TO TELL OR NOT TO TELL: DISCLOSING MENTAL HEALTH DIAGNOSES TO CHILDREN

by

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To my family, both the one I was fortunate to be born into and the one Josh and I have created together
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ABSTRACT

This online analogue study examined psychologists’ current mental health diagnoses disclosure practices to children. Specifically, this dissertation investigated participants’ self reported likelihood to disclose mental health diagnoses in relation to both psychologist (i.e., clinical services provided and years of clinical service) and client (culture, age, cognitive ability) characteristics. Forty-seven certified American Board of Professional Psychology (ABPP) Psychologists were recruited via email listserv for this research. Participants rated their likelihood to disclose mental health diagnoses to vignettes depicting children with varying demographic characteristics: culture, age, and cognitive ability. Participants also responded to open-ended questions exploring their current mental health diagnosis disclosure practices, including the impact of specific diagnoses on disclosure.

Analyses of open-ended questions revealed that psychologists consider the following factors in their decision to disclose diagnoses: (1) child characteristics (i.e., age, culture, cognitive ability, maturity, developmental and functioning level), (2) support (family, social, therapeutic relationship), (3) personal beliefs about disclosure, (4) diagnostic characteristics (e.g., prevalence, public familiarity, current biological evidence, stigma), (5) how to provide a supportive disclosure (e.g., kid friendly language), and (6) potential benefits. Combined open-ended and quantitative results provide empirical support suggesting that psychologists, like psychiatrists and pediatricians, are more likely to disclose diagnoses to: (a) children of an American culture than those of a Chinese-American culture, (b) older (16 years old) children rather than younger children (6 years old), and (c) children with an intellectual ability in the
Superior Range rather than those with an IQ in the Borderline Range. Psychologists’ years of clinical experience also significantly predicted their disclosure practice. Psychologists with between 13-31 years clinical experience reported more diagnosis disclosure to children than did participants with 32 years or more of clinical service when presented with a client who was of an American decent, 16 years old, or had an intellectual ability in the Superior Range. The services that psychologists provide (i.e., counseling, diagnostic evaluations, or both) did not significantly predict disclosure practices. Taken together, the findings of this study may be the first step to facilitate the development of evidenced based guidelines for the disclosure of mental health diagnoses to children.

*Keywords*: mental health, diagnosis disclosure, children, psychologist
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CHAPTER I

INTRODUCTION

A 10-year-old Caucasian female patient, “Jane”, was self-referred to an outpatient pediatric psychology clinic for an evaluation of attention concerns. This clinic provides evaluations, diagnoses, and recommendations. The evaluation is typically a one-time event with no follow up. Jane’s performance on assessments during the evaluation, parent and teacher reports, and observations support the diagnosis of Attention Deficit Hyperactivity Disorder, Inattentive Type. During the feedback session, Jane’s parents report being thankful that Jane can now receive additional support in school. Prior to ending the feedback session, Jane’s parents express a desire for you to explain the diagnosis and recommended accommodations to Jane.

Do you comply with Jane’s parents’ request to disclose the mental health diagnosis to Jane? Do you encourage her parents not to disclose the diagnosis to their child? What do you consider in making your decision to disclose or not to disclose the mental health diagnosis? What do you tell her? Do you use the name of the diagnosis? Psychologists working with children in a diagnostic capacity are confronted with case situations like Jane regularly. Although between 13% (Costello, Mustillo, Erkanli, Keller, & Argold, 2003) and 20% (New Freedom Commission on Mental Health, 2005; Shaffer et al., 1996) of children in the United States have mental health diagnoses, there is a dearth of empirical literature examining psychologists’ current mental health diagnoses disclosure practices (Allmon et al., 2010). For the purposes of this manuscript the term “diagnosis disclosure” will refer to telling an individual the actual name of their diagnosis, unless otherwise specified.
Mental Health Diagnoses Disclosure to
Children Research

The existing, but inadequate, literature on mental health diagnoses disclosure to children has centered on two diagnoses: autism spectrum disorder (ASD) and learning disabilities (LD). For most of these studies, children’s mental health diagnoses disclosure was not the primary research focus (e.g., Allmon et al., 2010; Raskind, Margalit, & Higgins, 2006). The information ascertained from these studies suggests that children often experience a delay between the time of their diagnosis and disclosure (Huws & Jones, 2008; See Table 1), age may impact disclosure (Allmon et al., 2010; Pearson et al., 1999; See Table 1), and parents may disclose mental health diagnoses to their children (Allmon et al., 2010; Pearson et al., 1999; See Table 1). These limited and often ancillary findings leave a void in the empirical literature that needs to be examined. Consequently, there is insufficient empirical evidence to understand psychologists’ current mental health diagnosis disclosure practices to children.

Current Diagnoses Disclosure Decision Making

Due to the lack of literature on disclosing mental health diagnoses to children, psychologists may base their disclosure decisions on clinical judgment and/or the adult mental health and children’s medical diagnoses disclosure literature. Clinical judgment, while a helpful component in making diagnoses disclosure decisions, is insufficient to provide a foundation for disclosure practices. The clinical implications of beliefs, such as children have a right to know or children should be protected from their diagnoses, have yet to be explored in the children’s mental health literature (Ross, 1974; LoCicero, 1976; Oberdorfer et al., 2006). However, both the adult mental health (e.g., Hwang, 2008;
Kitamura, 2005; McDonald-Scott, Machizawa, & Satoh, 1992) and children’s medical diagnoses disclosure literature have examined disclosure practices. There are challenges to applying the aforementioned research to mental health diagnoses disclosure due to differences in treatment, prognosis, and pressures for disclosure. Despite the limitations present for applying either adult mental health or children’s medical diagnoses disclosure research to mental health diagnoses disclosure to children, both provide preliminary considerations.

**Factors influencing disclosure.** Disclosure practices for adult mental health and children’s medical diagnoses are influenced by multiple factors. These factors include diagnoses (e.g., Hwang, 2008; McDonald-Scott, Machizawa, & Satoh, 1992), culture (e.g., Gupta, Willert, Piam, & Stein, 2008), children and adolescent’s age (e.g., Chesler, Paris, & Barbarin; Claflin & Barbarin, 1991), and cognitive ability (e.g., Abadia-Barrero & LaRusso, 2006).

The first factor, diagnosis, is comprised of many aspects that may influence psychologists’ mental health diagnosis disclosure decisions. Considerations subsumed under this factor include, but are not limited to, the prevalence and treatment for a specific diagnosis. For example, MacDonald-Scott, Machizawa, and Satoh’s (1992) survey of psychiatrists’ diagnosis disclosure practices indicated that psychiatrists were more likely to disclose diagnoses such as depression, anxiety, and substance abuse than schizophrenia because of its’ associated social stigma. Due to the broad nature of the factor ‘diagnoses’, in the present study psychologists were asked to provide responses to an open-ended question exploring how diagnoses alter their mental health diagnosis disclosure practices. Parent/Guardian mental health disclosure literature (Hatton, Akram,
Robertson, Shah, & Emerson, 2003), adult mental health literature (Hwang, 2008; McDonald-Scott, Machizawa, & Satoh, 1992; Yeung & Kam, 2008), and pediatric oncology literature (Gupta, Willert, Pian, & Stein, 2008; Mayer et al., 2005; Parsons et al., 2007) suggest that culture may influence psychologists’ mental health diagnoses disclosure practices with children. The third factor is age. Medical diagnoses disclosure studies examining both cancer (e.g., Claflin & Barbarin, 1991) and HIV (e.g., Abadia-Barrero & LaRusso, 2006), indicate that disclosure rates increase with age. The fourth and final factor is cognitive ability. Initial empirical evidence from mental health (Allmon et al., 2010) and medical diagnoses (Lester et al., 2002; Weiner et al., 2002) disclosure to children research suggests that children with high cognitive abilities may have their diagnoses disclosed frequently (Allmon et al., 2010) or even more often than those with average or low abilities (Weiner et al., 2002). There is a need to explore how these factors inform psychologists’ mental health diagnoses disclosure practices to children, as they may provide an initial basis for the establishment of disclosure guidelines for children.

**Importance of Current Study**

As demonstrated in the opening vignette, psychologists regularly face mental health diagnoses disclosure decisions. There is a breadth of literature examining medical diagnoses disclosure to children (e.g., Claflin & Barbarin, 1991; Vaz, Eng, Maman, Tshikandu, & Behets, 2010), which has resulted in the development of medical diagnoses disclosure practice guidelines (e.g., American Academy of Pediatrics, Committee on Bioethics, 1995; McCabe, 1996). This field of study suggests that there may be both positive (e.g., increased treatment adherence; Hamammi, Nostinger, & Hoereee, 2004;
Mellins Brackis-Cott, & Dolesal, 2002; Reikert, Wiener, & Battles, 1995; Wiener, Battles, Haven, & Heilman, 1998) and negative (e.g., initial increased psychological distress; Marhekfa, Tepper, Brown, & Farley, 2006; New, Lee, & Pao, 2003) implications for the disclosure of medical diagnoses to children. Further, research examining medical diagnoses disclosure in children has demonstrated that withholding information may not be beneficial (Claflin & Barbarin, 1991; Vaz et al., 1999). However, there is limited empirical data investigating mental health diagnoses disclosure practices to children (Allmon et al., 2010; Pearson et al., 1999). Additionally, no study exists that surveys psychologists’ current mental health diagnoses disclosure practices to children. Practice guidelines for mental health diagnoses disclosure to children are imperative in order to form a foundation for making diagnoses disclosure decisions for cases such as Jane’s. The first step towards the development of practice guidelines for mental health diagnoses disclosure to children is to gain an understanding of current practices.

**Current Study**

This study addressed limitations in the literature regarding current mental health diagnoses disclosure practices. The present study had the following six goals: (1) investigate the influence that the settings in which psychologists work (e.g., counseling, diagnostic evaluations, or both) have on the conditions under which they disclose mental health diagnoses to children; (2) examine the impact that years of clinical experience has on the conditions under which they disclose mental health diagnoses to children; (3) evaluate the conditions (i.e., culture, age, and cognitive ability) under which psychologists disclose mental health diagnoses to children; (4) explore psychologists’
reasons for disclosure or non-disclosure; (5) explore the impact that mental health diagnoses have on psychologists’ mental health diagnoses disclosure practices to children; and (6) investigate psychologists’ current mental health diagnosis disclosure practices.

These aims were achieved by surveying psychologists. The participants were licensed psychologists who hold American Board of Professional Psychology (ABPP) certification(s) and are currently employed in a position where they diagnose children. This online analogue study had three main components: (1) completing a background form, (2) reading and responding to questions following a series of vignettes, and (3) providing responses to open-ended questions. First, psychologists completed a background information form. In addition to identifying demographics, this form provided information about participants’ current work setting (i.e., services provided at this setting are counseling, evaluations, or both) and clinical experience (i.e., years of practice post internship). Second, participants were provided with six vignettes that emulated one of the factors (i.e., culture, age, and cognitive ability) that influence diagnoses disclosure practices in adults with mental health diagnoses (e.g., Hwang, 2008; Kitamura, 2005; McDonald-Scott et al., 1992) and/or children with medical diagnoses (e.g., Abadia-Barrero & LaRusso, 2006; Chesler, Paris, & Barbarin; Claflin & Barbarin, 1991; Dematteo et al., 2002; Gupta et al., 2008; Vaz et al., 2010). After reading each vignette, participants answered questions. These questions provided information about the likelihood that the participant would or would not disclose diagnoses and the reason why they made their disclosure or nondisclosure decision. Third, participants answered open-ended questions eliciting information about their current mental health diagnoses.
disclosure practices with children. Analyses of participant’s responses provide information about current mental health diagnoses disclosure practices.

This study provided initial empirical information about psychologists’ current mental health diagnoses disclosure practices to children, while taking into account the child’s culture, age, and cognitive ability. Psychologists working with children are challenged with diagnoses disclosure decisions. Because there are no practice guidelines for disclosing mental health diagnoses to children, current mental health diagnoses disclosure practices may be based upon clinical judgment or an overgeneralization of ancillary empirical literature. Finally, this study may aid in the future development of practice guidelines for the disclosure of mental health diagnoses to children.
CHAPTER II
LITERATURE REVIEW

This review begins by focusing on the importance of understanding current mental health diagnoses disclosure practices. Additionally, the review explores positive and negative implications of diagnoses disclosure to children. Next, the mental health diagnoses disclosure literature for adults and children is explored. Following this, factors related to making diagnoses disclosure decisions to children are examined. These factors include the following: diagnoses, culture, age, and cognitive ability. Finally, the current study design and its’ Research Questions and analyses are presented.

Importance of Mental Health Diagnoses

Disclosure Practices with Children

The number of children in the United States is growing (U.S. Census Bureau, 2011). Currently, over 24% of the United States population, more than 74 million people, is comprised of children (U.S. Census Bureau, 2011). Of these children, 13% (Costello, Mustillo, Erkanli, Keller, & Argold, 2003) to 20% (New Freedom Commission on Mental Health, 2005; Shaffer et al., 1996) are estimated to have mental health diagnoses. Although prevalence estimates are not as well documented in children as in adults, it is evident that mental health diagnoses are present in this population. For the purposes of this manuscript the term, “children,” will refer to any individual under the age of 18 years old, unless otherwise specified.

Despite the controversies surrounding diagnosing children with mental health disorders (e.g., labeling, Jones, 2001), diagnoses are imperative for appropriate mental health treatment. Psychologists assign mental health diagnoses to children for multiple
reasons including the following: 1) inform clients’ treatment plans (Rutter, 2002), 2) provide a means for developing appropriate goals and assessing their progress, 3) provide information about prognosis, 4) enable collaboration among treatment providers (e.g., school-based accommodations, medication management with psychiatrists), and 5) provide access to insurance benefits (Woo & Keatinge, 2008). Children can receive mental health diagnoses from multiple practitioners (e.g., pediatrician, psychiatrist, psychologist, psychiatric nurses, mental health counselors; National Institute of Mental Health, 2005).

Ways to Receive Mental Health Diagnoses

Two ways children can receive mental health diagnoses from a psychologist include ongoing counseling services or a one time diagnostic evaluation. In an ongoing therapeutic relationship the psychologist may have more time to determine an accurate diagnosis than when the relationship is a one time diagnostic evaluation. According to Patterson and Welfel (1994), mental health diagnoses are determined through:

- a process of identifying and specifying the problem (or set of problems) the client brings to counseling and then deciding whether counseling is an appropriate intervention for resolving it. A diagnosis is determined through a joint process of information gathering and hypothesis testing conducted until a tentative conclusion about the nature of the problem is agreed to by both counselor and client. (p. 82)

This is the diagnostic process for adult therapy clients. There is general agreement that counseling relationships with children differ from those with adults (Hendrix, 1991); however, how these relationships differ is unclear. Patterson and Welfel’s (1994) quote suggests the diagnostic process is collaborative in therapy with adults. This process may be similar with children; however, determining diagnoses is likely more of a group effort
involving reports from parents/guardians and/or others (e.g., teachers, pediatrician; Woo & Keatinge, 2008).

Diagnostic evaluations are commonly completed for children in order to provide information about a child’s diagnosis as a means of arriving at appropriate recommendations and/or treatment. Although the format of diagnostic evaluations may vary depending upon the site and referral question, they usually consist of one to a few assessment days during which information is collected from various sources (e.g., clinical interviews, previous records, teacher reports, assessments, observations; Morrison & Anders, 1999). This is not an ongoing relationship, but a one time psycho-diagnostic service. At the conclusion of the service, the child receives the diagnoses, if warranted, and recommendations. Diagnoses and recommendations are typically documented in a written report (Sattler, 2008). Presumably, the diagnostic process is similar to the collaborative process described in the therapeutic relationship; however, the time present for building therapeutic rapport and working with the family is more limited. In other words, a psychologist completing a diagnostic evaluation will use the clinical interview and feedback session to discuss potential diagnoses with the child’s parent/guardian(s) and determine the most appropriate one (Woo & Keatinge, 2008).

