ABSTRACT

GRAHAM, LATONYA MICHELLE. Justified Disclosure: A Phenomenological Study Exploring Licensed Professional Counselors’ Experiences with Breaking Confidentiality. (Under the direction of Dr. Siu-Man Ting and Dr. Lisa Bass).

The American Counseling Association (ACA) Code of Ethics is a guide for the counseling profession, with its latest revision published in 2014. Every counselor is responsible for reading, understanding, and following the ACA Code of Ethics and its subsequent revisions. Counselors need to know and adhere to applicable laws and regulations related to the recent modernization of the code. A current review of literature yielded no other studies addressing counselors’ understanding and application of the change in the 2014 ACA Code of Ethics pertaining to confidentiality and disclosure, revealing a gap in extant research in this area.

This phenomenological study examines the revision to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics as it relates to the understanding, application, and training needs of LPCs in North Carolina. The researcher addressed ethical concerns associated with third-party disease notification, coining the term justified disclosure. Theory of Planned Behavior (TPB) and Diffusion of Innovations (DOI) Theory provide a conceptual framework to study LPCs’ lived experiences with “duty to inform” and “justified disclosure” of health information to third parties placed at risk for contracting a life-threatening, communicable disease. Using this conceptual framework to underpin the data analysis process, the current study explored the independent knowledge, beliefs, and pre- and post-revision practices of LPCs. It also examined determinants of ACA Code of Ethics revision adherence and obtained a collective perspective of counselors’ knowledge of the disclosure process.

Data from Personal History Demographic Questionnaires, Individual Written Questionnaires, and focus group discussions were collected and analyzed for themes and
subthemes using content analysis. The emerging themes related to LPCs’ understanding and application of the revision to confidentiality and privacy section were “deprivation of information” and “responsibility to others.”

The results indicated that LPCs lack information, have limited resources, and find it necessary to search for information based on nonexistent guidelines and training opportunities for justified disclosure of health information to third parties placed at risk for contraction of a life-threatening, communicable diseases. Yet there appears to be consensus concerning LPCs’ responsibility to their clients, community, and the profession. Due to the complexities of this revision, counselors received a new set of responsibilities likely to leave even the most seasoned counselor with unanswered questions. Through this study’s examination of the issue, counselors have the potential to obtain a greater understanding of expectations, pitfalls, and strategies for ethical decision-making related to their legal “duty to inform.”
Justified Disclosure: A Phenomenological Study Exploring Licensed Professional Counselors’ Experiences with Breaking Confidentiality

by
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A dissertation submitted to the Graduate Faculty of North Carolina State University in partial fulfillment of the requirements for the degree of Doctor of Philosophy

Counseling and Counselor Education

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DEDICATION

I dedicate my dissertation to the first man that I ever loved and the one man who wanted this achievement for me with all his heart—my father, Thomas.
BIOGRAPHY

Latonya Michelle Graham earned a Bachelor of Science degree in Psychology and Bachelor of Arts degree in Sociology at the University of Alabama in Birmingham. Latonya also earned a Master of Arts degree in Psychology (Counseling) and a Graduate Certificate in Substance Abuse Studies at Fayetteville State University (FSU) in North Carolina. She is a National Certified Counselor and Licensed Professional Counselor Supervisor. Latonya has more than a decade of counseling experience serving children, adolescents, adults, couples, and families. Latonya has served as an Intensive In-home Services Clinician, Staff Psychologist II Trainee, and Community College Instructor, as well as serving as a Teaching Assistant for her doctoral program.

One of Latonya’s most rewarding experiences has been providing counseling, consultation, programming, mentoring, and supervision to racially and ethnically diverse students and staff in the university setting. As a member of the Division of Student Affairs, Latonya has held numerous leadership roles including the Residence Life Counselor for all residence halls on campus, Coordinator and Facilitator for Freshman Female Retention Initiative, Substance Abuse Prevention Coordinator, Alcohol Awareness Peer Mentor Advisor, University Representative for Safe & Healthy Campus Communities Coalition, Program Director for FSU Comprehensive Health Initiative, Senior Class Council Advisor, and Chair of various committees.

Latonya is a member and Doctoral Committee Chair of the Nu Sigma Chi Chapter of Chi Sigma Iota (CSI) International Honor Society, and past President of the FSU Chapter of Psi Chi National Honor Society in Psychology. She is a member of the American Counseling Association, as well as the North Carolina Counseling Association, and has previously served as Secretary of the North Carolina Association for Multicultural Counseling and Development. Her
research interests include ethics, aging population, and racial disparities in mental health. In 2016-2017, Latonya was selected as the Wilkinson Graduate Ethics Fellow.
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I am most thankful to God for His love and faithfulness toward me. I am also greatly appreciative of the service and various life lessons that I have learned while working with my dissertation committee. To Dr. Siu-Man Raymond Ting, Dr. Lisa Bass, Dr. Edwin Gerler, & Dr. Marc Grimmett, thank you for the ways each of you have guided me through this process while teaching me invaluable lessons about the importance of scholarship, leadership, advocacy, life balance, consistency, integrity, family, friendship, and love. I truly appreciate your immeasurable contributions to my work and my life.

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CHAPTER 1: INTRODUCTION

Chapter Introduction

This chapter introduces qualitative research that was conducted to investigate the revision to the 2014 ACA Code of Ethics’ confidentiality and privacy section pertaining to communicable, life-threatening diseases, as it relates to the understanding, application, and training needs of Licensed Professional Counselors (LPCs) in North Carolina. The current study explores the lived experiences of LPCs faced with new responsibilities outlined in the 2014 ACA Code of Ethics. This chapter provides background information, rationale, statement of the problem, purpose, theoretical foundation, significance, and additional information to support this research study.

In like manner that physicians practice medicine with their patients, professional counselors provide mental health services to diverse client populations. According to the 20/20 consensus definition endorsed by 29 major counseling organizations, counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals (Kaplan, Tarvydas, & Gladding, 2014). Counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve (ACA, 2014; AMCD, 1996; NBCC, 2017). While most clients seek support for psychological issues, some enter therapeutic relationships to address medical issues. Medical issues may include diseases or conditions that range from being severe, sudden, and short-term (acute) to those that are persistent, recurrent, and long-lasting (chronic). Some diseases are treatable and/or curable (such as gonorrhea, chlamydia, and syphilis), while others are considered life-long and incurable (such as the human immunodeficiency virus (HIV), human papillomavirus (HPV), and herpes simplex virus (HSV)). Certain diseases are deemed reportable, usually by physicians, based upon
public health standards. Some reportable diseases include cholera, cryptosporidiosis, HIV, and syphilis. Other diseases that are not considered reportable based upon public health standards include respiratory syncytial virus (RSV), Hand, Foot and Mouth disease (Enterovirus), Mononucleosis (Epstein-Barr Virus), Cytomegalovirus, Pediculosis (lice), Norovirus, Shingles, and other forms of non-neonatal HSV. There are many nuances to disease statuses and how they affect the mental health of individuals who receive these diagnoses.

In some cases, clients disclose that they have been diagnosed with a disease commonly known to be both communicable and life-threatening. The medical definition of communicable disease is an infectious disease transmissible, as from person to person, by direct contact with an affected individual or the individual's bodily discharges by indirect means. The definition of life-threatening disease refers to a potentially fatal disease that causes fear or anxiety by threatening great harm. Some untreated communicable, life-threatening diseases are fatal within hours (such as Ebola); while other communicable, life threatening diseases may take a longer period of time to disable the body (such as HIV).

The stigma associated with communicable and life-threatening diseases, such as HIV and acquired immunodeficiency syndrome (AIDS), may lead many clients to experience mental and emotional anguish. HIV is an incurable virus spread through certain body fluids that attack the body’s immune system, specifically the CD4 cells, often called T cells (CDC, 2017), and it can lead to AIDS if not treated. AIDS is the most severe phase of HIV infection. In this phase, the immune system is so badly damaged that the individual acquires an increasing number of severe sicknesses called opportunistic illnesses. People are diagnosed with AIDS when their CD4 cell count drops below 200 cells/mm or if they develop certain opportunistic illnesses (CDC, 2017).
Of the substantial number of varied communicable and life-threatening diseases, HIV and AIDS are probably the most publicly recognized conditions.

Some diseases are developed based on a genetic predisposition or reasons beyond the client’s control. However, there are other diseases that are contracted based on behaviors usually identified as immoral or illegal by society-at-large, including high-risk sexual contact or drug use. Clients identified as being diagnosed with preventable communicable and life-threatening diseases usually garner minimal empathy and concern. The disease status may even be viewed by others as a deserved natural repercussion or direct consequence for the person’s behavior. In other cases, the sentiment may be that consenting adults are responsible for their own health and prior verification of their chosen drug sharing or sexual partners’ disease status. The idea that the contraction of communicable, life-threatening diseases is completely avoidable based on better choices or different moral decisions dismisses entirely the many instances of unknown or unintended exposure and disease contraction by interaction with a trusted infected person who may or may not know their own disease status.

Regardless of the circumstances surrounding contraction, receiving a diagnosis of a communicable, life-threatening disease is likely to place the person in a vulnerable position. Along with facing mortality, the potential threat of having one’s disease status prematurely exposed is a unique stressor for many clients diagnosed with communicable, life-threatening diseases. Fears related to these types of diagnoses may also include self-harm (such as excessive concerns about personal cleanliness or additional infection), diminished self-worth, potential threat of harm to others, and rejection by family, friends, intimate partners, and society. Many clients may be reluctant to discuss or disclose their diagnoses due to an overwhelming sense of shame, personal responsibility, or threat of isolation.
In addition to the ways clients themselves respond to diagnoses of communicable and life-threatening diseases, the response of loved ones is also likely to become a major concern. Denial of the disease, the severity of the symptoms, or even the possibility of death is a common response among relatives of HIV/AIDS patients (Boyd-Franklin, Steiner, & Boland, 1995). When fear of their responses causes close family members and friends to no longer provide support, persons diagnosed with diseases commonly known to be both communicable and life-threatening may identify counselors as the only source of support for their emotional and mental health needs. The understanding that information shared in counseling sessions is both private and confidential could provide an elevated sense of relief for people under the perception that they have received a detrimental life-long label or death sentence.

**Study Background**

Trust is the cornerstone of the counseling relationship, and counselors have a responsibility to respect and safeguard the client's right to privacy and confidentiality (ACA, 2014). Though this is the expectation, instances occur when counselors have responsibilities to identifiable third parties. Based on their unique professional responsibilities and obligations, professional counselors also have specific duties related to warning, informing, and reporting directed by state and national governing authorities of the profession.

The California Supreme Court decision in *Tarasoff v. Regents of the University of California* (1974, 1976) set a standard for circumstances in which practitioners must reveal confidential information if needed to warn others of potential dangers from a client (Corbin, 2007). “Duty to warn” refers to the responsibility of a counselor to breach confidentiality if a client or other identifiable person is in clear or imminent danger. Simply reporting to or notifying police is insufficient action to protect the life of the intended victim or the counselor from a
lawsuit if the client's threat is carried out (Mobley & Naughton, 2011). Depending on location of practice, “duty to warn” requires most mental health professionals to break the confidentiality of a client and warn an intended victim when a client poses a threat to self or another individual. In situations where there is unambiguous evidence of danger to the client or other persons, the counselor must determine the degree of seriousness and notify the person in danger and those who are able to protect that person from harm.

Counselors faced with a “duty to inform” may be justified in disclosing information to identifiable third parties if the parties are known to be at serious and foreseeable risk of contracting a communicable and life-threatening disease from a client (ACA, 2014). The general expectation is that counselors will rely on their interpretation of “relevant” state laws concerning disclosure about the disease status of a client. In reference to North Carolina, there is no statute to guide clinicians in their “duty to warn” or protect third parties from patients or clients (Mobley & Naughton, 2011).

Some interesting differences exist between “duty to warn” and “duty to inform.” The public peril implied by “duty to warn,” as outlined in Tarasoff v. Regents of the University of California (1974, 1976), refers to a client threatening to physically harm and/or murder a third party. In the case of “duty to inform,” the focal point is the contagious and life-threatening diagnosis of a client and the potential risk to others through contact. Unlike the certainty of “duty to warn” situations, counselors faced with “duty to inform” circumstances may be justified in disclosing information to identifiable third parties if the parties are known to be at serious and foreseeable risk of contracting the disease.

In addition to these disclosure mandates, a counselor has a legal “duty to report” child abuse in all states, in line with the ethical codes of the American Counseling Association (ACA).
Moreover, many states have mandatory laws for all citizens about reporting abuse of the elderly and persons with disabilities. The “duty to report” spousal abuse and other forms of domestic violence is also usually applicable to medical personnel.

**Disclosure Guidelines of Other Disciplines**

Counselors are not the only professionals faced with responsibilities related to disclosure of client information to third parties. However, professional counselors receive guidance from the ACA Code of Ethics (ACA, 2014). According to Kaplan and Martz (2014), the Code of Ethics is a living document that reflects the combined wisdom of the profession and its values and professional obligations to the people who members serve. Since 1961, the ACA Code of Ethics has evolved from a focus on the counselor to a focus on the needs of the client.

According to Forester-Miller and Davis (1996), the foundation of the ACA Code of Ethics is Kitchener's (1984) five moral principles: autonomy (independence), justice (fairness), beneficence (do good), nonmaleficence (do no harm), and fidelity (loyalty). Counselors accept and respect their clients’ freedom of choice. If a client is going to be treated differently, the counselor must provide a rationale that explains the necessity and appropriateness of doing so. Counselors have a responsibility to aid their clients’ welfare, including being proactive and preventing them from harm, even from the counselor’s own personal beliefs and biases. Counselors do not intentionally inflict harm to their clients, nor do they engage in actions or assumptions that risk harming clients. They must be faithful in honoring their commitment not to threaten the therapeutic relationship or leave any obligations unfulfilled. ACA members and even professional counselors who are not members of the organization are expected to use these values and ethical principles for guidance in all counseling work (Meyers, 2014).
Other disciplines adhere to their own standards for practice and ethical codes that help guide them in their duties, including disciplines such as psychology, social work, marriage and family therapy, addictions, and medicine. Like LPCs, professionals from each of these disciplines have their own established duties involving both confidentiality and disclosures. Additionally, just as counselors, they are accountable to their own professional organizations. Table 1.1 below lists some disclosure guidelines used by other disciplines.

**Table 1.1: Disclosure Guidelines of Other Disciplines**

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<tr>
<td>Psychology</td>
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<td>Marriage and Family Therapy</td>
<td>American Association for Marriage and Family Therapies</td>
<td>AAMFT Code of Ethics</td>
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<tr>
<td>Addictions</td>
<td>National Association for Addiction Professionals</td>
<td>National Certification Commission for Addiction Professionals Code of Ethics</td>
</tr>
<tr>
<td>Medicine</td>
<td>American Medical Association</td>
<td>Code of Medical Ethics</td>
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For example, the professional organization for psychologists is the American Psychological Association (APA). The APA (2017) adheres to the Ethical Principles of Psychologists and Code of Conduct, which reads as follows when referring to confidentiality and disclosures, “Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law” (n.p.).
Similarly, the professional organization for social workers is the National Association of Social Workers (NASW), which follows a Code of Ethics that states:

(a) Social workers should respect clients' right to privacy. Social workers should not solicit private information from or about clients except for compelling professional reasons. Once private information is shared, standards of confidentiality apply; (b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client; (c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or others. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed. (NASW, 2017, n.p.)

The professional organization for marriage and family therapists is the American Association for Marriage and Family Therapists (AAMFT). AAMFT (2015) adheres to the following Standard II regarding confidentiality and disclosure:

Marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard the confidences of each individual client…Marriage and family therapists disclose to clients and other interested parties at the outset of services the nature of confidentiality and possible limitations of the clients’ right to confidentiality. Therapists review with clients the circumstances where confidential information may be requested and where disclosure
of confidential information may be legally required. Circumstances may necessitate repeated disclosures. (n.p.)

The organization for addiction professionals is the National Association for Addiction Professionals (NAADAC), which represents the professional interests of more than 100,000 addiction counselors, educators, and other addiction-focused health care professionals in the United States, Canada, and abroad. NAADAC (2016) is guided by the National Certification Commission for Addiction Professionals Code of Ethics, which requires addictions professionals to adhere to the following standards for confidentiality and disclosure, as written in Principle II, Confidentiality and Privileged Communication:

Addiction Professionals understand that confidentiality and anonymity are foundational to addiction treatment and embrace the duty of protecting the identity and privacy of each client as a primary obligation. Counselors communicate the parameters of confidentiality in a culturally-sensitive manner…Addiction Professionals, during informed consent, shall disclose the legal and ethical boundaries of confidentiality and disclose the legal exceptions to confidentiality. Confidentiality and limitations to confidentiality shall be reviewed as needed during the counseling relationship. Providers review with each client all circumstances where confidential information may be requested, and where disclosure of confidential information may be legally required. (n.p.)

The NAADAC (2016) goes on to address the circumstance of imminent danger:

Addiction Professionals may reveal client identity or confidential information without client consent when a client presents a clear and imminent danger to themselves or to other persons, and to emergency personnel who are directly involved in reducing the danger or
threat. Counselors seek supervision or consultation when unsure about the validity of an exception. (n.p.)

The professional organization for physicians is the American Medical Association (AMA). The AMA (2016) adheres to the following code for confidentiality and disclosures:

Patients need to be able to trust that physicians will protect information shared in confidence. They should feel free to fully disclose sensitive personal information to enable their physician to most effectively provide needed services. Physicians in turn have an ethical obligation to preserve the confidentiality of information gathered in association with the care of the patient. In general, patients are entitled to decide whether to disclose their personal health information, and to whom it is disclosed. When disclosing patients’ personal health information, physicians should (a) Restrict disclosure to the minimum necessary information; and (b) Notify the patient of the disclosure, when feasible. (p. 5)

For the AMA, however, there are some situations that do not require specific consent. Specifically, the AMA (2016) code states:

Physicians may disclose personal health information without the specific consent of the patient (or authorized surrogate if the patient lacks decision-making capacity) in cases such as (c) To other health care personnel for purposes of providing care or for health care operations; (d) To appropriate authorities when disclosure is required by law; or (e) To other third parties situated to mitigate the threat when in the physician’s judgment there is a reasonable probability that the patient will seriously harm him/herself or inflict serious physical harm on others. For any other disclosures, physicians should obtain the consent of the patient (or authorized surrogate) before disclosing personal health information. (AMA, 2016, p. 5)
Though mental health professionals and physicians are given some expectations about confidentiality and options for disclosure, specific guidelines outlining how to properly carry out disclosure of information to identifiable third parties, if the parties are known to be at serious and foreseeable risk of contracting a communicable and life-threatening disease, do not appear to exist for any of the disciplines.

**Rationale for the Study**

In June 2011, the ACA governing council appointed and charged the Ethics Revision Task Force with completing the latest revisions to the ACA Code of Ethics (Kaplan et al., 2017). The focus of this dissertation involves a revision to the confidentiality and privacy content, or more specifically, clarification of the meaning of “duty to inform.” This section of the ACA Code of Ethics (2005) addressing “duty to inform” has been underutilized based on the Ethics Revision Task Force’s conclusion that counselors have found it to be impossible to fulfill the requirement of confirming a client’s disease status if the client did not give permission to release such information (Kaplan & Martz, 2014). Physicians in the United States are bound by the Health Insurance and Portability and Accountability Act (HIPAA), which requires authorization forms for use of patients’ personal data collected by certain health care providers (Semaan, Klovdahl, & Aral, 2004). Due to these potential obstacles related to “duty to inform,” Section B.2.c. of the 2005 ACA Code of Ethics, “Contagious, Life-Threatening Diseases,” was revised by the Ethics Revision Task Force in the current 2014 version of the guidelines. The researcher for this study addressed ethical concerns associated with third-party disease notification, coining the term *justified disclosure* to refer to a clinician’s defensible disclosure of a client’s confidential medical condition to another person.
Problem Statement

The 2014 ACA Code of Ethics does not require a counselor to confirm a client’s communicable and life-threatening diagnosis as the initial step for being “justified” in their “duty to inform” or disclose the client’s status to a person at risk. The presumed advantage of this revision to the 2005 Code is that counselors can help with the reduction of the transmission of diseases with fewer hindrances. The expectation of the current code is that counselors will rely on their own interpretation of “relevant” state laws concerning disclosure of disease status rather than acquire a confirmation from another source. Therefore, whether professional counselors reach out to a third party is based on their assessment of the willingness of the client with the infection to disclose the information about their contagious, life-threatening disease status. Presently, these decisions are made without the benefit of specific guidelines or acquiring third-party expertise. Consequently, the current standard is potentially ambiguous, vague, value-laden, and lacking in an evidence-based ethical decision-making process. Professional counselors do not have a standardized protocol for making a justified third-party disclosure and opportunities for education and training to address this specific professional duty or responsibility do not currently exist.

