolescents.

Fletcher and Krug (2012) stated that there are, altogether, few harm reduction programs targeted at the youth population. Responses to drug and alcohol use among youth remain mostly preventative and punitive in nature (Fletcher & Krug, 2012). Kelly argued that this is likely due to the social and political ramifications that could arise since these programs do not push for abstinence. It is noteworthy to mention that there are few studies that have examined harm reduction programs with adolescents, which target alcohol and illicit drug use, and the results are promising (Kelly, 2012). Harm reduction programs for older adolescents show encouraging decreases in binge drinking and promising decreases in other harmful/risky behaviours (Kelly, 2012). As far as younger adolescents are concerned, harm reduction is more controversial due to the perceived inappropriateness of adopting a flexible approach to alcohol consumption with this group (Kelly, 2012).

**Summary**

In conclusion, harm reduction is an approach that recognizes that for some high-risk individuals, a complete withdrawal from a high-risk lifestyle and disruption of high-risk behaviours, is not realistic (Collins, Clifasefi, Logan et al., 2012). While abstinence is ideal, harm reduction aims to reduce risks associated with high-risk behaviours (Collins, Clifasefi, Logan et al., 2012; Larney et al., 2006). Harm reduction can be incorporated into a number of therapeutic modalities, most notably, cognitive behavioural therapy (Marlatt & Witkiewitz, 2002; Tatarsky, 2002; Tatarsky & Kellogg, 2012). This approach places a strong value on human rights, and argues that all individuals, regardless of circumstance, must have their basic needs met (Collins, Clifasefi, Logan et al., 2012). In this light, harm reduction psychotherapists are compassionate, non-

judgemental, unconditional, respectful and collaborative (Denning, 2000; Marlatt et al., 2001; Tatarsky & Kellogg, 2012).

## Ethical Issues when Working with Adolescents

This portion of the literature review explores three common ethical dilemmas encountered by psychologists, and identified by researchers (Dailor & Jacob, 2011; Kolay Akfert, 2012). Confidentiality, clinical competence, and obtaining informed consent are explored in this section. This review will examine how these matters present when working with adolescent populations. Suggestions and guidelines for managing are also considered.

### Clinical Competence

Determining clinical competence is a practical and ethical obligation (CPA, 2000; Wise, 2008). Establishing competence is not the most common ethical dilemma reported by practitioners, but that does not lessen its relevance (Dailor & Jacob, 2011; Kolay Akfert, 2012; Koocher, 2008). Studies conducted both in North America (Dailor & Jacob, 2011) and outside (Kolay Akfert, 2012) have demonstrated the ethical dilemmas that arise as a result of issues relating to competency.

In a qualitative study, Kolay Akfert (2012) interviewed 40 participants in Turkey. All participants were psychologists either employed as lecturers in university settings, or practicing in counselling settings. The researcher found that the participants who worked in counselling clinics reported experiencing ethical tensions when clients presented with issues that those psychologists had little familiarity with, or training in. Furthermore, participants reported feeling uncertain about how to manage these dilemmas. Study participants reported being unsure of how to proceed with helping their client and

resolving the ethical dilemma. Hence, the study members could not exercise clinical competence because they felt hampered in their decision-making.

In a North American study, Dailor and Jacob (2011) interviewed school psychologists in order to solicit information about their ethical dilemma experiences. The psychologists reported experiencing a two-fold issue; participants reported: 1) ethical dilemmas related to clinical competency and, 2) witnessing transgressions conducted by colleagues. Furthermore, resolution of these issues was not something every participant was willing to do. Those participants who had obtained more comprehensive training in ethical decision making reported feeling more prepared to resolve these dilemmas, than those who had no previous ethics training. Based on their research, Dailor and Jacob (2011) concluded that school psychologists must partake in continuing education and quality mentoring, in order to achieve, and maintain expertise. The study by Dailor and Jacob highlight the issue of professional competence and its relationship to ethical conflicts.

The issue of competence may be exacerbated when working with adolescent populations (Koocher, 2008). Adolescence marks a unique developmental chapter in a person's life (Kazdin, 1993). Research has shown that the development that occurs during this period creates unique needs, and hence, requires unique tools and practices when implementing psychotherapy for children and adolescents (Koocher, 2003). As an adolescent client moves through the wide array of cognitive, emotional, physical, and social changes common to this developmental stage, the treating psychologist should possess the necessary skills to help the adolescent manage some challenges that may arise (Koocher, 2003). Though many youth will progress through adolescence without

problems or concerns, some adolescents are vulnerable to a variety of disruptions, such as violence, trauma, and struggles in school (Jackson, Alberts & Roberts, 2010). Due to the distinctive events and challenges that arise during this developmental period, many researchers recommend that psychologists working with this demographic have specialized training to ensure professional competence (Berg, Hendricks & Bradley, 2009; Dewey & Gottlieb, 2011; Jackson et al., 2010; Koelch & Fegert, 2010; Koocher, 2003, 2008; Pidano & Whitcomb, 2012).

Koocher (2008) differentiates between two types of competence: emotional and professional. A practitioner needs to be *emotionally competent* when working with adolescent clients. Practitioners must consider whether they are personally and emotionally prepared to work with adolescents, and must give further thought to how personal experiences can affect professional work. For instance, if a practitioner has recently experienced the death of his or her child, that practitioner may find that working with adolescent clients, or families grieving the loss of their own adolescent, to be difficult. The practitioner would then be wise to proceed with caution when working with these populations (Koocher, 2008). Alternatively, a psychologist who is currently in the midst of a difficult divorce proceeding might find that working with families who are experiencing divorce, to be personally and professionally detrimental to all parties involved. According to Koocher, part of professional competency requires that the practitioner maintain a level of emotional preparedness, or competency, to work with adolescent populations.

In terms of *professional competence*, Koocher has emphasized that clinicians should partake and obtain the appropriate educational and training requirements to work

with the adolescent population (2008). Jackson et al. (2010) supported the recommendation of Koocher (2008) and argued that youth present with a series of distinctive and qualitatively different needs, from their adult counterparts. Youth require a psychologist with specialized psychotherapeutic skills (Jackson et al., 2010). Psychologists must obtain and integrate knowledge about the developmental stages of children, adults, and family systems, and integrate this knowledge into the work with the adolescent client (Jackson et al., 2010; Koocher, 2003; Pidano & Whitcomb, 2012). In conclusion, Koocher (2008) has argued that in order to provide clients with the best care, practitioners must maintain a level of professional and emotional competency.

Professional competency for psychologists who work with adolescent populations comes with training. The current tendency of undergraduate programs to provide one developmental psychology course within the entire program cannot ensure practitioners are competent to work with this population (Jackson et al., 2010; Koocher, 2003, 2008). Psychologists who are thoroughly educated in child psychopathology and its manifestations will have better outcomes than those who are not (Koocher, 2003). Jackson et al. (2010) recommend that psychologists-in-training complete courses that focus on child and adolescent psychopathology; developmental psychopathology; child, adolescent, family assessment and treatment; and issues specific to the ethical, legal, and professional challenges associated to adolescents, and their families. Training in the detection and assessment of child psychopathology is imperative (Jackson et al., 2010). Jackson et al. (2010) support not only academic training, but practical work as well. Participating in a supervised practicum or internship focused on child and adolescent psychology is advantageous. Furthermore, Jackson et al. (2010) believe it is imperative

that counsellors have access to, and partake, in frequent supervision and consultation sessions. Ongoing professional training should be required for these professionals once they are working in the field (Koelch & Fegert, 2010; Wise, 2008). The provision of psychological services to children and adolescents requires specified education and supervised training to ensure competent practice.

There are many aspects that a psychotherapist might take into account when working with adolescents. In efforts to counsel adolescents, a competent psychologist may consider how the biological, cognitive and psychological development of an adolescent, as well as how the events in the home, academic functioning, and the social environment, may enhance or diminish psychopathology (Jackson et al., 2010). Practitioners may need to explore how past and present experiences influence the various systems in an adolescent's life, such as the youth's family, school, or community (Jackson et al., 2010; Rubenstein, 2003). Culture can also play a role in the development or maintenance of a problem, and thus, there is a need to be culturally sensitive when providing treatment services (Berg et al., 2009; Dewey & Gottlieb, 2011; Jackson et al., 2010). Jackson et al. (2010) have suggested that in order to maximize the effectiveness of a treatment program, it should be provided within the context of the adolescent's life, such as, within their school or family environments (Jackson et al., 2010). Executing competent care of an adolescent who is undergoing psychological support includes the ability to consider these many, aforementioned aspects, and then determine the degree and type of impact on the client.

Child and adolescent psychologists should possess knowledge of family systems theory and preferably have some experience providing counselling services to

family/guardian units (Koocher, 2003; Jackson et al., 2010). This competency is important because many adolescents are in treatment at the request of family or guardians, and the inclusion of these members may constitute a portion of the treatment program (Koelch & Fegert, 2010; Koocher, 2003, 2008). In addition, some family members, or guardians, may disagree on the necessity of counselling and/or have varying expectations for the outcome of the sessions. The ability to acknowledge these circumstances, and their contribution to the outcome of the care being provided, can help to ensure the agendas of all the parties involved are considered (Koelch & Fegert, 2010; Koocher, 2003). Skillful practitioners will have the ability to attend to, and engage, multiple people simultaneously (Senediak & Bowden, 2007). Koocher (2003) concludes that with the use of strong mediation skills, a competent therapist can develop and deliver a treatment that considers the best interests of all parties involved. Family therapy can be complex and practitioners who are able to navigate these intricacies respectfully will be more effective (Koocher, 2003).

Working with youth who are involved in various systems can pose unique challenges for the treating psychologist (Dewey & Gottlieb, 2011). Adolescents involved in the criminal justice system require the treating psychologist involved to be well versed in several spheres (Dewey & Gottlieb, 2011). This population can present with a multitude of issues (e.g., addictions, mental health concerns, and behavioural problems). Therefore, psychologists who conduct court-ordered psychotherapy should be trained to provide counselling for each presenting issue (Dewey & Gottlieb, 2011). Psychologists working with this demographic, who are knowledgeable about the legal system and its processes, will provide better care (Dewey & Gottlieb, 2011).

Furthermore, as was explored in a previous section, building relationships with high-risk adolescents can be a challenging task (Smyth & Eaton-Erickson, 2009) and the therapist's ability to connect with a client often requires creativity on the part of the therapist. These youth may be involved in a number of systems, such as the Justice or Child Welfare system (Smyth & Eaton-Erickson, 2009). The high-risk client adds to the competency necessary to provide the best care possible, due to the increased number of systems that may be involved in these youth's lives, and to the unique challenges involved in relationship building with these youth.

It is not feasible to expect all practitioners to be perfectly trained for every situation that they are presented with. When a practitioner finds him or herself unsure of how to proceed with a client, it is his or her obligation to consult with other professionals to determine the best course of action (Berg et al., 2009; Jackson et al., 2010). When determining the best course of care for a youth, the therapist may need to acknowledge that he or she may not possess the skills required to achieve a successful outcome (Berg et al., 2009; Jackson et al., 2010). An ethical therapist will refer the client to someone who possesses the necessary skills (Berg et al., 2009).

Laws and ethical standards involved in the provision of services to minors often vary from location to location, and are generally quite extensive in their scope (Koocher, 2003). A practitioner must be informed of the regulations that govern the psychotherapeutic work with adolescents wherever he or she practices (Koocher, 2003). Ensuring a solid understanding of the ethics and legal obligations serves to facilitate the successful implementation of an effective care plan.

In order to foster a working alliance, psychologists may execute their work in a variety of styles. Rubenstein (2003) has suggested that traditional talk psychotherapy is not always effective when working with adolescent clients. Some adolescents may feel they do not need therapy, and thus, they will not be the ones to initiate the therapeutic contact (Dewey & Gottlieb, 2011; Koocher, 2008; Oetzel & Scherer, 2003). Psychologists who are creative and flexible in their approaches will experience more success (Oetzel & Schrerer, 2003; Rubenstein, 2003). Therapists may have to consider whether incorporating art, music, exercise or other forms of expressions, would be helpful to clients. Regardless of the form of therapy, Oetzel and Scherer (2003) have suggested that therapists adopt a proactive and direct approach, where the therapist assumes responsibility for initiating rapport. Those practitioners, who are empathetic and assertive, who do not flaunt expertise, and who are non-confrontational and non-abrasive, are more appealing to adolescents (Oetzel & Scherer, 2003).

In conclusion, achieving professional competency when providing psychological services to adolescent clients is a complex task. To achieve competent practice, psychologists should meet the educational and training requirements (Jackson et al., 2010), possess knowledge and experience in working with family units (Jackson et al., 2010; Koocher, 2003), and show creativity and flexibility in their therapeutic approach (Oetzel & Schrerer, 2003; Rubenstein, 2003). Counsellors should remain current with research pertaining to child and adolescent therapy and development (Koelch & Fegert, 2010; Wise, 2008), and should be well versed in the ethical obligations when working with this demographic (Koocher, 2003). Finally, psychologists should be prepared to refer the client to other professionals, should the psychologist find that he or she is not

professionally competent to continue providing services (Berg et al., 2012). Given these conditions and requirements, it can be concluded that determining professional competency is not only a complicated matter, but also a legal and ethical obligation (Jackson et al., 2010).

**Informed Consent**

Obtaining informed consent is a standard of practice, and a preliminary requirement prior to beginning counselling (CAP, 2010, 2013; CPA, 2000; College of Psychologists of British Columbia [CPBC], 2014). The attainment of informed consent has been shown to support a more productive working alliance between a counsellor and his or her client (Ascherman & Rubin, 2008; Fisher & Oransky, 2008). There are many unique challenges to ensuring that informed consent has been correctly secured (Berg et al., 2009; Dewey & Gottlieb, 2011; Koocher, 2008). Thus, it is imperative that counsellors approach this task with care and respect. This section reviews the process of acquiring informed consent when working with adolescents, and will explore the issues pertaining to this task.

Mental health practitioners must be informed of the laws and legislations that govern the provision of psychotherapeutic services to adolescent clients (Koocher, 2008). The following is a consolidation of the necessary components of informed consent, and has been derived from the CPA's Code of Ethics for Psychologists (2001), as well as the CPBC (2014) and CAP (2013) standards of practice. These samples are selected in order to demonstrate that within Canada there is significant consistency in what is required when acquiring informed consent. According to these regulatory bodies, the task of obtaining informed consent requires that:

- The client has the capacity to provide consent. Practitioners should be prepared to consult with translators. A practitioner may also have to tailor his or her approaches to ensure that it aligns with the cognitive and developmental level of the client.
- The client has been informed of all significant information pertaining to the psychotherapeutic service involved (e.g., treatment plan, risks and benefits, etc.).
- The client has given consent freely and without coercion.
- The client has been informed of the fees of service.
- The client has been informed of the limits to confidentiality.
- The client has provided consent in writing, whenever possible.
- The practitioner properly documents and stores the consent of the client, or that of his or her legal guardian.
- The practitioner explains to the client the consequences of declining participation.
- The practitioner explains to the client how to rescind consent, if he or she so wishes, and the benefits and consequences associated with that decision.

Acquiring informed consent when providing mental health services to adolescent clients presents practitioners with a number of challenges (Berg et al., 2009; Dewey & Gottlieb, 2011; Koocher, 2008). Prior to commencing work with adolescent clients, counsellors have the responsibility to determine whether an adolescent has the legal right to consent to receive treatment services (CAP, 2010; Koocher, 2008). With some exceptions, which will be discussed shortly, adolescents cannot legally consent to

treatment (CAP, 2010). When an adolescent client does not have this legal authority, the psychologist has the responsibility to determine who has guardianship, and in collaboration with the adolescent client, obtain informed consent from the guardian (Dewey & Gottlieb, 2011; Koocher, 2003, 2008; Wolbransky et al, 2013).

**Benefits of consent.** Obtaining informed consent is more than a simple ritual; it reinforces the client's autonomy and his or her right to self-determination (Fisher & Oransky, 2008; Wolbransky et al., 2013). The CPA has encouraged transparency within the counselling relationship, and has stressed that psychologists must ensure that clients have a full understanding of the process of counselling (2000). Clients need to be fully aware of the benefits and risks associated with therapy, and should agree to participate without feeling coerced or intimidated (CPA, 2000; Fisher & Oranksy, 2008). The Code of Ethics for Psychologists directs practitioners to "seek as full and active participation as possible from others in decisions that affect them, respecting and integrating as much as possible their opinions and wishes" (CPA, 2000, p. 10). Informed consent is more than having a client simply sign a piece of paper; it is an agreement between the client and the counsellor to work collaboratively during the course of therapy (CPA, 2000).

An early sense of collaboration between a client and his or her counsellor has long-term implications. When counsellors give clients the opportunity to make an informed decision regarding that client's choice to participate in therapy, this communicates respect for the autonomy, self-determination and personhood of the client (Fisher & Oransky, 2008). Ultimately, this enhances the collaborative nature of psychotherapy (Fisher & Oransky, 2008). This agreement to work together provides two major benefits: it satisfies an ethical obligation on the part of the counsellor, and sets the

groundwork for the formation of a healthy and balanced working alliance (Fisher & Oransky, 2008). The importance and contribution of informed consent towards the working alliance has been well documented (Alkhatib, Regan & Jackson, 2008; Ascherman & Rubin, 2008).