Irrespective of whether diagnoses are made by ongoing counseling or a one-time diagnostic evaluation, the process of determining appropriate mental health diagnoses for children or adolescents is riddled with challenges. Some of these difficulties include a lack of reasonable agreement among child, parent/guardian, and teacher about the nature of the problem; the potential adverse social consequences of a mental health diagnosis; the implications of a mental health diagnosis on a child's education; or involvement of
child welfare, the juvenile justice system, or a host of other entities (De Los Reyes & Kazdin, 2005). Additionally, the decision to make a diagnosis may be grounded in multiple considerations including clinical, financial (insurance), political (guild), or legal (Sattler, 2008; Woo & Keatinge, 2008). While the author acknowledges the importance of the aforementioned factors (e.g., incongruent reports from parents/guardians and teachers, financial concerns, legal considerations) that accompany the process of determining appropriate mental health diagnoses for children or adolescents; these considerations are beyond the scope of this literature review. Thus, this review will only address clinical considerations of mental health diagnoses disclosure to children.

Diagnoses Disclosure Practices

In both, ongoing counseling and diagnostic evaluations, the psychologist serves as “the gatekeeper of information for all family members” (Hendrix, 1991, p. 329). The psychologist collaborates to determine accurate diagnoses and then discloses the diagnoses to the parents/guardians. The flow of diagnostic information following this initial disclosure remains unclear in the psychological literature. Do psychologists, parents/guardians, neither, or both disclose the mental health diagnosis to the child? Unlike adults, children with mental health diagnoses, like children with medical diagnoses (Lesch et al., 2007), may not have control over when and how they are informed because parents/guardians and psychologists control the dissemination of information.

Unfortunately, there continues to be little research on the mental health disclosure practices to children and factors that psychologists consider in making these decisions. As a result, there are no current guidelines for disclosing mental health diagnoses to
6children. Therefore, it is reasonable to assume that psychologists may be basing their practices on clinical judgment or the overgeneralization of ancillary literature specifically, literature which addresses adult mental health or children’s medical diagnoses disclosure. While clinical judgment coupled with the aforementioned literature may provide initial guidance on how to explore mental health diagnoses disclosure to children, it is insufficient.

**Clinical Judgment**

Some psychologists may base their disclosure practices upon the belief that children either have the right to know their diagnosis or that they should be protected from their diagnoses (Ross, 1974; Ledlie, 1999; LoCicero, 1976; Oberdorfer et al., 2006). In a clinical article, Ross (1974) described his personal belief that children who are hospitalized due to mental health concerns are entitled to know why. Similarly, children may express a desire to understand the purpose of their treatment or evaluation (Ledlie, 1999; Lipson, 1994). If mental health diagnoses are not disclosed, how do parents/guardians or providers respond to questions from children regarding treatment (e.g., Why do I take this medicine? Why do I have special help in school? Why do I have to see a counselor?)? Additionally, psychologists may believe that it is their ethical imperative to disclose mental health diagnoses to their clients (Brewer & Faitak, 1989).

Although the American Psychological Association’s Ethics Code (2002) does not explicitly address mental health diagnoses disclosure to children, a psychologist might infer the need for disclosure or nondisclosure from their understanding of the ethics code (e.g., Principles A, C, D, E, or Standards 3.10, 9.03, 10.01, 9.10). Furthermore, they may adhere to other ethical codes (e.g., American Academy of Child and Adolescent
Psychiatry Principles of Practice, 2009; American School Counselor Association’s Ethical Standards for School Counselors, 2010; National Association of School Psychologists Ethics Code, 2009), which are more likely to encourage the disclosure of mental health diagnoses to children. Additionally, the extensive ethical literature and research that has explored children’s right to medical decision making (Chenneville, Sibille, & Bendell-Estroff, 2010), consent for psychological treatment (Grisso & Vierling, 1978; Kunin, 1997; Mannheim et al., 2002; Pope, 1992) and consent for psychological research (Barfield & Kane, 2008) may be a base from which psychologists are extrapolating current disclosure practices.

Practitioner characteristics (e.g., culture, clinical experience) may also influence their beliefs about disclosure. For example, McDonald-Scott, Machizawa, and Satoh (1992) found that psychiatrists with more years of clinical experience are more likely to disclose diagnoses to adult patients. Why disclosures increased with experience is unclear; however, it may be due to increased comfort with disclosing diagnoses, clinical experience teaching them to appreciate disclosure, or trust in the capacity of clients. More research is needed in order to understand the impact of experience on clinical judgment related to diagnoses disclosure.

In contrast to Ross’ (1974) perspective, some psychologists may believe in withholding mental health diagnoses from children. They may hold these beliefs for multiple reasons that have been cited in the adult mental health diagnoses disclosure literature, including a desire to protect the client (Gantt & Green, 1986; Green, 1984; McDonald-Scott et al., 1992), not knowing whether the client desires disclosure (Keightley & Mitchell, 2004), or a belief that the disclosure may negatively influence
treatment (McDonald-Scott et al., 1992). McDonald-Scott, Machizawa, and Satoh (1992) surveyed psychiatrists’ (N= 278) diagnoses disclosure practices for adults with varying diagnoses (e.g., schizophrenia, anxiety disorders). Frequent reasons for non-disclosure were centered on the premise that disclosure may lead to misunderstandings or that the disclosure might hurt the patient in some way. Similarly, Keightley and Mitchell’s (2004) survey of seven clinical psychologists about their disclosure practices with adult dementia patients found that the prominent reason for nondisclosure was feeling unsure if the patient would want to know the dementia diagnosis. Further, if the patient did not want to know, psychologists noted that disclosure could potentially cause harm (Keightley & Mitchell, 2004).

**Implications of Diagnoses Disclosure to Children**

Many mental health diagnoses begin in childhood or adolescence and are a lifelong struggle (Higgins, Raskind, Goldberg, & Herman, 2002; Janepson, 2010; Kessler, Chiu, Demler, Merikangas, & Walters, 2005). Kessler and colleagues (2005) found that half of all lifetime cases of mental illness begin by age 14. For these individuals, diagnoses disclosure might have positive or negative implications (Jones, 2001). Although there is a willingness to confront the implications of medical diagnoses disclosure, little attention has been given to psychological disorders (Lebolt, 2002). The disclosure of medical diagnoses, specifically HIV and cancer, to children has been extensively examined in the empirical literature (i.e., Chesler, Paris, & Barbarin, 1986; Claflin & Barbarin, 1991; Grubman, Gross, Lerner-Weiss, et al., 1995; New et al., 2003; Vaz et al., 2010; Wiener, Mellins, Marhefka, & Battles, 2007). Due to the lack of empirical evidence exploring the implications of mental health diagnoses disclosure to
children, the studies reviewed in the following section on the diagnoses disclosure implications literature will focus on the disclosure of HIV and cancer to children.

**Challenges to Applying Medical Diagnoses Disclosure Literature**

The implications of disclosing medical diagnoses, such as HIV, may differ from those surrounding the disclosure of mental health diagnoses to children. This discrepancy may exist due to differences in treatment, prognosis, and pressures for disclosure. Medical treatment for HIV can be intensive, aversive, and complicated. Cooperation with these treatments may be one reason for medical diagnoses disclosure to children (Wiener, Mellins, Marhefka, & Battles, 2007). Treatments for mental health diagnoses have potential risks and benefits (Woo & Keatinge, 2008); however, they may be less severe than those for HIV.

Due to the lifelong nature of many mental health diagnoses (Higgins et al., 2002; Janepson, 2010; Kessler et al., 2005), these children may have a longer duration of time to have disclosures made and cope with or adjust to diagnoses compared to those with medical diagnoses. Physicians working with children with HIV may be more concerned about survival (Wiener et al., 2007), than psychologists working with children’s mental health diagnoses (APA, 1994). For example, physicians may need to disclose medical diagnoses in order to provide appropriate end of life care. However, psychologists may be less likely to supply end of life care to children with mental health diagnoses only (i.e., children without co-existing medical diagnoses).

There are different pressures for disclosure or nondisclosure of medical diagnoses compared to mental health diagnoses. For example, as children with HIV develop
sexually, there may be public health concerns regarding transmission of HIV if they are unaware of their diagnosis (Grubman, Gross, Lerner-Weiss et al., 1995). These specific transmission risks do not exist with mental health diagnoses. In addition, there are pressures for nondisclosure from parents/guardians of children with HIV. If their child is made aware of their HIV status, parents/guardians may fear possible disclosure of their own HIV status and the resultant social stigma (see Wiener, Mellins, Marhefka, & Battles, 2007 for review). While experiences of social stigma may exist for mental health diagnoses (Jones, 2001), these may differ from the experiences of individuals diagnosed with HIV (Lipson, 1994; Waugh, 2003).

In sum, the implications of medical diagnoses disclosure to children are suggestive at best and should be read with caution. It is necessary to explore mental health diagnoses disclosure to children practices among psychologists in order to determine if the generalization of medical literature occurs.

**Medical Diagnoses Disclosure to Children**

It is difficult to determine specific positive and negative implications of medical diagnoses disclosure to children, because their medical diagnoses disclosure experiences are not well documented (Vaz et al., 2010). This is further complicated by the incongruous findings reported in the empirical literature regarding psychological adjustment to illness and treatment adherence.

**Psychological adjustment.** In a sample of 43 children with cancer, Claflin and Barbarin (1991) found similar levels of distress regardless of whether cancer diagnosis was disclosed or not. They concluded that non-disclosure failed to mask the distressing aspects of cancer. Similarly, non-disclosure has not been found to protect children with
HIV from psychological distress (Vaz et al., 2010). The reason that psychological distress was not found following disclosure may be related to the benefits that children receive from disclosure of an HIV diagnosis such as increased social support (Battles & Wiener, 2002), increased self-competence (Battles & Wiener, 2002), decreased problem behaviors (Bachanas, Kullgren, & Suzman-Schwarz, 2001; Battles & Wiener, 2002) and depression (Mellins et al., 2002; Reikert, Weiner, & Battles, 1995; Wiener et al., 1998), and more cohesive family relationships (Wiener et al., 1998).

In contrast to the previously reported enhanced psychological adjustment found when a diagnosis of HIV or cancer was disclosed to children, the literature also supports the finding that initial psychological distress may increase as a result of diagnosis disclosure (Wiener et al., 2007). New and colleagues (2003) examined psychological adjustment to diagnosis among 57 children with HIV. They found that children who knew their HIV status, versus those who did not know, reported significantly more internalizing and externalizing behavior problems. These behavior problems may be related to children’s affective responses to diagnoses disclosure. In a study examining HIV diagnoses disclosure to children (N=54), Dematteo and colleagues (2002) found that children had an initial negative affective response. These negative reactions included feeling both overwhelmed and shocked.

**Treatment adherence.** Discrepant findings, similar to those previously discussed for psychological adjustment, have been reported for treatment adherence among children who have been told of their HIV diagnosis. Among a survey of eleven caregivers for children with HIV, Hammami and colleagues (2004) found that following the disclosure of HIV, treatment compliance increased for previously adherent children.
This may inform Ferris and colleagues’ (2001) findings that knowledge of HIV infection status was associated with delay of HIV disease progression. Conversely, Marhefka and colleagues (2006) found decreased adherence to treatment following HIV diagnosis disclosure to children. Decreased adherence to treatment may provide additional support for Lester and colleagues’ (2002) findings that disclosure did not have any impact on disease related variables. Overall, children who know of their HIV diagnosis may or may not be more treatment adherent, which may or may not impact disease progression.

In sum, the nascent state of empirical literature investigating the experience of medical diagnosis disclosure among children coupled with study findings that the disclosure of HIV or cancer to children both increases (e.g., Claflin & Barbarin, 1991; Vaz et al., 2010) and decreases (e.g., New et al., 2003; Wiener et al., 2007) psychological adjustment to their illness and treatment adherence. Therefore, definitive conclusions cannot be drawn as to whether diagnoses disclosure has solely positive or negative implications.

**Importance of Diagnoses Disclosure Research Summary**

Psychologists who assign diagnoses to children must make disclosure versus nondisclosure decisions on a regular basis. Little is known about psychologists’ mental health diagnoses disclosure to children practices. Due to the dearth of information available, psychologists may base their diagnoses disclosure decisions on clinical judgment and adult psychiatric or child medical diagnoses disclosure literature. Additionally, the implications of adult psychiatric and child mental health diagnoses disclosure, while explored, remain unclear. It is uncertain if the aforementioned literature and empirical findings are generalizable to child mental health diagnoses disclosure.
Consequently, there is a need to understand current diagnoses disclosure practices so that practice guidelines can be developed.

**Current Mental Health Diagnoses Disclosure Practices**

The existing, but limited, literature exploring current mental health diagnoses disclosure practices to adults and children will be reviewed. This section will begin by exploring disclosure practices to adults among psychologists and psychiatrists for disclosing schizophrenia, mood disorders, and dementia. Additionally, it will examine reasons for disclosure and nondisclosure. This will be followed by a description of the few studies that have addressed mental health diagnoses disclosure to children. These studies will be organized by specific mental health diagnosis.

**Mental Health Diagnoses Disclosure to Adults**

There is an historical consensus that informing adult clients of their diagnosis is good practice (Byzewski et al., 2007; Green, 1984; Hwang, 2008; Keightley & Mitchell, 2004; Lebolt, 2002). However, studies have found that disclosure of mental health diagnoses to adults is not necessarily common practice (Byzewski et al., 2007; Clafferty, McCabe, & Brown, 2000; Gantt & Green, 1986; Green, 1984; Hwang, 2008; McDonald-Scott et al., 1992). The minimal research exploring mental health diagnoses disclosure to adults has demonstrated variable results, suggesting that disclosure may be diagnosis dependent; specifically, psychiatrists are more likely to disclose anxiety, depression, and substance abuse disorders and conceal the diagnosis of schizophrenia (see Paccaloni, Moretti, & Zimmermann, 2005 for review).

**Schizophrenia.** Studies demonstrate variable rates of the schizophrenia diagnosis disclosure by psychiatrists. In a qualitative study among four Chinese-American
psychiatrists, Hwang (2008) found that three of the four reported that relatively few of their patients diagnosed with schizophrenia would be able to accurately name their diagnosis or explain the purpose of their medication. These psychiatrists noted that they would be more likely to disclose the name of the diagnosis if it were less stigmatizing. Although fewer studies have examined the disclosure rates of psychologists versus psychiatrists, one dated study, Gantt and Green (1986), reported findings similar to those of Hwang (2008). Gantt and Green (1986) reported that only 20% of the psychologists (N=10) in their study disclosed the diagnosis of schizophrenia to their patients. However, Clafferty, McCabe, and Brown’s (2000) survey of 211 Scottish psychiatrists found that 59% of the psychiatrists disclosed the diagnosis of schizophrenia to patients following the first psychotic episode and 89% disclosed after the second or third psychotic episode. Even though these psychiatrists did not always disclose the actual name of the diagnosis of schizophrenia, 95% of them believed that they themselves were the best person to disclose the diagnosis to their patients. In a similar study, McDonald-Scott, Machizawa, and Satoh (1992) found that 70% of American psychiatrists (N=112) reported that they would inform patients of a schizophrenia diagnosis.

**Mood Disorders.** Mood disorders appear to be disclosed more readily than schizophrenia by both psychiatrists and psychologists. Gantt and Green (1986) found that 40% of psychologists disclosed the diagnosis of bipolar disorder (versus 20% disclosed schizophrenia). Likewise, psychiatrists also reported an increased rate of disclosure for mood disorders. McDonald-Scott and colleagues (1992) explored the diagnostic disclosure practices of 278 Japanese and American psychiatrists with a questionnaire containing six case vignettes of patients with different diagnoses. Over
90% of the psychiatrists reported that they would inform patients with affective and anxiety disorders. Consistent with these findings, Clafferty and colleagues’ (2000) survey of psychiatrists found increased likelihood of disclosing a mood or anxiety disorder (95%) when compared to their disclosure of schizophrenia.

**Dementia.** There may also be ways in which psychologists and psychiatrists are disclosing mental health diagnoses without using the actual names of diagnoses. Green (1984) suggested that disclosure might be made using a description of the diagnosis without naming it. In a study of dementia disclosure, progressive diagnosis disclosure was viewed as helpful (Byszewski et al., 2007). Progressive diagnosis disclosure occurs when a psychiatrist or psychologist tells the patient progressively more information about their condition until they actually disclose the name of the diagnosis itself (Byszewski et al., 2007). Practices, such as progressive diagnosis disclosure, may account for the less than 50% dementia disclosure rate reported by psychiatrists participating in Clafferty, McCabe, and Brown’s (2000) study.