Purpose of the Study

The purpose of this qualitative study was to investigate the revision to the 2014 ACA Code of Ethics’ confidentiality and privacy section pertaining to communicable, life-threatening diseases, as it relates to the understanding, application, and training needs of Licensed Professional Counselors (LPCs) in North Carolina. The researcher used a phenomenological approach to “reduce individual experiences with this phenomenon to a description of universal essence” (Creswell, 2013, p. 76). Data gathered from written questionnaires and focus groups
were collected and analyzed using content analysis. North Carolina LPCs’ perspectives about their “duty to inform” and justified disclosure were explored to provide insights that may be used to guide future training and practice.

**Theoretical Foundation for the Study**

**Theory of Planned Behavior**

In 1985, Icek Ajzen and Martin Fishbein developed the Theory of Planned Behavior (TPB). TPB is an extension of one of their previous models, Theory of Reasoned Action. TPB states that behavioral achievement depends on motivation (intention), ability (behavioral control), and beliefs described as either behavioral beliefs, normative beliefs, or control beliefs. Six constructs have been identified to collectively represent a person’s actual control over their behavior: (a) attitudes, (b) behavior intention, (c) subjective norms, (d) social norms, (e) perceived power, and (f) perceived behavioral control (Van Lange, Kruglanski, & Higgins, 2012).

For LPCs, an example of behavioral achievement is the adoption and practice of specific ethical standards as outlined in their ethical code. Regarding intention, LPCs are highly motivated to practice ethically to provide safe, effective services, avoid disciplinary action, and maintain licensure. All LPCs must demonstrate proficiency by passing an examination and completing extensive, supervised practice hours. Increased awareness and understanding about their behavioral, normative, or control beliefs may lend insight into LPCs’ adoption and practice of specific ethical standards as outlined in their code.

As part of their licensure agreement with the North Carolina Board of LPCs (NCBLPC), all LPCs agree to stay abreast of updates and revisions to their code of ethics. Continuing education is required for the renewal of an LPC’s license to ensure that these professionals maintain their knowledge and competency in the field of counseling (NCBLPC, 2017b).
According to the ACA’s (2014) Code of Ethics, “counselors recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity” (p. 9). Counselors maintain their competence in the skills they use, are open to new procedures, and remain informed regarding best practices for working with diverse populations (ACA, 2014). However, actual adoption rates of revisions are likely to vary from counselor to counselor based on many factors.

**Diffusion of Innovations Theory**

In 1962, Everett M. Rogers developed the Diffusion of Innovations (DOI) Theory (Rogers, 2003), one of the oldest social science theories in existence. According to Rogers (2003), people (innovators, early adopters, early majority, late majority, and laggards), organizations, or societies adopt new ideas, products, or behaviors at different rates or stages. The stages, known as Rogers’ Innovation Decision Process, include knowledge (recognition), persuasion (rationale/motives), decision (adopt/reject), implementation (actual use), and confirmation (maintenance) (Harting, Rutten, Rutten, & Kremers, 2009). The rate of adoption is affected by some predictable factors that include relative advantage, compatibility, complexity, trialability, and observability. DOI Theory has been used successfully in public health, social work, communication, marketing, criminal justice, and agriculture. The concepts associated with DOI Theory offer valuable insight about counselors’ adoption rate of changes or updates to professional guidelines or standards. Graphic depiction of Ajzen’s (1985) Theory of Planned Behavior and Rogers’ (1962) Innovation Decision Process is displayed in Figure 1.
Counselors, like physicians, are privy to sensitive health information shared when providing care. The responsibilities of both counselors and physicians extend beyond individual clients and patients to the health and safety of our society at large. Examining the parallel experiences shared by counselors and physicians could help determine an optimal way for counselors to fulfill their obligation to protect identifiable third parties believed to be at serious and foreseeable risk of contracting a communicable, life-threatening disease from one of their clients. As with physicians, counselors may benefit from the opportunity to partner with trained public health officials to ensure that the appropriate steps are taken to inform identifiable persons.
The counseling profession’s influence is far-reaching when considering all the disciplines and professions that adopt basic counseling tenets or strategies as part of their training and/or techniques. In the case of public health, the Centers for Disease Control and Prevention (CDC), the leading national public health institute, trains partner counseling and referral service (PCRS) providers in client-centered prevention counseling (CDC, 1992, p. 190). The CDC (1992) notes that PCRS providers include a wide variety of qualified, trained healthcare professionals, such as physicians, nurses, counselors, and disease intervention specialists (DIS). As part of their training process, public health professionals learn prevention counseling strategies. These prevention counseling strategies involve guiding clients to understand the risk of becoming infected with HIV and other diseases and developing plans to reduce that risk for themselves and their partners. *Client-centered prevention counseling* is defined as “counseling conducted in an interactive manner that is directly responsive to the specific needs of the individual client” (CDC, 1992, p. 190). According to the CDC (1992), such an approach requires an understanding of the unique circumstances of client behavior, culture, knowledge, and socioeconomic status. This training is vital for professionals who operate as DIS because of their unique relationship with physicians and their role in the partner notification process.

According to the AMA (2016) Code of Medical Ethics, the information disclosed to a physician by a patient should be held in confidence. However, when a patient threatens to inflict serious physical harm to another person or themselves and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, which may include notifying law enforcement authorities (AMA, 2016). This response strategy is also required for professional counselors.
As with other similar diseases, physicians have a legal “duty to inform” when they determine that a patient diagnosed with HIV is likely to transmit the virus to another identifiable person. The steps physicians take are determined by their state laws. A common step that physicians take to fulfill their legal obligation is to employ the assistance of trained public health officials, usually referred to as DIS, who properly carry out the steps to inform the identifiable person(s). Though they lack clear expectations or benefit of similar training related to their “duty to inform,” professional counselors have similar responsibilities when parties are known to be at serious and foreseeable risk of contracting the disease.

According to the North Carolina Department of Health and Human Services (2008), some communicable diseases declared to be dangerous to the public, and thus reportable, include anthrax, botulism, cholera, dengue, diphtheria, gonorrhea, leprosy, Lyme disease, malaria, measles, pelvic inflammatory disease, Q fever, rabies (human), Rocky Mountain spotted fever, rubella, smallpox, syphilis, whooping cough, yellow fever, and other specified conditions. Given North Carolina’s acknowledgement of more than 70 reportable, communicable diseases, determining which life-threatening, communicable diseases lead to justification for disclosure to persons at risk as part of a counselor’s “duty to inform” could be daunting unless, of course, there is one specific disease in mind. If that is the case, discrimination, on the part of counselors left to make these determinations, is a concern. Cases of discrimination are likely when determinations are based on personal fears or biases and a limited scope of the appropriate application of what constitutes life-threatening, communicable diseases. Some diseases designated as contagious or life-threatening, such as HIV/AIDS, are considered a disability. People living with HIV/AIDS (PLWHA) are protected against discrimination under the Americans with Disabilities Act (ADA), a federal act that guarantees persons with disabilities
have equal opportunities in employment, housing, public accommodations, telecommunications, and transportation (U.S. Department of Justice, 2014).

Lack of knowledge about the intricacies of revision to confidentiality and privacy standard in the 2014 ACA Code of Ethics is problematic on many levels. Since the revision is still relatively new for the counseling community, counselors have opportunities to be introduced to the content in many ways. However, gatekeeping, supervision, education, and training are challenged when information on best practices and specific guidelines for disclosure have not been created and do not exist for these circumstances. Due to the 2014 revision of the ACA Code of Ethics, counselors have received a new set of responsibilities that are likely to leave even the most seasoned counselors with many unanswered questions. One of the goals of this study was to identify the potential risks of this change for professional counselors and to offer potential solutions for those risks. This study worked to fill a gap because no other study has addressed the current perceptions, experiences, and training needs of LPCs related to the revision to the confidentiality and privacy section of the 2014 ACA Code of Ethics.

**Methodology Overview**

This phenomenological study examined LPCs' understanding of and responses to the change in the 2014 ACA Code of Ethics pertaining to confidentiality and specifically to disclosure of health information to third parties placed at risk for contracting a life-threatening, communicable disease. Purposeful sampling was employed to identify LPCs from North Carolina for participation in the study, and potential participants were prescreened and recruited via telephone calls, emails (see Appendix A), and word-of-mouth. Ten participants provided written informed consent (see Appendix B) acknowledging they were under no obligation to
participate and could cease participation at any time, while also giving permission to be both audio-recorded and video-recorded. However, no video-recording took place.

Participants were assigned a pseudonym for confidentiality. The data for the current study were obtained through Personal History Demographic Questionnaires, Individual Written Questionnaires, and focus groups held at a location designated for education in North Carolina. Completing all portions of the study took each participant approximately 90 minutes. There were two separate focus groups conducted with cohorts of five participants each, led by the researcher, with the focus groups meeting on different days.

**Research Questions**

This study attempted to answer the following research questions and used them to guide the study and the analysis:

1. What are Licensed Professional Counselors’ understanding and application of the revision to confidentiality and privacy as written in Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics?

2. What are the current training needs of Licensed Professional Counselors regarding the revision to confidentiality and privacy as written in Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics?

**Limitations and Delimitations**

**Limitations of the Study**

Based on the selection of a qualitative study approach, replication of this research would be difficult. Although this study addressed a national dilemma among counselors, purposeful sampling was used to identify local LPCs from North Carolina, and counseling ethics guidelines vary from state to state. Thus, this study’s findings may not be applicable to counselors in other
geographic regions based on its focus on the practices and views of North Carolina-based LPCs. Moreover, seeking convenience and availability when locating accessible participants may have limited this researcher’s opportunities for a more diverse sample. Due to the convenience, availability, location, specificity of this sample, and exploratory nature of the study, application of generalizations and transferability may be problematic.

**Delimitations of the Study**

An initial delimitation imposed on this study was the choice to administer web-based individual written questionnaires to introduce the focus group experience rather than conducting interviews with each of the 10 participants in addition to the focus groups. There were concerns about the effect that being exposed to information during the focus group could have on participants’ responses if interviews were held after the focus group. There was also concern about post-interview attrition and how the lapse of time or other unknown factors related to conducting all 10 interviews in advance could negatively impact the opportunity to complete the intended focus groups.

Another delimitation imposed on the current research was the use of a combination of constructs in applying both the TPB and DOI Theory to create the study’s conceptual framework. Specific questions from related studies based on these two theories were adapted to address the overarching research questions of the current study, but the selected conceptual framework did not account for other aspects of the individual theories.

**Definitions of Terms**

The following terms were used throughout this study:

*American Association for Marriage and Family Therapists (AAMFT):* A professional organization for marriage and family therapists which adheres to the AAMFT Code of Ethics.
The AAMFT strives to honor the public trust in marriage and family therapists by setting standards for ethical practice as described in their code, ethical standards which define professional expectations, and are enforced by the AAMFT Ethics Committee (AAMFT, 2015).

**Acquired Immunodeficiency Syndrome (AIDS):** The most severe phase of HIV infection in which people have such badly damaged immune systems that they contract an increasing number of severe illnesses, called opportunistic illnesses. People are diagnosed with AIDS when their CD4 cell count drops below 200 cells/mm or if they develop certain opportunistic illnesses (CDC, 2017).

**American Counseling Association (ACA) Code of Ethics:** A guide for professional counselors (ACA, 2014). This living document reflects the combined wisdom of the profession, its values, and its professional obligations to the people the ACA’s members serve (Kaplan & Martz, 2014).

**American Medical Association (AMA) Code of Medical Ethics:** Adopted principles that are standards of conduct which define the essentials of honorable behavior for a physician. It states that the information a patient discloses to a physician should be held in confidence (AMA, 2013).

**American Psychological Association (APA):** The professional organization for psychologists, which adheres to the Ethical Principles of Psychologists and Code of Conduct (APA, 2017).

**Americans with Disabilities Act (ADA):** A federal act that guarantees equal opportunities in employment, housing, public accommodations, telecommunications, and transportation for a person considered to have a disability (U.S. Department of Justice, 2014).
**Centers for Disease Control and Prevention (CDC):** The leading national public health institute and a United States federal agency under the Department of Health and Human Services. The CDC is the national headquarters for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States (CDC, 2017).

**Client-centered prevention counseling:** Counseling conducted in an interactive manner that is responsive to the individual’s needs. This approach requires an understanding of the unique circumstances of client behavior, culture, knowledge, and socioeconomic status (CDC, 1992).

**Communicable disease:** An infectious disease transmissible, as from person to person, by direct contact with an affected individual or the individual's discharges or by indirect means (Communicable, 2018).

**Counseling:** A professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals (Kaplan et al., 2014).

**Disease intervention specialists (DIS):** Also known as Disease Control Specialists, or DCS, a trained public health official who participates in the identification of high-priority HIV or sexually-transmitted disease (STD) cases, suspects, contacts, and associates through case review and analysis and field investigation. They properly carry out the steps for notifying patients and warning identifiable persons known to have been or currently be at serious and foreseeable risk of contracting infectious diseases. Employing this type of assistance is a common step taken by physicians to fulfill their legal obligation (CDC, 1992).
Duty to inform: A standard in which practitioners may be justified to disclose information to identifiable third parties if the parties are known to be at serious and foreseeable risk of contracting a communicable and life-threatening disease (ACA, 2014).

Duty to report: A standard for practitioners whereby all states legally require the reporting of child abuse (ACA, 2014), as do the ethical codes of the ACA. Many states have mandatory laws for all citizens about reporting child abuse, which may also extend to the elderly and persons with disabilities. This standard, as it relates to spousal abuse and other forms of domestic violence, is usually applicable to medical personnel (ACA, 2014).

Duty to warn: A standard for practitioners to reveal confidential information to warn others of potential dangers from a client (Corbin, 2007).

Ethics Revision Task Force: Counseling professionals appointed and charged with completing the latest revisions to the ACA Code of Ethics in June 2011 (Kaplan et al., 2017).

Health Insurance and Portability and Accountability Act (HIPAA): A federal act that requires authorization forms for use of personal data collected by certain healthcare providers, including physicians (Semaan et al., 2004).

Human Immunodeficiency Virus (HIV): An incurable virus spread through certain body fluids that attacks the body’s immune system, specifically the CD4 cells, often called T cells. HIV can lead to acquired immunodeficiency syndrome or AIDS if not treated (CDC, 2017).

Life-threatening: Referring to an illness that may be potentially fatal (Life-threatening, 2018).

National Association for Addiction Professionals (NAADAC): The professional organization for addiction professionals. Guided by the National Certification Commission for Addiction Professionals Code of Ethics, NAADAC represents the professional interests of more
than 100,000 addiction counselors, educators, and other addiction-focused healthcare professionals in the United States, Canada, and abroad (NAADAC, 2016).

*National Association of Social Workers (NASW):* The professional organization for social workers. They refer to the National Association of Social Workers Code of Ethics and Social Workers' Ethical Responsibilities to Clients as their guide (NASW, 2017).

*Partner Counseling and Referral Services (PCRS) providers:* A variety of healthcare professionals who are qualified and trained, including physicians, nurses, counselors, and DISs. As part of their training process, public health professionals learn prevention counseling strategies which involve guiding clients to understand the risk of becoming infected with HIV and other diseases and developing plans for reducing that risk for themselves and their partners (CDC, 1992).

*People living with HIV/AIDS (PLWHA):* A person considered to have a disability due to a physical impairment that substantially limits one or more major life activities or bodily systems. PLWHA are protected against discrimination under the ADA (U.S. Department of Justice, 2014).

**Chapter Summary**

Chapter 1 introduced the study, including background, rationale, problem statement, purpose, theoretical foundation, significance, research questions, and definition of terms. Chapter 2 follows with a review of the extant literature, including empirical studies regarding the study’s theoretical foundation. Chapter 3 then presents a detailed report of the method for obtaining data. Chapter 4 discusses the findings, followed by implications for counseling and recommendations for future research shared in Chapter 5.
CHAPTER 2: LITERATURE REVIEW

Chapter Introduction

This chapter provides a review of foundational literature related to the current study of the revision to confidentiality and privacy section of the 2014 ACA Code of Ethics, Section B.2.c., entitled “Contagious, Life-Threatening Diseases,” as it relates to the understanding, application, and training needs of Licensed Professional Counselors (LPCs). Extant literature discussed in this chapter includes information about the role of ethical decision-making in counseling, pre- and post-revision disclosure practices related to counselor’s “duty to inform,” knowledge of the current revision and disclosure process, and the impact of values on beliefs. The chapter also addresses various aspects of the Theory of Planned Behavior (TPB) and Diffusion of Innovations (DOI) Theory, including the use of the theories in the counseling field, generalizability and testability, and potential integration of multiculturalism and diversity concepts. The conclusion of the chapter highlights the combination of relevant concepts from both the TPB and DOI Theory that contributed to the conceptual framework for this study.

The United States Bureau of Labor Statistics (2016) states that the duties of mental health counselors are to provide counsel with an emphasis on prevention and working with individuals and groups to promote optimum mental and emotional health. More specifically, they note that mental health counselors may help individuals deal with issues associated with addictions and substance abuse; family, parenting, and marital problems; stress management; self-esteem; and aging. Social workers, psychiatrists, and psychologists are excluded from their mental health counselor designation. As part of the United States Bureau of Labor Statistics, the Division of Occupational Employment Statistics provides current national and state employment statistics; they cited that, as of May 2016, the national employment estimate for the number of mental
health counselors in the United States was 139,820. The employment estimate reported for the number of mental health counselors in the state of North Carolina in May 2016 was 4,000 (U.S. Bureau of Labor Statistics, 2016). According to the North Carolina Board of Licensed Professional Counselors (2018), there were 6,497 LPCs in the state as of February 23, 2018.

The North Carolina Board of Licensed Professional Counselors (2017a) defines counseling as follows:

Assisting individuals, groups, and families through the counseling relationship by evaluating and treating mental disorders and other conditions through the use of a combination of clinical mental health and human development principles, methods, diagnostic procedures, treatment plans, and other psychotherapeutic techniques to develop an understanding of personal problems, define goals, and plan action reflecting the client's interests, abilities, aptitudes, and mental health needs as these are related to personal-social-emotional concerns, educational progress, and occupations and careers. (n.p.)

Furthermore, the NCBLPC (2017a) notes that the “practice of counseling” does not include anything related to mediation efforts.

**Role of Ethical Decision-Making in Counseling**

Although they may appear to operate in silos, the actual development of LPCs is impacted by professors, supervisors, trainers, consultants, and other mentors. The foundational support provided by the counseling community is designed to yield clinicians who can independently treat their clients and make competent ethical decisions with confidence. When ethical dilemmas arise, counselors use their “ethical decision-making model to assess the situation from multiple angles” (Wade, 2015, p. 21). To help professional counselors address complex ethical dilemmas, the American Counseling Association (ACA) developed a practical,
sequential, seven-step, ethical decision-making framework, which lists the following steps: (1) identify the problem, (2) apply the ACA Code of Ethics, (3) determine the nature and dimensions of the dilemma, (4) generate potential courses of action, (5) consider the potential consequences of all options and choose a course of action, (6) evaluate the selected course of action, and (7) implement the course of action (Forester-Miller & Davis, 1996). Forester-Miller and Davis (1996) caution against the idea of “one right answer to a complex ethical dilemma” since “different professionals may implement different courses of action in the same situation” (p. 4).

LPCs are faced with several complex ethical dilemmas as a result of the revision to confidentiality and privacy section of the 2014 ACA Code of Ethics. Though counselors may be justified in disclosing information to identifiable third parties if the parties are known to be at serious and foreseeable risk of contracting a communicable, life-threatening disease, there are not clear guidelines to help counselors do so. Counselors must acknowledge that resolving ethical issues is a process that involves reasoning which includes consideration of professional values, professional ethical principles, and ethical standards (ACA, 2014).

A current review of literature yielded no other studies that address counselors’ understanding and application of the change in the 2014 ACA Code of Ethics pertaining to confidentiality and disclosure. To fill the gap, this study explored the independent knowledge, beliefs, and pre- and post-revision practices of LPCs. The study also examined determinants of ethical code revision adherence by obtaining a collective perspective of counselors’ knowledge of the disclosure process.

**Pre- and Post-Revision Practices**

Historically, counselors have avoided or rarely informed third parties of their exposure to a contagious, life-threatening disease based on the challenges imposed by Health Information
Privacy Authorization Act (HIPAA), which requires authorization forms to access personal data from physicians. The intended benefit of the latest revision to the ACA Code of Ethics, Section B.2.c. Contagious, Life-Threatening Diseases, was to reduce harm to third parties by simplifying the disclosure process for counselors to make it easier for them to inform individuals of risky exposure. It is unknown whether this revision has increased counselors’ application or use of disclosure to the intended third parties.

**Knowledge of Revision and Disclosure Process**

Beyond a perfunctory introduction or overview of the ACA Code of Ethics, professional counselors and students studying counseling and counselor education are unlikely to receive any detailed information about ongoing revisions and their consequences. Upon closer examination, there are several ethical disadvantages and newly identified challenges resulting from the revision to the code’s confidentiality and privacy guidelines. Meyers (2014) quotes Michelle Wade, an ethics specialist in the ACA Ethics and Professional Standards Department, who identifies “breaking confidentiality/mandated reporting” as one of the five most common ethical concerns. Efforts by the Ethics Revision Task Force to clarify the issue has led to the use of vague terminology likely to cause questionable application or relevancy for counselors.