Insofar as counselling with adolescent populations is concerned, the process of attaining informed consent can help build trust between the client and the counsellor, thereby leading to a strong working alliance (Ascherman & Rubin, 2008; Dewey & Gottlieb, 2011). By providing information to the client about the counselling process and the expectations of each party, youth are enabled to make a truly informed decision related to their participation in the therapy. Dewey and Gottlieb (2011) have argued that including young people in decision-making discussions can lead to feelings of empowerment for those young people. Assent on behalf of the adolescent encourages respect for autonomy and self-determination (Dewey & Gottlieb, 2011). It also allows adolescents to feel that they are playing an active role in the course of therapy, and therefore, may encourage the adolescent's willingness to participate in therapy (Dewey & Gottlieb, 2011). These are powerful outcomes and hence, obtaining informed consent should be considered a counselling priority.

**Problems in obtaining consent.** While the benefits of acquiring informed consent have been well documented (both in the literature and above review), the process remains a complex matter, which presents several challenges when counselling adolescent populations (Koocher, 2008). The first obstacle that mental health practitioners face, is determining who has the legal authority to provide consent for the adolescent (Koocher, 2008). Generally, adolescents do not have the legal capacity to

consent to receive psychotherapeutic services, and as such, a mental health practitioner working with this population needs to obtain the consent of the adolescent's guardian/s before commencing treatment (CAP, 2010, CPA, 2000). Although, as aforementioned, the agreement on the part of the guardian/s does not relieve the counsellor of obtaining assent from the adolescent as well (Alkhatib et al., 2008; Ascherman & Rubin, 2008; Dewey & Gottlieb, 2011).

Age of maturity or competence to consent to treatment, is generally determined by the state or government, and is not uniform across, or even within, North America (Powell, 1984). In the United States, the age of competence in most states is 18, however in some, it is 21 (Powell, 1984; Koocher, 2008). In Canada, the age of consent varies between 18 and 19 years (CAP, 2010; Koocher, 2008). These discrepancies require a prudent counsellor to be well aware of the legal requirements for the state or province in which he or she practices.

Consent to receive treatment is not solely determined by chronological age (CAP, 2010). Adolescents can vary in their level of development: for some adolescents, emotional and cognitive development might surpass chronological age, while others may not have achieved specific developmental milestones (Koocher, 2008). These developmental differences contribute to an already vague decision-making process. In some exceptions, the designation of the *mature minor* or *emancipated minor* can apply. The CAP has recognized that when a minor is deemed to be mature or emancipated, that young person has the legal ability to make his or her own decisions (2010). According to CAP however, adolescents cannot consent to receive therapeutic services prior to 15 years of age. Furthermore, even though youth prior to the age of 15 cannot consent to

receive treatment, CAP has determined that youth who are at least 12 years old, are developmentally mature enough to have a say in treatment. These guidelines offer a psychologist some discretion when discussing informed consent with his or her adolescent clients.

The second challenge that arises for practitioners in obtaining informed consent, relates to the designation of the mature/emancipated minor. The process in obtaining this designation is vague, convoluted and complicated. Generally, aside from the age restrictions, for a youth to be legally deemed a mature minor, he or she must appreciate the "nature and purpose of the treatment, as well as the consequences of giving or refusing consent" (Bemister & Dobson, 2011). This suggestion is however, informal and vague. The CAP defers to a Supreme Court of Canada ruling in *A.C. v. Manitoba 2009*. In its decision, the Supreme Court set out a number of guidelines that would aid the Court system, as well as, medical and mental health professionals, in determining who could qualify as a mature minor. The Court suggested that in assessing an adolescent's maturity, the following factors ought to be considered:

- the nature, purpose, and utility of the treatment, as well as its risks and benefits;
- the adolescent's intellectual capacity and ability to understand the relevant information, and an appreciation for the potential consequences;
- the stability of the adolescent's views, and whether this is an accurate reflection of that adolescent's values and beliefs;
- the impact of the independent decision on the adolescent's lifestyle, family and relationships;

- any emotional or psychiatric vulnerability that may affect the adolescent's decision-making ability; and
- any relevant information from adults who know the adolescent.

Aside from these guidelines by the Supreme Court, CAP does not provide any additional direction in this regard. Furthermore, the Court has asserted that this list is not intended to offer a formulaic approach, but only to suggest some assistance.

Ultimately, unless a youth is clearly identified to be a mature/emancipated minor, that youth's legal guardian/s retain the final decision making authority (CAP, 2010). However, in a review of the literature, there are four circumstances that were found in which youth are informally exempt from seeking the consent of their guardians prior to accessing counselling. These exceptions exist due to the concern that in requiring an adolescent to obtain guardian approval to access counselling for these presenting concerns, he or she may thus decline to access therapeutic services (Koocher, 2003, 2008; Rosenbaum, Abramson & MacTaggart, 2009; Wolbransky et al., 2013). These circumstances include instances where youth seek treatment for substance abuse, pregnancy, STD counselling and sexual abuse (Boldt, 2012; Koocher, 2003, 2008; Rosenbaum et al., 2009; Wolbransky et al., 2013). This particular challenge will be discussed further below.

Another complication that arises in obtaining informed consent are instances in which guardians are unavailable. In these cases, determining who can consent to services on behalf of a young person can become problematic (CAP, 2001; Dewey & Gottlieb, 2011; Dwyer, 2012). Determining who retains the decision-making authority over a young person can change according to location and circumstance (Wolbransky et al.,

2013). In Canada, as in the United States, children who are wards of the government, meaning that the State is their parent, must adhere to the child legislation laws of that province.

Counsellors who work with homeless and high-risk youth must consider the challenges that accompany obtaining informed consent with that population. Youth may not always have a guardian who is readily identifiable or available (Dewey & Gottlieb, 2011); some youth may have been abandoned by their parents, resulting in the youth living on the streets, in shelters, or residing with extended family members who may not retain legal guardianship or decision-making authority over the young person. In these instances, a counsellor may have to locate and pursue contact with a variety of people before they can proceed with treating that adolescent. Furthermore, in some situations birth parents may retain legal authority over their child, but may be disenfranchised themselves (Dewey & Gottlieb, 2011). Some of these families may be struggling with multiple barriers such as mental illness, lack of education, or highly emotionally charged situations, such as divorce or custody battles (Dwyer, 2012). As such, Dwyer has stated that it is the responsibility of practitioners to:

> ...provide information that is understandable and to give consideration to clients with lower intellectual functioning, less education, severe mental illness, different cultural backgrounds, or to those who otherwise might have difficulty in understanding and appreciating that to which they are providing consent. (2012, p. 111)

The matter becomes complicated when working with adolescents who are cared for by the government or involved in custody disputes (Dewey & Gottlieb, 2011;

Wolbransky et al., 2013). In custody disputes, or in cases where a child/adolescent's parents are divorced, acquiring informed consent may be emotionally, practically, or legally challenging for the counsellor (Nuttgens & Chang, in press). Given all of these intricacies, it is imperative that practitioners remain appraised of the legislations and practices regarding legal guardianship of children, in the counsellor's jurisdiction.

The final problem that arises within the process of acquiring informed consent is that this requirement may deter some adolescents from seeking out psychotherapeutic services and fully disclosing pertinent information in counselling (Boldt, 2012; Koocher, 2003; Rosenbaum et al., 2009; Tillet, 2005). Studies have shown that obtaining parental consent may actually influence how adolescents report high-risk behaviour (Rojas et al., 2008; Tigges, 2003).

A secondary-analysis study by Rojas, Sherrit, Harris and Knight (2008) explored the substance use reports of 670 adolescents, between the ages of 14 and 18, in Boston, Massachusetts. The researchers found that because the youth had to obtain parental consent to participate in the study, the youth were more likely to decline participation, or minimize their engagement in high-risk behaviours. As this was a secondary-analysis study, and not an experimental study, causality cannot be determined. Nevertheless, the authors reached two conclusions. First, they found that there was a strong indication that being required to obtain parental consent led to the minimization of reported substance use. Second, the authors discovered that the youth tended to exhibit a significant self-selection bias when exploring and disclosing high-risk behaviours (Rojas et al., 2008). In other words, youth either declined to participate in the study, or minimized their reporting of substance use.

In her review of the literature pertaining to how parental consent influences the reporting practices of high-risk behaviours by adolescents, Tigges (2003) arrived at similar conclusions. She found that having to obtain parental consent influenced the way that adolescents reported risk-taking behaviour. Again, this requirement led to a self-selection bias or the minimization of high-risk behaviours. Taken together, these results highlight a barrier in accessing mental health services in adolescent populations. These findings indicate that there may be a portion of adolescents that may not be getting the mental health services that they require, which is concerning.

**Summary.** Obtaining informed consent is a standard of practice, and a preliminary requirement prior to the onset of any counselling relationship (CAP, 2010, 2013; CPA, 2000; CPBC, 2014). When working with adolescent clients within a counselling capacity, acquiring informed consent can challenge even the most seasoned counsellor (Berg et al., 2009; Dewey & Gottlieb, 2011; Koocher, 2008). Counsellors must determine whether an adolescent has the legal right to consent to treatment services; and if not, the counsellor must acquire consent from that adolescent's guardians (CAP, 2010; Koocher, 2008). Acquiring consent from guardians can be challenging and complicated in instances where guardians are separated or divorced (Nuttgens & Chang, in press), where guardians are not available (Dewey & Gottlieb, 2011), or where obtaining guardian consent could negatively influence the adolescent's participation in treatment (Boldt, 2012; Koocher, 2003; Rojas et al., 2008; Rosenbaum et al., 2009; Tigges, 2003).

**Confidentiality**

The importance of confidentiality when working with adolescents has been well documented in both health care (Klostermann, Slap, Nebring, Tivorsak & Britto, 2005) and counselling (Jenkins, 2010; Koocher, 2003, 2008; Rubenstein, 2003; Schley, Yuen, Fletcher & Radovini, 2012). Within the health care system, adolescents rate trust and confidentiality as two of the most important characteristics they consider when evaluating a medical professional (Klostermann et al., 2005). Similarly, in psychotherapy, confidentiality is a major consideration for young people when deciding whether to enter counselling (Eyrich-Garg, 2008; Jenkins, 2010; Kearney, 1986).

The perceived quality of confidentiality that a professional may provide can be a determining factor for adolescents who are considering accessing counselling. In a study by Boulton et al. (2007), the perceptions of 99 secondary school students of peer counselling support services within the United Kingdom (UK), were examined. It was found that of those students who reported not using the services of school peer counsellors, more than a third attributed this decision to concerns regarding confidentiality. Students who had accessed counsellors, or would consider doing so, reported valuing counsellors who appeared trustful and whom the students believed would honor their confidences. The results of this study demonstrated that maintaining confidentiality is an important factor for students when considering whether or not to access counselling.

Fox and Butler (2007) found that confidentiality was both a benefit and a hindrance in the decision-making process of 415 British students (surveyed in focus groups) who were considering counselling. These students reported being aware that a

counselling relationship is meant to be confidential; however they expressed doubt that counsellors would maintain confidentiality. While the study did not find that students turned away from counselling due to confidentiality concerns; the students did explicitly state that counsellors should discuss the matter of confidentiality, and the limits thereto, early in the counselling relationship (Fox & Butler, 2007). Students wanted to know exactly what would, and would not, be kept confidential. For youth entering counselling, matters of confidentiality played a role in the decision-making process to enter counselling.

A study in the United States had more concerning results. This study explored the concerns of 2,438 adolescents who reported having forgone health care services in the past year (Lehrer, Pantell, Tebb & Shafer, 2007). Nearly 25% of the participants reported forgoing accessing health care due to concerns of confidentiality. The study also identified the youth who reported forgoing health services, to be members of a particularly high-risk population. The prevalence of mental health difficulties, sexual/reproductive health and substance abuse were highest among those youth that chose to not access services. Taken together, these studies provide evidence that the issue of assuring confidentiality, and belief in that assurance, are determining factors for youth seeking counselling (Boulton et al., 2007; Fox & Butler, 2007; Jenkins, 2010; Lehrer et al., 2007).

Maintaining confidentiality and sharing information becomes a balancing act between wanting to ensure an adolescent's privacy and confidence, while sharing information appropriately with those who concern themselves with that young person's welfare (Duncan et al., 2012; Lazovsky, 2008; Taylor & Adelman, 1998). Taffel (2005,

p. 150) stated that counsellors may find themselves torn between how to "guarantee privacy as you keep watch over an often dangerous teen world, yet how to gain trust if kids believe you are monitoring their behaviour?"

The CAP (2010) directs psychologists working with minors to tell adolescent clients that parents may be granted access to information shared during counselling. Knapp and VandeCreek (2006) have advised psychologists to create an agreement with adolescent clients, and the parents of those clients, where parental access to information other than that of imminent self-harm or harm to others, is limited. This may provide some adolescents with a greater sense of privacy, thus encouraging disclosure (Knapp & VandeCreek, 2006). Others have supported this recommendation and advised practitioners to discuss the limits of confidentiality with clients, and client's guardians, at the onset of therapy (Nagy, 2011; Koocher 2003, 2008).

**High-risk youth and ethical tensions.** When working with high-risk adolescent populations within a counselling capacity, a number of ethical tensions can arise for psychologists. Kearney (1998) provided an example of a complex ethical tension that practitioners working with high-risk and gang-entrenched youth, have experienced. He explained that youth involved in gangs have likely witnessed violence, and are at risk of being violent or of being the recipients of violence. When working with this population, practitioners may find themselves in a position where they learn of impending "hits" or targets on other individuals (Kearney, 1998). In these situations, maintaining confidentiality and forgoing ones duty to warn potential third parties of impending harm, can be ethically concerning and can result in potential harm to others (Kearney, 1998). Breaching confidentiality may be necessary to ensure the safety of the client and of other

people (Kearney, 1998). According to Taffel (2005) however, in following the ethical obligations, practitioners risk damaging the working alliance that they have developed with their client. In addition, Kearney adds that when working with high-risk youth, the working alliance is often very difficult to establish in the first place (1998).

Sullivan, Ramirez, Rae, Razo and George (2002) studied factors pediatric psychologists take into consideration when deciding whether to breach confidentiality. These factors include, but are not limited to, the apparent seriousness of the risk-taking behaviour, the negative effects of reporting, the duty to uphold the law, not wanting to disturb the process of therapy, and the likelihood of termination of therapy. In total, 74 participants responded to the survey, all of whom were psychologists that were registered with the American Psychological Association and the Society of Pediatric Psychology.

Sullivan and colleagues (2002) found that when deciding whether to breach confidentiality, practitioners considered two important factors: the nature of the behaviour and maintaining the therapeutic alliance. The authors found that when assessing the nature of the behaviour, psychologists took the frequency, intensity, and duration of the behaviour into account. Practitioners considered how often the youth engaged in the risky behaviour (frequency), to which extent they engaged in the behaviour (intensity) and how long they had engaged in the behaviour (duration). In addition, participants also considered the potential effect of the behaviour on the adolescent and on others. Behaviours considered by the psychologists as being dangerous included: smoking, alcohol and drug use, sexual behaviour and suicidal behaviour. Sullivan et al. (2002) further found that as behaviours increased in frequency and in duration, participants were more willing to breach confidentiality.

Sullivan et al. (2002) also found some inconsistencies in practitioner's decisions to breach confidentiality. In response to learning that adolescent clients were engaging in frequent risky behaviour, some psychologists breached confidentiality, while others did not. For instance, not all psychologists reported the client's use of tobacco, alcohol, or marijuana. Furthermore, not all psychologists reported the frequent sexual behaviour disclosed by participants. Practitioners wanted to make all possible efforts to maintain the working alliance. Practitioners were fearful that breaching confidentiality might result in the client's decision to terminate counselling prematurely. Moreover, practitioners were concerned that this rupture in the alliance could deter the client from seeking, or engaging in, future therapy.

The Sullivan et al. (2002) study contained a number of limitations, most notably of which is the small sample size. In addition, participants were presented with a limited number of options to pursue when faced with this ethical dilemma. Despite these limitations, the study drew attention to the lack of consensus among practitioners as to when to breach confidentiality (Sullivan et al., 2002). The researchers determined that a psychologist's decision to breach confidentiality is "multifactored and complex" (p. 400). Furthermore, that decision is influenced by the values of each participant and by the factors that they were presented with in the study. The results of the study suggest that practitioners may feel there are insufficient guidelines to direct the decision-making process. The authors of this study encourage psychologists to build an informed knowledge base on what adolescent risk-taking behaviour constitutes. Furthermore, the authors stress the importance of proper training in, and guidelines on ethical decision-

making. This may help psychologists make sound ethical decisions as opposed to decisions that simply “feel right” (p. 399).

A study done by Rae, Sullivan, Razo and Garcia de Alba (2009) found similar results to the Sullivan et al. (2002) study. These authors argued that given that adolescence is a period marked by experimentation with substances, risky sexual activity, self-destructive behaviours, and antisocial tendencies, practitioners are often tasked with having to decide whether they must breach confidentiality when youth disclose engagement in high-risk behaviours. According to Rae and colleagues, this decision becomes much more frequent when working with high-risk adolescents (2009).

In their study, Rae et al. (2009) presented 76 psychologists with several vignettes that contained one or more common areas of adolescent risk-taking behaviours (i.e., cigarette use, alcohol use, illicit drug use, sexual behaviour, suicidal behaviour and antisocial behaviour). Participants were then given information that increased or decreased the intensity, frequency and duration of the risk-taking behaviour. Participants were then asked to report whether they believed it ethically appropriate to breach confidentiality and to which degree they deemed it appropriate to do so.