**Disclosure reasons.** Psychiatrists and psychologists have reported multiple reasons for the disclosure of mental health diagnoses. For adults with varying diagnoses, psychiatrists and psychologists have reported the following reasons for disclosure: provide a means of normalization (Finn & Tonsager, 1992; Hwang, 2008), reduce stress (see Kitamura, 2005 for review), improve patient mood (Fisher, 2000; Holm-Denoma et al., 2008; Hwang, 2008), improve treatment response (Holm-Denoma et al., 2008; Hwang, 2008), increase opportunities for patients to learn about illness (Hwang, 2008), encourage patients to be more active in treatment (Hwang, 2008), and provide additional ancillary treatment options (e.g., support group; Hwang, 2008; MacLeod & Johnston,
Holm-Denoma and colleagues (2008) completed a clinical effectiveness study examining the affective responses to disclosure of 53 adult outpatients with a range of diagnoses (e.g., mood disorders, substance abuse, schizophrenia). Their findings suggest that diagnoses disclosure, when provided in a careful and constructive way, can increase patient’s positive emotions and hope for treatment.

Nondisclosure reasons. There are also many reasons why psychologists and psychiatrists do not disclose diagnoses to clients. One such previously discussed reason is that psychiatrists and psychologists feel that it may be inappropriate to disclose certain diagnoses, such as schizophrenia (see Kitamura, 2005 or Paccaloni, Moretti, & Zimmermann, 2005 for review). Other reasons expressed by surveyed psychologists and psychiatrists working with adults included the following concerns: the client may not have the competency to understand their diagnosis (Kitamura, 2005), diagnosis disclosure may be incongruent with a client’s culture (McDonald-Scott et al., 1992), fear that knowledge of the diagnosis may cause harm (Anthony, 2004; Gantt & Green, 1986; Hassan & Hassan, 1998; Higgins et al., 2002; Janepson, 2010; McDonald-Scott et al., 1992; Paranscandola, Hawkins, & Danis, 2002; Scheff, 1999) or overwhelm the client (Green, 1984), and feeling uncertain if the client would or would not want to know the diagnosis (Keightley & Mitchell, 2004).

Mental Health Diagnoses Disclosure to Children

Medical diagnoses disclosure to children has evolved from a movement of secrecy to one of disclosure (American Academy of Pediatrics, Committee on Pediatric AIDS, 1999; McCabe, 1996; Vaz et al., 2010; Wiener et al., 2007); it is unclear whether psychology supports similar practices. Previous research on mental health diagnoses
disclosure in children is both minimal and limited due to a heavy reliance on retrospective studies. There is extensive research examining parental experiences of being informed of their child’s mental health diagnosis (e.g., Brogan & Knussen, 2003; Knussen & Brogan, 2002; Pearson et al., 1999; Sloper & Turner, 1993), yet a paucity of research from the perspective of children with mental health diagnoses. Consequently, there is insufficient empirical evidence to understand psychologists’ current mental health diagnoses disclosure practices to children. The literature on mental health diagnoses disclosure to children has centered on two diagnoses: autism spectrum disorder (ASD) and learning disabilities (LD). This section will provide a review of the existing, but limited, literature on mental health diagnoses disclosure to children. Because there are few studies, they will be discussed in detail and organized by diagnosis.

Table 1

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<th>Author</th>
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| Allmon et al. (2010)    | Parents/Guardians of high ability youth with ASD or LD (N=38)               | • 95% parents chose to disclose  
• Diagnostic category and child’s age not significantly related to disclosure |
| Brogan & Knussen (2003) | Parents of child with autism spectrum disorder (N=126)                      | • 55% of parents satisfied or very satisfied with disclosure  
• More likely to be satisfied if (1) liked professional, (2) perceived quality of information as high, (3) given written information, (4) had opportunity to ask questions, and (5) if diagnoses confirmed suspicions  
• Higher satisfaction associated with: (1) their child was diagnosed with Asperger syndrome (as opposed to autism), (2) had a definite diagnosis, and (3) child was not currently in an educational placement |
These studies will be referenced throughout the review; to prevent repetition.

Table 1 describes the mental health diagnoses disclosure to children studies.

**Autism Spectrum Disorders.** The author could not locate any articles reporting the rates of disclosure of autism spectrum disorders (ASD) to children; however, a recent
qualitative study examined the disclosure experiences of young people with ASD. Huws and Jones (2008) conducted a qualitative study consisting of nine students diagnosed with high functioning autism (i.e., autism and an IQ in the average range or above) who were attending a college for people with ASD (See Table 1). At the time of the study, all participants were aware of their diagnoses; therefore, they retrospectively reflected on their diagnoses disclosure experiences. Huws and Jones’ (2008) findings suggest that participants experienced a delay in their diagnoses disclosure, with many being diagnosed as a young child (i.e., 4 years old) and not learning of their diagnoses until adolescence (i.e., 13-15 years old). Participants viewed disclosure as an event that offered an understanding of previous experiences (e.g., classroom placement). In addition to disclosure experiences, participants reported both positive (e.g., others understanding of behavior) and negative (e.g., discrimination) effects of labeling.

Learning Disabilities. The rate of disclosure of learning disabilities diagnoses to children has not been the central focus of any studies. However, the disclosure of learning disabilities has been reported in a study examining parent/guardian experience with diagnoses disclosure. Pearson and colleagues (1999) explored the experience of disclosure for 39 parents of children with moderate to severe learning disabilities. They found that 56% of parents with children ages 15 to 20 years old (N=16) reported that their child was present at the time of disclosure, compared to 82% of parents with children under the age of 5 years old (N=23; Pearson et al., 1999). Therefore, younger children were more likely to be present during disclosure than older children. The reasons for younger children’s presence during disclosure were not explored in the study. However, there are multiple possibilities such as: 1) it may be a reflection of changing mental
health disclosure practices by psychologists (i.e. 10 years ago psychologists may have been less likely to include children in the disclosure), 2) parent preference for disclosure, or 3) children under five years old may have been viewed as unable to understand the diagnoses so their presence may be irrelevant.

Although other studies do not explicitly report disclosure rates of learning disabilities, some authors imply that children know of their learning disability diagnoses (e.g., Higgins et al., 2002; Janepson, 2010; Raskind, Margalit, & Higgins, 2006). For example, Raskind, Margalit, and Higgins’ (2006) study implied that participants knew their diagnoses because participants were students who voluntarily joined online support groups specifically for individuals with learning disabilities. In addition to alluding to diagnoses awareness, these studies aid in understanding how support can be provided to children with mental health diagnoses. Raskind and colleagues’ (2006) study suggests that providing outlets, such as safe and secure online support groups, for children with mental health diagnoses may be an important avenue for self-expression and disclosure, which thereby may reduce the possible negative effects of diagnoses disclosure.

**ASD and LD.** A recent unpublished study examined disclosure among a group of 38 high ability youth with either an autism spectrum disorder (ASD) or a learning disability (LD) diagnosis. Allmon and colleagues (2010) sought to determine if children’s age influenced parent/guardian’s choice to disclose. Neither diagnostic category nor child’s age were significantly related to disclosure, likely because the majority (95%) of parents/guardians chose to disclose. Given the limited literature, no conclusions regarding current disclosure rates of either ASD or LD can be made.
However, the current literature suggests that, at least with children diagnosed with ASD or LD, parent/guardian diagnoses disclosure to children may be a frequent occurrence.

**Current Mental Health Diagnoses Disclosure Summary**

There is minimal research exploring the disclosure of mental health diagnoses to either adults or children. The extant research suggests that diagnoses disclosure rates vary and depend on multiple factors, such as diagnoses (i.e., Paccaloni, Moretti, & Zimmermann, 2005) and/or age (i.e., Pearson et al., 1999). However, one study also proposes that parent/guardian diagnoses disclosure of LD or ASD may be common (Allmon et al., 2010). Additional research is needed in order to establish an understanding of current mental health diagnoses disclosure practices to children so that children’s experiences with their diagnoses (e.g., implications of diagnoses) can be understood and appropriate diagnoses disclosure practice guidelines can be developed.

**Client Considerations**

Mental health diagnoses disclosure practices are likely not uniform and depend on individual client characteristics. However, the specific client factors that psychologists consider in making their diagnoses disclosure decisions remain unknown. The existing literature has focused on adult mental health diagnoses disclosure and medical diagnoses disclosure to children. Both, the medical literature examining the disclosure of HIV and cancer to children and the adult mental health literature, suggest that the following factors may impact diagnoses disclosure practices: 1) diagnoses (e.g., Vaz et al., 2010), 2) culture (e.g., Gupta et al., 2008), 3) children and adolescent’s age (e.g., Chesler, Paris, & Barbarin; Claflin & Barbarin, 1991; Dematteo et al., 2002; Gupta et al., 2008), and 4) cognitive ability (e.g., Abadia-Barrero & LaRusso, 2006; Lester et al., 2002; Wiener et
This section will provide evidence for the need to explore the aforementioned factors among mental health diagnoses disclosure to children by reviewing the literature concerning each of factor from various areas of study including: childhood mental health, adult mental health, and childhood medical diagnoses disclosure.

Diagnoses

The specific mental health diagnosis of a child may influence psychologists’ disclosure practices. Characteristics about specific diagnoses are not uniform. Some diagnoses may be perceived as more severe, have associated social stigma, be more or less prevalent, and require different types of treatment. These diagnostic characteristics will be discussed among the adult mental health literature and child medical literature. This discussion will conclude with characteristics of childhood and adolescent mental health diagnoses that are hypothesized to influence diagnoses disclosure practices.

Adult mental health diagnoses. The adult mental health literature suggests that the likelihood that clinicians will disclose a diagnosis depends on the specific diagnosis being disclosed (Clafferty et al., 2001; McDonald-Scott et al., 1992; Paccaloni et al., 2005; Pinner & Bouman, 2002). Because this literature was previously reviewed in detail, only a general summary will be provided. Multiple studies have found that both psychologists and psychiatrists are more likely to disclose mood, anxiety, and substance abuse disorders compared to schizophrenia, dementia, or personality disorders (Clafferty et al., 2001; Gantt & Green, 1986; McDonald-Scott et al., 1992; Pinner & Bouman, 2002). The discrepancies in disclosure based on diagnoses may be a result of the following: 1) schizophrenia, dementia, and personality disorders are perceived as diagnoses that may cause more harm than mood, anxiety, or substance abuse disorders if
disclosed (Clafferty et al., 2000; Green, 1984; McDonald-Scott et al., 1992), and/or 2) more social stigma is associated with certain diagnoses (e.g., schizophrenia; Hwang, 2008; Scheff, 1999; Sushinsky & Wener, 1975). Green (1984) described the perception of the diagnosis of schizophrenia as a “psychological death sentence” (p. 76). Although dated, Green’s (1984) comment illustrates the perceived severity of disclosing certain diagnoses, such as schizophrenia, felt by mental health professionals. Additionally, practices such as disclosing “vague diagnoses” (e.g., mood instability for bipolar disorder; Lebolt, 2002) and progressive disclosure (see “Mental Health Diagnoses Disclosure to Adults” section for more information; Byszewski et al., 2007) may decrease the rates of disclosure.

**Children’s medical diagnoses.** The medical literature endorses diagnoses disclosure (American Academy of Pediatrics, Committee on Pediatric AIDS, 1999; McCabe, 1996; Vaz et al., 2010). The American Academy of Pediatrics (AAP) stance of diagnoses disclosure is briefly summarized below. Despite the AAP’s viewpoint medical diagnoses disclosure is not always practiced. The medical literature suggests that disclosure may vary based on diagnoses. Although studies have not focused on the differences between the disclosure of HIV and cancer to children, research on cancer and research on HIV suggest diagnoses disclosure discrepancies that are discussed in this section.

**The American Academy of Pediatrics.** The American Academy of Pediatrics (AAP) provides an unambiguous stance endorsing diagnosis disclosure. The AAP Committee on Bioethics report (1995) explicitly states that health care professionals have an ethical obligation to provide counseling and full disclosure of HIV status. The AAP
acknowledges evidence of the possible ramifications of concealing information, which may lead to inappropriate or hurtful fantasies, isolation from potential support sources, or the possibility of a child learning of an illness in an unsupportive way (American Academy of Pediatric, 1999). Further, the Committee on Pediatric AIDS (1999) asserts that health care professionals will not accept parent/guardian requests to withhold diagnoses “under all circumstances” (p.165). Specifically, the AAP strongly encourages disclosure of HIV status to school-aged children. Moreover, if adolescents directly ask about their status, AAP states that health care professionals will “tell the truth” about the diagnosis (Committee on Pediatric AIDS, 1999, p. 165). Alternatively, the Committee on Pediatric AIDS (1999) recommends that younger children be told about what will happen in the immediate future, such as an upcoming treatment or immediate changes in the child’s daily routine. As seen within this brief review of the AAP’s Committee on Bioethics report (1995), the medical community acknowledges that diagnosis disclosure is both a necessary and complex task.

**Cancer and HIV disclosure.** By the early 1990’s research on the disclosure of cancer diagnoses to children demonstrated that open communication improved children’s psychological adjustment (Chesler, Paris, & Barbarin, 1986; Katz & Jay, 1984; Slavin, O’Malley, Koocher, & Foster, 1982; Spinetta & Maloney, 1978). This resulted in a shift in pediatric oncology practice to embrace disclosure among children with cancer (Wiener et al., 2007). HIV diagnosis disclosure to children has not been as prominent as the disclosure of oncology diagnoses, demonstrated by the many studies with child participants who did not know their HIV diagnosis (e.g., Abadia-Barrero, & LaRusso, 2006; Dematteo et al., 2002; Ferris et al., 2007; Ledlie, 1999; Oberdorfer et al., 2006;
Waugh, 2003). This may be due to the differences between the diagnoses of cancer and HIV including epidemiology, transmission concerns, prognosis, and treatment. These discrepant disclosure practices and concerns about disclosure for medical diagnoses may be found among the disclosure of different mental health diagnoses in children.

**Children’s mental health diagnoses.** Unlike the adult mental health and children’s medical diagnoses disclosure literature, there are little empirical data on the influence of specific mental health diagnoses on disclosure practices with children. In the following section the author hypothesizes a few of the potential components of specific mental health diagnoses that might impact psychologists’ disclosure practices. The components explored include the following: type of mental health diagnosis (e.g., cognitive vs. social-emotional), prevalence of diagnosis, and treatment for diagnosis (e.g., medication, therapy, classroom accommodations).

**Type of diagnosis.** Children’s mental health diagnoses might be conceptualized as a diagnostic type; categorized by the area impacted most by the diagnosis. Two of these types might include social-emotional diagnoses or cognitive diagnoses. Social-emotional diagnoses would cause difficulties in children’s social or affective functioning; cognitive diagnoses would most impact children’s cognitive functioning. Specific learning disabilities, global intellectual disability/mental retardation, and ADHD are examples of cognitive diagnoses, while depression and anxiety are examples of social-emotional diagnoses. Although Allmon and colleagues (2010) found that the specific diagnosis (i.e., ASD or LD) was inconsequential for parent/guardian rates of disclosure, this may have been due to the high disclosure rate (95%) and homogenous sample of
diagnoses. Therefore, it is unknown if type of mental health diagnosis influences disclosure practices.

*Social-emotional diagnoses.* Psychologists may or may not perceive the disclosure of social-emotional diagnoses as beneficial to children. Disclosure may be perceived as helpful or harmful to children (Jones, 2001). Based on inferences from the adult mental health literature, diagnoses disclosure to children may provide normalization (Finn & Tonsager, 1992; Hwang, 2008), opportunities for ancillary support (e.g., support groups; Hwang, 2008; MacLeod & Johnston, 2007), or understanding of previous experiences (Higgins, 2002). However, it may also be stigmatizing (Hwang, 2008). Given the previously discussed adult mental health literature (e.g., Clafferty et al., 2001; Gantt & Green, 1986; McDonald-Scott et al., 1992; Pinner & Bouman, 2002), psychologists may disclose social-emotional diagnoses to children more often than cognitive diagnoses if the diagnoses are perceived as less severe.