According to the ACA’s Code of Ethics section on confidentiality and privacy:

When clients disclose that they have a disease commonly known to be both communicable and life-threatening, counselors may be justified in disclosing information to identifiable third parties, if the parties are known to be at serious and foreseeable risk of contracting the disease. Prior to making a disclosure, counselors assess the intent of clients to inform the third parties about their disease or to engage in any behaviors that may be harmful to
an identifiable third party. Counselors adhere to relevant state laws concerning disclosure about disease status. (p. 7)

This standard leads to the following questions:

1. How do counselors determine which diseases are both communicable and life-threatening?
2. How do counselors determine justification for disclosure to third parties?
3. How do counselors ensure their personal safety when informing third parties or “persons at risk?”
4. How are counselors compensated for disclosure activities?
5. How much identifiable information does the counselor share about their client in the notification process?
6. After completing the notification process, is it ethical for counselors to accept these “identifiable third parties” as clients based on their request?

Based on lack of guidelines or appropriate training on disclosure, it is important to identify counselors’ level of individual and collective understanding of the standard’s components and the steps they deem necessary for its legal and ethical application.

**Impact of Values on Beliefs**

Another one of the five most common ethical concerns involve personal values (Meyers, 2014). The revision to the confidentiality standard is in direct conflict with Section A11.b of the ACA (2014) Code of Ethics, “The Counseling Relationship: Values Within Termination and Referral.” It states that LPCs should refrain from referring prospective and current clients based solely on the counselor’s personally held values, attitudes, beliefs, or behaviors. They should respect the diversity of clients and seek training in areas in which they are at risk of imposing
their values onto clients, especially when those values are inconsistent with the client’s goals or are discriminatory in nature.

Though the ACA Code of Ethics specifies that a professional counselor’s role is to uphold the values of the profession which focus on the worth and dignity of every human being rather than to impose personal values on clients, counselors are expected to navigate an apparently unforeseen ethical dilemma—one that may force them to impose or rely upon their personal values. That is, they are expected to determine whether to directly disclose initially private and confidential client information to identifiable third parties if the parties are known to be at serious and foreseeable risk of contracting a communicable and life-threatening disease from one of the counselor’s clients. Without additional education, training, or guidelines for disclosure, it is unlikely that counselors would possess the skills to competently disclose information to identifiable third parties known to be at serious and foreseeable risk of contracting a disease from a client. There is an expectation that counselors make referrals according to skills-based competency, not personal values (Kaplan & Martz, 2014), yet it is understood that personal values can greatly impact beliefs.

**Theory of Planned Behavior**

An area of interest for this study was the salient beliefs that counselors possess about their understanding and application or use of the revision to the confidentiality and privacy section of the ACA’s (2014) Code of Ethics. While commonly used to predict behavioral intention and behavior, the TPB can also be used to explain behavior by assessing the salient beliefs of a population (Ajzen, 1991; Whitaker, Wilcox, Liu, Blair, & Pate, 2016). Salient beliefs include behavioral, normative, and control beliefs. Salient beliefs include behavioral, normative, and control beliefs. *Behavioral beliefs* influence attitude and reflect the perceived advantages
and disadvantages of performing a behavior. *Normative beliefs*, by comparison, are those which affect subjective norms and are formed by the belief about whether important others approve or disapprove of the behavior. *Control beliefs* influence perceived behavioral control and relate to the presence or absence of barriers and enablers to behavioral performance.

Whitaker et al. (2016) used the TPB to examine pregnant women’s perceptions and intentions using a mixed methods study design. After recruiting women between 20 and 30 weeks gestation to complete an Internet-based survey, the researchers were able to identify the women’s salient beliefs toward weight gain, physical activity, and nutrition through open-ended responses and content-analyzed themes. They found that participants’ salient beliefs were consistent with the existing literature in non-pregnant populations, though they also noted the presence of many pregnancy-specific beliefs.

Behavioral beliefs were assessed by asking women to list up to five advantages and five disadvantages of meeting recommendations for weight gain, physical activity, and nutrition during pregnancy. Normative beliefs were examined by asking participants to list up to five people who influence these factors during pregnancy. Control beliefs were explored by asking the women to list up to five factors that make it difficult or easier to meet prenatal recommendations for weight gain, physical activity, and nutrition. The researchers reported the efficacy of the TPB as a framework for examining women’s weight-related intentions during pregnancy (Whitaker et al., 2016).

**Theory of Planned Behavior in the Counseling Field**

The TPB provides the counseling field with useful information about human behavior and effective interventions, and the application of the theory in various domains has allowed researchers to identify important psychological determinants of socially significant behaviors. By
using the conceptual framework and methodologies provided by the TPB, investigators have collected information about the behavioral, normative, and control-related determinants of many different behaviors, from exercising, eating a healthy diet, donating blood, and using illicit drugs, to conserving energy, using public transportation, and practicing safer sex (Van Lange et al., 2012).

Studies based on the TPB have produced knowledge that serves as a foundation for effective interventions designed to improve social behavior. Though the number of actual intervention studies to date is relatively small, especially compared to the many prediction studies, the TPB has demonstrated its usefulness as a basis for designing and evaluating the effectiveness of various interventions, including efforts to discourage car use, limit infant sugar intake, promote effective job search behaviors, and encourage testicular self-examination and condom use (Van Lange et al., 2012). According to McCabe and Rubinson (2008), the TPB has also been used to predict attitudinal and behavioral change in a variety of other contexts, including but not limited to shopping and purchasing behaviors in marketing research, charitable giving and philanthropic activities, engaging in high-risk sexual or drug behaviors, participating in physical activity, and intent to commit traffic violations.

Additionally, the TPB has been applied to the study of attitude and behavior change in schools, such as predicting teacher attitudes and willingness to integrate special education students in their classes with beliefs about inclusive education, positive teacher referents, and principals' support as the most important predictor of effective teaching behavior. Research based on the TPB within the rehabilitation services literature addresses employers’ attitudes toward hiring persons with disabilities, job-seeking behavior, adults with intellectual disabilities and physical activity, and job placement of consumers with HIV/AIDS, substance abuse
problems, bipolar disorder, and major depression; the literature also discusses employers’
attitudes toward prosthetic use, physical activity among persons with chronic disease, support for
persons with intellectual disabilities, and mobility among persons with spinal cord injury
(Hergenrather, Haase, Zeglin, & Scott, 2013).

Since the TPB has shown to have a limited ability to consider environmental and
economic influences, researchers have added constructs of the theory to components from other
theories to create a more integrated model.

**Generalizability and Testability**

Ajzen's (1991) TPB has been subjected to three decades of research, confirming the role
that beliefs and social influences hold on behavior (McCabe & Rubinson, 2008). Judging by the
sheer number of investigations it has stimulated, the TPB is perhaps the most popular of the
reasoned action models (Van Lange et al., 2012). According to Van Lange et al. (2012),
empirical support for the TPB comes from a host of correlational studies demonstrating its ability
to predict intentions and behavior, as well as from interventions showing that changes in
behavioral, normative, and control beliefs can alter one’s intentions as reflected subsequently in
their different behavior. At the time of their work, Van Lange et al. (2012) reported that the TPB
was the explicit theoretical basis for more than 222 studies published in medical databases and
610 studies published in psychological databases.

From three stages for data collection suggested when applying the TPB to their research,
Hergenrather et al. (2013) selected the third stage of the data collection process as their study’s
focus. They provide a description of the stages. In the first stage, the behavior being studied must
be identified and the behavioral, normative, and control beliefs of persons most likely to perform
that specific behavior (such as rehabilitation professionals) must be elicited. From the elicited
beliefs, modal beliefs would then be identified for specific determinants. Within the guidelines of the TPB, modal beliefs were identified as beliefs with the highest frequencies and which represent most of the elicited beliefs for each determinant. The second stage of the data collection process addressed the development of a quantitative assessment of modal beliefs in which each belief was paired with a corresponding outcome evaluation item. Both items were evaluated on a Likert scale. The psychometric properties of the assessment, including the identification of the TPB constructs from salient beliefs, were explored. In the third stage, the assessment was further explored to identify the influences of the specific TPB constructs on the intention to perform the behavior addressed (Hergenrather et al., 2013). Studies show that these steps are applicable for future research as well.

Integration of Multiculturalism and Diversity Concepts

Culturally competent counselors are responsible for acquiring and exhibiting awareness and respect for their client’s culture and ensuring that their own cultural values and biases do not impede their client’s progress. The outcomes of this research are potentially beneficial for counselors, especially school counselors, in their work with students who are a part of these largely marginalized groups. The TPB has successfully predicted positive academic achievement for African-American students (McCabe & Rubinson, 2008). The TPB framework was applied to research on decision-making among African-American freshman high school students regarding their intention to graduate. Students reported on their intention to stay in school, attitude toward finishing school, subjective norm (the extent to which important people in their life expected them to finish and would be disappointed if they did not), and perceived behavioral control to overcome any obstacles to finishing school, such as needing to work to bring income to the family. Results indicated that students' attitudes, subjective norm, and perceived control
predicted whether s/he finished their second year and graduated from high school on schedule three years later (McCabe & Rubinson, 2008).

According to McCabe and Rubinson (2008), the TPB framework had not previously been applied to the study of youth categorized as sexual minorities. As the rationale for their study, the researchers stated that “it appeared to be a suitable framework in which to assess beliefs and behavioral intention of advocacy toward lesbian, gay, bisexual, and transgender (LGBT) individuals, given its focus on attitudes, recognition of social norms, and perceived behavioral control” (McCabe & Rubinson, 2008, p. 474). Their article referred to the advantage of being able to assess school professionals' knowledge and beliefs about sexual stigmatization, heterosexism, and sexual prejudice as a means of predicting attitudes and behavior intention to address harassment and social injustices directed toward LGBT individuals (McCabe & Rubinson, 2008). The researchers also used the TPB framework to evaluate education graduate students’ beliefs, attitudes, and behaviors related to sexuality and harassment of minority youth. Their study revealed the need for additional training for school psychologists and counselors on LGBT issues, and suggested future research was needed to examine how training can best prepare graduate students in education to advocate for all youth regardless of their personal beliefs or subjective norms (McCabe & Rubinson, 2008).

**Diffusion of Innovations Theory**

In the realm of counseling, updates such as the 2014 revisions to the ACA Code of Ethics are considered innovations. Counselors adopt these revisions at different rates or stages. According to Harting et al. (2009), Rogers’ Innovation Decision Process has five distinct, successive stages. The first two are mental stages referred to as the dissemination process. The dissemination process begins with the knowledge stage, which requires potential users to first
become acquainted with and develop an adequate understanding of the innovation. The next mental stage is the *persuasion stage*, a mostly affective process in which potential adopters develop a positive attitude toward the innovation considering its perceived characteristics. These deciding factors include the innovation’s relative advantage, compatibility, complexity, ability to be tested, observability of its results to others, and flexibility. Perceived social or material risks or consequences may also play a part in the persuasion stage.

The last three stages of the diffusion process are behavioral stages called the *adoption process*, a process that begins with the *decision stage* in which potential adopters decide whether to adopt or reject the innovation by gathering further information and trying out the innovation to a limited degree. As part of the subsequent *implementation stage*, the diffusion process can be facilitated by previously gained positive experiences and positive social influences; notably, however, there is the possibility that perceived barriers could prevent actual implementation of the innovation. In the final *confirmation stage*, the innovation becomes part of the work routine, requiring reinforcement and positive feedback to maintain. The progression of an innovation through the five successive stages is further influenced by situational factors, the nature of the innovation decision, the communication channels applied, and the facilitators involved (Harting, et al., 2009).

Harting et al. (2009) conducted a qualitative study to gain an in-depth understanding of the determinants of guideline adherence among physical therapists in the Netherlands while at the same time evaluating the use of a theoretical framework in this context. The observational study consisted of three focus group interviews (n=12, 10, and 8) conducted between November 2002 and January 2003, during which physical therapists were asked to discuss their opinions about and experiences with the Dutch guidelines for low-back pain. Data were analyzed
qualitatively using a directed approach to content analysis. Both the interview route and the analysis of the interviews were informed by Rogers’ DOI Theory. The study yielded in-depth insights into the various determinants of guideline adherence. Overall, the participants had rather unfavorable opinions about issues related to the dissemination of the guidelines (first phase of the diffusion process) and provided relatively little information on the subsequent adoption process (second phase of the diffusion process). Findings indicated that the diffusion process of guidelines among physical therapists was not yet completed. The researchers recommend applying purposeful sampling to guarantee that focus groups include participants from each of the various stages of the diffusion process and noted that the use of theory can provide added value to guide implementation studies.

In Harting et al.’s (2009) study, they conducted focus group interviews using DOI theory to assess where participants were in the diffusion process. The knowledge stage (recognition) was assessed by asking participants about their experience with the guidelines, and they examined the persuasion stage (rationale/motives) by asking participants to share their opinions of the guidelines. Asking participants to what extent they have adopted or rejected the guidelines allowed the researchers to assess the decision stage, while the implementation stage (actual use) was explored through having participants tell each other how they currently apply the guidelines. Finally, the confirmation stage (maintenance) was assessed by asking participants about the kind of support they need to apply or use the guidelines successfully. Based on their study, the DOI Theory framework was useful as a tool to structure the focus group questions, systematically analyze the data collected, and determine what supplementary interviews would be necessary to cover the entire diffusion process.
Diffusion of Innovations Theory in the Counseling Field

DOI Theory emphasizes potential adopter perceptions as key to understanding adoption decisions, thus making it an ideal framework for evaluating barriers to use (Carper, McHugh, & Barlow, 2013). According to Carper, McHugh, and Barlow (2013), a particularly promising strategy for evaluating perceptions of use is to draw from theories of dissemination and implementation. For example, they refer to several models of dissemination that emphasize the characteristics of potential adopters as key to the spread of an innovation. Such perspectives linking dissemination and implementation science to the study of perceptions may help advance understanding of the adoption and utilization of these treatments.

According to Kuhn et al. (2014), DOI Theory proposes that the perceived attributes of the innovation held by potential adopters are especially important in this process. The theory highlights the importance of the innovation’s perceived relative advantage as compared to current practices; compatibility with clinicians’ values, needs and settings; ease of use or lack of complexity; trialability or ability to be tried or experimented with before fully implementing; and observability, which is the capacity to observe results of the innovation. In short, innovations that are perceived as being better than those currently being used, that are consistent with clinicians’ values, needs, and settings, are easy to use, are observable to others, and can be experimented with before being fully adopted will spread more quickly than those that lack these perceived characteristics. Clinician perceptions about innovative practices are important in the adoption decisions and the rate at which new practices become part of routine health care.

Generalizability and Testability

DOI Theory has been used successfully in public health, social work, communication, marketing, criminal justice, and agriculture. In public health, DOI Theory is used to accelerate
the adoption of important public health programs that typically aim to change the behavior of a social system. For example, an intervention to address a public health problem is developed, and then the intervention is promoted to people in a social system with the goal of adoption based on DOI Theory. According to Rogers (2003), the most successful adoption of a public health program results from understanding the target population and the factors that influence the rate of adoption.

Rogers’ (2003) widely used theory covers the entire diffusion process and offers the opportunity to integrate various theoretical constructs in the different steps of the diffusion process. This opportunity for integration informed Harting et al.’s (2009) selection to adopt the stepwise Innovation Decision Process of Rogers’ DOI Theory as the basis for their qualitative application examining determinants of guideline adherence among physical therapists.

**Integration of Multiculturalism and Diversity Concepts**

DOI Theory can provide researchers with the opportunity to gather categorical information about individuals who fall into each of the five established adopter categories. These trends may help in the selection of appropriate interventions or future research. There is obvious concern that the information has the potential to be used to stereotype or perpetuate biases against certain groups. In consideration of members of marginalized populations who are most vulnerable to discrimination, it is important to note that DOI Theory does not account for an individual’s resources or social support to adopt the new behavior or innovation.

As part of this current research study, DOI Theory offered a unique opportunity to provide individual professional counselors and the collective counseling profession with feedback about their adoption style or tendencies regarding revisions to the new code of ethics and other counseling-related updates. For over a decade, the ACA Code of Ethics Task Force has
responded to the impact of societal changes and the need for increasingly more culturally competent care by infusing multiculturalism throughout the code. As a result, the ethical expectations for professional counselors have also increased. This information related to personal and professional self-awareness will help prevent harm to clients who are at risk for the consequences of ignorance or refusal to adopt necessary and mandatory revisions.

**Synthesis of Conceptual Framework**

There are several limitations associated with both the TPB and DOI Theory. The TPB assumes the person has acquired the opportunities and resources to be successful in performing the desired behavior, regardless of the intention; it does not account for other variables that affect behavioral intention or motivation such as fear, threat, mood, or previous experiences. Though it does consider normative influences, the TPB does not account for environmental or economic factors that may influence a person’s intention to perform a behavior. The TPB assumes that behavior is the result of a linear decision-making process and does not consider change over time. While the added construct of perceived behavioral control was an important addition to the theory, it does not address actual control over behavior. Finally, the timeframe between “intent” and “behavioral action” is not addressed by the TPB.

DOI Theory does not account for an individual’s resources or social support to adopt the new behavior or innovation. DOI Theory is perceived to work better with adoption of behaviors rather than cessation or prevention of behaviors. Much of the evidence for this theory, including the adopter categories, did not originate in public health, and the theory was not developed to explicitly apply to adoption of new behaviors or health innovations. Finally, DOI Theory does not foster a participatory approach to adoption of a public health program. However, the combination of the TPB and DOI Theory provided this researcher with a practical framework to
apply in the current study’s efforts to learn more about counselors’ salient beliefs and stages of adoption related to the ACA Code of Ethics confidentiality revision.

Pursuant to North Carolina General Statutes § 90-330(a)(3), in the state of North Carolina the "practice of counseling" means holding oneself out to the public as a professional counselor by offering services that include but are not limited to counseling, appraisal activities, consulting, referral activities, and research activities. The "practice of counseling" does not include the facilitation of communication, understanding, reconciliation, and settlement of conflicts by mediators at community mediation centers authorized by G.S. 7A-38.5 (NCBLPC, 2017a). Though not specified in this definition, partner and third-party notifications of exposure to contagious, life-threatening diseases are also a part of counseling based on the ACA Code of Ethics.

Some counselors may have knowledge acquired through their studies about the expectations of counselors, but lack practice or application. Regarding “duty to inform” identifiable third parties about exposure to contagious, life-threatening diseases, categories of counselors may include: (1) counselors who lack awareness and do not know their duty; (2) counselors who are aware of their duty but do not know how to carry it out; and (3) counselors who are aware of and carry out their duty in an ethical manner, which is the preferred category. The scope of counselors’ need for preparation and training on the “duty to inform” and justified disclosure guidelines is unknown. To ensure that LPCs are equipped with timely, relevant information on these topics, the researcher hopes to identify foundational content to support guidelines and a training protocol based on the findings of this study.
Chapter Summary

Chapter 2 provided a review of the literature, including empirical studies regarding the study’s theoretical foundation. The two theories covered are TPB and DOI Theory, including assumptions and premises, key constructs, usefulness in the counseling field, generalizability, testability, and integration of multiculturalism and diversity concepts. Chapter 3 follows with a detailed discussion of the methodology and structure of the study, including the procedures used to collect and analyze data.
CHAPTER 3: METHODOLOGY

Chapter Introduction

This chapter addresses the research design of the study. The roles of both the researcher and the participants are highlighted. The study procedure, including data collection, data analysis, and validation strategies, are also discussed in this chapter.

Research Design

This qualitative study used a transcendental phenomenological approach (Creswell, 2013) to examine Licensed Professional Counselors’ understanding, application, and training needs related to the revision in the 2014 Code of Ethics pertaining to confidentiality. Qualitative methodologies provide a belief in multiple realities, a commitment to identifying an approach to in-depth understanding of the phenomena and a commitment to participants’ viewpoints. Conducting inquiries with minimum disruption to natural context of phenomenon and reporting findings in a literary style rich in participant commentaries are the main characteristics of qualitative methodologies (Streubert Speziale & Carpenter, 2007; Vaismoradi, Turunen, & Bondas, 2013). The use of transcendental phenomenology allows a researcher to focus on the descriptions of participants’ experiences to convey the overall essence of the shared experience (Creswell, 2013).

The current study’s phenomenological approach used focus groups to explore LPCs’ responses to the revision in the 2014 ACA Code of Ethics pertaining to counselors’ “duty to inform,” specifically their duty to disclose private and confidential health information about a client to third parties who may be at risk for contracting a life-threatening, communicable disease. Focus groups are group interviews (Bradbury-Jones, Sambrook, & Irvine, 2009; Sim, 1998; Webb & Kevern, 2001) designed to obtain data (Bradbury-Jones et al., 2009; McLafferty,
through group discussions focused collectively on a specific issue (Bradbury-Jones et al., 2009; Wilkinson, 1998). Bradbury-Jones et al. (2009) maintain that the use of focus groups can provide a greater understanding of the phenomenon under study. The focus group environment allowed the researcher to explore and reflect on multiple perspectives and opinions and to assess the scope of participants’ knowledge on the subject being studied (Creswell, 2006; Glesne, 2006; McCabe & Rubinson, 2008; Mertens, 2005).