Rae and colleagues (2009) also found that as the frequency and duration of the risky behaviours increased, practitioners became more comfortable with breaching confidentiality. Participants reported that as the client reported using drugs more frequently, the participant found it more ethical to breach confidentiality and disclose this information. This held true for drug and alcohol use, suicidal behaviours and sexual behaviour, however, it was not so for antisocial behaviour. Rae et al. (2009) hypothesize

that this could be due to the direct danger that suicidal behaviours, as well as drug and alcohol use, present.

Rae et al. (2009) found that for some high-risk behaviours, practitioners were willing to breach confidentiality even at a low level of frequency and duration. For instance, in relation to suicide, most school psychologists were willing to breach confidentiality immediately, even if the behaviour had occurred as an isolated incident some time ago. Again, this is likely due to the practitioner's evaluation of the high level of harm that the client places him or herself in when engaging in this behaviour (Rae et al., 2009).

There are a number of limitations in the Rae et al.'s (2009) study. First, the participant response rate was 43%, of which only 39% were usable. This can raise questions as to whether those that responded had particular interest in the topic. Second, the amount of information or data lost for those who did not respond should be considered. Third, practitioners were presented with a dilemma that did not provide much detail. Finally, the results were based on the participant's beliefs about what they would do, not their actual behaviour, which can leave the possibility that behaviour and intent can differ.

The third study of note was conducted by Duncan, Williams and Knowles (2012). These researchers interviewed 264 Australian psychologists, all of whom had experience working with adolescent clients. Participants were given two surveys. The first survey examined, through vignettes, the situations in which participants would breach confidentiality with adolescent clients. The second survey focused on the factors psychologists considered when deciding whether to breach confidentiality.

Through factor analysis, researchers produced four factors that represented the underlying constructs that the participants take into account when deciding whether to breach confidentiality. The most important of these factors was the negative nature of the behaviour and the need to maintain the therapeutic relationship. The researchers found that the most important consideration in deciding whether to breach confidentiality was the intensity of the risk-taking behaviour. The results of the study showed that the more severe the risk-taking behaviour was, the more willing practitioners were to breach confidentiality. On the other hand, practitioners were worried that in breaching confidentiality, consequences such as the premature termination of therapy, would occur.

A limitation of the Duncan et al. (2012) study is its location. This study examined the perspectives of Australian psychologists when dealing with adolescent clients and confidentiality. Furthermore, most participants were from a specific region in Australia, thereby diminishing its generalizability. Regardless, given the results of this, as well as the two aforementioned studies, it is clear that there is discrepancy in how practitioners decide to breach confidentiality. Further attention to these issues is necessary. In summary, all three studies found that an indicator of a psychologist's willingness to breach confidentiality lies within the frequency, intensity and duration of the risk-taking behaviour.

Research by Duncan and colleagues mirrored the Sullivan et al. (2002) study that was conducted in North America. Interestingly, the results were similar across the two continents. Duncan et al.'s (2012) study also indicated that the intensity of a risk-taking behaviour influenced psychologists' reporting practices. This study also demonstrated that psychologists in both of these countries grapple with similar confusions when

dealing with this sensitive issue. This confusion reiterates the importance of further training in this regard. Duncan and colleagues (2012) suggested that research should focus on training psychologists on how to enact breaches of confidentiality, while trying to sustain the therapeutic alliance.

## Literature Review Summary

The provision of counselling services to adolescent clients is complex and requires a multi-faceted approach. Furthermore, working with high-risk youth can be more challenging, as this population presents with unique concerns. These youth are typically involved in behaviours such as drug or alcohol use, sexual exploitation, criminal involvement, running away, homelessness, and gang involvement (Smyth & Eaton-Erickson, 2009). Working with this population requires a psychologist to be flexible, open, non-judgemental, anti-oppressive and harm-reducing (Smyth & Eaton-Erickson, 2009). Harm reduction is an approach that recognizes that for some high-risk individuals, complete abstinence from the risk-causing behaviour can be difficult to achieve (Collins, Clifasefi, Logan et al., 2012). While abstinence is the ultimate goal, harm reduction aims to reduce the harm associated with high-risk behaviours (Collins, Clifasefi, Logan et al., 2012; Kleinig, 2008; Marlatt, 1996). Though few harm reduction programs targeting adolescent populations are in existence, it has been argued that given that abstinence-based programs continue to yield little success, a harm reduction approach must be considered (Kelly, 2012)

The exploration of ethical tensions experienced by psychologists who work with adolescent populations, has yielded some concerning results. Matters of competence (Dailor & Jacob, 2011; Kolay Akfert, 2012; Koocher, 2008), informed consent (Koocher,

2008) and confidentiality (Bodenhorn, 2006; Duncan et al., 2012; Rae et al., 2009; Sullivan et al., 2002) are most salient for these practitioners. Concerns regarding confidentiality are particularly noted since whether it can be ensured, is a significant factor for adolescents who are considering accessing counselling services (Eyrich-Garg, 2008; Jenkins, 2010; Lehrer et al., 2007). When faced with having to breach confidentiality, counsellors consider the duration, frequency and intensity of the risky behaviour that was disclosed (Duncan et al., 2012; Rae et al., 2009, Sullivan et al., 2007). However, studies have shown that counsellors are inconsistent in their reporting practices, possibly to the concern that by breaching confidentiality, the working alliance between the adolescent and counsellor may be ruptured (Duncan et al., 2012; Kearney, 1998; Rae et al., 2009; Sullivan et al., 2007; Taffel 2005).

It is noteworthy to mention that there were no research studies found that examined the experiences of psychologists when faced with ethical tensions, as a result of their work with high-risk youth and use of a harm reduction approach. It cannot be determined if this gap in the literature exists as a result of this phenomenon not occurring, or simply because these studies have not been conducted.

# Chapter 3: Methodology

The study addresses the question: "What are the lived experiences of psychologists when they are faced with ethical tensions as a result of their work with high-risk youth and the incorporation of a harm reduction approach?" To answer this question, a small number of psychologists who work with this clientele and who use harm reduction, were interviewed. Interpretative phenomenological analysis (IPA) was used to guide the research and analyze the data.

## Interpretative Phenomenological Analysis

Interpretative phenomenological analysis (IPA) was developed in the 1990's by Jonathan Smith, who identified a need for a qualitative approach in psychology that emphasized the ability to capture the experiential and qualitative nature of psychology (Smith, Flowers & Larkin, 2009). The aim of IPA is to detail how people make sense of their personal and social worlds (Smith & Osborn, 2008). Interpretative phenomenological analysis attempts to examine how people understand, perceive, and react to their experiences. At its inception, most of IPA was grounded in health psychology, but it has since expanded to the clinical and counselling fields of psychology (Smith et al., 2009).

The endeavour of an IPA study is to make sense of another person's sense-making activities, with regard to a given phenomenon, and within a specific context (Palmer, Larkin, De Visser, & Fadden, 2010). This approach aims to explore, in detail, the lived experiences of participants in a study, as well as how those participants make sense of those experiences (Smith, 2004; Smith & Osborn, 2008). These features, according to Smith et al. (2009), highlight the phenomenological and interpretative

aspects of IPA. These aspects, along with the hermeneutic approach, combine to create the philosophical base of IPA (Biggerstaff & Thomson, 2008; Smith et al., 2009).

**Phenomenology**

Phenomenology is a philosophical approach that is concerned with the study of experience (Smith et al., 2009; Smith & Osborn, 2008). The focus of phenomenology is on the experience of being human (Smith et al., 2009). Insofar as psychology is concerned, this approach provides psychologists with ideas about how to examine and understand the lived experiences of other people (Smith et al., 2009). Major contributors to phenomenology include philosophers Edmund Husserl, Martin Heidegger, Maurice Merleau-Ponty, and Jean-Paul Satre.

Husserl, the founder of phenomenology (Larkin, Watts, & Clifton, 2006; Smith & Osborn, 2008), argued that experience should be examined in the way that it occurs (Smith et al., 2009). Husserl was interested in how a person comes to understand and know his or her experiences in the face of a specific phenomenon (Smith et al., 2009). Through this understanding, Husserl believed that people could identify the essential qualities of those experiences. This was important because people could then transcend the particular circumstances of their experiences, and share those experiences with others (Smith et al., 2009). Husserl argued that adopting a phenomenological attitude requires people to step outside of everyday experiences, turn the gaze away from the objects of those experiences, and turn it towards the perceptions of those experiences (Smith et al., 2009).

Heidegger, on the other hand, advocated for a more hermeneutic and existential emphasis on phenomenological inquiry (Smith et al., 2009). According to Heidegger, the

existence of a person is temporal and in relation to something (Smith et al., 2009). Meaning-making activities are central to Heidegger's approach to phenomenology (Smith et al., 2009). Heidegger stressed that phenomenology needs to adopt a more reflexive and interactive approach, while focusing on what is meaningful and possible in existence (Smith et al., 2009). Heidegger, Merleau-Ponty, and Satre believed in the need for a greater focus on the interpretive and worldly positions of people (Smith et al., 2009). These individuals believed that people are embodied and embedded in a particular historical, social, and cultural context (Larkin et al., 2013), and that each experience is unique to each individual (Smith et al., 2009).

**Hermeneutics**

Hermeneutics refers to the theory of textual interpretation (Smith et al., 2009). Hermeneutic theorists are concerned with the methods used to interpret data, whether it is possible to understand the intentions or meanings of an author, and the relationship between the context a text was produced in, and the context in which it is interpreted (Smith et al., 2009). Notable hermeneutic philosophers included Friedrich Schleiermacher and Martin Heidegger (Smith et al., 2009), the latter of whom also contributed heavily to phenomenology.

Schleiermacher, a central theorist in this field, adopted a very holistic view of hermeneutics (Smith et al., 2009). According to Schleiermacher, a text, or story, is not only shaped by the writer's conventions and the expectations of the linguistic community in which that person exists, but also by that writer's position within that language (Smith et al., 2009). A writer has specific and unique techniques, which create a particular form of meaning upon the text that he or she has produced. In addition, how a reader

understands a text, depends on his or her experiences and the wider context in which that text was produced and read (Smith et al., 2009). In this regard, the author does not have control over how the text is interpreted.

**Idiography**

The nomothetic approach assumes that the behaviour of a person is the result of laws that apply to all people (Smith & Osborn, 2008). In contrast, the idiographic approach focuses on the interplay of factors that are specific to a particular individual (Smith & Osborn, 2008). Idiography simply means concern with the particular (Smith et al., 2009). To contrast these two approaches further, consider that in the nomothetic approach, the analysis occurs at the level of groups and populations. The idiographic approach on the other hand, allows for the possibility of specific statements about specific individuals; and such a study would examine individual cases in depth (Smith & Osborn, 2008).

Interpretative phenomenological analysis commits to the particular on two levels (Smith et al., 2009). First, great attention is awarded to the detail and depth of data analysis. Second, there is an emphasis on understanding a particular phenomenon, from the perspectives of a particular person, within a specific context. Interpretative phenomenological analysis steers away from making gross generalizations about a population; instead, this approach involves a systematic and detailed analysis of a few individuals (Larkin et al., 2013; Smith et al., 2009; Smith & Osborn, 2008). Since an idiographic approach is concerned with the particular and details, it complements an IPA study, which aims to examine the specific experiences of people within specific situations.

## Rationale for Using IPA

Interpretative phenomenological analysis is best suited for researchers who want to learn about people's perceptions of, their involvement in, and orientation towards the world (Smith et al., 2009). This approach is particularly useful for trying to understand how individuals perceive particular experiences (Smith & Osborn, 2008). In IPA, researchers must give attention to two interrelated aspects of a person's account (Smith et al., 2009). Researchers must identify, describe and understand the phenomenon within a person's world, and then proceed to explore the experiential understandings that that person has toward that particular phenomenon (Smith et al., 2009). The researcher aims to create a coherent and clear third-party description, which is psychological in nature and tries to get as close to the participant's view as possible (Larkin et al., 2006).

In light of the research question, IPA was considered to be an appropriate methodology to assist in this endeavour. Interpretative phenomenological analysis is especially useful when researchers strive to understand the complexity, process or novelty of a phenomenon (Smith & Osborn, 2008). This research aims to understand these three qualities. Specifically, the exploratory aims of this research are to understand: 1) the types of ethical tensions practitioners experienced when using harm reduction in their work with high-risk youth; 2) how practitioners personally and professionally experienced these tensions; and 3) how participants personally and professionally managed these ethical tensions.

## Sampling

For the purpose of this research, and in agreement with IPA sampling strategies (Smith et al., 2009; Smith & Osborn, 2008), purposeful sampling was used. Through

purposeful sampling, researchers recruit a closely defined group of participants for whom the research question will be significant (Smith & Osborn, 2008). In IPA research, participants are selected according to their ability to provide insight into a particular experience (Smith et al., 2009).

When using IPA, researchers aim to find a relatively homogenous sample (Smith et al., 2009; Smith & Osborn, 2008). The extent of homogeneity in a sample depends on several factors, such as whether the research topic is rare, whether participants are difficult to recruit, or whether the topic is broad and therefore allows for a broader sample (Smith & Osborn, 2008). In order to build a homogenous sample in IPA research, sampling is done via referral or snowball sampling (Smith et al., 2009). For this study, psychologists from an agency known to work with high-risk youth and use harm reduction techniques, were invited to participate.

Interpretative phenomenological analysis seeks to understand the perspectives relating to a phenomenon, not a population, therefore the sample sizes in this methodology are small (Reid, Flowers & Larkin, 2005; Smith et al, 2009; Smith & Osborn, 2008). As IPA research is committed to providing a detailed interpretative account of the data, a small sample size of three to six participants is ideal for the novice researcher (Smith et al., 2009; Smith & Osborn, 2008).

In accordance with the recommendation by Smith et al. (2009), a small sample of individuals was used for this study. These authors suggest that for the first-time IPA researcher, three participants are satisfactory to provide sufficient data, while not overwhelming the researcher.

Participants for this study were recruited from an agency that works with high-risk youth. Participants included a psychologist-in-training and two registered psychologists, all of whom work with high-risk youth within a counselling capacity. All participants described adhering to the Code of Ethics for Psychologists, as set out by the Canadian Psychological Association (2000), as well as the standards of practice, as set out by the participant's respective location. All participants identified as having experienced an ethical tension as a result of their work with high-risk youth. Though participants used their preferred therapeutic model, all incorporated the harm reduction model as conceptualized by Collins, Clifasefi, Logan et al. (2012).

**Data Collection**

In IPA research participants are invited to provide detailed accounts of their experiences through in-depth interviews and diaries (Smith et al., 2009). These data sources provide an intimate, first-person account of the feelings and thoughts that these individuals have, which are elicited by the phenomenon being studied. Interviews are semi-structured and intended to function more like dialogues than interviews (Smith et al., 2009; Smith & Osborn, 2008).

For the purpose of the proposed study, a flexible interview schedule consisting of 11 questions was created (see Appendix A). As per Smith and Osborn (2008), these questions aimed to guide the participant to talk about the specific topic. Participants took the conversation in a direction of their choosing. When these questions were too vague or did not provide enough direction, prompts were used in order to provide more guidance (Smith & Osborn, 2008). On a final note, interviews occurred face-to-face and lasted

approximately 60-90 minutes. Interviews were conducted at a place that was accessible and convenient for the participants.

**Data Analysis**

Data analysis for this study followed the six steps suggested by Smith and colleagues (2009). Smith et al. (2009) have emphasized that IPA is not a prescriptive methodology. The following steps are suggested as guidelines, and these authors remind researchers that qualitative analysis is a personal process and that data analysis is interpretative work. In summary, Smith et al. (2009) have suggested the following process for data analysis:

1. Reading and rereading transcripts.
2. Initial noting.
3. The development of emerging themes.
4. Searching for connections across emerging themes.
5. Moving on to the next case.
6. Identifying patterns across cases.

The first step of IPA analysis requires researchers to immerse themselves in the data (Smith et al., 2009). This author read, and re-read the transcripts multiple times (Smith et al., 2009). This process is important since each re-examination of the data may reveal new insights (Smith & Osborn, 2008). At this time, researchers are encouraged to slow down and resist summarizing the data. The initial reading of the data can be overwhelming as ideas and possible connections emerge; it has been suggested, and was followed up on by this researcher, that researchers note some of these initial observations in a notebook, in order to allow the researcher to return to the raw data (Smith et al.,

2009). In doing so, the researcher tries to bracket his or her observations for a short period of time (Smith et al., 2009).

The next step involves what Smith et al. (2009) refer to as “initial noting” (p. 83). This step is both detailed and time consuming. In the noting stage of data analysis, researchers thoroughly examine the semantic content and language use (Smith et al., 2009). The researcher is looking to identify how the participant talks about, thinks about, and understands the phenomenon being investigated. To aid in this process, researchers make notes and underline important observations. Primarily, descriptive, linguistic and conceptual comments were noted (Smith et al., 2009).

The next task in the data analysis process involves developing emergent themes. The researcher attempted to reduce the volume of detail while simultaneously maintaining and mapping the interrelationships, connections, and patterns within the initial noting (Smith et al., 2009). Thematic analysis involved looking for phrases that identified the psychological essence of the discussion that was had. The themes, according to Smith et al. (2009), reflect the participant’s original words and thoughts, as well as the analyst’s interpretation of these.