*Cognitive diagnoses.* Cognitive diagnoses may influence psychologists’ disclosure practices. Even if psychologists believe disclosure is beneficial, they may be concerned that children or adolescents will not understand their diagnoses, as a result of the cognitive diagnoses. Additionally, psychologists may be more likely to disclose what are perceived as positive cognitive findings, such as ‘gifted and talented’, than diagnoses of cognitive disabilities. This may be similar to a parent’s desire to protect children from information that may be unpleasant (e.g., Claflin & Barbarin, 1991). These feelings may be less likely if the child’s cognitive abilities are viewed as a strength (e.g., gifted and talented).
Typically cognitive diagnoses follow extensive diagnostic evaluations, which unavoidably present the child with information (e.g., they needed testing or an evaluation). The assessment experience may influence psychologists’ disclosure of cognitive diagnoses. After completing the evaluation psychologists may feel that they have adequate information to disclose diagnoses to children in an appropriate and understandable way. Taking into account those considerations, Brewer and Faitak (1989) assert that children should receive feedback after a cognitive evaluation. Although Brewer and Faitak (1989) do not explicitly endorse diagnoses disclosure as a component of feedback, they assert that cognitive data should be explained to children in terms of cognitive strengths and weaknesses.

**Prevalence of diagnoses.** The prevalence of mental health diagnoses in children may impact the likelihood of disclosure. Although prevalence estimates are not as well documented in children compared to adults, it is evident that mental health diagnoses are present in many children (e.g., 20.9% of United States children ages 9 to 17 years old, Shaffer et al., 1996). Furthermore, half of all lifetime cases of mental illness begin by 14 years of age (Kessler et al., 2005). With increased prevalence, psychologists’ fear about potential stigmatization may decrease and their comfort with disclosing both mental health diagnoses and normalizing the experiences of children with mental health diagnoses may increase. These perceptions may also be influenced by increased open communication about mental health within the popular media.

Mental health diagnoses that are more common in the child and adolescent population may be disclosed more frequently. This may be due to increased services and accommodations available, increased public awareness and decreased social stigma, or
increased familiarity with these diagnoses. If higher prevalence rates increase disclosure, then diagnoses, such as ADHD, may be openly disclosed to children. A recent publication by the National Survey of Children’s Health (2010) not only suggests that ADHD has an increasing prevalence trend, but also estimates that 9.5% of children ages 4 to 17 years old are diagnosed with ADHD.

*Treatments or accommodations for diagnoses.* Children with mental health diagnoses may receive some form of treatment (Woo & Keatinge, 2008). Various treatments, such as medication, therapy, and classroom accommodations, may result from a mental health diagnosis (National Institute of Mental Health, 2009). The experience of living with a mental health diagnosis and receiving treatment may provide children or adolescents with the understanding that their experience is unique. Children may or may not ask questions about their treatment (e.g., why do I have to take medication?, why am I not in the regular classroom all day?, why do I come to therapy?). Both Ledlie (1999) and Lipson (1994) report that a reason for HIV disclosure to children is the need to respond to children’s questions. Having to respond to these questions may encourage psychologists to disclose mental health diagnoses to children. Moreover, the extent of accommodations, particularly those in public settings (e.g., school), may impact diagnoses disclosure practices. For example, if a student receives additional one-on-one help in school, takes medication, and only attends half days of school they may need to know their diagnosis as a means of responding to questions from peers or to prevent accidental disclosure by school personnel (e.g., the school nurse stating, “come take your ADHD medication”).

*Diagnoses summary.* Although there is limited empirical data examining the
impact of mental health diagnoses disclosure to children, the adult mental health literature and children’s medical literature suggest that the characteristics inherent in specific diagnoses may influence disclosure practices (e.g., Clafferty et al., 2000; McDonald-Scott et al., 1992; Wiener et al., 2007). The type, prevalence, and treatment for diagnoses may be particularly salient considerations taken into account by psychologists disclosing mental health diagnoses to children. While there is a need to understand how diagnostic characteristics impact disclosure practices so that they may be used to develop appropriate disclosure practice guidelines, the complexity of diagnosis disclosure requires consideration of the many factors involved in diagnosing a mental health disorder (e.g., peer and family relationships, academic performance, developmental history) as well as characteristics of specific diagnoses (e.g., type, prevalence, treatment). Therefore, the initial investigation of the impact that specific diagnoses have on psychologists’ disclosure practices with open-ended questions, as accomplished by the present study, is most appropriate.

**Culture**

Research has demonstrated that disclosure practices vary based on culture among practitioners disclosing diagnoses to parents/guardians of children with mental health diagnoses (Hatton et al., 2003), adult’s with mental health diagnoses (Hwang, 2008; McDonald-Scott, et al., 1992), and children with cancer (Gupta et al., 2008; Mayer et al., 2005; Parsons et al., 2007). The majority of research regarding the impact of culture on diagnoses disclosure, regardless of diagnostic population (e.g., parents/guardians of children with mental health diagnoses, adults with mental health diagnoses, or children with cancer) has focused on two cultures: Asian or Asian-American and Caucasian-
American culture. Therefore the focus of this discussion will be on Asian American culture. Although there is no research exploring the impact of children and adolescent’s cultural identities on psychologists’ mental health disclosure practices, the literature regarding multicultural competencies for working with children and adolescents is applicable to psychologists’ disclosure practices. Specifically, this section will explore the applicability of Liu and Clay’s (2002) Multicultural Counseling Competencies for working with children. It will also include a review of the literature regarding cultural considerations involved in diagnoses disclosure among parents/guardians of children with mental health diagnoses, adults with mental health diagnoses, and children with cancer.

Multicultural counseling competencies. Liu and Clay (2002) proposed a five-step guide to decision-making for working with diverse children; the first three steps may provide potential guidance for diagnoses disclosure. The first step is to “evaluate which, if any, cultural aspects are relevant” (Liu & Clay, 2002, p. 178). Developing awareness of potentially relevant cultural practices is two-fold. First, psychologists must consider the cultural identity of the child and determine if and how this may impact disclosure. For example, Asian-American clients with traditional beliefs may highly stigmatize mental health disorders (e.g., Hwang, 2008). Second, psychologists should consider any possible biases that they hold. These may be biases that are not typically thought of as potentially harmful or non-therapeutic (e.g., valuing autonomy and therefore feeling that a child has the right to know his or her diagnosis when this may be inconsistent with a client’s cultural values).

The second step is to “determine the level of skills and information necessary for competent treatment and possible referral,” which involves the education and
multicultural competency of the psychologist, such as knowledge of cultural norms and expectations (Liu & Clay, 2002, p. 178). They suggest that one way psychologists can develop this knowledge is to collect information about the cultural groups of their clients or potential clients. This information may come in the initial form of local census and demographic information, so that psychologists can anticipate potential culture-based diagnoses disclosure considerations.

Psychologists may easily overlook the third step which is to “determine how much, when, and how to incorporate cultural issues” (p. 178). In an effort to maintain cultural sensitivity, psychologists may assume the paramount importance and relevance of culture when it may be minimal. Evaluating the impact of cultural identity must be an active and ongoing process. Psychologists should explore the impact of culture in diagnoses disclosure as it may or may not influence the diagnoses disclosure decision-making process.

**Culture and diagnoses disclosure to parents/guardians.** There is little empirical research examining mental health diagnoses disclosure practices to children in general; therefore, the author could find virtually no studies exploring mental health diagnoses disclosure to culturally diverse children. However, the author did find one study, which explored the experiences of 26 South Asian parents of children with intellectual disabilities. Hatton, Akram, Robertson, Shah, and Emerson (2003) conducted a semi-structured interview with the participants. They found that disclosure experiences varied from very good to very poor. Factors that increased parents’ satisfaction with the disclosure experience included: the use of appropriate language for disclosure, the presence of both parents, and the presentation of
clear and practical information. This study suggests that disclosure practices may need to be altered in order to be culturally congruent. Some of the same factors may also be found in disclosure practices with South Asian children. For example, South Asian children may benefit from having parents present during disclosure, the use of a translator if the psychologist is not fluent in the client’s first language, and being given concrete recommendations for treatment.

**Culture and mental health disclosure to adults.** Mental health diagnoses disclosure literature relating to adults has explored both the impact of psychiatrist and client culture on mental health disclosure. Two studies exploring the practices of Asian psychiatrists, McDonald-Scott and colleagues (1992) and Hwang (2008), found that they disclose diagnoses infrequently. In the first study, McDonald-Scott and colleagues (1992) found that Japanese psychiatrists are less likely than American psychiatrists to disclose diagnoses, including affective disorders, anxiety disorder, schizophrenia, and schizophreniform. The second qualitative study provided some possible reasons why the discrepancies in disclosure practices may exist. Hwang (2008) completed qualitative interviews with four Chinese-American psychiatrists working with patients with schizophrenia. These psychiatrists also endorsed high rates of non-disclosure. Additionally, they reported that they do not voluntarily disclose the diagnosis of schizophrenia; but if they deem disclosure beneficial and they are specifically asked, then they would provide the diagnosis. Reasons given for their nondisclosure included the psychiatrists’ belief that their Chinese-American patients had greater stigmas for mental health diagnoses and thus, may not be able to tolerate knowing their diagnosis.
Because of studies like Hwang’s (2008), practice suggestions for disclosing mental health diagnoses to adults with culturally traditional illness beliefs have been developed (Yeung & Kam, 2008). In Yeung and Kam’s (2008) article they make the following suggestions for working with Chinese-American clients with psychiatric diagnoses and traditional illness beliefs: elicit and process illness beliefs, use multiple explanatory models, contextualize symptoms into physical health and social system, introduce Western psychiatric theory, involve the patient’s family, and use non-stigmatizing terminology. These practice suggestions, like Liu and Clay’s (2002) multicultural counseling guidelines, may be influencing current mental health diagnoses disclosure practices. However, additional research is necessary to determine the extent to which culture impacts psychologists’ practices.

**Culture and disclosing cancer to children.** Despite overall high rates of diagnoses disclosure among children with cancer, practices may differ when either the oncologist or the child is of an Asian culture. These discrepancies will be explored in this section in two ways. First, the differences present between practices of disclosure among Asian oncologists and American oncologists will be examined. Then, culturally congruent disclosure practices for Asian children with cancer will be explored.

Japanese pediatric oncologists and American pediatric oncologists differ in diagnoses disclosure practices towards children. Research has demonstrated that Japanese oncologists compared to U.S. oncologists are less likely to endorse disclosure (Mayer et al., 2005; Parsons et al., 2007). In a study examining physician cultural attitudes towards the disclosure of a cancer diagnosis to children, Parsons and colleagues (2007) reported that Japanese pediatric oncologists were more variable in their rates of
and reasons for disclosure. The authors found that 65% of U.S. oncologists endorsed always disclosing cancer diagnoses to children, compared to only 9.5% of Japanese oncologists. In addition, U.S. pediatric oncologist’s choice to disclose was primarily impacted by a sense of personal responsibility, while Japanese pediatric oncologist’s disclosure was influenced by personal attitudes, patient factors, and work culture (Parsons et al., 2007).

Differences in rates of disclosure between U.S. and Japanese oncologists have also been reflected in their recommendations for disclosure. For example, Mayer and colleagues (2005) found that Japanese oncologists were less likely (25.9%), compared to U.S. oncologists (84.5%), to endorse and encourage families to fully disclose their children’s cancer diagnoses upon school re-entry (i.e., telling school officials and classmates). Both Parsons and colleagues (2007) and Mayer and colleagues (2005) findings may be related to the high value placed on privacy in Japanese cultures.

Oncology disclosure practices to children not only differ based on the culture of the oncologist, but also by the culture of the child diagnosed with cancer. Gupta and colleagues (2008) explored cultural implications of diagnosis disclosure with a case study of an 11 year-old Asian-Indian boy recently diagnosed with leukemia. The authors acknowledge the importance of physician disclosure (as described by the American College of Physician’s Ethics Manual, 2005), which is rooted in the principle of autonomy. However, they also argue that the construct of ‘autonomy’ is premised on a western cultural perspective and may not be applicable in the same way for non-western clients. Gupta and colleagues (2008) conclude with culturally congruent suggestions
such as filtering the information provided to the child or using progressive disclosure (see Byszweski et al., 2007).

**Culture summary.** Parent/Guardian mental health disclosure literature (Hatton et al., 2003), adult mental health literature (Hwang, 2008; McDonald-Scott et al., 1992; Yeung & Kam, 2008), and pediatric oncology literature (Gupta et al., 2008; Mayer et al., 2005; Parsons et al., 2007) suggest that culture may influence psychologists’ mental health diagnoses disclosure practices with children. Specifically, the preponderance of literature has reported less disclosure of mental health diagnoses with Asian-American adults for worry of greater stigma for patients with traditional illness beliefs (Gupta et al., 2008; Hwang, 2008; Yeung & Kim, 2008). However, the extent of this impact on how psychologists currently make diagnoses disclosure decisions is unknown. Psychologists’ diagnoses disclosure decisions, like those of oncologists (Mayer et al., 2005; Parsons et al., 2007) and psychiatrists (Hwang, 2008; McDonald-Scott et al., 1992), may not only be influenced by their clients’, but also their own culture. Multicultural competency guidelines, like those suggested by Liu and Clay (2002), may provide insight as to how psychologists account for culture in making diagnoses disclosure decisions.

**Age**

In an effort to provide developmentally appropriate services, psychologists may alter their mental health diagnoses disclosure practices based on children’s ages. Currently there is limited information available to suggest that children’s ages impact mental health disclosure. However, the medical diagnoses disclosure literature consistently demonstrates that disclosure increases with age (e.g., Abadia-Barrero & LaRusso, 2006; Claflin & Barbarin, 1991); these findings may be a result of children’s
understanding of illness on a developmental level. This section will explore the literature examining how age relates to both mental health and medical diagnoses disclosure. Further, it will provide a review of Piaget’s theory of development as it relates to age and examine how theories of development may be helpful in understanding what children comprehend when having diagnoses disclosed to them.

**Mental health diagnoses disclosure and age.** The limited research available exploring age and mental health diagnoses disclosure to children, has produced conflicting results. Age was not significantly related to disclosure in Allmon and colleagues (2010; See Table 1); however, as previously stated, this may be a result of the high rate of disclosure to children by parents/guardians (95%). Contrarily, Pearson and colleagues (1999) found that younger children (birth to 5 years old) were more likely (82% disclosure) than older children (15 to 20 years old) to be present during diagnoses disclosure (See Table 1). These contradicting results may be due to the sample differences (e.g., diagnoses, cognitive ability). More research is needed prior to drawing conclusions about the impact of age on mental health diagnoses disclosure to children.

**Medical diagnoses disclosure and age.** Unlike mental health diagnoses disclosure to children, medical diagnoses disclosure research has produced consistent empirical data indicating that older children are either told their diagnoses or more information about their illness than younger children. This is found in both studies of pediatric cancer (e.g., Chesler et al., 1986; Slavin et al., 1982) and HIV (Aiges, 2008; Dematteo et al., 2002).

**Oncology.** Diagnoses disclosure guidelines for children with cancer (American Academy of Pediatrics, 1999) assert that age must be considered when physicians assess
readiness for disclosure. Prior to the development of disclosure guidelines, disclosure practices to children with cancer varied based on age (Claflin & Barbarin, 1991) with younger children (e.g., children under the age of 9 years old) rarely being told their diagnoses. The historical perspective of complete nondisclosure to children with cancer changed as a result of studies failing to find benefits from nondisclosure (Chesler, Paris, & Barbarin, 1986; Claflin & Barbarin, 1991; Katz & Jay, 1984; Slavin et al., 1982; Spinetta & Maloney, 1975; Spinetta & Maloney, 1978; Waechter, 1973). For example, Claflin and Barbarin (1991) found that children, regardless of age, experienced similar levels of distress, although younger children (under 9 years old) were told less information about their diagnoses. Reasons for disclosing less information to younger children included that due to cognitive limitations based on development and a belief that younger children do not have the capacity to cope with knowing their diagnoses. This suggests that although disclosure practices may be dependent upon the child’s age, telling less information does not protect the child from distress. It is unclear if these findings would be replicated in children with mental health diagnoses.