One intention of this study was to honor the participants’ individual values and allow for negotiation and incorporation of the collective values of the sample. The interpretive framework used for this qualitative study was *social constructivism*, an approach to inquiry that uses an inductive method of emergent ideas (through consensus) obtained by interviewing, observing, and analyzing texts (Creswell, 2013). According to Creswell (2013), “multiple realities are constructed through our lived experiences and interactions with others” and “reality is co-constructed between the researcher and the researched and shaped by individual experiences” (p. 36). The Theory of Planned Behavior (TPB) model and Diffusion of Innovations (DOI) Theory provided a useful organizational and conceptual framework through which to examine data obtained during the focus groups (McCabe & Rubinson, 2008).

Following are the research questions used to guide this study’s investigation of the ACA’s recent change to its ethics code:

1. What are Licensed Professional Counselors’ understanding and application of the revision to confidentiality and privacy as written in Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics?
2. What are the current training needs of Licensed Professional Counselors regarding the revision to confidentiality and privacy as written in Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics?

**Researcher Subjectivity**

The role of this researcher was to conduct a phenomenological study to examine the lived experiences of LPCs from North Carolina and their understanding, application, and training needs related to the revision to confidentiality and privacy section of the 2014 ACA Code of Ethics. This researcher addressed the potential effects of her own past experiences on the interpretation of participants’ feedback and conclusions drawn from the data by bracketing to combat researcher bias, which is actively setting aside past experiences to take a fresh perspective toward the phenomenon under examination (Creswell, 2013). This researcher is a Licensed Professional Counselor Supervisor (LPCS) with a background in public health, and as a result has been exposed to certain information related to this study that would not be otherwise available without previous public health training and work experience. Prior to acquiring education, experience, and licensure as a LPC, the researcher was previously employed as a disease control specialist for the North Carolina Department of Health and Human Services for several years. The researcher was formally trained to counsel clients and notify partners or identifiable third parties at risk of contracting Human Immunodeficiency Virus and/or syphilis. Although the knowledge obtained during the position may offer a unique vantage point to help understand the notification and training processes associated with contagious and life-threatening diseases, the researcher bracketed personal thoughts and feelings while conducting the current study with other LPCs in North Carolina.
Study Participants

Selection of Participants

A purposeful sampling approach was used for this qualitative research study. The study participants were selected to purposefully inform an understanding of research questions and responses of LPCs to the current confidentiality revision in the 2014 ACA Code of Ethics. According to Creswell (2013), the three considerations that go into the purposeful sampling approach include selection of study participants, the specific type of sampling strategy, and the size of the sample to be studied. As a phenomenological study in which all participants have experienced the same phenomenon to be studied, current LPCs in North Carolina who are subject to the ACA Code of Ethics and its revision were selected for the sample.

The specific type of sampling strategy used for the study was criterion sampling. Criterion sampling works well when all individuals studied represent people who have experienced the phenomenon (Creswell, 2013). To participate in the study, each participant had to be designated with the non-restricted, independent licensure status of LPC given to them by the NCBLPC. According to the NCBLPC (2017), all LPCs must successfully complete an application, verify their education via official transcripts, pass examinations, submit a professional disclosure statement, undergo a criminal background check, and provide verification of supervised professional practice before licensure can be attained.

Creswell (2013) maintains that the exploration of a phenomenon with a heterogeneous group of individuals who have all experienced it may vary in size from three to four individuals to as many as 10 to 15. Snowball sampling was also used for this study. The researcher generated a list of potentially eligible, local LPCs known through academic and professional affiliations. The second step in selecting the sample included accessing the NCBLPC website to verify current licensure status of known local LPCs and identification of other accessible LPCs located
within two hours of the study location. As a third step, previously obtained telephone numbers and email addresses, as well as publicly available information identified through online searches based on their current employment, were used to offer an initial invitation for participation and request names and contact information for other potential LPCs as study participants. During the fourth step, the researcher used the provided contact information for each referred, eligible LPC to offer an initial invitation for participation and request additional names and contact information for other potential LPCs as study participants. This process resulted in 17 LPCs with initial interest in study participation.

Each LPC received a letter of recruitment via email (see Appendix A). As an incentive to participate in this study, potential participants were offered compensation of a $25.00 gift card. Four of the 17 LPCs dropped out approximately a week before the first focus group began. Of the remaining 13 LPCs, an additional three participants dropped out on the day of their assigned focus group. Two focus groups were conducted on different days and times with cohorts of five participants per group, and each focus group was led by the researcher. Rather than solely relying on a structured question-and-answer format, focus groups were designed to allow participants to react to one another, providing richer data than might emanate from a single interviewer-subject format (Kruger & Casey, 2000; McCabe & Rubinson, 2008).

Description of Participants

This section described the 10 participants in this study investigating justified disclosure. In addition to their individual written feedback, participants’ experiences were openly shared during focus groups with their peers.

Barbara. Barbara, a 54-year-old female who identifies as African-American, earned a doctoral degree as her highest level of education. At the time of this study, she had 12 years of
professional experience since receiving professional licensure. Throughout her counseling career, she has served populations that include children and families. For professional development and continuing education training, Barbara prefers to attend conferences. The types of professional development and continuing education training topics she named as beneficial at this point in her career were those related to trauma-informed therapy.

**Vanessa.** A White female who is 67 years old, Vanessa has a master’s degree as her highest level of education. She reported having eight years of professional experience achieved after receiving professional licensure. Throughout her counseling career, the populations she has served have included children, adults, and couples. Her preferred means to obtain professional development and continuing education training is via workshops, and she feels that professional development and continuing education training topics related to couples and sexual addiction would be beneficial at this point in her career.

**Jerry.** Jerry is a White male who is 65 years old and holds a master’s degree as his highest level of education. Since receiving professional licensure, he has achieved eight years of professional experience, serving populations that include children, families, and parents. He prefers to receive professional development and continuing education training in person. The types of topics Jerry reports would be beneficial at this point in his career are those related to play therapy.

**Susan.** Susan is an African-American female who is 35 years old and has a master’s degree as her highest level of education. She has gained 11 years of professional experience since receiving professional licensure. Susan has served populations during her counseling career that include children, college students, and adults. She noted that she prefers to obtain professional development and continuing education training via in-person settings, workshops,
and webinars. Specifically, she feels that topics related to counseling center administration, brief therapy interventions, and diverse populations would be the most beneficial to her professional development and continuing education training.

**Bonita.** Bonita has a master’s degree as her highest level of education. She identifies as a White female and is 36 years of age. She had five years of professional experience at the time of this study. Populations she had worked with during her career up to the time of this study include families, juveniles, Latinx/Hispanic families, children, and domestic violence victims. Her preferred means of obtaining professional development and continuing education training are workshops, and she reported that she would find it beneficial to have training on topics related to internal family systems, acceptance and commitment therapy, and addressing White supremacy with clients of color.

**Wendy.** Wendy is a 39-year-old White female with a master’s degree as her highest level of education. She reported having eight years of professional experience as an LPC, serving populations such as children, adolescents, adults, college students, and members of the military. When obtaining professional development and continuing education training, Wendy prefers workshops and conferences, and stated that topics related to counselor supervision and DSM 5 would be beneficial to her career.

**Jackson.** A White male of 55 years of age, Jackson has a master’s degree as his highest level of education and has four years of professional experience as a licensed counselor. He has served populations in the past that include community members, adults, couples, families, and supervisees. Conferences, workshops, and online trainings are Jackson’s preferred formats for professional development and continuing education training. He would find professional
development and continuing education training topics related to supervision, social justice, advocacy, and substance use disorders beneficial.

**Clara.** Clara is a 53-year-old African-American female who earned a master’s degree as her highest level of education. Since becoming a LPC, she has gained four years of professional experience, serving adults and children throughout her counseling career. Trainings delivered in the classroom setting are Clara’s preferred way to obtain professional development and continuing education. She cited topics related to case management, community resources, dual diagnoses, and billable services as those she would find beneficial at this point in her career.

**Martin.** Martin is an African-American male who is 31 years old with a master’s degree as his highest level of education. He had three years of professional experience as a LPC at the time of this study and populations he has served in the past include children, young adults, domestic violence survivors, and clients in crisis. When obtaining professional development and continuing education, Martin prefers in-person, role play, and activities. The types of professional development and continuing education training topics he reported as beneficial are those related to crisis counseling, difficulties in the workplace, research, and assessments.

**Collette.** Collette’s highest level of education was to earn a master’s degree. She is 35 years old and identifies as a White female. She had six total years of professional experience after receiving her licensure and had served populations that include adolescents and adults. She prefers classroom-style and live counseling observations for her professional development and continuing education training. She reports that topics related to refining diagnostic skills, substance abuse, and working with children would be beneficial to her career.
**Participant Demographics**

The volunteer participants consisted of 10 counselors, each designated with the non-restricted, independent status of LPC according to the North Carolina Board of Licensed Professional Counselors (NCBLPC) to enable participation in the study. According to the NCBLPC (2017), all LPCs must successfully complete an application, verify their education by submitting official transcripts, pass examinations, submit a professional disclosure statement, undergo a criminal background check, and verify their supervised professional practice before licensure can be issued.

The study had both male and female African American and White participants, from 31 to 67 years of age. All participants had earned at least a master’s degree, and one had a doctoral degree. Their professional counseling experience ranged from three to 12 years. Below, Table 3.1 gives an abbreviated demographic breakdown of the study participants.

**Table 3.1: Abbreviated Participant Demographic Information**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Racial/Ethnic Identity</th>
<th>Highest Degree Attained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female (7)</td>
<td>Black/African American (4)</td>
<td>Masters (9)</td>
</tr>
<tr>
<td>Male (3)</td>
<td>White/ Caucasian (6)</td>
<td>Doctoral (1)</td>
</tr>
</tbody>
</table>
Table 3.2: below provides a detailed summary of participant demographics, including age, race, education level, years of experience, populations served, and more. Each participant was assigned a pseudonym for confidentiality.

Table 3.2: Participant Summary

<table>
<thead>
<tr>
<th>Participant</th>
<th>Participation Day</th>
<th>Age</th>
<th>Race</th>
<th>Level of Education</th>
<th>Years of Experience</th>
<th>Populations Served</th>
<th>Continuing Education Training Needed</th>
<th>Training Preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbara</td>
<td>Saturday</td>
<td>54</td>
<td>Black</td>
<td>Ph.D.</td>
<td>12</td>
<td>Children; Families</td>
<td>Trauma informed therapy</td>
<td>Conferences</td>
</tr>
<tr>
<td>Vanessa</td>
<td>Saturday</td>
<td>67</td>
<td>White</td>
<td>Master’s</td>
<td>8</td>
<td>Children; Adults; Couples</td>
<td>Couples; Sexual addiction</td>
<td>Workshops</td>
</tr>
<tr>
<td>Jerry</td>
<td>Saturday</td>
<td>65</td>
<td>White</td>
<td>Master’s</td>
<td>8</td>
<td>Children; Families; Parents</td>
<td>Play therapy; More training in Autism Spectrum Disorders (ASD)</td>
<td>In-person training</td>
</tr>
<tr>
<td>Susan</td>
<td>Saturday</td>
<td>35</td>
<td>Black</td>
<td>Master’s</td>
<td>11</td>
<td>Children; College Students; Adults</td>
<td>Counseling center administration; Brief therapy interventions; Diverse populations</td>
<td>In-person workshops; Webinars</td>
</tr>
<tr>
<td>Bonita</td>
<td>Saturday</td>
<td>36</td>
<td>White</td>
<td>Master’s</td>
<td>5</td>
<td>Children; Juveniles; Families; Latino/Hispanic Families; Domestic Violence Victims</td>
<td>Internal family systems; Acceptance and commitment therapy; Addressing White supremacy with clients of color</td>
<td>Workshops</td>
</tr>
<tr>
<td>Wendy</td>
<td>Sunday</td>
<td>39</td>
<td>White</td>
<td>Master’s</td>
<td>8</td>
<td>Children; Adolescents; College Students; Adults; Military</td>
<td>Counselor supervision; DSM V</td>
<td>Workshops; Conferences</td>
</tr>
</tbody>
</table>

52
<table>
<thead>
<tr>
<th>Participant</th>
<th>Participation Day</th>
<th>Age</th>
<th>Race</th>
<th>Level of Education</th>
<th>Years of Experience</th>
<th>Populations Served</th>
<th>Continuing Education Training Needed</th>
<th>Training Preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jackson</td>
<td>Sunday</td>
<td>55</td>
<td>White</td>
<td>Master’s</td>
<td>4</td>
<td>Community members; Adults; Couples; Families; Supervisees</td>
<td>Supervision; Social justice; Advocacy; Substance abuse disorders</td>
<td>Conferences; Workshops; Online training</td>
</tr>
<tr>
<td>Clara</td>
<td>Sunday</td>
<td>53</td>
<td>Black</td>
<td>Master’s</td>
<td>4</td>
<td>Adults; Children</td>
<td>Case management; Community resources; Dual diagnoses; Billable services</td>
<td>Classroom-style training</td>
</tr>
<tr>
<td>Martin</td>
<td>Sunday</td>
<td>31</td>
<td>Black</td>
<td>Master’s</td>
<td>3</td>
<td>Children; Young adults; Domestic violence survivors; Clients in crisis</td>
<td>Crisis counseling; Difficulties in the workplace; Research and assessment</td>
<td>In-person training; Role play and activities</td>
</tr>
<tr>
<td>Collette</td>
<td>Sunday</td>
<td>35</td>
<td>White</td>
<td>Master’s</td>
<td>6</td>
<td>Adolescents; Adults</td>
<td>Refining diagnostic skills; Substance abuse; Working with children</td>
<td>Classroom-style; Live counseling observations</td>
</tr>
</tbody>
</table>
Focus Group Protocol and Data Collection

The focus group process started with purposeful sampling prescreening (such as phone calls, emails, word-of-mouth, referrals) of potential LPCs in the local area. In phenomenological studies, criterion sampling works well when all individuals studied represent people who have experienced the phenomenon (Creswell, 2013). The status of each licensee was reviewed and verified using the online License Verification Search Form provided by the NCBLPC website. Upon verification of licensure status and participant interest, a Recruiting Form was distributed to prescreened eligible LPCs via email (see Appendix A).

Focus groups were scheduled on a first-come, first-served basis as participants responded to the email. Participants were given a copy of the Informed Consent Form before the start of the interview. The researcher explained the form in detail to each participant and explained how to withdraw from participation at any time during the process. Data collection for each focus group process took place in the same university computer lab on separate days. The researcher asked each participant for permission to audio-record the session for subsequent transcription and informed them that copies of the transcripts would be made available for their review. After collecting the signed Informed Consent Forms, the researcher directed the participants to complete the Individual Written Questionnaires, including online, web-based versions of informed consent and Personal History Demographic Questionnaires, at available computer stations within the same room designated as the study location.

Saturday Focus Group

The Saturday focus group consisted of five participants who possessed at least a master’s degree, with one of the five focus group participants having earned a doctoral degree. Four participants in this group identified as female and one participant identified as male. In response to racial/ethnic identity questions, three participants identified as White or Caucasian, while two
participants identified as Black or African American. The average age of the participants was 51 years old, but their ages ranged from 35 to 67 years old. The total number of years of professional experience participants had achieved after receiving professional licensure ranged from five to 12 years. The average total number of years of professional experience achieved after receiving professional licensure reported was approximately nine years.

Table 3.3 follows with a breakdown of the Saturday focus group participant demographics.

**Table 3.3: Saturday Focus Group Participants**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Age</th>
<th>Race</th>
<th>Level of Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbara</td>
<td>Female</td>
<td>54</td>
<td>Black</td>
<td>Ph.D.</td>
</tr>
<tr>
<td>Vanessa</td>
<td>Female</td>
<td>67</td>
<td>White</td>
<td>Master’s</td>
</tr>
<tr>
<td>Jerry</td>
<td>Male</td>
<td>65</td>
<td>White</td>
<td>Master’s</td>
</tr>
<tr>
<td>Susan</td>
<td>Female</td>
<td>35</td>
<td>Black</td>
<td>Master’s</td>
</tr>
<tr>
<td>Bonita</td>
<td>Female</td>
<td>36</td>
<td>White</td>
<td>Master’s</td>
</tr>
</tbody>
</table>
**Sunday Focus Group**

The Sunday Focus Group included five participants, and all of them possessed a master’s degree as their highest level of education. In this group, three participants identified as female and two participants identified as male. In response to racial/ethnic identity, three participants identified as White or Caucasian, and two participants identified as Black or African American. With their ages ranging from 31 to 55 years old, the average age of the participants was approximately 43 years old. The total number of years of professional experience participants achieved after receiving professional licensure ranged from three to eight years, and the average reported was approximately five years. Following are descriptions of each LPC who participated in this study.

Table 3.4 follows with a breakdown of the Sunday focus group participant demographics.

**Table 3.4: Sunday Focus Group Participants**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Age</th>
<th>Race</th>
<th>Level of Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wendy</td>
<td>Female</td>
<td>39</td>
<td>White</td>
<td>Master’s</td>
</tr>
<tr>
<td>Jackson</td>
<td>Male</td>
<td>55</td>
<td>White</td>
<td>Master’s</td>
</tr>
<tr>
<td>Clara</td>
<td>Female</td>
<td>53</td>
<td>Black</td>
<td>Master’s</td>
</tr>
<tr>
<td>Martin</td>
<td>Male</td>
<td>31</td>
<td>Black</td>
<td>Master’s</td>
</tr>
<tr>
<td>Collette</td>
<td>Female</td>
<td>35</td>
<td>White</td>
<td>Master’s</td>
</tr>
</tbody>
</table>
The sample for this study consisted of 10 professional counselors who were designated with the non-restricted, independent North Carolina LPC licensure status. Each participant identified and was verified as a LPC according to the North Carolina Board of Licensed Professional Counselors (NCBLPC). All 10 participants possessed a master’s degree, and one participant also held a doctoral degree. In the study, seven participants identified as female and three participants identified as male. In response to racial/ethnic identity, six participants identified as White or Caucasian, and four participants identified as Black or African American. Their ages ranged from 31 to 67 years old, with the average age at 47 years old.

The total number of years of professional experience reported by participants ranged from five to 14 years, and the average was approximately nine years. However, the total number of years of professional experience achieved after receiving professional licensure reported by participants ranged from three to 12 years, and the average total in this category was approximately seven years.

Past populations served by these participants include children, adolescents, adults; college students and members of the military; domestic violence survivors and clients in crisis; rural families and those of low-socioeconomic status; couples; clients involved in therapeutic foster care; and juveniles and families assigned as part of the state’s judicial system. The populations currently served by these participants were described as elementary school children (5 to 12 years old) and teenager (12 to 18 years old); adolescents; college students; graduate students; adults; community members; individuals and couples; parents; families; and Medicaid recipients and other private insurance clients.

The various counseling-related positions held by these participants over the course of their careers included staff counselor, outpatient therapist, intensive in-home therapist,
elementary and middle school counselor, school-based mental health therapist, psychotherapist, supervisor, clinical supervisor, academic advisor, adjunct instructor, teaching assistant, counselor educator, therapeutic home supervisor, intensive in-home team lead, community support team lead, professional administrator, clinical coordinator, assistant director of disability services, assistant director of counseling services; and business owner. The leadership positions held by these participants over the course of their careers were described as editor for a counseling journal, president for a counseling honors society, secretary of professional organizations, supervisor, committee chair, team lead, facilitator, and advisory council member.

**Counselor Training History and Preferences**

The participants shared information about the types of professional development and continuing education training courses they had taken since the completion of their counseling or counseling-related degree and after obtaining licensure, the training topics identified as beneficial at this point in their careers, and their preferred delivery method of professional development and continuing education training. The types of professional development and continuing education training courses that participants indicated they had received since the completion of their counseling or counseling-related degree included couples counseling; trauma counseling; eye movement desensitization and reprocessing; substance use disorders; trauma; strength; smart recovery; Adlerian therapy; motivational interviewing; illness management recovery; cognitive behavioral therapy (CBT); ethics; LBGT; systems of care; suicide assessment training; crisis counseling training; legal issues; counseling theories/techniques; mindfulness; multicultural counseling; human development; DSM; diagnosis and treatment planning; career counseling; research; assessment; and program evaluation; strategies specific to military members and their families; strategies specific to survivors of child abuse (including
sexual abuse); PTSD; couples counseling; play therapy; hypnosis; North Carolina Jurisprudence; interpersonal therapy course; and creative therapies.

The types of professional development and continuing education training courses that participants have received after obtaining licensure included eye movement desensitization and reprocessing; advanced theoretical approaches; DSM-5; substance use disorders; trauma; strength-based supervision; equine therapy; motivational interviewing; Adlerian therapy; illness management and recovery; Lesbian, Bisexual, Gay, or Transgender issues; ethics; mental health in the school system; counselor supervision; legal issues; CBT and mindfulness; multicultural counseling; human development; DSM 5 diagnosis and treatment planning; career counseling; research assessment and program evaluation; strategies specific to military members and their families; strategies specific to survivors of child abuse (including sexual abuse); PTSD; relaxation; meditation; family dynamics; counselor education doctoral courses; aromatherapy; trauma-focused CBT; dialectical behavior therapy (DBT); trauma-focused therapy; eco-systemic family therapy; Together Facing the Challenge; Triple-P Parenting; Autism Spectrum Disorders (ASD); Seven Challenges; and creative therapies.