As themes emerged, the researcher then searched for connections among emerging themes by charting and organizing how these themes fit together (Smith et al., 2009). Researchers should remain open-minded and realize that as they go through this process, they might find that some themes may be disregarded, while new themes may emerge (Smith et al., 2009). Themes can be organized according to categorical importance (abstraction), relevance toward a different theme (subsumption), contextual

elements, similarities and differences (polarization), frequency, and function (Smith et al., 2009).

The next step of the data analysis process involves moving on to the next case and repeating the same orderly process of examination of the data for each participant systematically. In doing so, the researcher repeated steps one through four. Researchers may find it difficult to not be influenced by what they have already discovered in previous data. As such, Smith et al. 2009) argue that the IPA researchers must learn to bracket as much as possible, the ideas and themes from the first case, while they move on to the other participants. By systematically following the steps of data analysis, researchers can allow new themes to emerge within each new case.

The final step of IPA data analysis involved looking for patterns across cases (Smith et al., 2009). Connections and differences were examined across the different cases as the researcher looked for the themes that were most important, emerged most frequently, gathered the most reaction, or generated the most questions. Smith and colleagues (2009) remind researchers that while the similarities across cases are important, attention should also be paid to the differences and the nuances between themes. Researchers are encouraged to explore how themes influence one another, how they are connected, and how one theme in one case can highlight a different case (Smith et al., 2009). The final task involved the write-up and presentation of these themes (Smith et al., 2009).

**Validity in IPA**

When assessing the validity of qualitative research, one looks for whether the research was carried out appropriately, and whether the findings are trustworthy and

reliable (Yardley, 2008). Yardley has suggested a set of criteria for qualitative studies that are indicative of good research. Studies must demonstrate sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance (Yardley, 2008).

**Sensitivity to context.** Sensitivity to context requires researchers to be aware of the contextual aspects of the study, such as foundational theories and the existing literature (Smith & Osborn, 2008; Yardley, 2000). A researcher demonstrates sensitivity to context early on in the study when IPA is identified as being the appropriate methodology to answer the questions of the study (Yardley, 2008). Yardley advises researchers to bear in mind the socio-cultural setting of the study, as well as the social relationship between the researcher and participant (2008). Researchers should acknowledge the interactional nature of the interview, show empathy, and put the participant at ease (Smith et al., 2009). In addition, a good IPA researcher should acknowledge and attempt to minimize the power differences between the researcher and participants (Smith et al., 2009).

**Commitment and rigour.** Commitment refers to engagement with one's topic, the development of competence and skill in the methods used, and the researcher's immersion in the data (Smith et al., 2009; Yardley, 2000). Commitment can be demonstrated by the researcher through the high level of attentiveness given to the participants during the interview process. It is further exemplified in the care employed during the analysis of the material. Rigour refers to the thoroughness of a study (Smith et al., 2009; Yardley, 2000). This means that the sample selected is appropriate for the

study, the quality of the interview is high, and the data analysis is detailed, thorough, and complete (Smith et al., 2009).

The number of participants were sufficient to provide sufficient data for the study. In addition, the interview questions were vetted with the supervisor to ensure that sufficient and appropriate data would be gathered to foster increased validity. The data analysis section of the study was clear, detailed, and documented. Notes were maintained clearly, and data and observations was clearly and securely charted.

**Transparency and coherence.** Transparency and coherence refer to the clarity of the description and argumentation of a study (Yardley, 2000). Transparency refers to how clearly the stages of research (participant selection, interview process and data analysis) are described in the written portion of the study (Smith et al. 2009). A prudent IPA researcher pays close attention to these features and details these processes of the study concisely (Smith et al. 2009). Coherence may also refer to the fit between the research question and the methodology (Smith et al., 2009; Smith & Osborn, 2008).

To meet the standard of transparency and coherence, the steps, procedures, and activities executed in relation to this research were recorded in a research journal. The journal detailed the research process, and documented changes made to the original study plan. The journal was also used to note reactions to the interviews, data, or process that the researcher experienced throughout the study. This was helpful as it allowed the researcher to note and reflect upon her reactions and experiences throughout the progression of the research study.

At this time it is relevant to briefly discuss the tension between the phenomenological and interpretative components of IPA. As discussed earlier,

phenomenology involves the examination of human experience. Husserl argued that we should examine "the thing itself," with the "thing" being the experiential content of consciousness (Smith et al., 2009). This seems to run contrary with Heidegger's notion of fore-conceptions, which are the prior experiences, assumptions and preconceptions that the researcher carries (Smith et al., 2009). However, Heidegger goes on to state that in interpretation, priority should be given to the new object, or the experience, rather than to the preconceptions. While the preconceptions, or fore-conceptions, preceded the new experience being studied, these factors will only be fully understood in terms of the new experience. In other words, once there is a better understanding of the new experience, only then, may the reader/researcher be in a place to better understand his or her preconceptions.

To remedy this apparent tension, this researcher engaged in several actions. During the first step of data analysis, the researcher read the transcripts and listened to the audio-recordings frequently. During later stages of data analysis the researcher returned to the original audio recordings and transcripts several times. This aided the researcher to remain close to the original data and the stories of the participants. The researcher also included many excerpts from the participants throughout the results section, thereby allowing the voices of participants to be central in the analysis and discussion. As stated earlier, the researcher also used a journal to document and reflect upon her reactions to the data, as well as the process of data analysis. This was helpful as this allowed the researcher to track her reactions and maintain transparency throughout the research process.

**Impact and importance.** Smith and Osborn (2008) state that for research to be important, it has to be practically relevant for practitioners, policy makers, or the general community or it must be, at the very least, theoretically important. A study's utility is dependent upon on the objectives of the analysis, the community that the findings are intended for, as well as its applications (Yardley, 2000). While some studies are important because they present a new and challenging perspective towards a topic, others may be practically important, if only for a small audience.

It is thought that the research will provide a new understanding of how psychologists experience ethical tensions as a result of their work with high-risk youth and their use of the harm reduction model. This can hopefully lead to practical applications, as well as direction for future research. For further discussions on relevance, please consult the introduction and conclusion portion of this thesis.

## Ethical Considerations

Ethical research is, according to Smith et al. (2009), a dynamic process that must be monitored throughout the data collection and analysis processes of the study. Smith et al. (2009) identified four critical aspects of an ethical study. Research must insure avoidance of harm, provide informed consent, allow participants to withdraw from the research at any point, and maintain proper management of the data collected (Smith et al., 2009). These aspects are also mandated by the Code of Ethics for Psychologists, as set forth by CPA (2000).

To minimize and eliminate the potential for harm, participants were informed of the topic and types of questions that would be asked in the interview, and were provided with information about their ethical rights as participants (Smith et al., 2009). They were

given the opportunity to ask questions about the research. Participants were given the informed consent document (Appendix B) and required to sign it prior to the study commencing, as it is regular practice to obtain informed consent from participants prior to their participation in the study (CPA, 2000). Participants were again given the opportunity to ask questions.

It was ensured that participants were aware that they may withdraw from the research prior, during, or following the interview up to the data analysis stage (Smith et al., 2009). Furthermore, they were informed that they may also withdraw any comments or data that they had provided. Finally, all data was stored securely, and in a way, that "attends to the needs for privacy and security" of the participants (CPA, 2000, p. 13). Plans with the supervisor were made in the event that the research cannot be completed due to the illness or death of the researcher. Finally, prior to commencing this research, ethical approval from the Athabasca University Research Ethics Board was obtained. All relevant Acts and Codes were adhered to.

# Chapter 4: Results

The analysis of the interviews revealed three major themes: *questioning*, *acting*, and *holding*. Each main theme consists of a number of subthemes, which are described in detail below. All identifying characteristics of the participants has been omitted or replaced from the excerpts. All names, including those of the participants, as well as the participant's clients and place of employment have been changed. Since all participants work for the same agency (name has been omitted) this place of employment is referred to simply as *(the) Agency*.

## Questioning

The first overarching theme to be discussed is *questioning*, which is contrasted with acting and holding. Acting and holding were associated with how participants managed tension, whereas questioning was characterised by the experiences of questioning different practices, beliefs and pressures, related to the presentation of an ethical tension. Though the theme of questioning was evident in all of the interviews, it should be noted that the type and frequency of questioning varied across participants. Subthemes within the questioning theme include *conflict about harm reduction, dissonance, institutional and governmental pressures, being outside the comfort zone, upholding beneficence* and *anxiety*.

### Conflict about harm reduction.

All the participants reported experiencing some degree of *conflict when implementing harm reduction approaches*. Conflict seemed to result from the discord between the personal or professional beliefs of the participants and harm reduction methods. Though all participants accepted and valued harm reduction approaches, some

discomfort existed in the application of this approach. These discomforts led participants to question the philosophy and implementation of harm reduction approaches. Maria, a psychologist-in-training, seemed to experience more discomfort than the other two participants. In the excerpt below, she questions the ultimate therapeutic goal of harm reduction. This uncertainty marks some of Maria's struggle to fully accept this approach. The statement "*back and forth*" also foreshadows her commitment to, and acceptance of, harm reduction. This hesitancy is apparent later in the interview as well.

> *Maria:* *It's interesting, cause I, sometimes I think about harm reduction…I, I, go back and forth between thinking it's eventually about reducing it completely, or is it just about reducing it? Period?*

At another point in the interview, Maria described an ethical tension that involved providing a client with her personal contact information. According to Maria, a harm reduction approach encourages this, as harm reduction stresses that client's must be met *"where they're at."* This overlap of personal and professional boundaries created stress and anxiety for Maria. She found it difficult, however, to articulate a specific ethical principle that had been breached. Nevertheless, she expressed discomfort regarding this dilemma. It seems that the practice of a harm reduction approach led Maria to feel as if she were acting unethically, even though no ethical standards were actually broken.

> *Maria:* *…And I think that that this was just one of those things that naturally, if you've been in a more traditional training environment, you're going to feel a little more uncomfortable with. It doesn't violate any ethical principles to actually do it, but you might feel like it does.*

Maria went on to provide another, more generic, example of an ethical tension. Many of her clients frequently use drugs and alcohol. Knowing that some youth are using drugs, but failing to report this to the proper authorities caused Maria to feel

uncomfortable. Furthermore, she reported that she often found herself questioning her level of culpability. Maria had difficulty articulating herself during this portion of the interview. This may be due to her speaking style, but may also be attributed to the discomfort in discussing this subject.

> *Maria:* *So like one thing that I struggle with working at the Agency is that we have…there's lots of underage kids who are doing umm…ahh…who are frequent drug users, right? And so, I know that, and I know it for certain, but you know, how…how do you, you know, like if I was taking just like a strict, I'm taking a line with my hands. If I was making a strict boundary, umm...I would umm…like I would be, you know, contacting somebody about that, right? And so, it doesn't happen at the Agency and that's part of the harm reduction idea, right?*

The second participant, Karl, also experienced conflict while implementing harm reduction approaches. Karl described discrepancies between his personal and professional beliefs and those of a harm reduction framework. Throughout his interview, Karl discussed how obtaining informed consent is a critical component of therapeutic work, and of a harm reduction approach. However, in the face of the ethical tension that Karl described, he stated that forgoing informed consent may become necessary to meet the best interests of the client, as well as the people around that client. This portion of the interview, displays these discrepancies between Karl's beliefs and his questioning of whether harm reduction approaches are most appropriate in this instance.

> *Karl:* *Well, my personal experience of that tension is that I visualize that a person in his circumstances, in contrast with all of my notions of informed consent and harm reduction, and willing participation in a therapeutic process; I believe that there are certain people that umm…are damaged. And I mean that in a literal sense. Damaged, umm…functionally damaged. And that may go right to the, you know… hippocampus or amygdala or whatever. That they require a forced process of change. They need to be apprehended and put in a place where they're safe, and other people are safe. And then a therapeutic process needs to be undertaken in that container that*

> *does not involve consent. So that's kind of a striking philosophical tension against informed consenting participation in a process of change.*

Though not as significantly as the first two participants, Karen also expressed conflict regarding the use of a harm reduction approach. In the excerpt below, she discusses the high-risk lifestyle of the clients that she works with. Some of the choices that her clients make, cause Karen to have to *"hold her breath"* when she knows that those clients remain in dangerous positions. Ultimately however, due to her own personal and professional ideological beliefs, Karen has to accept the choices that her clients make. Karen noted that the harm reduction approaches may not always be congruent with how traditional approaches encourage beneficence.

For Karen, part of the conflict she experienced when using harm reduction resulted from an awareness that these approaches do not always align with the traditional standards of ethical practice. As such, she described waiting for a challenge from an outside source, most likely a colleague, supervisor, or the regulatory body that governs her profession. This conflict had less to do with opposing beliefs about harm reduction, and more to do with her opinion of how other systems might react to harm reduction methods. There seemed to be a sense of trepidation in applying harm reduction methods, given that Karen knows that these approaches seem to run contrary to more traditional and endorsed methods. Regardless, Karen moved past this conflict, as in her opinion, she was ensuring the best interests of her client. Karen seemed to place this in higher importance than following traditional standards of ethical practice.

> *Karen:* *We constantly keep that ethical framework of the principles. Umm...and we do group supervision, individual supervision with that framework in mind. And so we're very mindful. But sometimes we're waiting for some sort of challenge from somebody, cause it's easy to say "well you did this and you didn't have parental*

> *consent." Yes, that might be happening at times. But I don't think it's from a professional unethical stance, because we can't find them anyways. Right? So, do we not talk to the girl who's trying to decide to have an abortion or not?*

**Dissonance.**

*Dissonance* is described as a "lack of agreement; *especially***:** the inconsistency between the beliefs one holds or between one's actions and one's beliefs" (Merriam-Webster's online dictionary, 2015). Throughout the analysis of the interviews, it was discovered that all the participants experienced some degree of disagreement between their beliefs and actions. Each participant described experiences where they held two conflicting beliefs. Most often, these discrepancies existed between harm reduction approaches and the participants' personal beliefs and values. It was as if participants were being pulled in two directions. This dissonance was tied to a period of questioning for participants, in which participants questioned their own beliefs and behaviours. It is unclear which experience occurred first. For instance, it is possible that the dissonance elicited a period of questioning, or that the questioning led to the experience of dissonance.

Of the three participants, Maria displayed the greatest dissonance. The first excerpt relates to the ethical tension that Maria disclosed, in which she was faced with providing her personal contact information to a client. In this excerpt, Maria seemed to struggle with a discrepancy between what she was taught in university, and actual practice. As a student, she was taught that disclosing personal contact information to clients was something to be avoided. However, she found that those standards were not always easily applied to practice.

> *Maria:* *I don't have like an office, or something where clients can contact me. Umm…it's just kinda of the guidelines that we, go with.*

*Umm…at here, in my program, is that we don't hand out umm…personal contact information. Because when I'm working with, when I'm working through here, as opposed through the Agency, there's a clinic where I can be contacted at.*

*Researcher:* *I'm just trying to get to kind of the root of where the tensions, exactly what…so…*

*Maria:* *I think it's because I've been taught through my training here that that is something that is best not done. And it's something that I opted to do.*

The excerpt below further demonstrates the experiences of Maria as she navigated between two of her belief systems. On the one hand, she holds values that align with the agency for which she works. She believes in a harm reduction framework and she considers it to be most beneficial when working with high-risk youth. On the other hand, she is aware of the inherent dangers of serious and prolonged drug use. She has both professional and personal second-hand experiences regarding drug use that tend to highlight the consequences of the behaviour. These contrasting beliefs led to feelings of being constrained and helplessness. It may be that dissonance leads to feelings of conflict about harm reduction approaches, or vice versa.

*Maria:* *Umm…but the tension is between like, caring for you on this one hand is kinda saying like "this is not healthy. This is going to have huge consequences down the road. And the other side is well this is your choice, and you know, you're deciding to do it and we just need to kind of not, not judge what you're choices are because we don't know what's bringing you to make those choices.*

Like Maria, Karl described a situation highlighting the interaction between two opposing beliefs that he held. His client is a young man who participated in multiple high-risk behaviours that placed himself and those around him at risk. The client was referred for counselling but declined to participate. Throughout the interview, Karl

described at length how “willingness to participate” and “informed consent” are crucial to both counselling and harm reduction approaches.

In light of the ethical dilemma that Karl described, he found himself torn between two belief systems: the aforementioned belief that change occurs only if the person is willing and consenting, and the belief that some people need to be forced to change. Karl’s experience of dissonance was fuelled by his concern for the young person involved and those around him.

> *Researcher:* *What was your experience? Your professional experience and your personal experience of that tension.*
>
> *Karl:* *Well, my personal experience of that tension is that I visualize that a person in his circumstances, in contrast with all of my notions of informed consent and harm reduction, and willing participation in a therapeutic process; I believe that there are certain people that umm…are damaged. And I mean that in a literal sense. Damaged, umm…functionally damaged. And that may go right to the, you know… hippocampus or amygdala or whatever. That they require a forced process of change. They need to be apprehended and put in a place where they’re safe, and other people are safe. And then a therapeutic process needs to be undertaken in that container that does not involve consent. So that’s kind of a striking philosophical tension against informed consenting participation in a process of change.*

It is also important to note that earlier in the interview, Karl discussed his commitment to, and the advantages of using a harm reduction model. Perhaps this furthered his experience of dissonance because it affirmed his personal and professional commitment to a harm reduction approach. The excerpt below provides a glimpse into Karl’s commitment to harm reduction approaches.