**HIV.** Although there is discrepant empirical data on the mean age of HIV diagnoses disclosure to children (e.g., late adolescence; Aiges, 2008; ten years old; Dematteo et al., 2002), research demonstrates that children with HIV are progressively disclosed more information as they get older (Abadía-Barrero & LaRusso, 2006; Aiges, 2008; Dematteo, et al., 2002; Mellins et al., 2002; Wiener et al., 1996; Wiener et al., 2007). These findings are similar to those previously discussed concerning children with cancer (e.g., Claflin & Barbarin, 1991). In one such study, Abadía-Barrero and LaRusso (2006) examined understanding of illness among 36 perinatally infected HIV positive
children. Semi-structured interviews with these children (ages 1-15 years old) revealed that although the majority did not have their diagnoses disclosed to them, older children were most likely to know their diagnoses. Therefore many of these participants’ current understanding of illness were inferred, based on their experiences with medication and hospitalization. Perceptions about AIDS were assessed without disclosing their diagnoses. The authors found that children under six years old reported that they learned to take medication and not ask questions about their illness. Children seven to nine years old perceived that both their illness and diagnoses of AIDS were negative. As the age range increased so did awareness of their diagnoses. Preadolescent participants connected negative social values to AIDS and reported feeling both shame and anger; similarly adolescents also reported feeling negatively both about their own life and AIDS. Overall, there was poor understanding among all participants about what AIDS was and how it was relevant to their experiences. Most participants’ understanding of AIDS was based on negative social perceptions of AIDS. These findings may be a result of children and adolescents understanding of illness based on age and developmental level. However, they may also be related to minimal diagnoses disclosure, and therefore a lack of information and understanding.

**Age and developmental understanding of illness.** In research examining the disclosure of mental health (Pearson et al., 1999), cancer (Claflin & Barbarin, 1991), and HIV (Lesch et al., 2007) diagnoses to children, authors consistently conclude that diagnoses disclosure should be a process related to children’s developmental level. Diagnoses disclosure may be viewed as a process of disclosing age-appropriate information to children to help them understand their experiences (e.g., attending therapy,
taking medication). In contrast to the view that children do not understand diagnoses, research drawing on Piagetian theory suggests that children are able to understand health and medical diagnoses when presented in a developmentally appropriate way (e.g., developmentally congruent language, use of concrete concepts; Bibace & Walsh, 1980; Lipson, 1994; Perrin & Gerrity, 1981; Wiener et al., 2007). Corresponding results are found in studies that suggest children’s understanding of medical illness increases with age (e.g., Kister and Patterson, 1980; Perrin and Gerrity, 1981). Developmental theories, such as Piaget’s theory of cognitive development (Smith, Cowie, & Blades, 1998), may help psychologists determine appropriate mental health diagnoses disclosure practices with children.

**Piaget’s theory of cognitive development and understanding diagnoses.** Piaget’s theory of cognitive development can assist in understanding how children may conceptualize their mental health diagnoses. Piaget’s theory conceptualizes intellectual growth in terms of progressive changes in children’s cognitive structures, advancing from concrete motor and sensory activities to being capable of abstract reasoning (Smith, Cowie, & Blades, 1998). Each stage (sensorimotor, preoperational, concrete operational, and formal operational) builds upon and is different from the one preceding it. In addition, he provides expected age ranges to correspond with each stage.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Age</th>
<th>Understanding of Diagnoses</th>
</tr>
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<tbody>
<tr>
<td>Preoperational</td>
<td>2-6 years old</td>
<td>• Symbolic thought develops and ability to use language increases</td>
</tr>
</tbody>
</table>
Table 2 continued

<table>
<thead>
<tr>
<th>Age Summary</th>
<th>Concrete Operational</th>
<th>7-10 years old</th>
<th>Formal Operational</th>
<th>11 years and older</th>
</tr>
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<tr>
<td></td>
<td>Children may base understanding of their mental health diagnoses on associations (e.g., ADHD means taking medication, psychologists, school accommodations)</td>
<td>Seriation and classification develops; thinking is logical, and begins to become more flexible (Smith, Cowie, &amp; Blades, 1998)</td>
<td>Abstract thinking and reasoning develops (Smith, Cowie, &amp; Blades, 1998)</td>
<td>Children may understand the interaction between their mental health diagnoses and the environment</td>
</tr>
<tr>
<td></td>
<td>Children may base understanding of their mental health diagnoses on seriation or classification (e.g., all children in my group are like me)</td>
<td>Children may understand the interaction between their mental health diagnoses and the environment</td>
<td>Children may understand social implications of their diagnoses</td>
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Table 2 provides a hypothesized example of how a child’s understanding of their mental health diagnoses might increase in complexity as they progress through Piaget’s second, third, and fourth stages.

**Age summary.** Medical diagnoses disclosure studies, examining both cancer (e.g., Claflin & Barbarin, 1991) and HIV (e.g., Abadia-Barrero & LaRusso, 2006), indicate that diagnoses disclosure increases with age. However, it is unclear from preliminary research if these findings would be replicated among mental health diagnoses disclosure practices. Theories of development (e.g., Piaget’s theory) may contribute to a
psychologist’s understanding of how to provide developmentally appropriate mental health diagnoses disclosures. Additional research investigating the influence of age on mental health diagnoses disclosure practices is needed.

**Cognitive Ability**

Cognitive ability may affect mental health disclosure practices. Though the author recognizes that in normal development age and cognitive ability progress together, for individuals with intellectual disabilities this is not the case. For the purposes of understanding cognitive ability as a factor that may influence mental health diagnoses disclosure, cognitive ability will be conceptualized as a unique entity, separate from age. This conceptualization is consistent with the studies presented in this section, which explore both mental health and medical diagnoses disclosure to individuals with cognitive disabilities.

**Disclosure and IQ.** Although only one children’s mental health diagnoses disclosure study provided information about participant’s cognitive abilities, presuppositions about the impact of cognitive ability on disclosure may be made. Allmon and colleagues (2010) study (See Table 1) found that 95% of high ability children had their diagnoses of ASD or LD disclosed. Although no definitive conclusions can be drawn and this is merely the report of one study, the high rate of disclosure may be due to the children’s high ability. Parents may have felt that their children could understand their diagnosis due to their cognitive abilities. This hypothesis is corroborated by studies from the HIV diagnosis disclosure literature, which suggest that cognitive ability may have a bearing disclosure rates. Lester and colleagues (2002) found that children with lower IQ’s were less likely to have their diagnoses disclosed. Likewise, Wiener and
colleagues (2007) review of HIV literature indicates that diagnoses disclosures were more frequent for children with higher IQs compared to children with lower IQs.

**Understanding of diagnoses among those with intellectual disabilities.** The view “ignorance is bliss” is often expressed by caregivers of individuals with intellectual disabilities and cancer (Bernal & Tuffrey-Wijne, 2008, p. 367). Bernal and Tuffrey-Wijne’s (2008) findings suggest that this view is invalid and that protection from information could cause harm to individuals who can be helped to understand their diagnoses. Moreover, Tuffrey-Wijne, Bernal, and Hollins’ (2010) research attests that many individuals with mild or moderate intellectual disabilities can understand a diagnosis of cancer. Tuffrey-Wijne, Bernal, and Hollins (2010) qualitatively examined the cancer diagnoses disclosure experiences of 13 adults with mild, moderate, or severe intellectual disabilities. Most (N=11) were told they had cancer. Two individuals demonstrated a clear and full understanding of cancer, while those with mild or moderate intellectual disabilities demonstrated some level of understanding.

**Cognitive ability summary.** Cognitive ability may inform psychologists mental health diagnoses disclosure practices. Although diagnosis is a relatively abstract concept, psychologists cannot assume that “those with poorer cognitive abilities will inevitably have a poorer understanding” (Bernal & Tuffrey-Wijne, 2008, p. 366). Preliminary data in one study suggest that most parents (95%) of high ability children disclose diagnoses (Allmon et al., 2010; see Table 1). These data are supported by HIV diagnoses disclosure literature suggesting that the amount of information children were disclosure about their medical illness was commensurate with their cognitive ability level (Lester et al., 2002;
Further examination is required to understand how children’s cognitive ability may shape mental health diagnoses disclosure practices.

**Summary of Considerations for Diagnoses Disclosure**

Components of psychologists’ mental health diagnoses disclosure decisions remain unknown; however, the adult mental health literature and children’s mental health literature provide incipient factors for consideration. These considerations include diagnoses (e.g., Vaz et al., 2010), culture (e.g., Gupta et al., 2008), age (e.g., Chesler, Paris, & Barbarin; Claflin & Barbarin, 1991), and cognitive ability (e.g., Abadia-Barrero & LaRusso, 2006). It is important to note that considerations for disclosing medical diagnoses, such as cancer or HIV, and disclosing mental health diagnoses to children may be discrepant due to the challenges present in applying medical literature to the mental health field. Thus, there is a need to explore how these factors inform psychologists’ mental health diagnoses disclosure practices to children. These factors may provide an initial basis for research to provide a foundation for the future establishment of mental health diagnoses disclosure guidelines for children.

**Conclusion**

An estimated 13% (Costello, Mustillo, Erkanli, Keller, & Argold, 2003) to 20% (New Freedom Commission on Mental Health, 2005; Shaffer et al., 1996) of children living in the United States have mental health diagnoses. Determining diagnoses is a complicated process that can differ depending upon the setting in which it is identified (e.g., clinical services or a diagnostic evaluation; Patterson & Welfel, 1994). Conclusions about limitations in children’s inability to cope with diagnoses may be premature. The very experience of living with a mental health diagnosis, determined via
a diagnostic evaluation or counseling, unavoidably presents the child with information. Although historically parents/guardians have had the responsibility of choosing to disclose mental health diagnoses to their children, psychologists also play an important role in determining what children are told (Knussen & Brogan, 2002). Psychologists’ current disclosure practices are unknown and may be based upon clinical judgment (e.g., Gantt & Green, 1986; Green, 1984; Keightley & Mitchell, 2004; LoCicero, 1976; McDonald-Scott et al., 1992; Ross, 1974), years of clinical experience (e.g., McDonald-Scott et al., 1992), or the generalization of adult mental health (e.g., Hwang, 2008) or children’s medical (e.g., Mayer et al., 2005; Parsons et al., 2007) diagnoses disclosure literature. Thus, the development of appropriate children’s mental health diagnoses disclosure guidelines is imperative.

The existing research on psychologists’ mental health diagnosis disclosure practices is scarce. Current mental health diagnoses disclosure literature among children is not only limited, but also variable (Allmon et al., 2010; Pearson et al., 1999). Reviewing the adult mental health and children’s medical diagnoses disclosure literature suggests that psychologist characteristics like work setting (e.g., Patterson & Welfel; Woo & Keating, 2008) and years of clinical practice (e.g., McDonald et al., 1992), as well as client demographics such as diagnosis (e.g., Vaz et al., 2010), culture (e.g., Gupta et al., 2008), age (e.g., Chesler et al., 1986; Claflin & Barbarin, 1991), and cognitive ability (e.g., Abadia-Barrero & LaRusso, 2006) influence disclosure decisions; however there are limitations and challenges to applying this literature to children’s mental health diagnoses disclosure. Therefore, it is unclear if these practices would be found among
mental health diagnoses disclosure. Clearly, there is a need to understand psychologists’
current mental health diagnoses disclosure practices.

**Current Study**

This study had six aims: (1) investigate the influence that the settings in which psychologists work (e.g., counseling, diagnostic evaluations, or both) have on the conditions under which they disclose mental health diagnoses to children; (2) examine the impact that years of clinical experience has on the conditions under which they disclose mental health diagnoses to children; (3) evaluate the conditions (i.e., culture, age, and cognitive ability) under which psychologists disclose mental health diagnoses to children; (4) explore psychologists’ reasons for disclosure or non-disclosure; (5) explore the impact that mental health diagnoses have on psychologists’ mental health diagnoses disclosure practices to children; and (6) investigate psychologists’ current mental health diagnosis disclosure practices. This study included three methods of exploration: demographic questions, an analogue methodology, and open-ended questions.

To address the first, second, third and fourth aim, the study surveyed practicing psychologists who work with children concerning the provision of diagnostic information in a set of clinically heterogeneous vignettes. Psychologists were presented with six unique vignettes that were identical with one exception, each varied on one client characteristic, either age, culture, or cognitive ability. Following each vignette, participants provided a Likert scale response indicating their likelihood of disclosure and a written response to the question, “On what basis did you make your disclosure decision for X (name of the child in the vignette)?” A research team using content analysis then coded these open-ended responses. The relationship between the response profiles,
developed on their replies to demographic questions, of psychologists working in settings which provide counseling versus diagnostic evaluations and those with low, moderate, and high years of clinical experience was evaluated. The fifth and sixth aims were explored through open-ended questions inviting psychologists to both identify mental health diagnoses that they are more or less likely to disclose and to describe their current disclosure practices with children.

This study provides initial frequency data to offer psychologists with a general metric against which to measure their disclosure practices. Instead of merely examining psychologists’ practice in isolation, a more interesting, and generalizable approach is to examine the interface among variables – e.g., how psychologist (i.e., work setting and years of clinical practice) and client (i.e., age, culture, cognitive ability) characteristics interact to inform clinical practice. Therefore, this study examines psychologists’ mental health diagnosis disclosure practices to children as a function of three variables from adult psychiatric and child medical diagnosis disclosure literature: culture, age, and cognitive ability. Using an analogue paradigm, it investigates the ways in which these salient variables inform psychologists’ willingness to disclose mental health diagnoses to children.

Overall, this structure of quantitative and written responses to both analogue and open-ended questions allowed researchers to better understand current mental health diagnoses disclosure practices to children providing an initial step towards the development of practice guidelines for the disclosure of mental health diagnoses to children.
Research Questions

To address limitations in the literature regarding psychologists’ mental health diagnoses disclosure to children current practices, the following Research Questions (RQ) are explored:

RQ1. Does the likelihood of disclosing mental health diagnoses to children vary as a result of the setting in which psychologists provide services?

RQ2. Does the likelihood of disclosing mental health diagnoses to children vary as a result of the number of years that psychologists have been in clinical practice?

RQ3. Do the conditions, culture, age, and cognitive ability, increase or decrease the likelihood of psychologists mental health diagnoses disclosure to children practices?

RQ4. Are there mental health diagnoses that psychologists are more or less likely to disclose to children?

RQ5. How do psychologists describe their mental health diagnoses disclosure practices with children?

RQ6. What reasons do psychologists give for the disclosure of mental health diagnoses to children?
CHAPTER III

METHODOLOGY

Rationale for Use of an Online Analogue

Methodology Approach

As the present study utilized an analogue methodology, an exploration of the advantages and limitations of this methodology is warranted. An analogue study refers to an investigation that attempts to replicate a real life situation. It is commonly utilized when the researcher hopes to gain greater experimental control over the independent variables. Analogue studies employ videotape (Burkard, Juarez-Huffaker & Ajmere, 2003), audiotape (Burkard, Ponterotto, Reynolds, & Alfonso, 1999) or written scenarios as stimuli (Dorland & Fischer, 2001). Through vignettes a parallel experience is created in which the constraints of availability and access to real situations are overcome (Gerbert et al., 2003). In the present study, for example, variables, such as client presenting problem, were held constant and others (i.e., culture, age, cognitive ability) manipulated in isolation. Analogue designs increase internal validity, affording researchers a level of control not found in field studies (Aruguete & Roberts, 2002). However, because in actual practice additional contextual information is present, analogue studies only provide an approximation of actual behavior. Although generalizability in analogue studies is limited, it does allow researchers to make claims about causation and more clearly define the observed phenomena (Heppner, Kivlighan & Wampold, 1999). Furthermore, analogue studies are often used when interventions with real clients are impractical and impossible due to ethical constraints (Shapiro et al., 1992).
Heppner et al. (1999) emphasize that the potential strengths and weaknesses for any methodology depend upon what has previously been completed in the area of study. Due to the lack of empirical investigation exploring psychologists’ current mental health diagnoses disclosure practices with children, the current study design was informed by research methodology used to examine other disclosures. A variety of methodologies such as analogue design (e.g., McDonald-Scott et al., 1992), qualitative interviews (e.g., Hatton et al., 2003), open-ended written responses (Allmon et al., 2010), and case study methodology (Gupta et al., 2008) have been used in the adult psychiatric mental health and child medical diagnosis disclosure literature. By combining both an analogue paradigm with open-ended questions the present study sought to broaden the methodology used to create a richer understanding of current mental health diagnosis disclosure practices with children. Open-ended questions were designed to develop a deeper understanding of participants’ current mental health diagnosis disclosure practices with children (Neuendorf, 2002). Analogue methodology is a good complement to strict qualitative approach, as multiple facets of disclosure practices can be better understood. This methodology provides the opportunity for the initial exploration of psychologist decision making coupled with findings in the literature that suggest psychologist (e.g., years of clinical practice and services provided) and client (e.g., culture, age, cognitive ability) characteristics may influence disclosure decision making.