Potential professional development and continuing education training topics that participants reported as beneficial at this point in their careers were more refined diagnostic skills training and learning new competency areas, such as working with children and substance abuse, supervision, social justice, advocacy; case management and community resources; dual diagnoses; billable services; crisis counseling training, difficult situations in workplace, research and assessments; counselor supervision, specific DSM 5 diagnoses and criteria; couples and sexual addiction counseling; internal family systems; acceptance and commitment therapy; how to address White supremacist society in a counseling session with White clients as well as with
clients of color; trauma-informed therapy; play therapy; more Autism Spectrum Disorders (ASD) training; counseling center administration; brief therapy interventions; and working with diverse populations. Participants reported that they preferred to obtain professional development and continuing education training via classroom or live counseling observations; conferences, workshops, and online trainings; in face-to-face settings; by incorporating role play or an activity; daylong trainings; and occasionally webinars. The 10 participants were divided into two focus groups of five participants each.

Below, Tables 3.5 and 3.6 display a summary of the professional experience held by the LPCs who participated in this study’s Saturday and Sunday focus groups, respectively.

**Table 3.5: Saturday Participant Professional Experience Summary**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Years of Experience</th>
<th>Populations Served</th>
<th>Continuing Education Training Needed</th>
<th>Training Preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbara</td>
<td>12</td>
<td>Children; Families</td>
<td>Trauma informed therapy</td>
<td>Conferences</td>
</tr>
<tr>
<td>Vanessa</td>
<td>8</td>
<td>Children; Adults; Couples</td>
<td>Couples; Sexual addiction</td>
<td>Workshops</td>
</tr>
<tr>
<td>Jerry</td>
<td>8</td>
<td>Children; Families; Parents</td>
<td>Play therapy; More Autism Spectrum Disorders (ASD) training</td>
<td>In-person training</td>
</tr>
<tr>
<td>Susan</td>
<td>11</td>
<td>Children; College students; Adults</td>
<td>Counseling center administration; Brief therapy interventions; Diverse populations</td>
<td>In-person workshops; Webinars</td>
</tr>
<tr>
<td>Bonita</td>
<td>5</td>
<td>Families; Juveniles; Latino/Hispanic families; Children; Domestic violence victims</td>
<td>Internal family systems; Acceptance and commitment therapy; Addressing White supremacy with clients of color</td>
<td>Workshops</td>
</tr>
</tbody>
</table>
### Table 3.6: Sunday Participant Professional Experience Summary

<table>
<thead>
<tr>
<th>Participant</th>
<th>Years of Experience</th>
<th>Populations Served</th>
<th>Continuing Education Training Needed</th>
<th>Training Preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wendy</td>
<td>8</td>
<td>Children; Adolescents; Adults; College students; Military</td>
<td>Counselor supervision; DSM V</td>
<td>Workshops; Conferences</td>
</tr>
<tr>
<td>Jackson</td>
<td>4</td>
<td>Community members; Adults; Couples; Families; Supervisees</td>
<td>Supervision; Social justice; Advocacy; Substance use disorders</td>
<td>Conferences; Workshops; Online training</td>
</tr>
<tr>
<td>Clara</td>
<td>4</td>
<td>Adults; Children</td>
<td>Case management; Community resources; Dual diagnoses; Billable services</td>
<td>Classroom style</td>
</tr>
<tr>
<td>Martin</td>
<td>3</td>
<td>Children; Young adults; Domestic violence survivors, Clients in crisis</td>
<td>Crisis counseling; Difficulties in the workplace; Research and assessment</td>
<td>In person; Role play and activities</td>
</tr>
<tr>
<td>Collette</td>
<td>6</td>
<td>Adolescents; Adults</td>
<td>Refine diagnostic skills; Substance abuse; Working with children</td>
<td>Classroom style; Live counseling observation</td>
</tr>
</tbody>
</table>

### Instrumentation

The conceptual framework for this study was formulated based on a combination of selected constructs derived from Theory of Planned Behavior (TPB) and Diffusion of Innovations (DOI) Theory. The indirect TPB constructs were salient beliefs, and those applied to this study were behavioral, normative, and control beliefs, which were assessed using open-ended questions about the revision to confidentiality and privacy language in Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics. These open-ended questions were a part of the initial online, web-based questionnaire that included a copy of the Informed Consent, Personal History Demographic Questionnaires, and Individual Written Questionnaires.

Behavioral beliefs were assessed by asking participants to list up to five advantages and five disadvantages of the ACA’s code revision. Normative beliefs were examined by asking
participants to list up to five people who influence their understanding and application or use of the revision to confidentiality and privacy Section B.2.c. in the ACA’s 2014 Code of Ethics. Control beliefs were explored by asking participants to list up to five factors that make it difficult or easier for them to understand and apply or use the ACA’s revision to confidentiality and privacy guidelines in its 2014 ethics code. Other questions were posed to gain information about participants’ experiences and knowledge of the revision. There was a total of 28 initial online questions, 14 personal history demographic questions, and 14 individual written questions posed to participants.

After completing the initial online, web-based questionnaires, participants moved from their selected computer stations to the main central area of the room for the focus group questions. The 12 focus group questions were designed to help participants process their understanding and application of the ACA’s revision to confidentiality and privacy guidelines. The initial six collective focus group questions were based on concepts from the DOI Theory, specifically Rogers’ Innovation Decision Process. Rogers’ Innovation Decision Process includes dissemination and adoption processes. The DOI theory was selected to examine ethical code revision adherence. The combination of the dissemination and adoption processes include knowledge stage (recognition), persuasion stage (rationale/motives), decision stage (adopt/reject), implementation stage (actual use), and confirmation stage (maintenance).

The knowledge stage (recognition) was assessed by asking participants about their experience with the 2014 ACA Code of Ethics and the extent of their familiarity with the revisions. The persuasion stage (rationale/motives) was examined by asking participants about their opinions of the revisions, and the decision stage (adopt/reject) was assessed by asking participants about the extent to which they have adopted or rejected the code’s revisions. To
explore the implementation stage (actual use), participants were asked to tell each other about the way they currently apply the revisions to confidentiality and privacy guidelines. Asking participants to describe the kind of support needed for them to successfully apply or use the revised guidelines for confidentiality and privacy enabled the researcher to assess the confirmation stage (maintenance). The remaining six of the 12 questions were replicated from the initial online written questions related specifically to knowledge of the revision.

**Study Procedure**

Ten participants received written informed consent that explained that they were under no obligation to participate and could cease participation at any time. The written informed consent included permission to be both audio-recorded and video-recorded; however, no video-recording took place. Participants were assigned a pseudonym for confidentiality. The data for the current study were obtained through Personal History Demographic Questionnaires, Individual Written Questionnaires, and focus groups held at a university classroom/computer lab in North Carolina. The completion time for all these aspects of the study was approximately 90 minutes.

Upon obtaining written informed consent, each participant was seated at a computer station within the same room designated as the study location, where they were provided a temporary username and password to gain access to the online version of the written Informed Consent Form, the Personal History Demographic Questionnaire, and the Individual Written Questionnaire. These documents were combined and administered to the participants as a web-based questionnaire, which each participant completed in approximately 30 minutes to 45 minutes.

After a brief intermission and light refreshments, all participants transitioned to the central area of the room designated for the collective focus group interaction. Each participant
was given a folder at the end of the focus group, containing a copy of their signed written Informed Consent Form, a copy of the 2014 ACA Code of Ethics, and a $25.00 gift card as compensation for their participation. Participants were informed that copies of the transcripts would be made available for their review.

**Data Collection**

This research study examined counselors’ understanding, application, and training needs related to the changes pertaining to confidentiality in the 2014 ACA Code of Ethics. A representative sample of LPCs from North Carolina were prescreened and recruited by email messaging, telephone calls, and word-of-mouth or referrals. These LPCs were interviewed individually via written questionnaires and participation in focus group discussions to learn about their understanding of these changes, including their responsibilities, expectations, and how they remain current and/or receive professional updates on the ACA’s ethics code. Data were gathered through a personal history demographic questionnaire, an individual written questionnaire, and focus group discussions to explore the participants’ adoption or lack of adoption of the current ethical code revision, as well as to identify deficits in their knowledge about disclosure of health information to third parties placed at risk for contraction of a life-threatening, communicable disease.

Upon dissertation committee acceptance of this research study’s proposal, approval to conduct the study was sought from the university’s Institutional Review Board (IRB). Written informed consent was obtained from participants before beginning the study, and participants were informed that their participation in this study was entirely voluntary. Other pertinent information shared with each participant in the Informed Consent Form included the purpose of the study, their right to be released from the study at any point, and any potential risks associated
with their participation. Participants received a $25.00 gift card as an incentive to participate in this study.

**Personal History Demographic Questionnaire.** Participants received an initial Personal History Demographic Questionnaire inquiring about race, gender, age, years of education and training, professional counseling experience, types and preferences of professional development and continuing education training, and populations served currently and previously (see Appendix C).

**Individual Written Questionnaire.** Participants received an Individual Written Questionnaire designed to explore their salient beliefs, an indirect TPB construct (see Appendix D). These salient beliefs are behavioral, normative, and control beliefs (Whitaker et al., 2016). Salient beliefs toward Licensed Professional Counselors’ understanding and application of the revision to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics, and their current training needs about the revision, were captured through open-ended responses. Behavioral beliefs were assessed by asking participants to list up to five advantages and five disadvantages of the code’s revision regarding confidentiality and privacy. The researcher explored the participants’ normative beliefs by asking them to list up to five people who had influenced their understanding and application of the ACA ethics code revision. Finally, control beliefs were explored by asking the LPCs in this study to list up to five factors that make it difficult or easier for them to understand and apply the code’s revision in their daily professional work.

In addition to exploring their salient beliefs, participants were asked the following questions about their view of the ACA Code of Ethics section on confidentiality and privacy, both before and after the 2014 revision:
1. Prior to the revision of the 2014 American Counseling Association Code of Ethics related to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases,” were you ever in a position to perform your “duty to inform” a third party placed at risk for contracting a life-threatening, communicable disease?
   - If so, what steps did you take?
   - Did you feel prepared to address this issue?
   - What specific training did you receive to address this issue?
   - If you were never in the position to perform your “duty to inform” a third party placed at risk for contraction of a life-threatening, communicable disease, do you feel you were prepared address this issue?
   - What specific training have you received to address this issue?

2. After the revision of the 2014 American Counseling Association Code of Ethics related to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases,” were you ever in a position to perform your “duty to inform” a third party placed at risk for contracting a life-threatening, communicable disease?
   - If so, what steps did you take?
   - Did you feel prepared to address this issue?
   - What specific training have you received to address this issue?
   - If you were never in the position to perform your “duty to inform” a third party placed at risk for contraction of a communicable, life-threatening, disease, do you feel you were prepared address this issue?
   - What specific training have you received to address this issue?
The Individual Written Questionnaire also assessed the specific knowledge necessary for a LPC to competently, legally, and ethically disclose information to third parties who may have been exposed to a client with a communicable, life-threatening disease. Knowledge related to justified disclosure was assessed based on six questions asked in the Individual Written Questionnaire. The same six knowledge-based questions were repeated as part of the collective focus group questions, as listed below. The purpose of administering the Individual Written Questionnaire prior to participation in the focus group was to obtain participants’ independent, uninfluenced answers.

Focus groups. The focus group questions were designed to help participants process their understanding and application of the ACA Code of Ethics’ revision to confidentiality and privacy guidelines. Answers to the prescribed list of 12 focus group questions allowed for the process of categorization and sub-categorization via content analysis. The initial six of the 12 focus group questions were constructed in accordance with Rogers’ Innovation Decision Process, concepts from DOI theoretical framework (see Appendix E). As suggested by Harting et al. (2009), the semi-structured focus group questions were guided by a topic list to ensure that the key issues of the five steps of the innovation decision process were discussed.

The five topics based on the five stages of the innovation decision process were knowledge (recognition), persuasion (rationale/motives), decision (adopt/reject), implementation (actual use), and confirmation (maintenance).Addressing the knowledge stage (recognition), the first question was, “To what extent are you familiar with the revision to confidentiality and privacy, Section B.2.c., ‘Contagious, Life-Threatening Diseases,’ in the 2014 ACA Code of Ethics?” The second question addressed the persuasion stage (rationale/motives) by asking, “What are your opinions of the revision to confidentiality and privacy, Section B.2.c.,
‘Contagious, Life-Threatening Diseases,’ in the 2014 ACA Code of Ethics?” The decision stage (adopt/reject) was covered by the third question, which asked, “To what extent would you say that you have adopted or rejected the revision to confidentiality and privacy, Section B.2.c., ‘Contagious, Life-Threatening Diseases,’ in the 2014 ACA Code of Ethics?” The fourth question related to the implementation stage (actual use), inquiring, “What can you tell each other about the way you currently apply the revision to confidentiality and privacy, Section B.2.c., ‘Contagious, Life-Threatening Diseases,’ in the 2014 ACA Code of Ethics?” To address the confirmation stage (maintenance), the fifth question asked, “What kind of support do you need to apply or use the revision to confidentiality and privacy, Section B.2.c., ‘Contagious, Life-Threatening Diseases,’ in the 2014 ACA Code of Ethics?” Table 3.7 below provides an overview of these questions and their relationship to the stage of the decision-making process.
The final six questions posed to participants as prompts for their focus group discussion were based on various aspects of the wording and expectations of the actual revision to confidentiality and privacy, Section B.2.c.:

1. How do counselors determine which diseases are both communicable and life-threatening?
2. How do counselors determine justification for disclosure to third parties?
3. How do counselors ensure their personal safety when informing third parties or “persons at risk?”
4. How are counselors compensated for disclosure activities?
5. How much identifiable information does the counselor share about their client in the notification process?
6. After completing the notification process, is it ethical for counselors to accept these “identifiable third parties” as clients based on their requests?

These same six knowledge-based questions were posed as part of the initial web-based Individual Written Questionnaire. The purpose of a second administration of the six knowledge-based questions during the focus group was to obtain participants’ collective responses and explore the impact or influence of the group upon individual responses.

Data Analysis

Data gathered from the Personal History Demographic Questionnaires, Individual Written Questionnaires, and focus group responses were used to provide comprehensive descriptions of the sample, the two focus groups, and each individual participant. These questionnaires provided insight about the participants’ initial thoughts and perceptions prior to their exposure to peers in the focus group. As Bradbury-Jones et al. (2009) maintain, the focus groups helped provide the researcher with greater understanding of the phenomenon under study.

Ten participants who met the research criteria volunteered for the study. Based on their availability and preference, each LPC was assigned to one of two separate focus groups, both with five participants. The participants provided responses both in written form via questionnaires completed via web-based and verbally by answering focus group questions, explaining their perceptions of the change in the 2014 ACA Code of Ethics guidelines related to confidentiality, specifically disclosure of health information to third parties at possible risk for contraction of a life-threatening, communicable disease. In addition to addressing how they understood and applied the ACA’s change in the its ethics code, participants also discussed their current training needs regarding the change.
Audiotaped recordings of the focus groups allowed the researcher to review detailed participant reflections in response to the interview questions. Data were analyzed using content analysis (Bengtsson, 2016; Vaismoradi et al., 2013). The themes and subthemes that emerged from the data provide insight about LPCs’ understanding, application, and current training needs regarding the revision to the ACA (2014) Code of Ethics section on confidentiality and privacy related to contagious or life-threatening diseases. The audio-recorded focus groups were transcribed verbatim and imported into text documents, and then a qualitative content analysis with a direct approach was used to analyze the data in the NVivo qualitative analysis program. Hsieh and Shannon (2005) state that analysis starts with a theory or relevant research findings as guidance for initial codes with a directed approach.

Content analysis is well-suited to analyze the multifaceted, important, and sensitive phenomena (Bengtsson, 2016; Elo & Kyngäs, 2008; Vaismoradi, Salsali, & Mark, 2011; Vaismoradi et al., 2013). *Content analysis* is a systematic coding and categorizing approach used for unobtrusively exploring large quantities of textual information to determine trends and patterns of words, their frequency and relationships, and the structures and discourses of communication (Bengtsson, 2016; Gbrich, 2007; Mayring, 2000; Pope, Ziebland, & Mays, 2006; Vaismoradi et al., 2013). Such an approach is appropriate if existing theory and prior research about a phenomenon are incomplete or would benefit from further description (Harting et al., 2009).

As suggested by Vaismoradi et al. (2013), the researcher began the process of content data analysis with the preparation phase of familiarizing with data. Next, the researcher transcribed the interview and obtained a sense of the whole by reading the transcripts several times. At this point, the researcher chose manifest content (developing categories) over latent
content (developing themes) before proceeding to the next stage of data analysis. Open coding, collecting codes under potential subcategories/subthemes or categories/themes, and comparing the emerged coding's clusters together to the entire data set comprised the next stage of data analysis, called the organizing phase in content analysis.

Qualitative content analysis, specifically manifest analysis, was implemented to “organize and elicit meaning from the data collected and draw realistic conclusions from it” (Bengtsson, 2016, p. 8). Based on the use of manifest analysis, this researcher chose to “describe what the participants actually say, stay very close to the text, use the words themselves, and describe the visible and obvious text” (Bengtsson, 2016, p. 10). The four main stages of content analysis are decontextualization, recontextualization, categorization, and compilation, as described in Table 3.8 below.

### Table 3.8: Stages of Content Analysis

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decontextualization</td>
<td>Transcribed text was broken down into meaning units (or smallest units of insight determined by the researcher).</td>
</tr>
<tr>
<td>Recontextualization</td>
<td>Re-read the original text in relation to the final list of meaning units to consider whether other text provided answers to research questions.</td>
</tr>
<tr>
<td>Categorization</td>
<td>Condensed meaning units that have become codes are further broken down into specific content areas referred to as subthemes and themes.</td>
</tr>
<tr>
<td>Compilation</td>
<td>Explored how the participants made sense of the experience and transform experiences into consciousness.</td>
</tr>
</tbody>
</table>

Themes were derived from the transcribed focus group interview responses. Table 3.9 below shows results from raw data in an example content analysis schedule based on transcribed focus groups with LPCs.
Table 3.9: Example Content Analysis Schedule – Transcribed Focus Groups with NC LPCs

<table>
<thead>
<tr>
<th>Meaning Unit</th>
<th>Code</th>
<th>Subtheme</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I have no idea what you mean by that. Like compensation, is that a billable activity?” (Wendy)</td>
<td>Don’t know</td>
<td>Lack of Information</td>
<td>Deprivation of Information</td>
</tr>
<tr>
<td>“I would not disclose the client’s name. I would give the person the name of the disease and give them resources on where they can be treated.” (Clara)</td>
<td>Not disclose client’s name</td>
<td>Responsibility to Client</td>
<td>Responsibility to Others</td>
</tr>
</tbody>
</table>

During decontextualization (Stage 1), the transcribed focus group text was broken down into meaning units (or the smallest units of insight determined by the researcher). In this open-coding process, these meaning units were labeled with a code that was understood in relation to the context. This study employed an inductive reasoning design in which codes were generated or created during the analyzing process. In the recontextualization stage (Stage 2), the researcher re-read the original text in relation to the final list of meaning units to consider whether answers to the research questions were provided. The categorization stage (Stage 3) allowed the researcher to condense meaning units into codes, further breaking them down into specific content areas referred to as subthemes and themes. NVivo, a qualitative data analysis computer software package, was used to facilitate the process of locating codes and grouping data into categories.

Based on the findings, conclusions about meaning units, codes, subthemes, and themes were identified. In the compilation stage (Stage 4), the way the participants made sense of and transformed experiences into consciousness was explored. The researcher attempted to find the essence of the studied phenomenon and reach a deeper understanding of it, even if on a descriptive level. Using manifest analysis, each category was considered using the participants’
words in the original text. Table 3.10 below provides a summary of themes and subthemes that emerged from the current study.

**Table 3.10: Summary of Themes and Associated Subthemes**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subtheme One</th>
<th>Subtheme Two</th>
<th>Subtheme Three</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deprivation of Information</td>
<td>Lack of Information</td>
<td>Limited Resources</td>
<td>Search for Information</td>
</tr>
<tr>
<td>Responsibility to Others</td>
<td>Responsibility to Clients</td>
<td>Responsibility to Community</td>
<td>Responsibility to the Profession</td>
</tr>
</tbody>
</table>

To validate the outcome and strengthen the validity of the study, the data were returned for agreement of accuracy via participant validation emails (see Appendix F). Findings are presented in the Chapter 4.