> *Karl:* *But I’m imagining that there’s probably a substantial amount of research to indicate that in, in bringing about change that involves a reduction of risk, the harm reduction approach is more successful than the…than the process of umm…imposing circumstances that bring about immediate safety.*

…

*Karl:* *I guess my approach, my commitment to harm reduction is experiential for one thing. Umm…that, that has arisen out of dealing with many ethical dilemmas dealing with harm reduction, which we can refer to later. It's also informed by reading literature on say the effectiveness of methadone clinics as compared with criminalizing behaviour. Criminalizing the behaviour would be kind of the extreme of safety and the imposition of circumstances of abstention. And that doesn't seem to work very well.*

The experience of dissonance was also evident in Karen's interview, though not to the same degree that it did for the other two participants. Karen acknowledged the dissonance, but moved on from it quite swiftly. It seemed to pose practical challenges for Karen, as opposed to the philosophical and existential questions it raised for the other two participants. Whether this was due to Karen's greater amount of experience, or due to her way of being, is unclear.

Karen seemed to experience dissonance when reporting high-risk behaviours disclosed by clients. Karen noted that it was her ethical obligation to make reports if clients disclosed intent to harm themselves or others. However, she was uncomfortable and hesitant to report these disclosures because she was uncertain how this information might be received by the person she shares the report with. Karen's reluctance stemmed from the possibility that further harm could come to her client if the agency to whom she made her report did not use a harm reduction approach. There was a dissonance between her reporting obligations, and the knowledge that in reporting, the best interests of her clients may not always be sustained.

*Karen:* *Well it's mostly that I don't trust other…like the people you report. Like at some point, you lose control, right? And you gotta hope that at the point where you lose control of the situation and other people pick it up, that the people who pick it up, get it, right? So, anytime I have somebody like John* (inter-agency colleague) *to go to, I'm…I'm…*

*Researcher:* *You're relaxed.*

*Karen:* *I get it. Yeah, but when I have to call up an office that I've never worked with before, I've no relationships, I've…yeah that scares me, because I expect harm. And I can't protect the youth from harm, because this theoretical "I must report in order to protect…" when I know that will actually hurt, cause they're not using a harm reduction model. So this idealistic 24 year old, who is going to scoop my street-savvy 13 year old and try to put her into a group home, cause that will keep her safe. I'm thinking "ugh…I hate this."*

**Institutional and governmental pressures.**

The third subtheme within the overarching theme of questioning is the existence of *institutional or governmental pressures*. Contributing to each participant's experience of ethical tensions was a perceived or real pressure to conduct themselves in a certain manner. This pressure seemed to stem from either the participant's place of employment or a regulatory body governing the participant's profession. These pressures led participants to question the motives and practices set forth by these institutional and governmental agencies. For Maria and Karl, these pressures stemmed from their own agency and its encouragement to implement harm reduction policies. For Karen, the tension stemmed from pressures to use more traditional methods of treatment.

The following excerpt details Maria's experiences of the pressures to professionally conduct herself in a certain manner. Maria acknowledged that she has an obligation to report severe drug use by clients. Presumably, the governing body that regulates her profession placed this obligation on her. However, Maria also discussed how she had to abide by the rules and expectations of the organization where she works. The Agency, which uses harm reduction strategies, fully accepts clients as they are and does not report client drug use, except in immediate life-threatening circumstances. These external pressures both create and contribute to Maria's experience of the ethical tension.

*Maria:* *Right. So the other part of it is that we're in a building that is non-judgemental and accepting, umm…and so, because of that and because those are kinda the stated principles of the agency, umm…I don't want kinda go against those when I'm, when I'm there. Right'. So I'm part of a caring team and what' I'm, what I'm trying to do is to care for you.*

Karl discussed feeling external pressure to professionally conduct himself in a specific manner. For Karl, his belief that some people may be *"damaged"* led him to feel constrained because he did not want to challenge certain methods of practice. Those methods of practice encouraged him to tailor his approach in a harm reduction fashion. In this instance, the tensions that Karl felt were heightened given that this belief in this circumstance is partly at odds with that of the agency he works for.

*Karl:* *So from an experiential phenomenological perspective, yeah I feel a sense of anxiety, I feel a sense of urgency, I feel a sense of frustration…umm…*

*Researcher:* *What kind of frustration?*

*Karl:* *The frustration is that umm…there are certain dialectical constraints on carrying on an open conversation about possibility without offending certain ideals of practice. That are…yeah…and it's a very…the tension there is because of existing, anxiously existing in an unclear ethical territory.*

Karen spoke about ethical tensions that can arise through external pressures that psychologists may experience, when their beliefs about harm reduction conflicts with their regulatory body's position. Given that Karen is an avid supporter of harm reduction strategies, it is conceivable that her experiences of tensions were heightened due to governmental approaches that do not align themselves with harm reduction approaches.

*Karen:* *People are building bridges or barriers. A harm reduction model sits with a person-centered view of the world. How can I not be harm reduction oriented, if I accept that people are autonomous? Like people have the right and the responsibility to make self-directed choices. How can I do anything but harm reduction? The minute I start doing "this is what's good for you" I'm doing harm.*

*Researcher:* *I'm trying to bring more awareness, or I'm trying to think of how to bring more awareness and more ideas. Overall, there's not a lot of research specifically that I found on this topic.*

*Karen:* *Well, I think that our Regulatory Body, as a psychologist, our Regulatory Body actually creates barriers and stops people from doing this, cause it instills fear. Cause it's a power-over model. So if you do the right things for what a youth needs, but you haven't got a paper signed, you could be chastised. You could be disciplined.*

**Outside the comfort zone.**

Being *outside their comfort zone* was a subtheme noted by two of the three participants. Both Maria and Karen associated this experience with the ethical tension that they each faced. Being outside their comfort zone was associated with feelings of being in unfamiliar territory and a sense of loss of control. Most often, this led to feelings of discomfort. The experience of being outside the comfort zone were associated with some experiences of questioning for these participants. This experience led participants to question their decisions, the best course of action, and perhaps even question their comfort zones. This questioning led to the development of other themes of experience, such as conflict about harm reduction and anxiety.

In alignment with harm reduction strategies, Maria was tasked with having to provide her personal contact information to a client. Though this would satisfy the client's best interests, the interaction between Maria's professional and personal life, caused her some unease. In the excerpt below, Maria's reaction to this tension was evident when she provided her client with her personal contact information. The breach of perceived ethical standards (giving out her personal information to clients) clearly caused some anxiety for this participant. When faced with such a tension, there was a

heightened sense of awareness for Maria. For Maria, the tension placed her in an unfamiliar territory, or outside her comfort zone.

> *Maria:* *I think it's really interesting because for me, umm…personally, I got a lot more like "oh my god, I have to monitor, you know, I have to monitor this much more closely than I would otherwise. Cause like, I'm not good at like, answering my phone or responding to text messages, or anything like that. So it was like I have to be a little more aware and be a little more available than I would otherwise be.*

In the excerpt below, Maria relayed how the prospect of providing her personal phone number to a client led to feelings of anxiety. Much of that anxiety stemmed from not knowing what to expect and worry about losing control. She spoke about not knowing if boundaries were going to be respected. How the tension would unfold was no longer within her in control; the control had shifted to the client. Perhaps her sense of being "outside my comfort zone" was a result of not being able to exercise control over how this incident would progresses.

> *Maria:* *Mhmm…I just, I didn't really know what to expect. *laughs* umm…so, what was, what was going to happen, whether those boundaries were going to be respected. Umm…those kinds of things. I tend to be a little bit of an anxious person anyways, so it's just, you know, do something that's just a little bit outside of your comfort zone and you're "oh my god!" (Higher pitch to voice). But it was fine.*

Karen described a situation in which she was also outside her comfort zone. In the following example she discusses having to contact child welfare to report concerning disclosures made by youth. Throughout the interview, Karen had emphasised that she is a supporter and enforcer of harm reduction approaches with high-risk youth. For Karen, conducting herself in a manner that was congruent with harm reduction principles was well within her comfort zone. In addition, working with people who share these values, produced ease.

Karen described a scenario in which she had to phone a child welfare office that she was unfamiliar with. These types of situations produced unease; she was uncertain if the people she would speak with would share her commitment to harm reduction. Karen linked the feelings of uncertainty with a sense of loss of control. The loss of control was due to her unfamiliarity with the offices and people that she phoned. She felt that she could not control what would happen to the youth. She expressed having no power over whether the offices would honour a harm reduction framework with her clients. Her inability to control the outcome led her to question the motives and effectiveness of other professionals. Ultimately, she finds herself questioning whether, and how, her response to the ethical tension will lead to the best possible outcomes for her client.

*Karen:* *Well it's mostly that I don't trust other…like the people you report. Like at some point, you lose control, right? And you gotta hope that at the point where you lose control of the situation and other people pick it up, that the people who pick it up, get it, right? So, anytime I have somebody like John* (inter-agency colleague) *to go to, I'm…I'm…*

*Researcher:* *you're relaxed…*

*Karen:* *I get it. Yeah, but when I have to call up an office that I've never worked with before, I've no relationships, I've…yeah that scares me, because I expect harm. And I can't protect the youth from harm, because this theoretical "I must report in order to protect…" when I know that will actually hurt, cause they're not using a harm reduction model. So this idealistic 24 year old, who is going to scoop my street-savvy 13 year old and try to put her into a group home, cause that will keep her safe. I'm thinking "uhh…I hate this."*

**Upholding beneficence.**

For each participant, upholding the *principle of beneficence* was of central importance when navigating through ethical tensions. Maintaining the client's best interests was a major contributing factor in the formation of an ethical tension.

Furthermore, as the participants sought resolutions to the ethical tensions that they were experiencing, they did so with the principle of beneficence for their clients, at their forethought. Participants were constantly questioning whether the client's best interest and beneficence was maintained throughout the progression of the ethical tension.

The excerpt below demonstrates how Maria carefully balanced the principle of beneficence against other principles when she contemplated giving a client her personal phone number. Whether the client's best interests were being maintained was a primary concern for Maria. This concern gave rise to the ethical tension: should she cross a common ethical boundary and provide the client with her phone number? In doing so, she would be creating the opportunity for therapeutic work, outside the confines of the agency. Maria concluded that the action would ultimately serve her client better.

> *Maria:* *Within this particular umm…therapeutic relationship, this client doesn't necessarily do super well actually at the Agency, umm…because there's too much in that environment that reminds her what it was to use. Umm...so as part of the harm reduction, especially when we're talking about the framework that we're talking about earlier, part of what we've done, part of what I did, and I did it with the, you know after consulting with my supervisor, and that, and that I've actually given her, given her my cell phone number so that she can contact me if she needs support, in either in her course, or in umm…in the actual therapeutic relationship. And so the reason that I opted to do that, is that I always keep in you know kind of in the back of my mind, my primary ethical principle is that I want to help without harming, and I really felt that if she didn't have that, that connection to that person, and umm…you know someone, to a certain extent holding her a little accountable umm…that she might umm…she might actually be more harmed, than she would, you know, kind of doing the cost/benefit analysis…*

The following excerpt details how Maria rationalized her breach of an ethical protocol (divulging personal contact information) using the principles of harm reduction. The act was acceptable if it encouraged the best interests of the client. Ultimately this led to better therapeutic work.

*Maria:* *I think part of what this did is that it let her feel like somebody was out there, that was, you know, that she had something that she need to talk about, was there that could, you know that she can talk about it with. And I think it actually led to better therapeutic work afterwards, umm…because that, you know, thinking about that relationship is, she felt a lot more comfortable in it, than she had before if I had kinda said "no, we're not going to do that, umm…we're gonna keep this boundary and it's going to be bounded by when I'm at the Agency only."*

Another dilemma that Maria described regarded the concern she experienced as a result of worrying that she was not encouraging the beneficence of her clients. In the excerpt below, she describes knowing that some youth were actively using drugs. Maria explains that she did not know how to engage the youth in other activities. Maria described feeling a sense of complicity by her lack of action. This may have even led to a sense of guilt or culpability. She wondered if she was encouraging beneficence, and seemed to question herself and her role as a counsellor.

*Researcher:* *kid A, has said to kid B, "let's go for a walk." Umm…what's going on in that moment for you?*

*Maria:* *For me? *laughs* I tend to think like, "you have got to be kidding me. Like…you don't even try to hide it, you just straight out go and do it…" and it's almost like there's a certain amount of, like I, what I don't like is that I feel like there's a certain amount of umm…complicitness, does that make sense?*

*Researcher:* *mhmm…*

*Maria:* *I'm, you know not stopping them from going and doing it, I'm just kind of letting them go and I know what they're gonna go and do, but I feel like I…you know, I'm kinda like well I don't know what to say, umm…to kinda encourage them to perhaps think of something else to do instead.*

*…*

*Maria:* *so it's hard to kinda watch that, and watch it just kinda at the for a lot of the younger kids, it's at the beginning stages and it's just kinda like see red flag here, red flag there. This is…Ok the trajectory is fairly clear. But like if you could do something were*

> *you just kinda stopped it, you could change that trajectory and it would be, you know, it would be very different. And so that's kind of, that's like the more personal kinda side, is like I've seen where this goes, and it's not a positive place.*

For Karl, a major contributing factor in the creation of the ethical tension he experienced was the well-being of his client and the people around that client. Karl's client was participating in a number of high-risk behaviours, and had actively refused to participate in treatment. According to ethical codes and harm reduction approaches, treatment cannot be imposed. Karl was left wondering if treatment should be obligatory for that particular young person. He was concerned that without treatment, the client's best interests were not being sustained. Karl's ethical tension seemed to stem from wondering if the principle of beneficence was being upheld, even though the young person had turned down treatment.

> *Karl:* *He's posing a risk to the public, to certainly to himself, but extending it beyond that to the public at large. His behaviours have, you know, he's damaged property, he's put others at risk. So…so, to place him in a position where he has the potential to change toward a more sociable and adaptive form of behaviour… Before he permanently harms himself or kills himself or someone else, how can change be brought about in that youth's life, so without breaching informed consent?*

Lastly, in her interview, Karen discussed how obtaining guardian consent to provide treatment to an adolescent could contrast with the desire to support the best interests of that young person. For Karen, this ethical tension stemmed from the challenge of obtaining informed consent. In her example, Karen argued that some ethical standards do not always promote the best interests of a youth. At times, and for a variety of reasons, obtaining guardian consent was challenging. When this occurred, Karen described following a harm reduction approach and providing counselling for a youth, even if there was no guardian to provide consent. It is evident that Karen believed that

following a harm reduction approach and forgoing some ethical standards, was acceptable, if in doing so the best interests and beneficence of a young person were maintained.

> *Karen:* *Well the other side of it is, it's also in the best interests with respect for the dignity of the person. so, if we see this youth who has no one in their life who that's safe and healthy talking to them, and they have no supports; making some adult sign a piece of paper, is not gonna help that youth in that moment. We're not respecting their dignity. In fact, we're taking it away.*
>
> *Researcher:* *Mhmm...*
>
> *Karen:* *So we always have that tension of looking for a guardian to give consent. Always, always, always. Umm...but at the same time, we're respecting the youth as "this person has made a choice that sometimes being on the street is safer than being at home." I'm not gonna argue that one. And sometimes the person who gives consent is the perpetrator. So, so we have to really always be mindful that we can't necessarily do traditional therapy. And that sometimes we have to go really, really slow, and not name it as therapy, but therapeutic. And we work with the limitations.*

In another example, Karen discussed how practitioners have to follow through on their obligations and report concerning problematic behaviour disclosed by a youth. Karen noted that by making this report, the working alliance between a counsellor and youth might rupture. Counsellors are obligated however to manage that risk, in order to ensure that the clients best interests are upheld. In the following excerpt, it is clear how the principle of beneficence remains at the forefront of the ethical tension. Karen discussed trying to manage the tension in such a way that the client's best interests were met, and the working alliance between the client and that client's counsellor, was sustained.

> *Karen:* *So this is the tension. Did I do a good enough job at my intake of informed consent, to allow me to talk to Child Welfare without rupturing the therapeutic alliance? That's the crux of the matter. And that's hard to do. And so, sometimes the tension is "do I put*

> *the therapeutic alliance at risk by making a disclosure to Child Welfare," or do I just say "well, you know...this has to be done?" So often what we do in our work, is to say "Ok. Where is the therapeutic alliance needing to be maintained? Who is the most important person in this person's life? Ok. Who can be sacrificed?" *laughs* and that's the person who makes the report.*

**Anxiety.**

The last subtheme in questioning, is *anxiety*. Each participant disclosed a unique experience on the spectrum of anxiety. Maria, the first participant, seemed to experience the most anxiety. Karen disclosed experiencing the least. Anxiety is included in the *questioning* theme, as it seems to be related to many of the previous subthemes already discussed.

Maria's anxiety seemed to be concerned with how her professional life was going to impact her personal life. By allowing her client to have her phone number, Maria experienced a heightened sense of awareness in her professional and personal life. Maria's experience of anxiety appeared to be tied to her experience of being outside her comfort zone. It may be that these experiences had a recursive relationship. When outside of her comfort zone, her anxiety increased, and as her anxiety increased, she felt increasingly outside her comfort zone.