The rationale for the use of an analogue study design was based on the following: (a) the researchers were interested in understanding how a specified set of client characteristics (i.e., vignette types [i.e., culture, age, cognitive ability]) and conditions [i.e., HEDR and LEDR]) impacted the likelihood of psychologists mental health
diagnoses disclosure practices with children, (b) the researcher sought both high internal validity and experimental control over contextual variables so that they could be isolated, (c) disclosure interventions with real clients were both impractical and impossible due to many constraints of availability and access of disclosure situations with children, (d) the ability to minimize ethical constraints because the potential client benefit or harm as a result of diagnosis disclosure remains unknown, and (e) the researcher sought an opportunity to explore a nascent area of psychologists current practices, both quantitatively and through open-ended questions, while incorporating findings from related literature.

The current study combined analogue methodology with the Internet. It was decided that the survey would be presented online for a number of reasons. Primarily, online methodologies offer valuable internal validity for psychology research (Kraut, Olson, Banaji, Bruckman, Cohen, & Cooper, 2004). Additionally, online research was considered more cost-effective, as it is less expensive and easier to conduct than paper-and-pencil methods (Kraut et al., 2004). Further, conducting online research may minimize data entry errors and result in higher response rates in target samples when compared to paper-and-pencil research. As with all forms of data collection, concerns exist about using online methodology (Kraut et al., 2004). Specifically, participants may not take the survey seriously and researchers lack the control to ensure environmental consistency. For example, participants may take the survey in vastly different environments, which may impact their responses. Online research is also subject to self-selection bias and drop out. As such it is difficult to calculate a response rate, as is seen in the present study. Confidentiality and privacy with online research, as with all
methodologies, are areas of ethical concern. Particularly, when information is transmitted online confidentiality cannot be guaranteed. Despite the limitations, Gosling et al.’s (2004) review concluded that the data obtained online are at least as good as data obtained in more traditional paper-and-pencil methods.

Measures

Due to the lack of previous research examining mental health diagnoses disclosure to children, there were no specific measures assessing this construct. Therefore, the survey presented in this section was developed specifically for this study. The survey was then pilot tested with a sample of 5 licensed psychologists and 9 graduate students who work in a setting where they work with children who have mental health diagnoses. Pilot participants were asked to complete the survey and provide comments and suggestions for improvement following each question and vignette, as well as overall thoughts about the survey. Because the survey was created for this study, both its content and development are discussed.

Development of a children’s mental health diagnoses disclosure survey

To assess psychologists’ current mental health diagnoses disclosure practices with children, the Children’s Mental Health Diagnoses Disclosure Survey was developed for this study (See Appendix D). It is modeled on a similar analogue survey from previous research (McDonald-Scott et al., 1992) exploring psychiatrists mental health diagnoses disclosure practices with adults, using principles outlined by Dillman, Smyth, and Christian (2009). Although Dillman et al. (2009) recommend against open-ended questions in a written survey, it was decided that these questions were a necessary
adjunct to the analogue format, given that this is one of the first explorations of mental health diagnoses disclosure to children. The survey is comprised of the following three parts: background information form, vignettes and diagnoses disclosure Likert scale, and open-ended questions exploring current mental health diagnoses disclosure practices with children.

**Background Information Form.** The background information form, designed for the current study, collects basic demographic information as well as affirmation of eligibility criteria. The nine questions on this form serve three purposes: (1) to confirm that participants are psychologists and are currently employed in a position where they diagnose mental health diagnoses in individuals under the age of 18 years old, thus meeting eligibility criteria, (2) to obtain demographic information (e.g., gender, ethnicity, ABPP specialty), and (3) to determine the services provided by participants (e.g., counseling services, diagnostic evaluations, or both) and psychologists years of clinical experience following internship. The background information form was intentionally kept short as recommended by Dillman et al. (2009). Demographic information was obtained in order to provide descriptive statistics of the sample, so that it may be comparable to future research about mental health diagnosis disclosure. The final two questions on the background information form (e.g., years of clinical service and type of services provided) were asked in order to identify psychologist characteristics that may influence diagnosis disclosure (e.g., address Research Questions 1 and 2). Psychologist characteristics, years of clinical service and type of services provided, were discerned from the minimal disclosure research. Individuals typically receive mental health diagnoses through one of two avenues: clinical services (e.g., therapy; Patterson &
Welfel, 1994) and diagnostic evaluations (Woo & Keating, 2008). Through the question, “At the setting in which I diagnose children with mental health diagnoses I provide which of the following services?”, researchers sought to determine if there was an impact on disclosure practices depending upon the avenue through which it was received. Although information is not available among the child mental health disclosure literature, there is evidence suggesting that psychiatrists with more years of clinical experience are more likely to disclose diagnoses to adult patients (McDonald-Scott et al., 1992). Therefore the final question on the background information form was developed, “Please indicate the number of years you have provided clinical service?”

**Vignettes.** Six vignettes were created for this study. Each vignette depicted a client featuring one (of three) vignette types and one (of two) vignette conditions. The vignette three types, culture, age, and cognitive ability, were derived from the child medical and adult psychiatric diagnosis disclosure literature to represent factors that may influence mental health diagnoses disclosure practices to children. In addition to the types, the vignettes also varied based on condition. These conditions were designed to represent demographics that, based on the literature, would maximize differences in culture, age, and cognitive ability. Two vignette conditions were identified (i.e. Higher Expected Disclosure Ratings [HEDR] and Lower Expected Disclosure Ratings [LEDR]). The HEDR condition vignettes were hypothesized, from evidence in the adult mental health and child medical diagnoses disclosure literature, to result in higher diagnosis disclosure likelihood ratings, while the LEDR condition vignettes were hypothesized to result in lower diagnosis disclosure likelihood. Therefore, two vignette conditions (i.e.,
HEDR and LEDR) were developed for each of the three vignette types (i.e., culture, age, cognitive ability). Thus, six total vignettes were generated.

The culture type vignettes were based on the parent/guardian mental health disclosure literature (Hatton et al., 2003), adult mental health literature (Hwang, 2008; McDonald-Scott et al., 1992; Yeung & Kam, 2008), and pediatric oncology literature (Gupta et al., 2008; Mayer et al., 2005; Parsons et al., 2007) that suggests that cultural determinants may influence psychologists’ mental health diagnoses disclosure practices with children. The preponderance of this literature has reported less disclosure of mental health diagnoses with Asian-American adults for worry of greater stigma for patients with traditional illness beliefs (Gupta et al., 2008; Hwang, 2008; Yeung & Kim, 2008). Consistent with this literature, the conditions for the culture type vignette pair were comprised of the following: the Higher Expected Disclosure (HEDR) condition depicted a Caucasian child of European descent, and the Lower Expected Disclosure (LEDR) condition described a Chinese-American child.

The age type vignettes, like the culture type vignettes, were based on medical diagnoses disclosure studies examining both cancer (e.g., Claflin & Barbarin, 1991) and HIV (e.g., Abadia-Barrero & LaRusso, 2006; Aiges, 2008), which indicate that diagnoses disclosure increases with age. In Clafin and Barbarin’s (1991) exploration of children diagnosed with cancer found that children under the age of 9 years old were provided with less information, while those over the age of 14 were told more. Similarly, Dematteo et al. (2002) found that the average age of HIV disclosure was 10 years old. Therefore, in the age vignette pair the conditions consisted of the following: the Higher
Expected Disclosure (HEDR) condition depicted an older child (16 years old), and the Lower Expected Disclosure (LEDR) condition described a younger child (6 years old).

Cognitive ability, the final varying vignette type, was cultivated on the empirical evidence suggesting that the amount of information children were provided about their medical illness was commensurate with their cognitive ability level. Wiener et al.’s (2007) review of the HIV literature reported that children with higher intellectual abilities were provided more information about their diagnosis. Consistent with the medical literature, preliminary data in one study suggests that parents of high ability children are likely to disclose diagnoses of learning disabilities and/or ASD (Allmon et al., 2010).

Thus the conditions for the cognitive ability type vignette pair were comprised of the following: the Higher Expected Disclosure (HEDR) condition depicted a child functioning in the Superior Range (FSIQ= 120), and the Lower Expected Disclosure (LEDR) condition described a child functioning in the Borderline Range (FSIQ= 79).

Variability in presentation, language, sentence structure, and client demographic information in each vignette was limited to the characteristic of interest (e.g., age, culture, cognitive ability).

Table 3

<table>
<thead>
<tr>
<th>Vignette Condition</th>
<th>Culture</th>
<th>Age</th>
<th>Cognitive Ability</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEDR</td>
<td>American</td>
<td>16 years old</td>
<td>Superior FSIQ</td>
</tr>
<tr>
<td>LEDR</td>
<td>Chinese American</td>
<td>6 years old</td>
<td>Borderline FSIQ</td>
</tr>
</tbody>
</table>

Note: HEDR= Higher Expected Disclosure Ratings; LEDR= Lower Expected Disclosure Ratings.
For example, in the cognitive ability vignettes pair, age, culture, presenting concerns, academic, social, and family history were controlled, such that only the details surrounding cognitive ability varied (e.g., WISC-IV scores). See Table 3 for a visual presentation of the six vignettes by type and condition.

After reading each of the six vignettes, the participants were instructed to respond to two questions based on the vignette. These questions were designed for the current study and are modeled after those developed by McDonald-Scott, Machizawa, and Satoh (1992) in their study of mental health diagnoses disclosure practices to adults. First, participants used a Likert scale to report their likelihood of disclosure to the child described in the vignette by answering the question, “What would you tell X (i.e., child’s name in vignette)?” This item is anchored on a 10 point Likert scale. Higher scores indicate disclosure of more information to the child in the vignette (e.g., 1= Even if asked, I would not tell him/her any information about the diagnosis or the name of the diagnosis; 10= I would tell him/her the name of the diagnosis and give a thorough explanation of it (e.g., treatment, prevalence). Second, participants provided a vignette elicited disclosure reason, or written explanation for their disclosure decision, by answering the question, “On what basis did you make your disclosure decision for X (i.e., child’s name in vignette)?”

**Open-ended questions.** Following the vignettes, participants responded to two open-ended questions. These questions were a necessary adjunct to the analogue study, because it is one of the first to explore mental health disclosure. First, participants responded to the question, “Are there diagnoses that you are more or less likely to disclose to children? Please describe.” The adult mental health literature suggests that
characteristics inherent in specific diagnoses, such as prevalence, associated stigma, and treatment, may influence disclosure practices. Overwhelmingly, the literature provides evidence that psychiatrists are less likely to disclose diagnoses with strong negative stigmas, such as schizophrenia, than diagnoses of anxiety or depression to adults (e.g., Clafferty et al., 2000; Gantt & Green, 1986; Paccaloni et al., 2005). Due to the infancy of this area of research and the sheer number of mental health diagnoses, the exploration of disclosure practices for specific mental health diagnoses was beyond the scope of this study. Therefore, this researcher sought to provide an initial exploration to determine if psychologists included mental health diagnoses in their disclosure decision-making process. The final survey question, “Please provide information (e.g., considerations for disclosure or non-disclosure, your decision making process) about your mental health diagnoses disclosure practices with children”, gave participants the opportunity to describe their disclosure practices.

**Administration and data collection website.** Survey materials were provided to participants via the secure, internet website, www.qualtrics.com. According to Hite (2011), Qualtrics administrator, the website has certified that it adheres to the Safe Harbor Privacy Principles of notice, choice, onward transfer, security, data integrity, access, and enforcement. Additionally Qualtrics has Transport Layer Security (TLS) encryption (HTTPS), SAS 70 Certification, and hides Qualtrics accounts behind passwords and all data is protected with real-time data replication.

**Pilot testing.** Dillman et al. (2009) also recommends reviews of the survey prior to sending it to participants. This survey was piloted with 5 local licensed psychologists (not ABPP certified) and 9 Counseling and School Psychology Ph.D. level graduate
students from a large Midwestern University who work with children to improve clarity and content of the survey. See Table 4 for pilot study demographic information.

Participants were recruited via a personal email message for psychologists or an email message sent to a doctoral program listserv (See Appendix A). The email message contained a link to the online survey (See Appendix B).

Table 4

*Characteristics of Pilot Sample*

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>29</td>
</tr>
<tr>
<td>Female</td>
<td>10</td>
<td>71</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>White</td>
<td>13</td>
<td>93</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Current Position</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Graduate Student</td>
<td>9</td>
<td>64.3</td>
</tr>
<tr>
<td>Licensed Psychologist</td>
<td>5</td>
<td>35.7</td>
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<tr>
<td>Primary Work Setting</td>
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<td>%</td>
</tr>
<tr>
<td>Clinic</td>
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<td>29</td>
</tr>
<tr>
<td>Hospital</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>Medical School/Academic Medical Center</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>Schools/Educational Setting</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>University Setting</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Setting Service Provided</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Both Counseling Services and Diagnostic Evaluations</td>
<td>8</td>
<td>57</td>
</tr>
<tr>
<td>Counseling Services Only</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Diagnostic Evaluations Only</td>
<td>6</td>
<td>43</td>
</tr>
<tr>
<td>Terminal Degree</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Ph.D.</td>
<td>14</td>
<td>100</td>
</tr>
<tr>
<td>Years of Clinical Service</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>0-13 years</td>
<td>12</td>
<td>85</td>
</tr>
<tr>
<td>14-31 years</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>&gt;32 years</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

Note: N=14
All questions on the survey were pilot tested and pilot participants were both provided the opportunity and encouraged to give feedback on any items (See Appendix B). During this pilot study the vignettes were reviewed to determine if they appropriately demonstrate each of the three types (i.e., culture, age, and cognitive ability) and thus establish vignette content and face validity. The pilot study vignettes accurately portrayed the factor intended (i.e., culture, age, cognitive ability) with the one exception, the American culture vignette (See Table 5 for results).

Table 5

*Pilot Study of Vignette Represented Salient Factors*

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Cognitive Ability</th>
<th>Age</th>
<th>Culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. American</td>
<td>36%</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>2. Chinese American</td>
<td>14%</td>
<td>21%</td>
<td>64%</td>
</tr>
<tr>
<td>3. Age 6</td>
<td>14%</td>
<td>86%</td>
<td></td>
</tr>
<tr>
<td>4. Age 16</td>
<td></td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>5. Superior FSIQ</td>
<td>62%</td>
<td>38%</td>
<td></td>
</tr>
<tr>
<td>6. Borderline FSIQ</td>
<td>85%</td>
<td>15%</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* N= 14. Table 5 provides the percent of pilot participants who indicated it was the most salient factor for each vignette.

In order to increase the face and content validity, the American culture vignette was altered. In accordance with suggestions made by pilot study participants the American culture vignette was elaborated with the inclusion of details that the child is of European decent and that his/her great grandparents immigrated to the United States and his/her family has resided in the United States since that time. Additional suggestions, provided in the open-ended section of the pilot study, aided in structuring the vignettes so
that they are clear in what they measure. Information obtained from the pilot study was used to make appropriate alterations and elaborations to the vignettes. These suggestions included the following: (1) Chinese culture vignette (e.g., culture type, LEDR condition) includes a traditional Chinese name, that the child is a second generation American citizen, that his/her great grandparents immigrated to the United States from China and his/her family has resided in the United States since that time; (2) both age vignette conditions (e.g., HEDR and LEDR condition) include the child’s grade level in school; and (3) both cognitive ability vignettes (e.g., HEDR and LEDR condition) include WISC-IV Index Scores and academic school placement (e.g., HEDR vignette condition - gifted and talented programming; LEDR vignette condition- Individualized Education Plan).