**Validation Strategies**

Concepts linked to trustworthiness are relevant to the current study’s findings and analysis. Credibility, dependability, transferability, and confirmability, concepts created by Lincoln and Guba (1985), were used to examine the content analysis and other steps taken during the study. *Credibility* refers to the study process, specifically establishing how the data and the analysis procedures are carried out to ensure that no relevant data have been excluded. Credibility was increased for this study through member checking and consultation with dissertation chairs. *Dependability* refers to stability, specifically the extent to which data change over time and the modifications made in the researcher’s decisions during analysis. The use of a qualitative data analysis computer software package increased dependability. The use of NVivo software provided a systematic way of locating codes and grouping data into categories. These
methods increased the researcher’s confidence when narrowing concepts and identifying meaning units, codes, subthemes, and themes. Transferability refers to the degree to which the results may be applicable to other settings or groups and to the number of informants or study objects. This qualitative study focused on the depth of the sample of 10 LPCs in North Carolina; based on the size and specificity of this sample, generalizing from the findings would be problematic. Confirmability is largely an issue of presentation and refers to the objectivity or neutrality of the data (Bengtsson, 2016; Polit & Beck, 2006). Since replication is always difficult and there is no definite “truth” in qualitative studies, “researchers are more interested in depth understanding of a specific issue and in showing different perspectives rather than aiming at singular truth and generalization” (Bengtsson, 2016, p. 13).

For this study, bracketing and how it affects interpretation of participants’ feedback and conclusions given as findings were addressed. This researcher acknowledges an identity as a licensed professional counselor with a background in public health, which has led to exposure to certain information related to this study that would not be otherwise available without previous training and work experience.

**Chapter Summary**

Chapter 3 presented a detailed report of the methodology of the current study, including research design, study participants, study procedure, data collection and process. There were 10 participants who were divided into two focus groups, each with five participants. The participants were assigned the following pseudonyms: Barbara, Vanessa, Jerry, Susan, Bonita, Wendy, Jackson, Clara, Martin, Collette. This chapter provided individual descriptions of the participants including each counselor’s training history and their preferences. The chapter also provided collective descriptions of the Saturday Focus Group and Sunday Focus Group. Data
were collected from participants using Personal History Demographic Questionnaire, Individual Written Questionnaires, and focus groups, and analyzed for insights and emergent themes.

Chapter 4 discusses the findings of the study, including emergent themes and subthemes from individual and group responses.
CHAPTER 4: FINDINGS

Chapter Introduction

This qualitative phenomenological study examined the revision to confidentiality and privacy guidelines as written in Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 American Counseling Association (ACA) Code of Ethics as it relates to the understanding, application, and training needs of North Carolina Licensed Professional Counselors (LPC). The first three chapters offered an introduction to the problems surrounding professional counselors’ lack of standardized protocol for making a disclosure, a review of the literature, and the methodological design utilized. This chapter presents the findings that emerged from the data collected and analyzed about the phenomenon of justified disclosure among LPCs.

The two overarching research questions used to guide this study’s investigation of the ACA’s recent change to its ethics code were:

1. What are Licensed Professional Counselors’ understanding and application of the revision to confidentiality and privacy as written in Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics?

2. What are the current training needs of Licensed Professional Counselors regarding the revision to confidentiality and privacy as written in Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics?

Study Findings

This section provides the findings from the research study. Gathering individual written feedback and conducting focus groups with participants provided data on the phenomenon of justified disclosure among LPCs.
Individual Written Feedback

Regarding the revision to confidentiality and privacy section of the ACA’s 2014 Code of Ethics, the following findings from individual feedback include salient behavioral, normative, and control beliefs, pre- and post-revision practices, and the justified disclosure process knowledge of LPCs.

This qualitative study uniquely contributes to the literature by using the TPB to examine the beliefs of LPCs regarding their understanding and application of the revision to the ACA’s 2014 Code of Ethics in the section on confidentiality and privacy related to contagious, life-threatening diseases. Study participants provided the following individual written feedback about their salient behavioral, normative, and control beliefs.

Behavioral beliefs. Behavioral beliefs were assessed by asking participants to list up to five advantages of the revision to the confidentiality and privacy guidelines in Section B.2.c. of the ACA’s 2014 Code of Ethics. The participants’ independent responses exhibited their sense of responsibility for community, as several of the LPCs discussed protection of the community, specifically protecting innocent people from being harmed as well as protecting public health, identified individuals’ health, and an identifiable other from a life-threatening illness.

When asked about their behavioral beliefs, the participants cited advantages related to justified disclosure and the confidentiality revision. Collette stated, “This is an important topic and counselors may not understand the seriousness of the threat of contagious diseases. Having the revision will bring attention to the important topic and provide information for counselors to base ethical decision-making on.” Similarly, Martin commented on the importance of “informing third parties that they are interacting with an individual with a disease, ensuring the safety of others, educating the client on the risk of interacting with others, and preventing the risk of the disease spreading to other people.” Vanessa also pointed to the benefits of the new ACA ethics
code guidelines, noting that the revisions will “help to protect innocent people who have not been made aware they may be infected.” Other benefits of the new ACA ethics code change identified by Vanessa include “helping the client, within therapeutic sessions, to accept responsibility for their behaviors and choices and reducing the stigma of receiving therapy.”

The participants’ independent responses about the disadvantages of the revised ACA Code of Ethics language revealed concern for the counseling relationship. Several participants specifically discussed damage to counselor and client rapport, damage to trust in the counseling relationships, and the consequences if the client feels reluctant to review or disclose the information in the session. Participants cited several disadvantages to justified disclosure and the ACA’s code confidentiality revision. Collette remarked:

> Once the information is in the codes, we are accountable for responding to the issue as it arises. While I believe it is important to inform and protect the necessary parties from a potential disease, this would require some additional training and knowledge to know what diseases give due cause to break confidentiality as necessary.

Vanessa suggested that the revised guidelines “might keep client from disclosing important information in therapy…[which] could be detrimental to building positive therapeutic relationship.”

**Normative beliefs.** Normative beliefs were examined by asking participants to list up to five people who influence their understanding of the revision to confidentiality and privacy in Section B.2.c. in the 2014 ACA Code of Ethics. In their independent responses, the counseling professionals identified specific influencers of their understanding of the code’s revision. Such potential influencers of understanding include qualified professionals, care coordinators, clinical directors, supervisors, mentors, professors, instructors, colleagues, co-workers, and family
members. When asked about their normative beliefs, several participants cited this researcher as having influenced their understanding of justified disclosure and the confidentiality revision—an unanticipated finding. Susan’s reply was simply “the researcher of this study,” and, likewise, Jerry said that the “study leader” had influenced his understanding. Collette explicitly stated, “The investigator of the current study has provided some knowledge or understanding in the past, when discussing it in class. I am not sure of anyone else.” She went on to add information she had likely come across in an insurance training or counseling practice training:

Again, the current study's investigator caused me to think about the topic and ethical steps I would take. Also, the office manager at the private practice where I work recently bought up a discussion among the employees to get an idea of how we all would handle it.

Although the current study’s researcher had some influence over several of the participant LPCs’ understanding of the revised ACA (2014) Code of Ethics, none of the participants reported being influenced to actually apply the revision to confidentiality and privacy in Section B.2.c. in the 2014 ACA Code of Ethics by any sources.

Control beliefs. Control beliefs were explored by asking the LPCs to list up to five factors that make it difficult for them to understand the revisions to confidentiality and privacy guidelines in the 2014 ACA Code of Ethics. The participants’ independent responses identified a variety of barriers to understanding the revision, which included lack of awareness about the revision specifically related to limited training, limited communication of changes between professionals, lack of familiarity with the code, not knowing the revisions or what the former Code of Ethics stated, and absence of clarity on wording. When asked about their control beliefs, the LPCs in this study cited several barriers to their understanding of justified disclosure and the confidentiality revision. Collette pointed to her lack of medical knowledge:
The factors that make it difficult to understand is-- I do not have the medical training to understand what disease is life-threatening; I would not know how to get in contact with the person and would not want to discuss the details with law enforcement.

Bonita noted the code is “very seldom discussed” and that there is “little guidance or awareness around this topic” that touches on a “complexity of issues and systems.” Agreeing with the other LPCs, Susan said that the profession needs to “clarify what classifies as a contagious, life-threatening disease,” and admitted that she “cannot honestly say I know what was in place prior to this revision.”

Control beliefs were further explored by asking the North Carolina-based LPCs to list up to five factors that make it easier for them to understand the revision to the confidentiality and privacy section B.2.c. of the ACA’s 2014 Code of Ethics. The participants’ responses were intended to identify enablers that can help counselors understand the revision, but such enablers to understanding were reported as unknown by most of the participants. However, consulting the ACA website, providing an example to accompany Section B.2.c., and discussing the fine points of the guidelines and how to apply them to new situations in therapy were mentioned. When asked about their control beliefs, participants cited several potential enablers to their understanding of justified disclosure and the confidentiality revision. Clara noted that “clarity of wording, providing examples, highlighting the differences from the previous version, and understanding the purpose of the guidelines would aid her understanding.” Bonita suggested that outside sources were ideal enablers of understanding, suggesting:

Talking about it with colleagues, professors, et cetera. Attending a continuing education course or webinar on it (I haven't done so, but it could help). Hearing from rights activists or individuals living with communicable, infectious diseases like HIV or Hepatitis
regarding their views and opinions on this issue. Reviewing the basic principle of the ACA Code of Ethics (nonmaleficence, beneficence, autonomy, et cetera) to examine how this new revision fits into the overall code.

Attention to helping LPCs understand the code can serve to enable its better implementation and application in practice.

The LPCs’ control beliefs were also investigated by asking participants to list up to five factors that make it difficult for them to apply the revision to confidentiality and privacy to their own practice. From their responses, the participants named a variety of barriers to application of the revision, which included lack of information about the revision, specifically too little information or guidance; ambivalence over the revision; limited communication among peers; lack of ability to help clients to understand the application; knowing the expected extent one should go to access a third party to inform; and primarily working with children or minors. When asked about their control beliefs, participants in this study cited a few additional barriers to successful application of the ACA’s justified disclosure and confidentiality revisions to its 2014 Code of Ethics. Collette argued that she “would need the medical training to feel confident to apply the information in the code,” going on to say that she felt “more research and discussion would need to happen about how to apply it.” Similarly, Clara noted the importance of “ensuring that the client fully understands,” confirming the “third party's commitment,” and “not having enough information about the Code of Ethics revisions…[or] persons available to ask questions in a timely manner.” Wendy asked, “It would be difficult for me to break confidentiality. I may not have the information needed to inform the third party—would the client willingly share that with me?” Likewise, Susan said that “clarifying what identifies as a contagious, life-threatening disease” and “knowing how to access a third party” were critical.
The participants’ independent responses identified a variety of enablers to the application of the code’s revision, including ACA training, workshops, and more education. When asked about their control beliefs, participants cited several enablers to application of justified disclosure and the confidentiality revision. Clara, for instance, said “having a person available to address questions to” would be useful, as would “clarity on the wording, sound and clear examples, and knowing the revisions by comparing the previous version to what has been revised.” Susan furthermore added that it was vital to be able to “identify the third party and their level of risk of being exposed to said contagious, life-threatening disease.”

Pre-revision practices. Only one of the 10 LPCs in this study reported ever being able to act upon their “duty to inform” a third party placed at risk for contraction of a life-threatening, communicable disease prior to the revision of the 2014 ACA Code of Ethics on confidentiality. This singular instance prompted Clara to consult with the client and the clinical director, because she admitted that she did not feel prepared to address the issue due to a lack of information and clarity on the standard. Clara shared that she took an online ethics course to try to gain greater insight about how to address the issue. The remaining nine participants reported never being able to act upon their “duty to inform” a third party placed at risk for contracting a life-threatening, communicable disease prior to the revision of the 2014 ACA Code of Ethics related to confidentiality. Five of these nine participants indicated, however, that they did feel prepared to address this issue when needed, while the remaining four LPCs indicated that they did not feel prepared to do so. The LPC participants provided several reasons for feeling either prepared or unprepared to address this issue. When asked to report the reasons why they felt prepared to address the issue of acting upon their “duty to inform” a third party placed at risk for contraction of a life-threatening, communicable disease, participants named several factors. Jackson, for
example, claimed that, for him, “consulting with peers and clinical staff would have provided direction.” Martin answered:

I feel prepared, because as a counselor it is my job to ensure that the third party is not at risk. If my client mentions hurting or harming another individual, I am legally and ethically bound to warn them. If I do not warn the third party, it could result in a loss of my job and license.

Wendy said that she had received “a lot of training and supervision related to ethics and legal issues,” and Susan pointed to the value of having “access to resources for professional consultation.” Additionally, participants cited “needing a better understanding,” “having too little education,” “not being sufficiently aware of the rule,” possessing “strong feelings about the rights of people living with HIV,” and “never hav[ing] been in that situation” as reasons they did not feel prepared to address the issue of acting upon their “duty to inform” a third party placed at risk for contraction of a life-threatening, communicable disease. Collette stated, “I would not have thought of the medical issue as a (counselors’) “duty to inform” issue, since it was a medical situation I would have leaned on the doctors to handle that one.”

Of the nine participants who reported that they were never in a position to act upon their “duty to inform” a third party placed at risk for contraction of a life-threatening, communicable disease prior to the revision of the 2014 ACA Code of Ethics related to confidentiality, six participants indicated that they have never received any specific training to address this issue. To address this issue, the specific training reportedly received by the remaining three participants were “yearly HIV training”, “crisis training and suicide prevention training”, and “the Jurisprudence exam every two years and a webinar on ethics and legal issues.”
Post-revision practices. Two of the 10 LPCs reported having been able to act upon their “duty to inform” a third party placed at risk for contraction of a life-threatening, communicable disease after the revision of the 2014 ACA Code of Ethics related to confidentiality. Collette reported refraining from taking the final steps toward disclosure because the counseling relationship did not continue, and the client did not share information about their sexual partners. Clara shared a singular instance that prompted her to inform the client and obtain supervision from the clinical director. Though Collette stated that she felt prepared to apply the revision as it is stated in the ACA (2014) Code of Ethics, Clara admitted that she did not feel prepared to address the issue because she felt that she was violating her client's rights. Both participants shared that they have not received any training related to how to address the revision to confidentiality and privacy guidelines in the 2014 ACA Code of Ethics.

The remaining eight participants reported that they were never able to act upon their “duty to inform” a third party placed at risk for contraction of a life-threatening, communicable disease after the revision of the 2014 ACA Code of Ethics related to confidentiality. Of the eight participants, six participants indicated that they felt prepared to address this issue, while the remaining two participants admitted not feeling prepared to address the issue. The participants provided several reasons for feeling either prepared or unprepared to address the issue of acting upon their “duty to inform” a third party placed at risk for contraction of a life-threatening, communicable disease. For instance, Jackson noted that “clinical and ethical consultation was available,” much like Jerry, who simply pointed out that he had “received notice of the change.” Martin spoke in more detail, “I feel that I am prepared because I am knowledgeable to communicate with my client about the consequences of spreading a life-threatening disease. I also feel that I can communicate with the third party as well.” Wendy pointed to the fact that she
had received “a lot of training and supervision over the last 12 years.” While she did note that she was “more prepared now,” Bonita said that she would still like “more information and guidance” on the code changes, and Susan similarly cited her “access to professional resources for consultation.” When asked to cite the reasons participants did not feel prepared to address the issue of acting upon their “duty to inform” a third party at risk for contraction of a life-threatening, communicable, participants replied needing “a better understanding” or “not applicable.”

Of the eight participants who reported that they were never able to act upon their “duty to inform” a third party at risk for contraction of a life-threatening, communicable disease after the revision of the 2014 ACA Code of Ethics related to confidentiality, four LPCs indicated never receiving any specific training to address this issue. To address this issue, the specific training reportedly received by the remaining four participants were “HIV and infectious disease training,” “crisis counseling training and suicide prevention training,” “the Jurisprudence exam every two years and a webinar on ethics and legal issues,” and “just reading.”

**Knowledge-based questions.** The individual written responses to the six knowledge-based questions provided insight about participants’ uninfluenced, independent thoughts regarding the revision of the 2014 ACA Code of Ethics related to confidentiality and the justified disclosure process. It was evident that the participants were unsure how to answer most of the questions. However, participants reported research, training, and consultation as optimal ways to increase or enhance their knowledge about their “duty to inform.” A unique area of consensus for the sample was that all 10 participants independently indicated their belief that it is unethical for counselors to notify identifiable third parties placed at risk for contraction of a life-threatening,
communicable diseases by their current client, and then to subsequently accept the identifiable third parties as clients.

**Collective Feedback via Focus Groups**

The 12 focus group questions were a combination of questions to examine determinants of ethical code revision adherence and assess participants’ knowledge of the justified disclosure process as it relates to the revision to the 2014 ACA Code of Ethics. Rogers’ Innovation Decision Process is derived from DOI Theory, and the five stages of Rogers’ process provided a framework to gain greater understanding of the stage(s) that applied to the LPCs’ adoption of the code revision. Table 4.1 below outlines the most frequently coded focus group responses to questions based on the dissemination and adoption processes of Rogers’ Innovation Decision Process.
Based on the participants’ responses, lack of knowledge or awareness of the revision causes adoption of the revision to not occur. During the dissemination process, it did not appear that recognition of the revision occurred as part of the knowledge stage. As Jerry stated, “I was not aware of those changes prior to coming here today.” Barbara commented, “I actually teach that course to my graduate students and I love it. But I do not know anything about this particular topic.” Similarly, Jackson reflected a lack of knowledge of the topic, commenting, “I had heard

### Table 4.1: Rogers’ Innovation Decision Process

<table>
<thead>
<tr>
<th>Process</th>
<th>Stage</th>
<th>Focus Group Questions</th>
<th>Most Frequently Coded Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissemination</td>
<td>Knowledge (recognition)</td>
<td>To what extent are you familiar with the revision to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics?</td>
<td>Not aware of revision</td>
</tr>
<tr>
<td>Persuasion (rationale/motives)</td>
<td>What are your opinions of the revision to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics?</td>
<td>No clear guidelines</td>
<td></td>
</tr>
<tr>
<td>Adoption</td>
<td>Decision (adopt/reject)</td>
<td>To what extent would you say that you have adopted or rejected the revision to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics?</td>
<td>Understand why it’s there, understand the need</td>
</tr>
<tr>
<td>Implementation</td>
<td>What could you tell each other about the way you currently apply the revision to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics?</td>
<td>Include in informed consent and disclosure form</td>
<td></td>
</tr>
<tr>
<td>Confirmation (maintenance)</td>
<td>What kind of support do you need to apply or use the revision to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics?</td>
<td>Don’t apply revision/ Don’t know</td>
<td></td>
</tr>
</tbody>
</table>

Training guidelines/ Process for contacting third party
about it. But as far as actually exploring it, I have not. I am saying I am unaware of it.” Though the persuasion stage of the dissemination process shows that some participants may understand the need or presence of the revision, they are not likely to apply it without clear guidelines. Clara remarked, “I think it’s necessary, but I also think it needs to be clarified so that everybody fully understands.” Barbara explained in more detail:

It is very risky for counselors. For one, there’s no real guidelines in terms of what the expectations are. There’s no clear guidelines of what it means to assess. It just says you need to assess the client’s intent. Is there an assessment tool or some type of measure that would say, “Okay, if they say yes to this, then you give them a .4 and then that is what you are doing, sort of like what you would when you are looking at suicide interventions?” So, I just feel like we are kind of left out there guessing. Waiting to make a mistake.

During the decision stage of the actual adoption process, the study participants admitted that they had not adopted the revision to confidentiality as part of their practice. However, some participants reported seeing the value of the revision and were willing to adopt it through its incorporation into informed consent and disclosure statement. Jerry explained:

I agree that the confidentiality statement and the limits of the confidentiality at the agency I work talks about being a mandated reporter for abuse, neglect, and things like that. But there is nothing, no mention of this. So, I think that is probably an issue for lots of similar agencies.

Collette discussed the fact that she has had few occasions when she would want to apply it:

I would say that I have very limited number of situations where I would need to apply it. But, I would say that I have kind of tucked it away as something that I might come across. But then there becomes the question of, “Does this need to be in the disclosure statement?”
So that clients are aware that if they tell us about this disease…it feels very unfair if someone were to say that and then later on say, “Well, I got to report this,” and they were not aware that there would be a potential break in confidentiality. So, they may choose…I’ve had a client that I believe had HIV or AIDS and didn’t disclose it, denied it. So, there is this kind of situation of, like, I don’t know what would have happened had that relationship continued. But that would have been a really difficult situation to deal with if it was shared and if it wasn’t in my disclosure statement and that sort of thing.

Regarding the implementation stage of the adoption process, participants reported that they have not implemented the revision. Wendy stated, “I have not applied this specific part of the code in my practice.”

During the confirmation stage of the actual adoption process, participants are more likely to maintain the revision to confidentiality if they have clear guidelines and training associated with the justified disclosure and the confidentiality revision. Barbara commented, “Training, training, and more training. And just telling us what to do is not sufficient. We need to know the how to do it.” Wendy addressed the question of how to go about contacting the third party:

I would like some guidelines or step-by-step process to how that would work. As I was thinking about this, how would I even contact this third party? Is the client going to willingly give me this information if I do not even know the person’s name? So, I think that I have a lot of questions that I do not have answers to even carry this out on my own. I would need supervision.
Jackson also felt that training was needed to help him understand the revision:

   Since I am vaguely aware of the change and have not had to implement it in any situation that I have been in, I would definitely like to have some training or a full workshop on the changes and how to apply them both agency settings and private practice.