*Maria:* *Yeah, I don't know. It's been a good experience. I would say I was, I was anxious about it before, and I would say I'm not anxious about it now.*

*Researcher:* *ok. And can you tell me a little bit about that anxiousness?*

*Maria:* *Mhmm…I just, I didn't really know what to expect. *laughs* umm…so, what was, what was going to happen, whether those boundaries were going to be respected. Umm…those kinds of things. I tend to be a little bit of an anxious person anyways…*

Karl disclosed feelings of anxiety when reflecting upon the case of his young client who refused therapy. As per harm reduction approaches, therapy cannot be forced

upon a client, therefore the tension, and resulting anxiety remained ongoing. When presented with a new piece of information about the client in question, Karl disclosed feeling a surge in his experience of anxiety. The anxiety seemed to be a result of his feeling of powerlessness, of not being able to engage in a problem-solving activity that would solve the tension, and of concern for the client. Hence, when Karl felt this increase in his level of anxiety, he disclosed using that anxiety to try to resolve the ethical tension.

*Karl:* *The ethical tension remains very active in those situations. Because unless I was able to forget about the situation, umm…it's always pushing towards a kind of completion of that Gestalt in a certain way. It's…and there are many situations that I've involved in, ethically, that are like that…*

*Researcher:* *So it's enduring? The tension is still there.*

*Karl:* *Yeah.*

*Researcher:* *And there might be, for example, would there be a flare up if a new piece of information comes to your attention?*

*Karl:* *I would become…it's…yeah. It's not so much a fl…well I guess it's a flare up to a certain extent…a triggering or certain feeling state which happens, even as I'm talking about it and recollecting it…*

*Researcher:* *Mhmm…and then sorry, you said a feeling flare up, and you said as you were talking about. You know, a flare up of feelings even as you're talking about it.*

*Karl:* *Yeah. I feel a sense of kind of physical activation that relates to apprehension and anxiety about this person, and the people around him, on an ongoing basis when I visualize that circumstance.*

Lastly, Karen's experience of anxiety, seemed to differ significantly from the other two participants. She stated that she did not experience any feelings of anxiety. Karen described a *"disconnect from reaction"* in those situations. This disconnect allowed her to manage the tension, in an unbiased, calm manner. It may be that early on

in her career, Karen experienced anxiety in response to ethical tensions, but experience seems to have taught her how to subdue those responses.

> *Karen:* *And it's sort of like you can't react, you can't freak out. Because the minute you start freaking out, you're gonna make ethical errors.*
>
> *…*
>
> *Researcher:* *So if I'm hearing you correctly, you don't really…it doesn't sound like you get that…you get…your Spidey senses go off but not a fluttery moment of …*
>
> *Karen:* *"Oh my god?" No, no, no no. I…I've been always working in this kinda mess. So the messy tension…*

It is difficult to conclude that Karen did not experience any anxiety. She discussed entering a problem-solving mode when tensions arose, so it may be that over years of practice she has developed effective ways to manage it. In a different portion of the interview, Karen described experiencing a physiological response to ethical tensions. That experience, though seemingly subdued compared to the experiences of anxiety of the other two participants, may have been how Karen experienced anxiety.

> *Karen:* *I always talk about this part of my neck, this nape of my neck, being my spider senses. And so for example, I'm teaching a Graduate class and my feedback again and again and again, is if that warning bell, whether you feel it in the back of your neck, in your gut, if you get a niggle, the thing is to not ignore it. It's to blow fire…or blow on it and get it to be more than. Pay attention to it and drill down into it. Why is that warning bell going off? What warning bell is it? What's this connected to?*

**Acting**

The second overarching theme to be discussed is *acting*. The first theme, *questioning*, explored the more reflective experiences of participants once the ethical tension arose. The theme of acting captures the experiences of how the participants managed those ethical tensions. When presented with an ethical tension all participants

engaged in some form of behaviour or thought process that led to a subsequent action. This experience of ethical tension involved *decision-making processes, self-care regimen, social change endeavours, processes of negotiation,* and *consultation and supervision*.

**Decision-making process.**

When presented with an ethical tension each participant engaged in a process of *decision-making*. The first participant, Maria, was asked to provide her personal contact information to a client in order to maintain the best interests of that client. Though Maria reported that she wanted to encourage the beneficence of her client, she also stated that she had been taught to establish a boundary between her personal and professional life. This boundary was something that Maria valued, both personally and professionally.

When presented with this ethical tension, Maria engaged in an active decision-making process. Maria considered the drawbacks and benefits of providing her phone number to her client. Ultimately, Maria decided in favour of giving the client her phone number. She argued that in doing so, this would reduce the harm that this young person might encounter.

> *Maria:* *I really felt that if she didn't have that, that connection to that person, and umm…you know someone, to a certain extent holding her a little accountable umm…that she might umm…she might actually be more harmed, than she would, you know, kind of doing the cost/benefit analysis.*

In addition, Maria considered her client's circumstances in her decision-making process. This would indicate that breaching ethical norms as a means to resolve ethical tension, when using a harm reduction approach, may be done on a case-by-case basis after careful consideration of the risks involved. In addition, Maria's use of words such as

*"…it wasn't something that I took lightly..."* exemplifies the seriousness of the situation for Maria. These words signify the heaviness of this decision.

> *Maria:* *It really was a hard decision for me. Like it wasn't something that I took lightly, umm…and I don't think I would have done it with umm…every client. This client is particularly well adjusted and actually has a good support system behind her. So it was, in that way, it wasn't as difficult. If it had been a client who umm…was experiencing significantly more distress or who umm…really didn't have a support system, or anything like that behind it, then I might have gone a different route.*

The second participant, Karl, described his experiences of working in a residential treatment centre. At times, youth would return to the group home after unapproved leaves and would be highly intoxicated. Karl described that he felt pressured to follow the residential rules which dictated that the youth had to be reported to the authorities and removed from the premises. Despite these procedures, Karl wanted to employ harm reduction strategies, thereby ensuring both the immediate and long-term benefit to the youth. Karl describes how he engaged in an active-decision making process which consisted of considering the immediate and longer term outcomes for the youth in question.

> *Karl:* *My personal experience of those tensions would be to be a residential supervisor, have youth return to the premises, having breached the agreed upon curfew, highly intoxicated, either on alcohol, crystal meth, often of course on pot. And having to make a decision to come into their bedrooms so they can go to sleep or deal with their behaviours when they come in. And you know, this might be the middle of winter, or you would know that in the case of…well girls especially, but not exclusively, if you didn't have them come in they would be very vulnerable on the street, in any season. So you know, my experience would be to bring them in, without creating harm to myself or others.*

The third participant, Karen, described a methodical and purposeful decision-making process when faced with an ethical tension. She reported that she considered the

people involved, who is at greater risk and what kind of risk is presented. Karen seemed to approach ethical tensions as a math problem, in which she could work out the solution methodically. As discussed earlier, Karen did not seem to experience anxiety in the face of ethical tensions. She appeared to have a "disconnect from reaction," and instead engaged in a problem-solving mode.

*Karen:* *And so as we're trying to process how to manage this from an ethical perspective, you know, you start looking at, well who's at risk? Is it an ongoing harm? Is it a static harm that has occurred that we have to prevent? So just understanding what happened. Umm...then what do you do with that information?*

…

*Karen:* *So part of it for me is to just sort of see the template happening of the scenario, and then thinking about "ok, how are we gonna manage the details here…" so in some ways I look at it and I get a disconnect from reaction. So it's sorta like a "this happened. *deep breath* Let's start pulling it apart. What do we need to do?" so it does really pull for the steps, and "ok, who is most vulnerable here? What are we gonna do?" And that very mindful ethical decision making kicks in…*

**Self-care.**

When faced with an ethical tension as a result of using a harm reduction perspective with high-risk youth, practitioners gave significant consideration to the practice of *self-care.* In the excerpt below Maria discussed her personal and professional beliefs about self-care. She identified them as an important component in a psychologist's life. The ethical tension that Maria experienced was partly due to the threat to her self-care regimen. The event caused her professional and personal life to interact, something that Maria believed was important to prevent. The interaction described below appears to have made Maria uncomfortable.

*Maria:* *Yeah, but it is, it's a personal choice, to kinda maintain a boundary between my private life and my professional life.*

*Researcher:* *Ok. And I'm gonna ask, why do you think that's important, or how do you think that's important?*

*Maria:* *Umm…well I think it's important because, *pause and exhale* ahh, such an interesting question. Umm…I think it's important because as psychologists, we need to have a personal life, umm…and that umm…I, and this is my own opinion, umm…don't think that clients need to be able to contact me 24/7, umm…there could be emergency contact obviously, but umm… it's not, it's just not something that I feel comfortable with.*

During his interview, Karl discussed how the process of acceptance, in the face of an unsolvable ethical dilemma, could contribute to a healthy self-care regimen. Karl discussed that in certain situations he had to accept that there was nothing he could do to immediately solve an ethical tension. From his perspective, to further engage in problem-solving attempts, would be destructive. As such, he had to accept the limits of his abilities, and in doing so, maintain a healthy level of self-care. For Karl, it would seem, awareness about maintaining a level of self-care, is critical throughout the process of solving ethical tensions.

*Karl:* *And…and I have a sense that it would be very destructive personally, from the perspective of self-care, to become any more engaged in that situation.*

Karen also discussed the importance of attending to self-care. For Karen, having a strong support network of people, both personal and professional, contributes to her self-care and professional resiliency. Having people around her who support her, and who she in turn supports, allows her to feel that she is contributing to change at the *"micro and the macro"* levels. For Karen, this appears to be critical to her endurance in this field.

*Karen:* *The people who do this work, don't do self-care very well, in the sense of…but having said that, umm…I exercise on a regular basis, I work out three times a week with a trainer, and I've had the same trainer for 15 years, I physically move. Umm…I have a very strong group of folk around me who are very big-picture folk, right? So people who see…who are involved politically. You know,*

> *they're people who do things. Right? So working at the micro and the macro. In my personal life, I see that around me. Umm…Like I have lots of friends who do the marches. I don't go out and march, cause I'm doing my stuff at the front-level. I feel good about that, but I'll hang out with the people who will go out and do the missing and murdered women march, things like that. So I get all of that validation that I'm on the right track from those friends. I don't know how…I think you have to have a big, deep, rich network to do this for the long haul.*

**Social change endeavours.**

For two of the three participants, the experience of ethical tensions was coupled with a desire to engage in *social change endeavours*. Though these strategies did not help contribute to the resolution of the immediate tension, the participants both alluded to these strategies as tools for helping them manage ethical tensions. During her interview, Maria discussed how she carried the ethical tensions from work, home with her. She expressed how these tensions were converted into the desire to produce lasting change for the young people she worked with. Though these actions did not resolve the ethical tension that Maria was dealing with, they perhaps caused her to feel that she was acting to reduce future tensions.

> *Maria:* *I take it home. Umm…but I think for me…*laughs* when I take it home, it more manifests in a desire to change things. So for example this year, our umm…we participated in a fundraising program, umm…and so that's directly because of some of those personal idea.*

When discussing some of the ongoing risks that youth face, Karen reported that she was often aware that many youth engaged in high-risk behaviours, such as drug use and prostitution. When asked how she managed this awareness, Karen described using a combination of acceptance and a desire to contribute to change on a social level. She reported that she contributes to agencies that work with high-risk youth in order to try to reduce the high-risk activities that the youth were exposed to. Similar to Maria's

example, this did not serve to reduce the current tension. Knowledge that these practitioners may be contributing to future change, can perhaps allow them to foster a feeling of hope.

> *Karen:* *Hmm…I have *long pause*…ahh…I support a lot of agencies, so I make donations to the support network that funds the distress line. And I attend fundraisers for agencies that do work with the youth that I work with. So I financially support places so that we increase the likelihood that the kids are gonna be there.*

In the excerpt below, Karen described how her agency has engaged in strategies to reduce some of the risks that high-risk youth are exposed to. Engaging in these strategies, not only contributes to the general well-being of a youth, but can also promote a therapeutic value. These harm reducing strategies have immediate and long term benefits for the management of some potential ethical tensions. Again, the future reduction of ethical tensions, seemed to help Karen in the immediate realm as well.

> *Karen:* *Anyway, umm…so one of the things we're doing at the Agency is we're just gonna have beds, because the kids had to walk about all night, in order for me to do therapy, that kid has to have an hour's nap. So I'm just gonna build into my practice, the ability for that kid to just crash in a safe place for a couple of hours, sleep in a way that they can actually sleep without having one eye open. And that might be the best I can do.*

**Negotiation.**

Another subtheme in the overarching theme of acting is *negotiation*. What was negotiated, and with whom the negotiation occurred, varied across the participants. Each participant engaged in some form of negotiation when attempting to resolve the ethical dilemmas that they each described. Some of the participants, negotiated with themselves, others with clients, and others with outside agencies. During the thematic analysis, it was discovered that the experience of negotiation was a central process in the management of ethical tensions.

As discussed, Maria struggled with providing her personal contact information to a client, even though it was in the spirit of extending beneficence to that client. To moderate that tension, Maria and her client negotiated boundaries around how the exchange was going to be managed. This negotiation appeared to be effective for Maria. She was able to exercise some control over an activity that made her uncomfortable (as we saw from previous excerpts). It is noteworthy that in this case, even though harm reduction contributed to the ethical tension, it was also instrumental in how that tension was managed.

*Researcher:* *So in the end you decided, in the end you decided to give her your phone number.*

*Maria:* *And I mean we also talked about, like "this is to be used for this purpose," right? So it wasn't "here," it was "ok, so we need to communicate about these things and that's kind what this is for."*

During his interview, Karl discussed the importance of negotiating a harm reduction approach with agencies or schools who work with high-risk youth. He discussed how some agencies may self-identify as being aligned with harm reduction strategies, but have little tolerance for youth found in possession of drugs or alcohol. Karl stated that when working with high-risk youth, he would find himself engaged in negotiations with such agencies. In essence, he would end up encouraging them to implement harm reduction approaches because he considered these to be beneficial for the youth.

*Karl:* *Yeah…group homes, schools, or other agencies. So the Agency has a policy of you know…no substances, no dealing, no violence, to be able to come and participate in the programs that are presented. Group homes, even if the harm reduction oriented group home has a requirement to not bring substances on the premises, or to be intoxicated on the premises. And schools, the public schools have a very strict policy that if you're found to be in possession of a substances, that you'll be suspended or expelled…*

> *There seems to be some very large agendas at stake in those kinds of rule settings. So negotiating a position of harm reduction within those contexts has varying levels of difficulty, but is extremely important.*

Karl also mentioned that aside from negotiating the use of harm reduction strategies with outside agencies, these negotiations often extended to conversations with the youth as well. Even though a specific example was not discussed, Karl stated that at times, he needed to engage in conversations and strategies with youth, which were harm reducing, in order to encourage the immediate best interests of those youth. Even though these negotiations had the potential to lead to other ethical principles being breached (e.g., failing to report high-risk behaviour) failing to implement harm reduction also produced further risk to the youth.

*Researcher:* *Can you think of a specific example of a tension, or a specific situation?*

*Karl:* *Sure, umm…it often arises out of, out of activities around substance use. Where substances are not usually allowed. There's an agreement that youth will not bring substances into agencies, or agency locations. Umm….and or schools. And so, youth are found with those substances umm…should they be, should they be umm…barred from coming into those locations, because they broke that rule? Or should a harm reduction approach be negotiated with them, because the alternative, is often if they don't have access to that agency, or that school, or that residence, umm…they are put into a highly unsafe position.*

Finally, Karen, like the other participants, described negotiation as having a substantial role in her decision to adopt a harm reduction approach with high-risk youth. The two excerpts below, though they reference different ethical tensions, highlight how negotiation aligns with a harm reduction approach. In the first excerpt, Karen discussed planning strategies with youth that would assist those youth to find adequate housing in the evening. The second excerpt relates to situations in which psychologists have to

report high-risk behaviour on the part of the youth. In both excerpts, Karen discussed engaging in a period of negotiation with the youth that would help them maintain a level of safety and well-being.

> *Karen:* *This is that ethical tension you were talking about…you have to do safety planning in the sense of "where do you go if you need to warm up? And what part of the city are you gonna be in? If you're in the North end, let's brainstorm some places that are gonna be open.*
>
> *…*
>
> *Karen:* *So, the higher risk behaviours that the youth is involved in, the more likely they are gonna need a protective stance. So one of the things we start talking to the youth about is about how, umm...being with them is being protective. So yes, so we have to start explaining that the authorities might come in to investigate. Well what does that mean? Right? So let's talk about what that means. So lots of education around what's gonna happen, and then affirming that we're gonna be there with them. And that they can't...even if they get apprehended that we're gonna go with them. You know, that they can still come to the Agency or wherever they're connected. Umm…We have safety plans, we talk about layers and layers and layers. And so, sometimes we will negotiate with the youth umm… for quite a while before we make a report. Like a week, right? So you start doing the... "It's not an investigation, but it's a layering of support" and start breaking down resistance, so that the relationship has a chance of surviving. Cause what we don't want is a betrayal. So that's an important piece.*

Throughout Karen's interview, it became apparent that negotiation also marked her experience of ethical tensions. Karen discussed having to make reports regarding the high-risk behaviour disclosed by youth. When having to do so, Karen carefully considered whom the report would be made to. She was cognizant that the receiver may not employ or embrace harm reduction strategies. In anticipation, she prepared herself to negotiate with that individual in order to obtain the best possible outcome for her clients.