There were no suggestions or needs for alterations on the background information form, Likert scale, or open-ended questions provided by pilot participants as such they remained in their original form for the final study. After this review, it was determined that 15-20 minutes was typically needed to complete the survey.

The results of pilot testing were also analyzed quantitatively and through concept analysis. Conceptual analysis, using frequency coding, was completed with the pilot participant responses as training for the coders as well as the development of an initial pilot codebook. Interrater reliability was almost perfect (0.81-1.00; Landis & Koch, 1977) as Krippendorff’s $\alpha$ ranged from 0.92-0.98 for the three pilot study open-ended questions.

**Procedure**

The Institutional Review Board at the University of Iowa approved all procedures. The population from which the sample was drawn consisted of licensed psychologists
who hold American Board of Professional Psychology (ABPP) certification(s). ABPP certified psychologists were sent an invitation to participate via the ABPP listserv. The invitation included a brief description of the study and instructions to access the study’s website at www.qualtrics.com (See Appendix C).

Participants who expressed interest in the study clicked on or cut and pasted the survey link into their web browser. Upon accessing the website page, participants were immediately presented with the online informed consent outlining eligibility for participation, purpose of the study, procedures for study participants, estimation of time needed to complete the study, potential risks and benefits for participants, risks to confidentiality, and the rights of voluntary participation, followed by the subsequent measures (See Appendix D). The informed consent page instructed participants that selecting the “next button” served as their consent to participate. Following participant provision of consent, they were then transferred to the background information form including eligibility criteria questions. If respondents were licensed psychologists currently working with children with mental health diagnoses they were directed to complete the online survey; however, if they did not meet eligibility criteria they were immediately routed to the end of the survey and were not able to participate. Then, participants were presented with: (a) the six vignettes, each followed by mental health diagnoses disclosure Likert scale, followed by (b) a request for participants’ to describe their reasons for their disclosure decision for the preceding vignette, and (c) two open-ended questions exploring current disclosure practices. Upon survey completion, a webpage expressed appreciation to each participant for their time and contribution to the
research project and contact information for the researcher should any questions or concerns arise.

**Data Analytic Strategy**

This mixed-methods analogue study used vignettes to investigate psychologists’ current mental health diagnosis disclosure practices to children. It employed both quantitative analyses and concept analysis of open-ended questions. Although it would have been preferable to analyze the quantitative data via a Four Way Repeated Measures Analysis of Variance (ANOVA), due to the small sample size (N=47) this analysis could not be conducted. Thus the quantitative analyses utilized in this study were two 3-way mixed between-within subjects Repeated Measures of Analysis of Variance (ANOVA), with post-hoc analyses completed when appropriate. An ANOVA (Analysis of Variance) is a statistical analysis that estimates the differences between group responses or a test to determine differences in means (Trochim, 2001). A Repeated Measures Analysis of Variance provides an analysis of variance when the participants are measured once (i.e., Likert scale disclosure decision) under each of multiple conditions (i.e., three vignette type pairs and two conditions; Vogt, 1999). Repeated measure designs are a common methodology used in both psychological and behavioral science research (Keselman et al., 1998). This methodology addressed Research Questions one, two, and three, by assessing for main and interaction effects. Although ANOVA statistics are sensitive to violations of their derivational assumptions (Keselman & Keselman, 1993), when assumptions are met this design is appropriate for studies with smaller sample sizes, allows for the exploration of interactions between factors, and minimizes type I error (Keselman, Algina, & Kowalchuk, 2001). The necessary assumptions (e.g.,
sphericity, residual variation, homogeneity of inter-correlations, homogeneity of variance; Vogt, 1999) were verified prior to conducting these statistical analyses. Data analysis consisted of the following steps: (1) descriptive statistics were computed for all relevant variables; (2) participants’ reported years of practice were analyzed to identify thirds to group high, moderate, and low years of service; (3) Research Questions 1, 2, and 3 were analyzed using repeated measure 3-way analyses of variance (ANOVA’s); and (4) Research Questions 4, 5, and 6 were analyzed via conceptual analysis. As such, each analysis for the six previously stated Research Questions will be discussed separately. Since Research Question 3 could be analyzed by either the first or second 3 Way ANOVA, for clarity it will be discussed and analyzed under the second 3 Way ANOVA (with Research Question 2).

**Research Question 1.** To address Research Question 1, a 3 x 3 x 2 repeated measures design was employed, with one between-subjects factor (setting services) and two within-subject factors (vignette type and condition). The independent variables included were setting (three levels: counseling services, diagnostic evaluations, and both counseling and evaluations); vignette type (three levels culture, age, cognitive ability); and vignette condition (two levels: HEDR and LEDR). The one dependent variable is the Likert scale score responses measuring disclosure of mental health diagnoses.

**Research Questions 2 and 3.** Similar to the analysis of Research Question one, a 3 x 3 x 2 repeated measures design was employed to address Research Questions two and three, with one between-subjects factor (years of clinical service) and two within-subject factors (vignette type and condition). The independent variables included were years of service (three levels: low, moderate, high); vignette type (three levels culture, age,
cognitive ability); and vignette condition (two levels: HEDR and LEDR). The one
dependent variable is the Likert scale score responses measuring disclosure of mental
health diagnoses. Prior to conducting this 3 way ANOVA participants’ reported years of
practice were analyzed to identify thirds to group high, moderate, and low years of
service. This method of dividing the number of clinic years into an evenly distributed,
more easily understood grouping (e.g., thirds) is modeled on a similar analogue survey
from previous research (McDonald-Scott et al., 1992). McDonald-Scott et al. (1992)
explored psychiatrists mental health diagnoses disclosure practices with adults, and
provided evidence suggesting that psychiatrists with more years of clinical experience are
more likely to disclose diagnoses to adult patients. Creating a categorical years variable
(e.g., low, moderate, high years) from the original continuous years variable (e.g., 0-45
years) enabled the researcher to compare results with the McDonald et al. (1992) findings
(See Discussion section).

**Research Questions 4, 5, and 6.** All open-ended responses, Research Questions 4, 5, and 6, were analyzed via conceptual analyses. A three person research team
including the author of this study, a faculty advisor, and one counseling psychology
graduate student completed the open-ended concept analysis. Conceptual analysis, also
called thematic analysis, is a scientific method involving the reduction of textual material
into manageable units of data that are then classified according to their meaning into
quantifiable content categories (Neuendorf, 2002). The goal of this analytic method is to
focus on the occurrence of codes within a text. First, researchers read the data for themes
and compiled code lists. Following the ideas of Glaser (1992), these codes were data-
driven, rather than from preexisting categories, and were recorded. Preliminary
codebooks (one for each of the three Research Questions, 4, 5, and 6) composed of the research teams overlapping and distinct themes were developed. Codes were structured based on Boyatzis’ (1998) definition of a meaningful code and as such included the following qualities: (1) a label, (2), definition of what the code concerns, (3), description of how to know when the code occurs, (4) description of any qualifications or exclusions to the identification of the code, and 5) examples, both positive and negative, to eliminate possible confusion when looking for the code.

Once a preliminary codebook was established for each of the three open-ended questions, interrater reliability was established for each set of codes by randomly selecting 10 units of text that were coded separately. Interrater reliability was calculated to use some means of checking for accuracy in coding, as it strengthens the overall trustworthiness of the data (Morrow, 2005). Krippendorff’s (2004) $\alpha$ was chosen to check interrater reliability because it is applicable to two coders, accepts missing data, and is sensitive to small sample sizes. Additionally Krippendorff’s (2004) $\alpha$ measures disagreements instead of being a mere correction of percent agreement. As suggested by Hayes and Krippendorff (2007), we sought a conservative minimum interrater reliability of 80% before coding of all units commenced. Krippendorff’s $\alpha$ was calculated and a minimum interrater reliability of 80% was achieved for all questions (see Table 6). Consistent with conceptual analysis methods, frequency coding was implemented. The codes were then themed to generate more abstract constructs as Auerbach & Silverstein (2003) recommended when using conceptual analysis.
Table 6

*Open Ended Questions Interrater Reliability*

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Research Question</th>
<th>Krippendorff’s ( \alpha )</th>
<th>Percent Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnoses More/Less</td>
<td>4</td>
<td>0.93</td>
<td>94.52</td>
</tr>
<tr>
<td>Disclosure Practices</td>
<td>5</td>
<td>0.92</td>
<td>93.59</td>
</tr>
<tr>
<td>Vignette Elicited Disclosure Reasons</td>
<td>6</td>
<td>0.89</td>
<td>90.84</td>
</tr>
<tr>
<td>American (Culture Type/HEDR Condition)</td>
<td></td>
<td>0.87</td>
<td>88.50</td>
</tr>
<tr>
<td>Chinese-American (Culture Type/LEDR Condition)</td>
<td></td>
<td>0.98</td>
<td>98.27</td>
</tr>
<tr>
<td>16 years old (Age Type/HEDR Condition)</td>
<td></td>
<td>0.88</td>
<td>89.86</td>
</tr>
<tr>
<td>6 years old (Age Type/LEDR Condition)</td>
<td></td>
<td>0.93</td>
<td>94.20</td>
</tr>
<tr>
<td>Borderline FSIQ (Cog. Ab. Type/HEDR Condition)</td>
<td></td>
<td>0.84</td>
<td>86.78</td>
</tr>
<tr>
<td>Superior FSIQ (Cog. Ab. Type/LEDR Condition)</td>
<td></td>
<td>0.84</td>
<td>86.10</td>
</tr>
</tbody>
</table>

CHAPTER IV

RESULTS

Quantitative Analyses

This chapter will present both quantitative and open-ended results. The results will be presented in the following order: 1) participants, descriptive statistics, and related analyses (e.g., psychologists characteristics), 2) power analysis for all quantitative results, 3) diagnoses disclosure rating means, 4) results of three way ANOVA exploring the influence of setting on diagnoses disclosure ratings (i.e., analysis of Research Question 1), 5) results of three way ANOVA exploring the influence of years of clinical experience and client demographics (i.e., vignette type and condition) on diagnoses disclosure ratings (i.e., analysis of Research Questions 2 and 3), 6) concept analysis results of the open-ended question exploring the impact of mental health diagnosis on disclosure (i.e., analysis of Research Question 4), 7) concept analysis results of the open-ended question exploring psychologists description of current disclosure practices (analysis of Research Question 5), and finally 8) concept analysis of the vignette elicited open-ended responses (analysis of Research Question 6). The influence of client demographics on disclosure ratings (e.g., Research Question 3) could be analyzed simultaneously with the three way ANOVA for either setting (Research Question 1 analysis) or clinic years (Research Question 2 analysis). To aid in reader clarity, the influence of client demographics (Research Question 3) will be discussed, only once, with the clinic years three way ANOVA (Research Question 2).
Participants

The population from which the sample was drawn consisted of licensed psychologists who hold American Board of Professional Psychology (ABPP) certification(s). Originally it was desired to recruit child focused American Psychological Association (APA) division members. However, prior to conducting this study, APA released a policy against the solicitation of research participants over APA email lists (APA, 2012). Given this statement and policy change, alternative populations were sought out. The ABPP population was chosen due to the ABPP research committee’s expressed interest in completing the study and the rigorous training and evaluation completed by those who hold ABPP certifications. The ABPP is an organization that provides specialty certification in psychology. Board certification indicates that the psychologist has successfully completed the education, training, and experience requirements of a specialty in psychology, including an examination (ABPP, n.d.). There are 14 possible ABPP specialties. The ABPP committee that evaluates and approves research dissemination felt it was important that all ABPP certified members be given the opportunity to participate in the study. For example, an ABPP specialist certified in neuropsychology who assesses for mental health diagnoses and works solely with children would be an appropriate participant, while a member with the same certification might only see adults and consequently, not meet study criteria eligibility.

Descriptive Statistics. As a first step in the data analysis, descriptive statistics were examined. Survey data was reviewed for completeness and random responding. Overall, the survey yielded 56 psychologists who met eligibility criteria. Eighty–four percent of those who began the survey completed it and were included in the data
analysis of the study (n= 47). One participant was included who had any missing data points. This participant missed one quantitative item. The missing data was replaced by the group item average. Participants in this study were 47 psychologists who hold ABPP certification(s) and work in a position where they diagnose children with mental health diagnoses. Demographic information is reported in Table 7.

3132 ABPP certified specialists were emailed with an invitation to participate in the study. Coverage error was created by the complication of not knowing how many psychologists in each specialty meet eligibility criteria. The author made repeated efforts to obtain characteristics of the ABPP population as a means to determine response rate. The author corresponded with Drs. Sweet (ABPP Treasurer and Research Review Committee) and Cox (ABPP Executive Officer), but sufficient information was unavailable to reasonably estimate a response rate and thus, was not calculated (personal communication, April 28, 2013; personal communication; May 7, 2013).

Participation was equally divided among males (51.1%) and females (48.9%). Most participants were Caucasian (91.5%) and had attained their Ph.D. (93.6%). The 2012 ABPP Diversity Committee (Morris et al., 2012) reported that the majority of ABPP specialists were male (66%) and white (88%). The current sample was more equally divided among males and females; however, the ethnic demographics were similar to those found by the ABPP Diversity Committee. Participants’ clinical experience ranged from 6 to 45 years with a mean of 23.13 (SD= 11.9) years. As discussed in the methods section, participants’ reported years of practice were analyzed to split the data into three groups using the 33rd and 67th percentile (i.e., high [>32], moderate [14-31], and low [0-13] years of service) prior to conducting the analyses to
enable the comparison of current findings with McDonald-Scott et al’s (1992) study. 31.9% of participants had between 0-13 and 14-31 years, while 36.2% had 32 or more years of clinical experience. The majority of participants (48.9%) provided both counseling services and diagnostic evaluations to children, with the remaining participants delivering either counseling services (25.5%) or diagnostic evaluations (25.5%) only. Eight of the possible 14 ABPP certifications were represented in the current sample: Clinical Child and Adolescent Psychology (29.8%), Clinical Psychology (29.8%), Clinical Neuropsychology (19.1%), Counseling Psychology (10.6%), Cognitive Behavioral Psychology (6.4%), Clinical Health Psychology (2.1%), Couple and Family Psychology (2.1%), and School Psychology (2.1%). The participants worked in a variety of settings, the most frequent being independent practice (38.3%), university settings (19.1%), medical schools or academic medical centers (10.6%), hospitals (10.6%), and clinics (10.6%). Table 7 presents demographic data for the entire sample.