**Emergent Themes and Subthemes**

Themes and subthemes emerged from the content analysis of participants’ responses to six knowledge-based questions posed in both the Individual Written Questionnaire and as part of the collective focus group questions. Each theme and subtheme were supported by direct quotes from participants.

**Theme #1: Deprivation of Information**

   Based on participants’ responses, these North-Carolina based LPCs lack information, have limited resources, or are in search for information as it relates to their understanding and application of the revision to the 2014 ACA Code of Ethics’ confidentiality and privacy section pertaining to communicable, life-threatening diseases.

   **Subtheme #1: Lack of Information**

   Participants indicated that they were not familiar with the revision to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics. For example, Jerry reported, “I was not aware of those changes prior to coming here today.”

   **Subtheme #2: Limited Resources**

   Participants reported that they have had limited experiences with the 2014 ACA Code of Ethics and the revision to confidentiality and privacy. For example, Barbara recalled,
I actually teach that course to my graduate students and I love it. But I don’t know anything about this particular topic.

Subtheme #3: Search for Information

Participants stated that they do not know how to determine which diseases are both communicable and life-threatening. According to Collette, “I would search the Internet and probably consult with someone that I know from the medical profession.”

Theme #2: Responsibility to Others

Subtheme #1: Responsibility to Clients

Although participants lacked certainty about how much identifiable information counselors share about their client in the notification process, they mention responsibility for the protection of their client’s identity. For example, Clara stated,

I would not disclose the client’s name. I would give the person the disease and give them resources on where they can be treated.

Subtheme #2: Responsibility to Community

Participants expressed responsibility for the members of their community when asked about their opinions of the revision to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics. Susan discussed “thinking about the risk of someone else being exposed if my particular client had some sort of malicious intent or something in terms of harming someone else.”

Subtheme #3: Responsibility to Profession

All participants indicated that they believe that it is unethical for counselors to notify identifiable third parties placed at risk for contraction of a life-threatening, communicable
diseases by their current client, and then to subsequently accept the identifiable third parties as clients. According to Wendy,

You would have information about that person prior to seeing them and that is unethical.

But I do think it would be your responsibility to refer them somewhere else and provide them with resources.

Table 4.2 below displays the “Deprivation of Information” theme with corresponding emerging subthemes and related focus group questions.

<table>
<thead>
<tr>
<th>Example Question</th>
<th>Example Participant Response(s)</th>
<th>Sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>“To what extent are you familiar with the revision to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics?”</td>
<td>“I was not aware of those changes prior to coming here today” (Jerry).</td>
<td>Lack of Information</td>
</tr>
<tr>
<td>“What is your experience with the 2014 ACA Code of Ethics?”</td>
<td>“I actually teach that course to my graduate students and I love it. But I don’t know anything about this particular topic” (Barbara).</td>
<td>Limited Resources</td>
</tr>
<tr>
<td>“How do counselors determine which diseases are both communicable and life-threatening?”</td>
<td>“Google was the first thing that popped into my head” (Wendy).</td>
<td>Search for Information</td>
</tr>
<tr>
<td></td>
<td>“I would search the Internet and probably consult with someone that I know from the medical profession” (Collette).</td>
<td></td>
</tr>
</tbody>
</table>
Table 4.3 below displays the “Responsibility to Others” theme with emerging subthemes and related focus group questions.

**Table 4.3: Responsibility to Others – Emerging Subthemes & Related Focus Group Questions**

<table>
<thead>
<tr>
<th>Example Question</th>
<th>Example Participant Response</th>
<th>Sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>“How much identifiable information does the counselor share about the client in the notification process?”</td>
<td>“I would not disclose the client’s name. I would give the person the disease and give them resources on where they can be treated (Clara).”</td>
<td>Responsibility to Clients</td>
</tr>
<tr>
<td>“What are your opinions of the revision to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics?”</td>
<td>“...think about the risk of someone else being exposed if my particular client had some sort of malicious intent or something in terms of harming someone else” (Susan).</td>
<td>Responsibility to Community</td>
</tr>
<tr>
<td>“After completing the notification process, is it ethical for counselors to accept these ‘identifiable third parties’ as clients based on their request?”</td>
<td>“You would have information about that person prior to seeing them and that is unethical. But I do think it would be your responsibility to refer them somewhere else and provide them with resources” (Wendy).</td>
<td>Responsibility to the Profession</td>
</tr>
<tr>
<td></td>
<td>“It would be a conflict of interest” (Clara, Martin, &amp; Collette).</td>
<td></td>
</tr>
</tbody>
</table>

Though participants lacked the resources to support their understanding and application of the ACA code revision, they agreed on their responsibilities to clients, community, and the profession.

**Unanticipated Findings**

Based on the lack of information available on this topic, most of the findings are as the researcher anticipated. However, there were several unanticipated findings from the study. When assessing salient normative referents, this study’s researcher exerted the largest influence on the counselors for understanding of the revision. Knowledge of different aspects of the revision and the justified disclosure process were assessed by posing the same six questions using the administration of the Individual Written Questionnaire and as part of the Focus Group Questions.
Differences were shown between participants’ individual written responses and their collective focus group responses. Many of the counselors attempted to answer the questions posed in both formats. A need to appear knowledgeable, capable, or impressive may have played a role in some of the counselors’ posturing stance. It appears that group formats encouraged increased confidence to admit that they did not know or were not sure about specific answers to questions if the majority shared the same sentiment. Table 4.4 below outlines a sample response comparison for one participant.

**Table 4.4: Sample Response Comparison – Martin**

<table>
<thead>
<tr>
<th>Question</th>
<th>Individual Written Responses</th>
<th>Focus Group Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do counselors determine which diseases are both communicable and life-threatening?</td>
<td>The counselor would use their best judgement to determine if the third party is indeed at risk of contracting a communicable and life-threatening disease. Counselors know which diseases are communicable and life-threatening by medical research that has been conducting.</td>
<td>“I believe that that should be determined by the medical profession and then that information may be passed down on to counselors, so we can provide that information to clients.”</td>
</tr>
<tr>
<td>How do counselors determine justification for disclosure to third parties?</td>
<td>If the counselor feels that the third party is at risk or any harm may be done.</td>
<td>“I am not sure either.”</td>
</tr>
<tr>
<td>How do counselors ensure their personal safety when informing third parties or “persons at risk?”</td>
<td>A counselor may take an additional counselor for support when discussing the matter with the third party.</td>
<td>“When I originally answered the question on the assessment, I put having another additional counselor go with you, but I do not think that is a an accurate answer. I am not sure.”</td>
</tr>
<tr>
<td>How are counselors compensated for disclosure activities?</td>
<td>Counselors are not financially compensated for their disclosure. I believe they are mentally compensated by knowing that they did the legal and ethical thing in the matter.</td>
<td>“I don’t know if there is any financial compensation.”</td>
</tr>
<tr>
<td>How much identifiable information does the counselor share about their client in the notification process?</td>
<td>The counselor only shares the information regarding the communicable disease. The counselor should not share information about their client during the notification process.</td>
<td>“I assume it would be...you would not want to share information that could be traced back to your client. Just kind of what’s factual. Like Collette said, name and disease.”</td>
</tr>
</tbody>
</table>
Table 4.4: Continued

<table>
<thead>
<tr>
<th>Question</th>
<th>Individual Written Responses</th>
<th>Focus Group Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>After completing the notification process, is it ethical for counselors</td>
<td>No, because it may cause a conflict of interest. The counselor would be working with the</td>
<td>“I agree with Clara. It would be a conflict of interest. I believe mentally for the</td>
</tr>
<tr>
<td>to accept these “identifiable third parties” as clients based on their</td>
<td>individual that spread the disease and working with the individual with the disease. I use</td>
<td>counselor because you are counseling the person that has the disease and the person</td>
</tr>
<tr>
<td>request?</td>
<td>the example that a mental health counselor cannot work with a murderer and the victim’s</td>
<td>that transferred the disease to someone else. I believe it would be a conflict of</td>
</tr>
<tr>
<td></td>
<td>family. It would cause mental despair upon the counselor.</td>
<td>interest.”</td>
</tr>
</tbody>
</table>

It should be noted that Martin was the youngest participant with the least amount of professional experience. The answers he provided on the Individual Written Questionnaire and the responses given during the collective focus group were drastically different. As evidenced by Martin’s individual written responses, he chose to refrain from indicating that he did not know or was not sure about any answer. He used the strategy of restating the question as a statement and providing a minimal response. In contrast to his individual written responses, Martin admitted that he either did not know or was not sure about several of the knowledge-related questions posed during the focus groups. He also mentioned agreement with other members of the focus group as part of his answers. The differences between the individual written responses and the focus groups are unanticipated findings.

**Chapter Summary**

This chapter presents a summary of the focus group findings, including the initial written forms completed by participants, as well as the themes that emerged from the data analysis. The focus group protocol and analysis process are also described. The chapter concludes with an overall summary of the findings and emergent themes. Chapter 5 follows with a discussion of the study’s findings.
CHAPTER 5: DISCUSSION

Chapter Introduction

This chapter includes a discussion about the findings from the focus groups conducted for the current study on justified disclosure. As a final check, the researcher must consider how the new findings correspond to the literature and whether the results are reasonable and logical (Bengtsson, 2016). The following discussion includes implications, limitations, suggestions for future research, and concluding remarks.

As previously stated, the purpose of this qualitative study was to investigate the revision to the 2014 ACA Code of Ethics’ confidentiality and privacy section pertaining to communicable, life-threatening diseases, as it relates to the understanding, application, and training needs of Licensed Professional Counselors (LPCs) in North Carolina. A current review literature yielded no other studies that address counselors’ understanding and application of the change in the ACA (2014) Code of Ethics pertaining to confidentiality and disclosure. To initiate foundation for relevant notification guidelines, practice, and training, this research explored North Carolina-based LPCs’ perspectives about their “duty to inform” third parties. Data were gathered about the independent knowledge, beliefs, and pre- and post-revision practices of LPCs. The participants of this study provided individual and collective feedback about their knowledge and use of justified disclosure in their own counseling practice. This study also examined determinants of ethical code revision adherence and obtained a collective perspective of LPCs’ knowledge of the disclosure process.

The current study focused on LPCs in North Carolina, due to the variation of laws and regulations from state to state. Based upon verification of eligible licensure status and professional affiliations, 10 LPCs from North Carolina were prescreened and recruited for this
phenomenological study by email messaging, telephone calls, and word-of-mouth or referrals. To participate in the study, each participant must have been designated with the non-restricted, independent licensure status of LPC, according to the North Carolina Board of Licensed Professional Counselors (NBCBLPC). The NCBLPC (2017) mandates that all LPCs successfully complete an application, verify their education via official transcripts, pass examinations, submit a professional disclosure statement, undergo a criminal background check, and provide verification of supervised professional practice before licensure can be issued. Two focus groups of five participants each were conducted on different days.

**Essence of Phenomenon**

The conceptual framework applied in this study included both Theory of Planned Behavior (TPB) and Diffusion of Innovations (DOI) Theory. The findings were outlined according to the research questions, themes, and subthemes that supported the purpose of the study. The research questions that guided this study were:

1. What are Licensed Professional Counselors’ understanding and application of the revision to confidentiality and privacy as written in Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics?
2. What are the current training needs of Licensed Professional Counselors regarding the revision to confidentiality and privacy as written in Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics?

The first overarching research question in this study asked about LPCs’ understanding and application of the revision to confidentiality and privacy guidelines in Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics. Even with the
variation in this sample of participants, there were commonalities and consistencies in their understanding, application, and training needs as they relate to the code’s revision.

Only one of the 10 LPCs reported ever being able to act upon their “duty to inform” a third party placed at risk for contraction of a life-threatening, communicable disease, which occurred prior to the revision of the 2014 ACA Code of Ethics. Upon assessing their pre-revision practices and post-revision practices, findings revealed that most of the participants had not been presented with or recognized opportunities to apply the revision in their practice.

Based upon content analysis, one of the emerging themes was “Deprivation of Information.” The subthemes for “Deprivation of Information” included “Lack of Information,” “Limited Resources,” and “Search for Information.” Commonalities in participants’ lived experiences are reflected in the lack of information, limited resources, and search for information as it relates to their understanding and application of the revision to confidentiality and privacy guidelines in the 2014 ACA Code of Ethics.

The second emerging theme was “Responsibility to Others,” and its subthemes included “Responsibility to Clients,” “Responsibility to Community,” and “Responsibility to Profession.” Despite the absence of vital information necessary to carry out the justified disclosure process, the participants individually and collectively acknowledged the value of rapport with clients and concern for the best interests of the community and profession.

As a result, there is a desperate need for an intentional, systematic way of ensuring the dissemination of the ACA’s Code of Ethics, and any forthcoming revisions, to all LPCs. The creation of notification guidelines and training programs are vital toward this end, as these will allow LPCs to begin ethically and legally applying the principle of justified disclosure in their practice. The participants’ responses exhibited an understanding of the importance of their roles
as licensed professional counselors and the potentially negative impact of not having guidelines and training related to counselors’ “duty to inform” third parties about contagious, life-threatening diseases.

The second overarching research question that guided this study asked about the current training needs of LPCs regarding the 2014 ACA Code of Ethics’ revision to confidentiality and privacy, Section B.2.c. During the administration of the initial Individual Written Questionnaires, participants expressed an openness to attending face-to-face workshops and conferences as well as completing online training or webinars. Participants also reported having engaged in a variety of professional development and continuing education training courses since completing their counseling or counseling-related degree and obtaining licensure. However, there was no mention of the revision to confidentiality and privacy language in the ACA’s Code of Ethics as an area of need or interests when the question was posed during the Initial Written Questionnaire. This early finding is likely due to most LPCs’ lack of awareness of the existence of the revision or absence of clear understanding of the revision itself.

The need for training on this topic was indicated by study participants during the focus groups when they were collectively asked what kind of support they needed to apply or use the revision to confidentiality and privacy in the 2014 Code of Ethics. Two of the 10 Licensed Professional Counselors reported ever being able to act upon their “duty to inform” a third party placed at risk for contraction of a life-threatening, communicable disease after the revision of the 2014 ACA Code of Ethics related to confidentiality. One of these participants reported refraining from taking steps for disclosure because the counseling relationship did not continue, and the client did not share information about their partners.
Summary of Research Findings and Additional Impressions

The current study’s findings indicated that LPCs lack information, have limited resources, and are forced to search for information based on nonexistent guidelines and training opportunities for justified disclosure of health information to third parties placed at risk for contracting a life-threatening, communicable diseases. Yet, there appears to be consensus concerning LPCs’ responsibility to their clients, community, and the profession. Due to the complexities of the ACA’s 2014 revision, counselors received a new set of responsibilities that require applying their ethical decision-making model and receiving consultation or support from others in the counseling community. Through this examination of the issue, counselors have the potential to obtain greater awareness of expectations, pitfalls, and strategies for ethical decision-making when addressing clarification of their “duty to inform.”

Implications of the Study

Implications for Practice

LPCs are faced with several complex ethical dilemmas resulting from the revision to the ACA’s (2014) Code of Ethics regarding confidentiality and privacy as written in Section B.2.c. Though counselors may be justified in disclosure of information to identifiable third parties if the persons are known to be at serious and foreseeable risk of contracting the disease, the fact remains that LPCs do not have clear guidelines how to do so. Counselors are to acknowledge that resolving ethical issues is a process; ethical reasoning includes consideration of professional values, professional ethical principles, and ethical standards (ACA, 2014).

Based on this study’s findings, some participants reported seeing the value of the revision and were willing to adopt it through incorporation into informed consent and disclosure statement. Additionally, the counseling profession and licensing board may benefit from an organized, systematic way to widely disseminate revisions and other updates to LPCs. This is
especially important for individual counselors who lack resources or social support. The current study also supports the creation of justified disclosure notification guidelines and subsequent training for counselors. The goal for the proposed justified disclosure notification guidelines and training is increase counselors’ understanding of the expectations of them under the 2014 ACA Code of Ethics. The guidelines would also encompass selected ethical decision-making models that counselors use to instill confidence in the fact that the corresponding actions are both ethically and legally sound.

This research study was initially inspired by concerns about the vagueness of the terminology associated with the ACA’s 2014 revision to its confidentiality guidelines in its Code of Ethics. The adoption of a separate and new concept of “duty to report” gives counselors the option and support to notify appropriate public health officials as a means of taking sufficient action to protect themselves from lawsuits related to clients’ behavior that may be harmful to identifiable third parties exposed to communicable, life-threatening diseases.

Until it is addressed in a future revision, the vague terms used in Section B.2.c. of the 2014 ACA Code of Ethics, entitled “Contagious, Life-Threatening Diseases,” are likely to lead to inadequate interpretations and errors, and ultimately harm to the client perceptions of counseling relationships and the counseling profession. Therefore, LPCs are encouraged to consider the option of reporting these incidents to health directors at their local county health departments to ensure the proper notification of persons at risk as is done by physicians and other public health workers. There are many potential benefits of the counseling profession’s adoption of the proposed “duty to report” referral option. These include uniformity and clarification for all counselors, new opportunities for collaboration and partnership with public health officials,
future specialty area development in persons-at-risk/partner notification counseling, and the additional related practice of counselors’ selected ethical decision-making model.

Implications for Theory

The conceptual framework for this study was derived from concepts from both the TPB and the DOI Theory. The inclusion of TPB was based on the structure it provided in learning more about LPCs’ salient beliefs regarding the revision to confidentiality and privacy, Section B.2.c. of the 2014 ACA Code of Ethics. For LPCs, an expectation related to behavioral achievement is the adoption and practice of specific ethical standards as outlined in their ethical code. Regarding intention, the expectation is that LPCs are highly motivated to practice in an ethical manner in order to provide safe and effective services, avoid any disciplinary action, and maintain professional licensure. In reference to ability or behavioral control, all LPCs have demonstrated proficiency by passing an examination and completing extensive supervised practice hours.

This study sought to identify how increased awareness and understanding about their behavioral, normative, or control beliefs would lend insight into LPCs’ adoption and practice of specific ethical standards as outlined in their code. Some participants reported seeing the value of the revision and were willing to adopt it through incorporation into informed consent and disclosure statement. Although the timeframe between “intent” and “behavioral action” is not addressed by the TPB, participants in this study expressed urgency and concern about having access to justified disclosure notification guidelines and training for ethical and legal implementation of the ACA code revision.

The inclusion of DOI Theory (Rogers, 2003) was based on how the five stages of Rogers’ Innovation Decision Process allowed for examination of determinants of ethical code revision.
adherence. DOI Theory was also selected based on the perception that this theory works better with adoption rather than cessation or prevention of behaviors. The findings revealed that most participants were either in the knowledge stage and unaware of the revision, or they were in the persuasion stage with no clear understanding of the revision. Notably, DOI Theory does not account for an individual’s resources or social support to adopt the new behavior or innovation. Participants who were current students, recent graduates, or educators in counseling or counselor education programs had greater opportunity for intentional exposure to the ACA Code of Ethics and subsequent revisions through academic resources or peers.

Based on the findings and implications of this study, the combination of the TPB and DOI Theory provided a practical framework to learn more about counselors’ salient beliefs and stages of adoption related to the confidentiality revision in the ACA Code of Ethics. From the stance of environmental response to individuals with a disability, social construction and disability theories offer interesting directions for future research opportunities. Creswell (2013) refers to researchers using a disability-interpretive lens to focus on disability as a dimension of human difference and not a defect, which would provide an opportunity to research disease status as a human difference or a defect.
**Implications for Policy**

Based on a revision to the confidentiality and privacy guidelines in Section B.2.c. of the 2014 ACA Code of Ethics, counselors faced with “duty to inform” may be justified in disclosing information to identifiable third parties if the parties are known to be at serious and foreseeable risk of contracting the disease (ACA, 2014). An implication of the policy is that LPCs are justified in notifying third parties of disease exposure without first verifying the current client’s disease status. The general expectation is that counselors will rely on their interpretation of “relevant” state laws concerning disclosure about the disease status of a client. North Carolina has no statute to guide clinicians in their “duty to warn” or protect third parties from patients or clients (Mobley & Naughton, 2011). Mobley & Naughton (2011) concluded that these types of situations “can be dire” and “the clinician is continuously in jeopardy (p. 10).”

Wheeler and Bertram (2012) provide direction on how to address clients with AIDS/HIV positive status; the authors did not discuss other diseases in this edition. After contacting the state public health department to ascertain one’s obligations, counselors should remain current about appropriate ways to protect against transmission of AIDS and HIV and consider speaking with the client to educate him or her about safe sex practices to determine if the client is then willing to make a responsible decision (p. 106). Wheeler and Bertram (2012) also advised counselors to consider consulting the public health agency, an attorney, and a colleague well-versed in ethical decision-making. In a later edition of their work, Wheeler and Bertram (2015) stated that these suggestions may be applicable to other public health and infectious issues, such as Ebola (p. 140).

**Implications for Advocacy**

This study reflected that HIV/AIDS is the primary disease of focus for the revision to confidentiality and privacy guidelines in Section B.2.c., “Contagious, Life-Threatening
Diseases.” As stated earlier, people living with HIV/AIDS (PLWHA) are protected against discrimination under the Americans with Disabilities Act (ADA), a federal act that guarantees equal opportunities in employment, housing, public accommodations, telecommunications, and transportation (U.S. Department of Justice, 2014). Although the language of the revision does not specify HIV/AIDS as the focal point, it appears evident that its reference is understood by most, if not all, LPCs (including the study participants).