It is clear from Karen, Maria, and Karl's interviews that when managing ethical tensions, the experiences of these psychologists were marked by a period of negotiation.

> *Karen:* *And the tension is that you have to make a report. Who do you make it to? So phoning up the intake line for Child Welfare is gonna get you an inept response. So you have to go to somebody who understands the community. You have to also negotiate with them, or be prepared to negotiate an intervention that will work. So having a harm reduction orientation, does not match with a law and order kinda impulse of "who you gonna charge?" Cause the youth won't charge anybody.*

**Consultation and supervision.**

The final subtheme within the theme of acting, is *consultation and supervision*. When faced with ethical tensions, all participants in this study discussed the importance of engaging in a process of consultation or supervision with colleagues. The participants referenced these practices frequently, which may indicate their high value when incorporating harm reduction approaches with high-risk youth. The practitioners seemed to want and need support from their colleagues and peers in making ethical decisions.

In this study Maria experienced the most conflict and anxiety in response to ethical tensions. She sought out the assistance of her supervisor to manage this tension. The reassurance Maria received from her supervisor (someone she considered to have more experience) had the effect of lessening Maria's feelings of anxiety.

> *Researcher:* *And then umm…to the anxiety piece, did you, how did you find your sense, your notion of anxiety to progress? Did you find that you were getting at any point more anxious or the same or less anxious?*
>
> *Maria:* *Umm…no, it was kinda like stayed the same. After I talked to my supervisor at the Agency, I got less anxious.*
>
> *Researcher:* *Ok.*
>
> *Maria:* *Umm…cause I was like "umm…ok. If you're thinking it's ok, then I'm good with it."*

*Researcher:* *Ok.*

*Maria:* *You've been a registered psychologist for a number of years, who works with high-risk populations, so like if you're comfortable with it, I'm good.*

Karl discussed the importance of consultation and supervision throughout his interview. When faced with ethical tensions, he mentioned that it was important to frequently consult with colleagues, as these consultations assisted in resolving the tension.

*Karl:* *But, it's more of a solution oriented engagement into which that anxiety and tension is directed. "Ok. This is a new piece of information. Consult to determine if some new perspective can be taken that will ultimately complete that picture or, you know, reduce my state of seeking a solution tension."*

Lastly, Karen raised the issue of consultation and supervision frequently throughout her interview as well. Most of the conversation that centered on this topic related to the importance of inter-agency communication and consultation. In the excerpt below, Karen discusses the benefit of inter-agency consultation. It would seem that these professional connections, like those within an agency, can ease the experience of an ethical tension.

*Karen:* *If you have a therapeutic alliance with your client, but it's not connected to the...the professional alliances you have with other professionals...like if I want to make a disclosure to a Child Welfare worker, I don't pick up the phone and phone an anonymous intake worker. I phone one of the people I have a relationship with in the Child Welfare industry: John Smith. "John this is what we're dealing with. What do I do? How do we get this kid" and I make sure before I name the kid, that I have a strategy that will work with somebody who knows the youth. It's not like these are unknown to child welfare. But they're not the youth that will go with a worker and sit in a...shelter. Overnight in a shelter or hostel, or whatever. And so we have to go to the people who are gonna be able to help us. So I can't be helpful to the youth, unless I have these relationships with other people.*

## Holding

The final theme that arose during the analysis of the interviews is *holding*. In many ways, this theme appears to stand in opposition to the last. Action encompassed the participants' experiences of ethical tensions as the participants engaged in behaviour to manage the tension. This theme captures the experience of participants during a period of inaction, or a pause. This does not mean that participants were not reacting to the tension. The reaction to the tension, as demonstrated below, appears to follow a reflective process and a conscious decision to engage through inaction. The term holding has a two-fold meaning. Holding can refer to a pause before engaging in some sort of action. This is similar to being on hold. The term holding can also refer to holding a, or sitting with, a tension, as will be discussed later. The subthemes *acceptance* and *sitting with tension* are explored in detail below.

### Acceptance.

*Acceptance* refers to the participants' acknowledgement, and acceptance of, the limits of their ability to resolve the ethical tension. All three participants described feeling varying levels of frustration in their roles. At times, this was due to the inequalities in the systems in place to support high-risk youth. At other times, it was due to the ongoing high-risk lifestyle of the youth. Occasionally, this led to the participants' realization that in some situations nothing could be done to help a youth. In these instances, the experience of acceptance seemed to be shared by all three participants in varying manners. For some participants, acceptance seemed to happen almost reluctantly. For other participants, acceptance was a mindful, conscious, and active choice. Two of

the participants also linked the process of acceptance to the experience of working from a harm reduction approach.

Maria's experience of ethical tension was marked by a sense of reluctant acceptance. Maria acknowledged being aware that many of her clients were actively using drugs. This awareness seemed to produce an ethical dilemma for Maria: should she report the drug use by the youth given that that use can lead to negative effects, or should she not disclose the drug use and attempt to engage the youth in other therapeutic activities that discourage drug use. Maria seemed to feel trapped, as evidenced by her use of the word "*complicitness*" in an earlier excerpt. However, in the excerpt below, Maria reaches a sense of acceptance, brought about by her personal beliefs, her commitment to harm reduction approaches, and her reluctant realization that in some cases, there was nothing more she could do.

> *Maria:* *It's just this feeling of like "what, you know, I'm constrained by the agency in which I work, and I'm constrained by, to a certain extent, by some, you know some personal you know, some personal beliefs about harm reduction that kinda go, "well is that really as bad as this…you know, at least these kids are not, at least they're not, you know, out on the street, right? They're coming here, they feel safe to come here." Umm…versus like, they're not allowed to deal in the building, but I know that they more than likely bring drugs into the building. So, how do you, how do I…I don't know. And I haven't worked through it yet, right? like I'm just kinda, I'm in a, I feel like I'm in a bit of a holding pattern, where I'm like, I don't…I've just kinda accepted it and I'm kinda sitting in it, but I'm like, I don't feel like I've solved anything, for a lack of a better way to talk about it.*

Karl's dilemma concerned a young man who had been referred for counselling, but did not consent to participate. Karl described experiencing some anxiety when he reflected upon the high level of risk this young person presented to himself and to those around him. Despite this risk, Karl conceded that there was nothing he could do from a

practical and ethical perspective, since the young person had not consented to counselling. Regardless of that factor, Karl relayed that when he reflected upon the situation, the tension remained active for him. The excerpt below illustrates how coming to a place of acceptance, and perhaps using the tactic of distraction, helped Karl manage tension that otherwise could not be resolved. For Karl, acceptance is congruent with the philosophy of harm reduction, his belief being that the two went hand-in-hand.

*Researcher:* *How do you respond, or how did you respond to that tension?*

*Karl:* *My response is that…my response is fairly consistent in those situations, or in situations, is to simply accept what I cannot do and move on from that situation, ensuring that others and myself are as safe as can possibly be made. Considering the risks that are involved. And there has to be a further ripening, or maturing of that situation, I guess, aging/ripening of that situation before action is taken. And that…that's all that I can do.*

*Researcher:* *Can you tell me a little bit about that acceptance? That's kind of interesting…*

*Karl:* *Umm…yeah. Umm…that acceptance is, it's fueled by a number of things. It's fueled by what I feel is an assessment of what I can and cannot do. Both from the perspective of capability and from the perspective of ethics.*

…

*Karl:* *Going right back, it kind of folds in on itself. Or conflates on itself in this way: if you're going to practice harm reduction, the acceptance that you reach a certain point at which you leave that problem and move on to another problem, while certain things progress in that problem, is part of harm reduction. Harm reduction means "I'm gonna leave that, at that point in a process, and I'm gonna concentrate on these other things where I'm going to have some effect."*

Karen also associated acceptance with a harm reduction orientation. For Karen, the acceptance was coupled with a sense of hesitancy, as evidenced by her use of the

words *"hold my breath."* Acceptance for Karen was a result of her own assessment of her professional and personal capabilities.

> *Karen:* *Often we have to be okay with the idea, not that we accept it or like it, but we have to accept that our kids will be homeless tonight. It can be 30 below and we don't know that they'll have a place to stay. And we have no control over that.*

For Karen, the experience of acceptance seemed to be fueled by the realization that in some cases there was little she could do to help her clients. The systems within which she worked had limited resources to accommodate all youth. From the excerpts below, it can be surmised that for Karen, this was not always a comfortable acceptance.

> *Karen:* *So there's always a sense of helplessness. And you've gotta accept…In order to do this work you have to have this weird tension of being outraged at the lack of resources and the way our society is built; and this acceptance that our society is built this way and there's nothing in this moment that I can do for this youth. Right? I can't take him home. Even if I could take him home, that wouldn't work, right?*

**Sitting with tension.**

The last subtheme discussed is *sitting with tension*. Each participant described a stage where they had accepted the limits of their power and that immediate resolution of the tension was unachievable, and instead had to resolve to accept the ongoing tension. Though each participant used a different term for this process, the description used by Karl, "sitting with tension," was deemed most fitting.

Sitting with tension differs from the experience of acceptance described earlier. In this case, participants accepted and seemed to create a relationship with the ethical tension, as opposed to simply accepting the limits of their own powers. Maria and Karl both used the words *"sitting in it"* or *"sitting with"* when it came to accepting the tension. This portrays the tension almost as its own being, something outside of their

control, and something that they had to coexist with. Karen's use of expression was different and is discussed below.

Each participant had a different experience of sitting with tension. Karl and Karen did so with slightly more comfort, whereas Maria seemed the least comfortable. This might be attributed to personal approaches, personality, or simply less experience with ethical tensions, as Maria was still at the start of her career. Regardless of the reason, participants described a period of acceptance for this type of tension in their professional life.

Maria referenced the tension regarding the ongoing drug use by her clients. Maria was torn between wanting to implement harm reduction approaches, which emphasized acceptance, and her reporting obligations. The excerpt below highlights Maria's process through this ongoing tension. Her use of the phrase *"holding pattern"* is suggestive that she felt stuck and is in a pattern of waiting. It indicates that she believed, or rather hoped, that there may be further resolution to this matter. Maria's use of the words *"sitting in it"* also indicated that, even if only temporarily or reluctantly, she had accepted the dilemma. The dilemma seemed to be its own being, as evidenced by the word *"it."* Maria was not comfortable with the process: she mentioned that she had not solved anything yet. This would imply that she was still hoping that a resolution to this tension would occur.

*Maria:* *It's just kind of, I, it's just this feeling of like "what, you know, I'm constrained by the agency in which I work, and I'm constrained by, to a certain extent, by some, you know some personal you know, some personal beliefs about harm reduction that kinda go, "well is that really as bad as this…you know, at least these kids are not, at least they're not, you know, out on the street, right? They're coming here, they feel safe to come here." Umm…versus like, they're not allowed to deal in the building, but I know that they more than likely bring drugs into the building. So, how do you, how do I…I don't know. And I haven't worked through it yet,*

> *right? like I'm just kinda, I'm in a, I feel like I'm in a bit of a holding pattern, where I'm like, I don't…I've just kinda accepted it and I'm kinda sitting in it, but I'm like, I don't feel like I've solved anything, for a lack of a better way to talk about it.*

Karl, by contrast, seemed to accept sitting with tension willingly. Karl described sitting with tension as being congruent with a harm reduction approach. For him, the process was not something that he felt forced to do because he had not resolved the tension. This experience was part of harm reduction, and something he seemed almost eager to do. Part of the harm reduction philosophy promotes patience and non-judgemental stance. For Karl, it would appear that sitting with tension was part of practicing harm reduction. Karl suggested that an air of patience and resolve needed to be implemented when faced with ethical tensions.

> *Karl:* *Since harm reduction is based upon duration, it requires the ability to sit with tension. I think the practices that are contrasted with harm reduction arise from the inability to sit with tension. In other words, "I'm gonna incarcerate that person, I'm gonna force them to stop doing something, or they should stop doing something immediately, because if they stop doing something immediately, I no longer have any tensions about it, right?" The problem is solved. The ability to…harm reduction…practicing harm reduction involves the ability to sit with tensions. It involves the ability to sit with tension in one owns life.*
>
> …
>
> *Karl:* *Yeah. Yeah. I mean harm reduction is by, by nature umm…an unfolding narrative process. It isn't the instant gratification and I think…and it also isn't the ability to control the outcome. And so, there seems to me to be a social bias in controlling…to control outcomes. And to avoid, and to have instant gratification. Instant gratification means the instant resolution of the tension. And…and everything about harm reduction becomes fraught with difficulty because it is not congruent with that.*

The last participant, Karen, also described sitting with tension. For Karen, the experience was tied to her awareness that in some instances, there was nothing she could

do for a client. In these cases, the experience of sitting with tension seemed as much to be related to capabilities, as to a philosophy.

In the excerpt below, Karen gives a specific example of how she experienced sitting with tension. Though she used different words to describe the experience, Karen seemed to go through a similar process. For Karen, the experience was akin to *"holding her breath."* "Holding her breath" was parallel to sitting with tension. It is the experience of facing something uncomfortable, but having to continue through it. Her use of these words indicate that at some point, she must continue breathing. Karen linked the experience to harm reduction. For her, knowing that she had to step back and accept the resources of the individuals she was working with, even though some situations cause her to hold her breath, was part of the process of harm reduction.

*Karen:* *So for example, if I accept that this person who's putting this girl out on the street, will always give her a place to stay when she needs it. So he beats her, he arranges for her to get raped regularly, but accepts her back whenever she runs away and lets her sleep on his couch. There's a safety with him that she can't get anywhere else. And I have to really sort of hold my breath a bit cause I know she's not healthy, but I also have to respect that I'm not there at 3am in the morning when there's no one open and there's scarier things on the street than him. Right? That's harm reduction. So I have to be very careful to not think that I am smarter than her about survival on the street, or that I can fix anybody.*

# Chapter 5: Discussion

This research explored the ethical tensions among psychologists and psychologists-in-training who work with high-risk youth using a harm reduction approach. The analysis of the interviews revealed three overarching themes that captured the participant's experiences. These themes are *questioning*, *acting,* and *holding*.

The early stages of an ethical tension prompted a period of questioning for the participants. Though the individual experiences varied (in other words, how or what participants questioned varied) the theme of questioning was prominent throughout the interviews. Participants experienced *conflict when implementing harm reduction* strategies and questioned the philosophy and application of this approach. They also questioned the *expectations for practice* placed upon them by their place of employment and/or the regulatory body that governs psychological practice in the participant's respective location. Participants questioned their role and effectiveness as counsellors and whether the client's *beneficence was being upheld*. Participants experienced *dissonance* between two or more conflicting beliefs and thus questioned their own beliefs and practices. Finally, these experiences of questioning subsequently produced varied experiences of *anxiety* for the participants.

While resolving ethical tensions, the participant's experiences were marked by *acting*, *holding* or a combination of both. The overarching theme of *acting* was used to mark the process of engaging in an action to resolve tension. The subthemes within acting include *decision-making processes, self-care regimen, social change endeavours, negotiation,* and *consultation and supervision*. During the analysis it was apparent that each theme seemed to influence the other themes. The themes did not occur in isolation,

nor did each theme occur for all participants. For instance, while some participants described engaging in a self-care regimen, others did not.

*Holding* refers to the more reflective practices of the participants. Holding does not mean the absence of action or awareness. In fact, holding has a two-fold meaning. Holding refers to the experience of being on hold, or a pause, before further action is undertaken. Holding can also refer to the holding of an object, or a state, in this case, holding ethical tensions. Participants engaged in holding and did so consciously and/or willfully. The subthemes of *acceptance* and *sitting with tension* mark the greater overarching theme of holding. Again, these experiences of action or holding might occur in isolation, or might be combined. Regardless of whether they were combined or not, the effect was common for all the participants; it lessened the negative impact of the tension that was being experienced.

Acceptance refers to the participants' experience in the moment when that participant felt that he or she had exhausted all possible solutions to resolve an ethical tension. Participants were led to accept that in some cases there was nothing more they could do for a youth. This may have been due to realistic or true limits (those influenced by ethics and capability), as well as limits that arose due to the participants' adherence to a harm reduction model. For instance, one participant, when discussing a young person that was homeless, stated that she could not take that youth home, regardless of her desire to, and had to trust in that client's own resources. The participant acknowledged that this was due to a harm reduction approach. This participant, like the others, found it necessary to acknowledge the limits of their ability to influence a given situation, even if that involved harm or potential harm to a youth.

Sitting with tension characterized the experiences of all participants. They all articulated the need to learn to coexist with tension. Participants linked this coexistence with harm reduction. One participant noted that "*…practicing harm reduction involves the ability to sit with tensions."* This relationship is important because every participant indicated that working with high-risk youth is an experience dominated by ethical tensions. Moreover, even though each individual struggled with practicing a harm reduction technique at times, each participant valued harm reduction as a philosophy and considered it one of the more effective approaches when working with high-risk youth. The interactions between acceptance and sitting with tension demonstrated once again that the participants did not experience these phenomena in isolation. All of the experiences of ethical tension influenced one another and were interrelated.