The irony of the Ethics Task Force’s use of vague and broad terminology, specifically “contagious, life-threatening diseases” in the ACA’s 2014 Code of Ethics is that it implicates more than 70 diseases deemed reportable according to North Carolina Department of Health and Human Services (2008). Based on the confidentiality revision and their “duty to inform,” LPCs may be justified in disclosing exposure notification about any one of these diseases to third parties who have had contact with their clients. However, the findings of the current study indicated that none of the participants knew how to determine which diseases are communicable and life-threatening. Consequently, diseases that are not required to be reported, such as Respiratory syncytial virus (RSV), Hand, Foot and Mouth disease (Enterovirus), Mononucleosis (Epstein-Barr Virus), Cytomegalovirus; Pediculosis (lice), Norovirus, Shingles, and other forms of non-neonatal HSV, may be placed in the category of communicable, life-threatening diseases based on reputation or assumptions made by LPCs.

An implication of the revision to confidentiality in the ACA’s 2014 Code of Ethics is the potential harmful effects of counselors’ negative interpretation of clients’ disabilities or disease status. Hergenrather, Rhodes, and McDaniel (2005) found that, among 155 public rehabilitation counselors, those who self-reported feeling comfortable working with a consumer with HIV/AIDS had a significantly higher level of intention to place the consumer in a job than those
rehabilitation counselors who were not comfortable with the person’s disease. Knowledge of
disability has been previously identified as predictive of higher levels of comfort when working
with individuals with spinal cord injuries (Hergenrather et al., 2005). In exploring how
comfortable rehabilitation counselors are in addressing issues of sexuality with consumers who
have disabilities, again, knowledge was found to be a significant predictor of comfort. As a
counselor’s knowledge increased, his or her discomfort decreased. Other researchers found that
managers who rated themselves as having good knowledge of the ADA and job accommodations
also rated themselves as having less negative perceptions about persons with disabilities in the
workplace.

The latest revision to confidentiality and privacy language in the ACA’s ethics code lends
itself to dependency on assumptions and, ultimately, discrimination by LPCs. Labels and
stereotypes associated with communicable, life-threatening diseases may lead to marginalization
and discrimination by others. Acceptance of disease-related labels and stereotypes as one’s
identity is likely to have detrimental effects on clients’ self-esteem, relationships, and overall
outlook. These types of circumstances provide opportunities for LPCs to serve as advocates for
their clients and other citizens facing communicable, life-threatening diseases.

As far as advocating for counseling as a profession, consideration may be given to the
proposal of shifting counselors’ responsibility from “duty to inform” to “duty to report” to fulfill
their obligation to protect identifiable third parties believed to be at serious and foreseeable risk
of contracting a communicable, life-threatening disease from one of the counselor’s clients. As
with physicians, counselors may benefit from the opportunity to partner with trained public
health officials to ensure that appropriate steps are taken to inform identifiable third parties.
Research Limitations and Delimitations

Research Limitations

Application of generalizations and transferability may be problematic based on the sampling type (i.e., snowball), location, specificity of this study’s sample, and exploratory nature of the study. Another limitation of the study was that participants were provided the written confidentiality revision as part of the initial Individual Written Questionnaire; thus, their prior knowledge of the confidentiality revision was not assessed before administering the initial questionnaire. Though this may have introduced bias to participant responses, it was necessary to obtain participants’ perceptions. Based on their lack or limited recognition of the revision to confidentiality (as identified in the first two dissemination stages), the participants provided minimal information about the determinants of the decision, implementation, and confirmation stages (later three adoption stages) of Rogers’ Innovation of Decision Process. The theoretical saturation observed after two focus groups applied only to the first two stages (knowledge and persuasion) of the diffusion process.

Research Delimitations

A delimitation imposed on this study was the choice to administer web-based individual written questionnaires as part of the introduction to the focus group experience instead of conducting interviews with each of the 10 participants prior to or following the focus groups. This was due to concern about the effect that exposure to information during the focus group could have on participant responses if individual interviews were scheduled after participation in a focus group. In addition, there was also concern about post-interview attrition and how lapse of time or other unknown factors related to conducting all 10 interviews in advance could negatively impact the opportunity to complete the intended focus groups.
Theoretical grounding for the study was derived from the use of both the TPB to explore salient beliefs and DOI Theory to examine the determinants of ethical code revision adherence. Hence, another delimitation imposed on this study was that the selected conceptual framework did not account for other aspects of the individual theories. Specific questions from related studies based on these two theories were adapted to address the overarching research questions of this study.

**Recommendations for Future Research**

Future interventions should seek to increase awareness about the revision to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases,” in the 2014 ACA Code of Ethics. The participants stated that training would help them meet the expectations of the revision. Given that Licensed Professional Counselor Supervisors (LPCS) are expected to provide oversight and consultation on counseling issues, including revisions, it may be beneficial for future research to examine Licensed Professional Counselor Supervisors’ awareness of the revision and whether they think they can effectively support counselors seeking full licensure and provide consultation to colleagues.

Participants discussed barriers and enablers to their understanding and application of the revision to the ACA’s 2014 Code of Ethics regarding confidentiality and privacy. For participants at risk for unknowingly violating the revision to confidentiality, it may be valuable to focus on strategies to overcome barriers to understanding and applying the revision’s guidelines in their counseling practice. Moreover, there is potential value in identifying strategies to assist LPCs with proactively and systematically familiarizing themselves with the revised ACA Code of Ethics before any ethical or legal issues arise. Future interventions may consider
the empowerment of LPCs by teaching them how to apply strategies to increase their understanding and application of the code’s revision.

An observation of the current study was the differences in individual feedback and collective responses of focus group participants. Thus, a potential area of research may involve exploration of private practice counselors’ responses to new expectations in the absence of disclosure guidelines. An assessment tool based on adopter scales geared toward counselors may provide the counseling profession with a better understanding of counselors’ adoption styles or tendencies regarding rate of adoption of revisions to the new Code of Ethics and other counseling-related updates.

Interviews based on the later three adoption stages of Rogers’ Innovation Decision Process are recommended to obtain a better understanding of LPCs’ ethical code revision adherence. Future studies could also include a more diverse sample of LPCs from a broader North Carolina territory or other states to expand generalizability.

**Conclusion**

LPCs are in desperate need of justified disclosure processes or guidelines and training. In reference to ethical justification for breaking confidentiality, Mobley & Naughton (2011) provide the following:

Though counselors may be ethically justified for breaking confidentiality in cases of threats of violence from a client toward a third party, there is no legal requirement or expectation to do so. In other words, counselors are expected to act as a reasonable professional if they assess a client to be violent or dangerous to others; this may or may not involve warning the potential victim if they are identifiable, based upon (a) the absence of statute requiring us to do so, (b) the
statute deeming communications between counselor and client confidential and
privileged, and (c) the contradictory ethical aspiration to protect others. Therefore,
the key question is “How do counselors fulfill their ethical duties when no legal
requirement exists?” (p. 10).

Based upon data analysis, this research provided feedback that supports the importance of
addressing the potential dangers of counselors operating with an incomplete understanding or
misunderstanding of the ACA’s confidentiality revisions to its Code of Ethics. This study’s
findings support the necessity of offering specific disclosure guidelines and training protocols for
counselors to have an optimal understanding of the revision to the code and its expectations.
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APPENDICES
Appendix A: Participant Recruiting Letter

Dear Licensed Professional Counselor:

Your role as a North Carolina State University dissertation study participant is greatly appreciated. The purpose of this dissertation study is to explore licensed professional counselors’ perspectives about breaking confidentiality. Your feedback has the potential to inform future training and practice. You will have the opportunity to provide confidential feedback on this topic in an individual written format and verbally as part of focus group.

All study participants will be treated in a respectful manner. We will meet at a convenient location and time for all members of your focus group. The completion time for your focus group session, including completion of individual written feedback, is approximately 90 minutes. In order to ensure accurate analysis, the focus group will be both audio and video recorded. The information provided will remain in a secured location.

In order to participate in the study, each participant must meet the requirements to be designated with the non-restricted, independent licensure status, Licensed Professional Counselor, according to the North Carolina Board of Licensed Professional Counselors (NCBLPC). According to the NCBLPC (2017), all Licensed Professional Counselors must successfully complete an application, education (verifiable via official transcripts), examinations, professional disclosure statement, criminal background check, and verification of supervised professional practice before licensure can be issued.

Participants who complete the entire study will be offered compensation of a $25.00 gift card. If you and/or other Licensed Professional Counselors are interested in participating in this study, please contact me at xxx@ncsu.edu. Thank you for your assistance.

Sincerely,

Latonya M. Graham, MA, LPC-S, NCC
Doctoral Candidate, Counseling & Counseling Education
Department of Educational Leadership, Policy, & Human Development
North Carolina State University
Appendix B: Informed Consent Form

North Carolina State University

INFORMED CONSENT FORM FOR RESEARCH

Title of Study: Justified Disclosure: A Phenomenological Study Exploring Licensed Professional Counselors’ Experiences with Breaking Confidentiality

Principal Investigator: Latonya M. Graham

Faculty Sponsors: Dr. Siu-Man Ting, Dr. Marc Grimmett, and Dr. Lisa Bass

You are being asked to take part in a research study. Your participation in this study is voluntary. You have the right to be a part of this study, to choose not to participate or to stop participating at any time without penalty. However, participants will receive a $25.00 gift card as a result of their full participation in the study. The purpose of research studies is to gain a better understanding of a certain topic or issue. You are not guaranteed any personal benefits from being in a study.

Research studies also may pose risks to those that participate. In this consent form, you will find specific details about the research in which you are being asked to participate. If you do not understand something in this form, it is your right to ask the researcher for clarification or more information. A copy of this consent form will be provided to you. If at any time you have questions about your participation, do not hesitate to contact the researcher(s) named above.

Purpose of the Study
The purpose of the study is to explore licensed professional counselors’ perspectives about justification for breaking confidentiality. Specifically, this study will employ participants in focus groups to examine Licensed Professional Counselors’ understanding of and responses to the change in the 2014 Code of Ethics pertaining to confidentiality, specifically pertaining to disclosure of health information to third parties placed at risk for contraction of a life-threatening, communicable disease. The outcomes of this research will inform future training and practice.

Participation Duration and Study Procedures
If you agree to participate in this study, you will be asked to meet with this researcher and other focus group participants for approximately 90 minutes at a time and place that is convenient for all parties. At the time of the focus group, the informed consent form will be reviewed with all participants. Each participant and researcher will sign the informed consent form prior to the start of the focus group session. Each participant will be given the opportunity to ask questions about the study before, during, or after the focus group.

Throughout the process, the researcher will request information from each participant that may be considered personal or confidential as it relates to your background and career as a Licensed Professional Counselor. On an individual basis, participants will complete a personal history demographic information form and an individual written form. Upon complete of the initial forms, all participants will join the focus group. The information shared in the focus group will be audio and/or video recorded for transcription and analysis. As a customary practice in academia, these recordings will be retained in case...
data needs to be revisited for accuracy checks, further analysis, reports, and presentations for up to seven years prior to being destroyed.

All these questions will be asked of participants to provide necessary contextual information needed for the study. Each participant may choose the information that he or she is comfortable sharing in the study. You may discontinue participation at any time without penalty. However, compensation is provided as a result of full participation in the study. The researcher will consult with you regularly to ensure that you feel safe and respected.

**Risks**
Based on participation in a focus group of other licensed professional counselors, there is the possibility of professional and reputational risks associated with verbal responses related to the use of the code of ethic. The risks to you for participating in the study are minimal. In order to minimize risks, I will use pseudonyms to protect your confidentiality. Additionally, the expectation that all participants will respect the privacy of their peers by agreeing not to share information disclosed as part of the study is addressed with each participant on an individual basis as part of the informed consent.

**Benefits**
There are no direct benefits to your participation in this research. As a participant in this dissertation study, your perspective about the topic may be broadened based on the emphasis and feedback provided by the process and other focus group participants.

**Confidentiality**
The information in the study records will be kept confidential to the full extent allowed by law. Data will be stored securely only on devices that are password protected. The audio and/or video recordings will be retained in case data needs to be revisited for accuracy checks, further analysis, reports, and presentations for up to seven years prior to being destroyed.

The recorded data will be sent to an online transcriptionist. The data files will be encrypted before they are sent to the transcriptionist and any transcription files will also be encrypted, consistent with the data security information in this protocol. You will be assigned a pseudonym and code to protect, organize, and analyze confidential information. No reference will be made in oral or written reports which could link you to the study.

Please note that participation in focus groups is not completely anonymous. Confidentiality of information shared in the presence of other participants cannot be guaranteed. However, the expectation is that all participants will respect the privacy of their peers by agreeing not to share information disclosed as part of the study.

**Compensation**
Each participant will receive a $25.00 gift card for their full participation in the study. The compensation is based on a single meeting with this researcher and other focus group participants for approximately 90 minutes. The gift card will be given directly to the participant at the end of the focus group. If the participant does not complete the study from beginning to the end, he or she will not be eligible for compensation.
**Research Withdrawal and Participant Inquiries**
Your participation is voluntary. You may refuse to participate at any time and withdraw from the study. If you would like further information about the study, you may contact the researcher, Latonya M. Graham, at xxx@ncsu.edu.

**Participant Rights**
If you feel you have not been treated according to the descriptions in this consent form, or that your rights as a participant in this research have been violated during the course of this study, you may contact the North Carolina Institutional Review Board at 919-515-4514.

**Consent to Participate**
I have read and understand the above information. I agree to participate in this study until I decide otherwise. I have received a copy of this form.

Subject's signature__________________________ Date _______________

Investigator's signature_______________________ Date _______________
Appendix C: Revised Personal History Demographic Questionnaire Form

1. Please indicate your gender identity. ______________________________

2. Please indicate your racial or ethnic identity. _______________________

3. Please indicate your age. __________

4. Please indicate your highest level of education completed.
   a. Bachelor’s degree
   b. Master’s degree
   c. Doctoral degree
   d. Other training (specify) _______________________

5. Please indicate your total number of years of professional counseling experience. _____

6. Please indicate how many years of professional counseling experience you have achieved after receiving licensure. ______

7. Please indicate the types of professional development and continuing education training you have received since completing your last degree. ______________________________
   ______________________________
   ______________________________

8. Please indicate the types of professional development and continuing education training you have received after licensure. ______________________________
   ______________________________
   ______________________________

9. What populations do you currently serve? (Please indicate if you are unemployed.)
   ______________________________
   ______________________________
   ______________________________
10. What populations have you served in the past? ______________________________
________________________________________________________________________
________________________________________________________________________

11. What positions have you held? ___________________________________________
________________________________________________________________________
________________________________________________________________________

12. What leadership positions have you held? ________________________________
________________________________________________________________________
________________________________________________________________________
Appendix D: Individual Questionnaire Form

ACA (2014) Code of Ethics, Section B.2.c. Contagious, Life-Threatening Diseases:

When clients disclose that they have a disease commonly known to be both communicable and life-threatening, counselors may be justified in disclosing information to identifiable third parties, if the parties are known to be at serious and foreseeable risk of contracting the disease. Prior to making a disclosure, counselors assess the intent of clients to inform the third parties about their disease or to engage in any behaviors that may be harmful to an identifiable third party. Counselors adhere to relevant state laws concerning disclosure about disease status.

1. In reference to your application or use as a Licensed Professional Counselor, please list up to five advantages of the revision to confidentiality and privacy, Section B.2.c., Contagious, Life-Threatening Diseases in the 2014 ACA Code of Ethics.
   a. ________________________________________________________________
   b. ________________________________________________________________
   c. ________________________________________________________________
   d. ________________________________________________________________
   e. ________________________________________________________________
   f. ________________________________________________________________

2. In reference to your application or use as a Licensed Professional Counselor, please list up to five disadvantages of the revision to confidentiality and privacy, Section B.2.c., Contagious, Life-Threatening Diseases in the 2014 ACA Code of Ethics.
   a. ________________________________________________________________
   b. ________________________________________________________________
   c. ________________________________________________________________
   d. ________________________________________________________________
   e. ________________________________________________________________
   f. ________________________________________________________________

3. Please list up to five people (and their role) who influence your understanding of the revision to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases” in the 2014 ACA Code of Ethics.
   a. ________________________________________________________________
   b. ________________________________________________________________
   c. ________________________________________________________________
   d. ________________________________________________________________
   e. ________________________________________________________________
4. Please list up to five people who influence your **application or use** of the revision to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases” in the 2014 American Counseling Association Code of Ethics.
   a. __________________________________________________________
   b. __________________________________________________________
   c. __________________________________________________________
   d. __________________________________________________________
   e. __________________________________________________________

5. Please list up to five factors that **make it difficult or easier for you to understand** the revision to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases” in the 2014 American Counseling Association Code of Ethics.
   a. __________________________________________________________
   b. __________________________________________________________
   c. __________________________________________________________
   d. __________________________________________________________
   e. __________________________________________________________

6. Please list up to five factors that **make it difficult or easier for you to apply or use** the revision to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases” in the 2014 American Counseling Association Code of Ethics.
   a. __________________________________________________________
   b. __________________________________________________________
   c. __________________________________________________________
   d. __________________________________________________________
   e. __________________________________________________________

7. **Prior to the revision** of the 2014 American Counseling Association Code of Ethics related to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases:”
   a. Were you ever in a position to perform your “duty to inform” a third party placed at risk for contraction of a life-threatening, communicable disease? __________
   b. If so, what steps did you take? ________________________________
      __________________________________________________________________
      __________________________________________________________________
   c. Did you feel prepared to address this issue? ______________________
   d. What specific training did you receive to address this issue? __________
      __________________________________________________________________
      __________________________________________________________________
   e. If you were never in the position to perform your “duty to inform” a third party placed at risk for contraction of a life-threatening, communicable disease, do you
feel you are prepared to address this issue? ____________________________

f. What specific training have you received to address this issue? ____________

8. **After the revision** of the 2014 American Counseling Association Code of Ethics related to confidentiality and privacy, Section B.2.c., “Contagious, Life-Threatening Diseases:”
a. Were you ever in a position to perform your “duty to inform” a third party placed at risk for contraction of a life-threatening, communicable disease? ____________
b. If so, what steps did you take? ________________________________

c. Did you feel prepared to address this issue? ____________________________
d. What specific training did you receive to address this issue? ____________

e. If you were never in the position to perform your “duty to inform” a third party placed at risk for contraction of a life-threatening, communicable disease, do you feel you are prepared to address this issue? ____________________________
f. What specific training have you received to address this issue? ____________

9. How do counselors determine which diseases are both communicable and life-threatening? ________________________________

10. How do counselors determine justification for disclosure to third parties? ____________

11. How do counselors ensure their personal safety when informing third parties or “persons at risk?”: ________________________________

12. How are counselors compensated for disclosure activities? ________________________________
13. How much identifiable information does the counselor share about their client in the notification process?

________________________________________________________________

14. After completing the notification process, is it ethical for counselors to accept these “identifiable third parties” as clients based on their request? Why?

________________________________________________________________
Appendix E: Focus Group Questions

1. What is your experience with the 2014 ACA Code of Ethics?
2. To what extent are you familiar with the revision to confidentiality and privacy, Section B.2.c. Contagious, Life-Threatening Diseases in the 2014 Code of Ethics?
3. What are your opinions of the revision to confidentiality and privacy, Section B.2.c. Contagious, Life-Threatening Diseases in the 2014 Code of Ethics?
4. To what extent would you say that you have adopted or rejected the revision to confidentiality and privacy, Section B.2.c. Contagious, Life-Threatening Diseases in the 2014 Code of Ethics?
5. What could you tell each other about the way you currently apply the revision to confidentiality and privacy, Section B.2.c. Contagious, Life-Threatening Diseases in the 2014 Code of Ethics?
6. What kind of support do you need to successfully apply or use the revision to confidentiality and privacy, Section B.2.c. Contagious, Life-Threatening Diseases in the 2014 Code of Ethics?
7. How do counselors determine which diseases are both communicable and life-threatening?
8. How do counselors determine justification for disclosure to third parties?
9. How do counselors ensure their personal safety when informing third parties or “persons at risk?”
10. How are counselors compensated for disclosure activities?
11. How much identifiable information does the counselor share about their client in the notification process?
12. After completing the notification process, is it ethical for counselors to accept these “identifiable third parties” as clients based on their request?
Appendix F: Participant Validation Email

Thank you again for your participation in the study. Your individual and collective contribution to this work have been invaluable. The purpose of this study is to examine Licensed Professional Counselors’ understanding, application, and training needs in reference to the confidentiality revision in the 2014 Code of Ethics. In an effort to bring awareness to justified disclosure and guide best practices, this researcher is requesting that you review the embedded description and attached copy of our focus groups transcripts for accuracy. Upon review, please notify me of your agreement of accuracy. If you find any inaccuracies, this researcher requests that you share them with me so that I may make those corrections on your behalf. I appreciate how you have shared your time and expertise for this cause.