A new review of the literature was conducted prior to writing this discussion in order to determine if any new studies had been published since this study was undertaken. A variety of search tools were used and the search yielded no new research. The searches were limited by the selection of words used in the search and hence, it is possible that some terms may have been missed. In addition, none of the studies used for the literature review examined the participant's lived experiences of ethical tension when using harm reduction approaches. The literature review did not produce any published studies that explored how participants internalized and experienced ethical tensions. It is this researcher's conclusion that this study appears to be the first of its kind to do so.

The findings of this study are aligned with findings cited in the literature review. Informed consent and confidentiality are among some of the concerns for participants working with high-risk youth. All of the three participants recounted ethical tensions

pertaining to confidentiality; and two of the three participants disclosed ethical tensions relating to obtaining informed consent. Concerns with maintaining the working alliance were also prevalent. The participants in this study wanted to maintain the best interests of their clients while adhering to their ethical obligations. Research by Sullivan, Ramirez, Rae, Razo, and George (2002) and Duncan, Williams, and Knowles (2012) support the finding of this study that maintaining the working alliance is a significant factor for psychologists who work with adolescents. While there were no previous studies canvassed that explored the lived experiences of psychologists working with high-risk youth and using harm reduction methods, there were similarities in the types of ethical tensions identified in the literature.

**Implications for Practice and Further Research**

It is this researcher's belief that the findings of this study can contribute to the field of ethics and psychology in a number of ways. Firstly, it provides insight into how some practitioners experience ethical tensions when working with high-risk youth using a harm reduction model. This insight can perhaps normalize the experiences of new psychologists who are faced with tensions and find themselves feeling isolated in their experiences. The findings of this study also raise awareness about the types of ethical tensions practitioners working with high-risk youth experience when incorporating harm reduction approaches.

Secondly, this research encourages discussion around ethical standards and education as they relate to harm reduction approaches. One participant stated that the regulatory body that governs psychological practice in her location creates barriers to the ability of psychologists to use harm reduction techniques. These barriers could potentially

hinder or prevent the use of certain features of the harm reduction model. According to one participant, this is because psychologists may be concerned that they will be censured for not following more traditional forms of therapy and using a harm reduction approach. For instance, this participant described feeling obligated to obtain guardian informed consent prior to providing psychological services to a young client, even though this was not immediately in the best interests of that client. The participant decided to proceed without obtaining guardian consent, as per harm reduction strategies, concluding that forgoing this obligation may be more beneficial to the youth. She did note, however, that even though she could successfully rationalize her decision, this could lead to censure by the psychological governing body, since informed consent was not obtained.

It would be valuable to investigate this further to ascertain if, and how, other practitioners experience pressures that might arise when professional ethical standards conflict with features of the harm reduction model. If this is indeed the case, as this researcher suspects, a discussion at the regulatory level regarding the ethics and practice of harm reduction may be beneficial. Using harm reduction approaches, at least for these participants, is conducive to working with high-risk youth. It may be advantageous to further explore and reconcile, if needed, the use of this approach with the ethical standards and practice of this field of work. It was apparent that maintaining the working alliance between client and counsellor is important to practitioners (this study; Duncan et al., 2012; Sullivan et al., 2002). This should be thoroughly explored within the context of harm reduction approaches and ethical decision-making.

One of the central themes that emerged in this study were the experiences of acceptance and sitting with tension. Adding these discussions to undergraduate and post-

graduate ethics courses might assist students in mastering these concepts. However, due to the small number of participants in this study it would be gainful to research this experience further. Do acceptance and sitting with tension continue to exist for a larger cohort? How does one learn to sit with tension? Can this be taught? Are there any linkages between personality styles, acceptance, and sitting with tension? It may be important to note that further research in this area would not only benefit psychologists working with high-risk populations. All psychologist who experience ethical tensions may benefit from further research regarding acceptance and "sitting with" ethical tensions.

The experience of ethical tensions was different for each practitioner. Those with more experience seem to be more comfortable with ethical tensions and how to handle them. The first participant, Maria, had the least amount of professional practice. This may have contributed to her more significant experience of anxiety and concerns about implementing harm reduction approaches. Karen, on the other hand, who is a more seasoned psychologist, experienced the least anxiety. It is unclear if this is can be attributed to level of experience, personality styles, or perhaps some combination of each. It may be useful to explore how individual differences influence the experience of ethical tension among those who use a harm reduction model.

Further research that focuses on implementing harm reduction strategies with high-risk youth, is needed. The ethical tensions practitioners experience when working with this population, and how these experiences are managed, needs to be studied as well. Though the number of psychologists who work with high-risk youth and use harm reduction strategies may be small, it is this author's opinion that the experiences of this

group are important and relevant to the field of psychology. The participants in this study described being frequently faced with ethical tensions and operating in a high-stress environment. Abstinence-based approaches have been met with limited success (Kelly, 2012; Marlatt, Blume & Parks, 2001; Poulin, 2006). As the participants indicated, harm reduction is a suitable and appropriate approach when working with high-risk populations, and this approach has shown some promising results in reducing alcohol-use and other risky behaviours in adolescents (Kelly, 2012). In addition, studies have shown that working with vulnerable and high-risk populations can lead to increased risks of burnout among mental health professionals (Newell & MacNeil, 2010; Oser, Biebel, Pullen, & Harp, 2013; Rupert, Miller, & Dorociak, 2015). Improving our understanding of the ethical tensions that seem inherent to the work of these professionals may lead to reduced practitioner burnout and better outcomes for the clients whom they serve.

It is worth considering the role that alternative methodologies can play in helping to explicate a given phenomena (Smith et al., 2009). It would be appropriate to note that aside from IPA, there are other methodologies that could profitably be used to increase understanding of ethical tensions experienced by psychologists who subscribe to a harm reduction approach. A narrative research study may also have been appropriate to explore this issue. According to Creswell (2013), a narrative study consists of gathering data from a select few number of participants through the collection of their stories and experiences. A narrative study may shed light upon the "identities of individuals and how they see themselves" (Creswell, 2013, p. 71). A narrative research design would also have been well suited to capture the experiences of psychologists who are faced with ethical

tensions in greater contextual detail, thus helping to identify how one's personal story intersects with the phenomena under investigation.

Aside from a narrative study, a case study methodology may also be appropriate to investigate this phenomena. Case studies can provide an in-depth understanding of a case (Creswell, 2013), which would be beneficial if one is trying to gain a deeper understanding of the experience of acceptance and/or sitting with tension. For instance, a case study may shed light to how sitting with tension is learned and adapted across the span of one's career.

Finally, though qualitative research into this phenomena is certainly beneficial, quantitative research may also shed further light on this topic. It may be useful to investigate the types and prevalence of ethical tensions that psychologists experience when working with high-risk youth and using harm reduction. Knowing if, and how many, psychologists use harm reduction approaches may warrant further exploration of how this approach can be applied into counselling practices with high-risk youth.

**Limitations**

There are a number of limitations present in this study. Though Smith et al. (2009) suggest a small number of participants for the first-time researcher, a larger sample could increase confidence in the validity of the themes and subthemes identified in this research. In addition, the role and impact of the place of employment might have altered he findings of this research. All of the participants in this study were employed by the same agency. Having participants from different agencies, and perhaps even different cities, could lead to important nuances with respect to this study's findings. Furthermore, one cannot help but wonder how the findings may have been different had participants

worked for an agency that did not endorse harm reduction approaches. As such, this, as well as the small number of participants, is a limitation of the study and a note for further research on this topic.

Because this research is qualitative and uses a small sample size, the findings cannot be generalized to the greater population of psychologists. Hefferon and Gil-Rodriguez (2011) suggest that rather than generalizability, which is not typically a goal of qualitative research, researchers ought to aim for transferability. Transferability means that other individuals who experience the same phenomenon as the one described in the study, can transfer knowledge from this respective study to their own practice (Hefferon & Gil-Rodriguez, 2011). As mentioned, IPA does not attempt to draw conclusions about a general population, but instead focuses on a smaller group of people experiencing a specific phenomenon, in a specific context (Smith et al., 2009). It is this researcher's opinion that this study meets the criteria of transferability and that the findings of this study can be applied to the practice of psychologists who experience ethical tensions as a result of using harm reduction approaches with high-risk youth.

Another limitation that may have arisen in this study is the accuracy of events that the participants recalled (Heppner & Heppner, 2004). Glesne (2011) stated that some common issues that arise in interviews include the hesitancy of participant to discuss certain topics, or the overzealous pursuit of a topic because participants believe that it is what the researcher is interested in hearing about. To remedy this concern, questions prompted participants to provide their accounts, but did not influence how participants told their stories. Participants were given the opportunity to reflect on their experiences or consult case notes.

A final concern was the potential reluctance of participants to disclose their experiences of using harm reduction when counselling high-risk youth. Harm reduction is still, in some communities, a controversial practice, and its social, political, and philosophical critiques are well documented (Carter, Miller & Call, 2012; Hathaway, 2001). In the use of harm reduction, it is possible that some practitioners may not have followed the protocol required by their agency or governing regulatory body, which dictate responding actions once clients report engaging in risk-taking behaviours. Participants may have been unwilling to share this information for fear that they will be reported to their supervisors or to a governing regulatory body.

To mediate this concern, all questions about anonymity and confidentiality and the study were addressed. Participants were directed to information that outlined their rights as participants, and whom to contact if they have any questions. Participants were reminded that they can withdraw from the study and request removal of the data provided prior to analysis. Participants did not display or report any hesitancy with disclosing harm reduction interventions. All participants were strong advocates of this approach and stated so throughout their involvement in this research study.

**Conclusion**

In conclusion, this research provides a small, yet important look into the lived experiences of psychologists who experience ethical tensions as a result of working with high-risk youth while adhering to a harm reduction approach. Though each psychologist will likely have unique experiences of this phenomenon, for the participants in this study, the common experiences of questioning, acting, and holding characterized their experiences.

In particular, sitting with tension can be contrasted with conventional beliefs and practices that suggest how ethical tensions should be managed. This study introduces the idea that an immediate ethical response might in some circumstances give way to a form of coexistence with an ethical tension. This is especially significant for those professionals who work in environments where ethical tensions are common and resolutions of these tensions are hampered by philosophical and practical constraints. It may be important for psychologists to take a step back from solving an ethical tension and allow the client to work through that process for themselves. As one participant said,

> *"Harm reduction is by, by nature umm…an unfolding narrative process. It isn't the instant gratification and I think…and it also isn't the ability to control the outcome. And so, there seems to me to be a social bias in controlling…to control outcomes. And to avoid, and to have instant gratification. Instant gratification means the instant resolution of the tension. And…and everything about harm reduction becomes fraught with difficulty because it is not congruent with that."*

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*Appendix A: Interview Questions*

**Background Information**

1. Tell me a little about your career? (Without specifics)
    a. What is your professional designation?
    b. How long have you worked in this field?
2. What made you choose this career/job?
3. What do you like most/like least?
4. Why did you choose to work with high-risk youth?
5. Tell me a little about your clients, generically...
6. Is there anything else you would like to mention?

**Theoretical Models**

1. Tell me about your theoretical models or approaches.
    a. The following serve as prompts:
        i. Why these models (particularly, harm reduction)?
        ii. What is your professional attraction to these models (particularly, harm reduction)?
        iii. What about your personal attraction (particularly, harm reduction to these models)?
        iv. What is your agency's/supervisor's stance on your model of choice? Do they encourage or discourage the use of any particular model? What is the agency's/supervisor's stance on harm reduction?
        v. Tell me about some of the therapeutic techniques you use in your work?
2. Is there anything else you would like to mention?

**Ethical Tensions**

1. Tell me about an ethical tensions that you have encountered when working with high-risk youth.
    a. The following serve as prompts:
        i. What happened?
            1. What made it an ethical tension?
            2. Did harm reduction play a role? How?
        ii. What was your experience?
        iii. How did you feel?
            1. Professionally?
            2. Personally?
        iv. How did you respond?

1. Professionally?
2. Personally?

v. What therapeutic approach formulated your response?

2. Was there a conflict between your professional and personal reactions to the dilemmas?
    a. The following serve as prompts:
        i. How did you feel?
        ii. What did you do/How did you manage this?
3. Is there anything else you would like to mention?

*Appendix B: Informed Consent Document*

Ethical Tensions, High-Risk Youth, and the Harm Reduction Approach –

Information Sheet


| **Researcher:** Patricia Suteu | **Supervisor:** Simon Nuttgens |
|---|---|
| Athabasca University | Athabasca University |
| Graduate Centre for Applied Psychology | Graduate Centre for Applied Psychology |
| Graduate Student | Associate Professor |
| **Email:** patricia.suteu@gcap.ca | **Email:** simonn@athabascau.ca |
| **Cell phone:** 403.969.0391 | **Work phone:** 250.496.5143 |


**Purpose of the research.**

You are being in invited to participate in a study that explores the experience of ethical tension among psychologists who work with high-risk youth using a harm reduction perspective. Research indicates that ethical dilemmas are more common among psychologists who work with this population. It is thought that psychologists who embrace a harm reduction approach with high-risk youth will experience unique ethical tensions. At present, there is no research to support this assumption; hence, the reason for the current study.

**Who can participate in the research?**

You must be either a psychology internship student, provisional psychologist, or registered psychologist to participate in the study. You may use any therapeutic model, but must incorporate harm reduction in your practice with high-risk youth.

**What choice do I have?**

You may withdraw your participation in this study at any time up until the data analysis stage. If you choose to withdraw from the research prior to the data analysis stage, all of the information you have provided will be destroyed. There is no penalty for discontinuing to participate.

**What will I be asked to do?**

Interviews will be audio-taped and will take 60-90 minutes. You will be asked questions regarding your work with high-risk youth and your experience of ethical tensions with this population. You may choose to not to answer any questions that make you feel uncomfortable or you do not wish to answer.

**What are the risks and benefits of participating?**

It is hoped that the information learned will be able to inform practice and education in this regard. Participants will receive a Tim Hortons (or equivalent) gift card (valued at $20) as a thank-you for participating in the study. You will receive this gift card

regardless of whether you decide to withdraw from the study. No other compensation, financial or otherwise, will be offered.

There are no identifiable risks associated with participating in this study. Your participation in this research is confidential. No identifying information (e.g., place of employment, age, name, etc.) will be linked to you. This researcher and her supervisor will be the only ones with access to the data. All data will be stored on a password-protected laptop. Paper data will be stored in a locked cabinet at the researcher's home.

**How will the information collected be used?**

A copy of the results will be provided to participants upon request. Results of the study will be used as a partial fulfillment for the completion of a Master's thesis. In the event of a publication or presentation resulting from the research, no personally identifiable information will be shared.

**What do I need to do to participate?**

To participate, you must read and sign the consent form. The researcher will then contact you to determine a suitable time and location to conduct the interview. You are encouraged to ask questions at any time prior to and during the interview.

**Consent form**

This is to verify that I have read the Letter of Information, as well as this Consent Form was provided to me.

My signature demonstrates that:

1. I understand that my participation on this study is voluntary and that I may withdraw at any time without consequence or needing to provide a reason.
2. I understand the scope, purpose, benefits, and risks of this study as described in the Information Letter.
3. I am aware of what is required of me as a participant in this study and all questions have been answered to my satisfaction.

| | |
|---|---|
| X _____ | X _____ |
| Participant | Researcher |
| _____ | _____ |
| Date | Date |

This study has been reviewed by the Athabasca University Research Ethics Board. Should you have any comments or concerns regarding your treatment as a participant in this study, please contact the Office of Research Ethics at 780-675-6718 or by e-mail to rebsec@athabascau.ca

A copy of this consent will be given to you. Please keep it for your reference.

## *Appendix C: Member Checking*

Participants were given the opportunity to review the results for accuracy. Two of the three participants did so, the third being unable to do so due to time constraints. The two participants who did review the analysis reported that the findings were in line with their experiences.

*Appendix D: Memorandum from Athabasca University Research Ethics Board*

Athabasca University
RESEARCH CENTRE

January 28, 2015

Miss. Patricia Suteu
Faculty of Health Disciplines\Graduate Centre for Applied Psychology
Athabasca University

File No: 21666

**Expiry Date: January 27, 2016**

Dear Miss. Patricia Suteu,

The Faculty of Health Disciplines Departmental Ethics Review Committee, acting under authority of the Athabasca University Research Ethics Board to provide an expedited process of review for minimal risk student researcher projects, has reviewed you project, 'Exploring the Experiences of Using Harm Reduction with High-Risk Youth'.

Your application has been **Approved on ethical grounds** and this memorandum constitutes a ***Certification of Ethics Approval***. You may begin the proposed research.

AUREB approval, dated January 28, 2015, is valid for one year less a day.

As you progress with the research, all requests for changes or modifications, ethics approval renewals and serious adverse event reports must be reported to the Athabasca University Research Ethics Board via the Research Portal.

To continue your proposed research beyond January 27, 2016, you must submit an Ethics Renewal Request form before January 2, 2016.

**When your research is concluded**, you must submit a Project Completion (Final) Report to close out REB approval monitoring efforts.

At any time, you can login to the Research Portal to monitor the workflow status of your application.

If you encounter any issues when working in the Research Portal, please contact the system administrator at research_portal@athabascau.ca.

If you have any questions about the REB review & approval process, please contact the AUREB Office at (780) 675-6718 or rebsec@athabascau.ca.

Sincerely,

Sherri Melrose
Chair, Faculty of Health Disciplines Departmental Ethics Review Committee