Table 7

<table>
<thead>
<tr>
<th>Characteristics of Study Sample</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>24</td>
<td>51.1</td>
</tr>
<tr>
<td>Female</td>
<td>23</td>
<td>48.9</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>43</td>
<td>91.5</td>
</tr>
<tr>
<td>Black</td>
<td>2</td>
<td>4.3</td>
</tr>
<tr>
<td>American Indian</td>
<td>1</td>
<td>2.1</td>
</tr>
<tr>
<td>Other</td>
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<td>2.1</td>
</tr>
<tr>
<td>ABPP Certified Specialty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Child and Adolescent Psychology</td>
<td>14</td>
<td>29.8</td>
</tr>
<tr>
<td>Clinical Psychology</td>
<td>14</td>
<td>29.8</td>
</tr>
<tr>
<td>Clinical Neuropsychology</td>
<td>9</td>
<td>19.1</td>
</tr>
<tr>
<td>Counseling Psychology</td>
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<td>Cognitive Behavioral Psychology</td>
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<td>6.4</td>
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Table 7 continued

<table>
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<tr>
<td>School Psychology</td>
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Primary Work Setting

<table>
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<tbody>
<tr>
<td>Independent Practice</td>
<td>18</td>
<td>38.3</td>
</tr>
<tr>
<td>University Setting</td>
<td>9</td>
<td>19.1</td>
</tr>
<tr>
<td>Hospital</td>
<td>5</td>
<td>10.6</td>
</tr>
<tr>
<td>Clinic</td>
<td>5</td>
<td>10.6</td>
</tr>
<tr>
<td>Medical School/Academic Medical Center</td>
<td>5</td>
<td>10.6</td>
</tr>
<tr>
<td>Community Mental Health</td>
<td>2</td>
<td>4.3</td>
</tr>
<tr>
<td>Other Academic Setting</td>
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<td>2.1</td>
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<td>Overseas Private Practice</td>
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Setting Service Provided

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</thead>
<tbody>
<tr>
<td>Both Counseling Services and Diagnostic Evaluations</td>
<td>23</td>
<td>48.9</td>
</tr>
<tr>
<td>Counseling Services Only</td>
<td>12</td>
<td>25.5</td>
</tr>
<tr>
<td>Diagnostic Evaluations Only</td>
<td>12</td>
<td>25.5</td>
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Terminal Degree

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<tbody>
<tr>
<td>Ph.D.</td>
<td>44</td>
<td>93.6</td>
</tr>
<tr>
<td>Psy.D.</td>
<td>2</td>
<td>4.3</td>
</tr>
<tr>
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<td>2.1</td>
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</table>

Years of Clinical Service

<table>
<thead>
<tr>
<th>Years</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (0-13 years)</td>
<td>15</td>
<td>31.9</td>
</tr>
<tr>
<td>Moderate (14-31 years)</td>
<td>15</td>
<td>31.9</td>
</tr>
<tr>
<td>High (&gt;32 years)</td>
<td>17</td>
<td>36.2</td>
</tr>
</tbody>
</table>

Note: N=47

Psychologist Characteristics:

Clinic Years and Setting Analyses. Two demographic characteristics, years of clinical experience and setting, were collected and analyzed to answer Research Questions 1 and 2. Thus prior to exploring these Research Questions, it is important to determine if there is a relationship between clinic years and setting that might influence their findings. Cross tabulation was performed to establish the distribution of psychologists with low, moderate, and high years of clinical experience across settings (See Table 8). Because of low expected cell frequencies, the chi-square test results are
not reported. However, since years of clinical experience was originally a continuous variable, an ANOVA was conducted using the original variable.

Table 8

Distribution of Years of Clinical Experience by Setting

<table>
<thead>
<tr>
<th>Setting</th>
<th>Low Years</th>
<th>Moderate Years</th>
<th>High Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Counseling</td>
<td>7 (58.33%)</td>
<td>2 (16.67%)</td>
<td>3 (25.00%)</td>
</tr>
<tr>
<td>Diagnostic</td>
<td>3 (25.00%)</td>
<td>5 (41.67%)</td>
<td>4 (33.33%)</td>
</tr>
<tr>
<td>Both</td>
<td>5 (21.74%)</td>
<td>8 (34.78%)</td>
<td>10 (43.48%)</td>
</tr>
<tr>
<td>Total</td>
<td>15 (31.9%)</td>
<td>15 (31.9%)</td>
<td>17 (36.17%)</td>
</tr>
</tbody>
</table>

The ANOVA yielded no significant differences between the mean years of experience for psychologists’ providing counseling, diagnostic evaluations, or both, $F(2, 44) = 2.40, p = 0.10$. The means and standard deviations for psychologists’ years of clinical experience across settings are presented in Table 9. Although the difference was not statistically significant at the chosen alpha level ($\alpha = 0.05$), there may in fact be a difference between these groups that went undetected. If the estimated effect size ($\text{partial } \eta^2 = 0.098$) is accurate the power of this hypothesis test was only 0.46.

Table 9

Mean Years of Clinical Experience by Setting

<table>
<thead>
<tr>
<th>Setting</th>
<th>Years of Clinical Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
</tr>
<tr>
<td>Counseling</td>
<td>18.08</td>
</tr>
<tr>
<td>Diagnostic Evaluations</td>
<td>21.33</td>
</tr>
<tr>
<td>Both</td>
<td>26.69</td>
</tr>
</tbody>
</table>
**Power Analysis.** On the basis of the current sample size (N=47), a power analysis was completed for both 3 Way Repeated Measures ANOVAs. Please see Table 10 for results.

### Table 10

*Power Analysis for All Quantitative Analyses*

<table>
<thead>
<tr>
<th>Source</th>
<th>Observed Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting</td>
<td>.31</td>
</tr>
<tr>
<td>Vignette Type</td>
<td>.68</td>
</tr>
<tr>
<td>Vignette Condition</td>
<td>&gt;.99</td>
</tr>
<tr>
<td>Condition X Type</td>
<td>&gt;.99</td>
</tr>
<tr>
<td>Type X Setting</td>
<td>.11</td>
</tr>
<tr>
<td>Condition X Setting</td>
<td>.067</td>
</tr>
<tr>
<td>Condition X Type X Setting</td>
<td>.19</td>
</tr>
</tbody>
</table>

*Power Analysis for Years of Clinical Service X Type X Condition 3 Way ANOVA (RQ 2 and 3 Analysis)*

<table>
<thead>
<tr>
<th>Source</th>
<th>Observed Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years</td>
<td>.61</td>
</tr>
<tr>
<td>Vignette Type</td>
<td>.73</td>
</tr>
<tr>
<td>Vignette Condition</td>
<td>&gt;.99</td>
</tr>
<tr>
<td>Condition X Type</td>
<td>&gt;.99</td>
</tr>
<tr>
<td>Type X Years</td>
<td>.18</td>
</tr>
<tr>
<td>Condition X Years</td>
<td>.83</td>
</tr>
<tr>
<td>Condition X Type X Years</td>
<td>.23</td>
</tr>
</tbody>
</table>

*Note:* N=47.

**Diagnosis Disclosure Rating Means**

The diagnosis disclosure Likert scale score means and standard deviations for all vignettes by setting (i.e., counseling only, diagnostic evaluations only, and both counseling and diagnostic evaluations) and years of clinical service (i.e., low, moderate, and high years) are contained in Table 11. Table 11 also provides overall means and standard deviations for each independent variable, setting, years of clinical service, and
each vignette type (i.e., culture, age, cognitive ability) and condition (i.e., HEDR, LEDR), investigated in the study.

Three Way Analysis of Variance:

Setting and Diagnoses Disclosure (Research Question 1)

Research Question 1 explored the how the likelihood of disclosing mental health diagnoses to children varied as a result of the type of setting in which psychologists provide services. To explore this Research Question, a 3 (setting [i.e., counseling, diagnostic evaluations, both]) x 3 (vignette type [i.e., culture, age, cognitive ability]) x 2 (vignette condition [i.e., HEDR, LEDR]) ANOVA was conducted on participants’ diagnosis disclosure ratings. Means and standard deviations are presented in Table 11. Results are illustrated in Table 12.

The 3 way ANOVA results fail to indicate that there is a main effect for the setting or vignette type variables, as well as an interaction effect between condition x type x setting, condition x setting, or type x setting on the dependent variable (disclosure ratings; See Table 12). However, the main effect for vignette condition and the vignette condition x vignette type interaction were significant. These results are not discussed further as they will be examined thoroughly in Research Question 3 below. Although Research Question 3, which explored the influence of child characteristics on disclosure ratings, could be analyzed conjointly with either the analysis of Research Question 1 or 2, for clarity it will be discussed and analyzed under the second 3 Way ANOVA (with Research Question 2). Though it appears that setting services psychologists provide, counseling service, diagnostic evaluations, or both, did not significantly impact their reported diagnostic disclosure practices among vignettes that varied based on type (e.g.,
### Table 11

**Means and Standard Deviations for Likert Scale Disclosure Decisions**

<table>
<thead>
<tr>
<th>Vignette Condition: Vignette Type</th>
<th>Counseling M</th>
<th>SD</th>
<th>Diagnostic Evaluations M</th>
<th>SD</th>
<th>Both M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition HEDR: Culture (American)</td>
<td>6.08</td>
<td>2.43</td>
<td>7.50</td>
<td>2.43</td>
<td>6.39</td>
<td>2.57</td>
</tr>
<tr>
<td>Age (16 years old)</td>
<td>7.25</td>
<td>2.43</td>
<td>8.58</td>
<td>2.02</td>
<td>8.00</td>
<td>2.04</td>
</tr>
<tr>
<td>Cognitive Ability (Superior FSIQ)</td>
<td>6.33</td>
<td>2.27</td>
<td>7.67</td>
<td>2.53</td>
<td>6.78</td>
<td>2.24</td>
</tr>
<tr>
<td>Condition LEDR: Culture (Chinese American)</td>
<td>4.92</td>
<td>1.93</td>
<td>6.92</td>
<td>2.43</td>
<td>5.78</td>
<td>2.35</td>
</tr>
<tr>
<td>Age (6 years old)</td>
<td>4.42</td>
<td>2.02</td>
<td>6.08</td>
<td>2.61</td>
<td>4.74</td>
<td>2.78</td>
</tr>
<tr>
<td>Cognitive Ability (Borderline FSIQ)</td>
<td>4.67</td>
<td>1.83</td>
<td>5.83</td>
<td>2.79</td>
<td>5.13</td>
<td>2.69</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years of Clinical Experience</th>
<th>Low (0-13 years) M</th>
<th>SD</th>
<th>Moderate (14-31 years) M</th>
<th>SD</th>
<th>High (&gt;32 years) M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition HEDR: Culture (American)</td>
<td>7.33</td>
<td>2.16</td>
<td>7.33</td>
<td>2.35</td>
<td>5.29</td>
<td>2.52</td>
</tr>
<tr>
<td>Age (16 years old)</td>
<td>8.33</td>
<td>1.63</td>
<td>9.20</td>
<td>1.01</td>
<td>6.53</td>
<td>2.32</td>
</tr>
<tr>
<td>Cognitive Ability (Superior FSIQ)</td>
<td>7.20</td>
<td>2.14</td>
<td>7.93</td>
<td>1.67</td>
<td>5.71</td>
<td>2.54</td>
</tr>
<tr>
<td>Condition LEDR: Culture (Chinese American)</td>
<td>5.53</td>
<td>1.92</td>
<td>6.93</td>
<td>2.22</td>
<td>5.18</td>
<td>2.56</td>
</tr>
<tr>
<td>Age (6 years old)</td>
<td>4.87</td>
<td>2.00</td>
<td>5.87</td>
<td>2.67</td>
<td>4.35</td>
<td>2.91</td>
</tr>
<tr>
<td>Cognitive Ability (Borderline FSIQ)</td>
<td>4.93</td>
<td>1.87</td>
<td>5.87</td>
<td>2.77</td>
<td>4.82</td>
<td>2.77</td>
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<thead>
<tr>
<th>Setting</th>
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<th>SD</th>
<th>Diagnostic Evaluation Only M</th>
<th>SD</th>
<th>Both Counseling and Diagnostic Evaluations M</th>
<th>SD</th>
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</thead>
<tbody>
<tr>
<td>Counseling Only</td>
<td>5.61</td>
<td>0.61</td>
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<td>Diagnostic Evaluation Only</td>
<td>7.09</td>
<td>0.61</td>
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<td></td>
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</tr>
<tr>
<td>Both Counseling and Diagnostic Evaluations</td>
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<td>0.44</td>
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<table>
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<th>Low Years M</th>
<th>SD</th>
<th>Moderate Years M</th>
<th>SD</th>
<th>High Years M</th>
<th>SD</th>
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</thead>
<tbody>
<tr>
<td>Low Years</td>
<td>6.37</td>
<td>0.52</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Moderate Years</td>
<td>7.19</td>
<td>0.52</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>High Years</td>
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<td>0.49</td>
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<table>
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<th>SD</th>
<th>Age M</th>
<th>SD</th>
<th>Cognitive Ability M</th>
<th>SD</th>
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<td>Culture</td>
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<tr>
<td>Age</td>
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<td>2.77</td>
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<tr>
<td>Cognitive Ability</td>
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Table 11 continued

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<th>Vignette Condition</th>
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<tr>
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<td>2.37</td>
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<td>LEDR</td>
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<table>
<thead>
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<th>Vignette Condition</th>
<th>Setting</th>
<th>Counseling</th>
<th>Diagnostic Evaluations</th>
<th>Both Counseling and Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>HEDR</td>
<td>6.5</td>
<td>2.32</td>
<td>7.91</td>
<td>2.32</td>
</tr>
<tr>
<td>LEDR</td>
<td>4.43</td>
<td>2.02</td>
<td>6.27</td>
<td>2.58</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vignette Type</th>
<th>Setting</th>
<th>Counseling</th>
<th>Diagnostic Evaluations</th>
<th>Both Counseling and Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Culture</td>
<td>5.08</td>
<td>2.48</td>
<td>7.21</td>
<td>2.39</td>
</tr>
<tr>
<td>Age</td>
<td>5.83</td>
<td>2.49</td>
<td>7.61</td>
<td>2.29</td>
</tr>
<tr>
<td>Cognitive Ability</td>
<td>5.50</td>
<td>2.49</td>
<td>6.75</td>
<td>2.79</td>
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</table>

<table>
<thead>
<tr>
<th>Years of Clinical Experience</th>
<th>Low (0-13 years)</th>
<th>Moderate (14-31 years)</th>
<th>High (&gt;32 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>HEDR</td>
<td>7.62</td>
<td>0.54</td>
<td>8.16</td>
</tr>
<tr>
<td>LEDR</td>
<td>5.11</td>
<td>0.54</td>
<td>6.22</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vignette Type</th>
<th>Years of Clinical Experience</th>
<th>Low (0-13 years)</th>
<th>Moderate (14-31 years)</th>
<th>High (&gt;32 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Culture</td>
<td>6.43</td>
<td>2.20</td>
<td>7.13</td>
<td>2.25</td>
</tr>
<tr>
<td>Age</td>
<td>6.60</td>
<td>2.51</td>
<td>7.53</td>
<td>2.60</td>
</tr>
<tr>
<td>Cognitive Ability</td>
<td>6.06</td>
<td>2.88</td>
<td>6.90</td>
<td>2.48</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Vignette Condition</th>
<th>Vignette Type</th>
<th>Culture</th>
<th>M</th>
<th>SD</th>
<th>Age</th>
<th>M</th>
<th>SD</th>
<th>Cognitive Ability</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEDR</td>
<td>(American)</td>
<td>6.6</td>
<td>2.5</td>
<td>7.96</td>
<td>2.1</td>
<td>6.89</td>
<td>2.3</td>
<td>(Superior FSIQ)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEDR</td>
<td>(Chinese American)</td>
<td>5.85</td>
<td>2.3</td>
<td>5.00</td>
<td>2.6</td>
<td>5.19</td>
<td>2.5</td>
<td>(Borderline FSIQ)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: N=47. HEDR= Higher Expected Disclosure Ratings; LEDR= Lower Expected Disclosure Ratings.
Table 12

Setting X Type X Condition 3 Way ANOVA

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>F</th>
<th>p</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Between subjects</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Setting</td>
<td>2</td>
<td>1.56</td>
<td>0.21</td>
<td>0.066</td>
</tr>
<tr>
<td>Vignette Type</td>
<td>2</td>
<td>2.84</td>
<td>0.060</td>
<td>0.084</td>
</tr>
<tr>
<td>Vignette Condition</td>
<td>1</td>
<td>138.14</td>
<td>&lt;.0001***</td>
<td>0.61</td>
</tr>
<tr>
<td>Condition X Type</td>
<td>2</td>
<td>15.59</td>
<td>&lt;.0001***</td>
<td>0.29</td>
</tr>
<tr>
<td>Type X Setting</td>
<td>4</td>
<td>0.23</td>
<td>0.92</td>
<td>0.015</td>
</tr>
<tr>
<td>Condition X Setting</td>
<td>2</td>
<td>0.22</td>
<td>0.79</td>
<td>0.005</td>
</tr>
<tr>
<td>Condition X Type X Setting</td>
<td>4</td>
<td>0.56</td>
<td>0.69</td>
<td>0.030</td>
</tr>
<tr>
<td><strong>Within subjects</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Note: N=47. *p<.05; **p<.01; ***p<.001
culture, age, ability) or condition (e.g., HEDR and LEDR), these results must be interpreted with caution given that there may in fact be a difference between these groups that went undetected due to the limited power of this test.

**Three Way Analysis of Variance: Years of Clinical Experience, Client Demographics, and Disclosure**

(Research Questions 2 and 3)

One 3 (years of clinical service [i.e., low, moderate, high]) x 3 (vignette type [i.e., culture, age, cognitive ability]) x 2 (vignette condition [i.e., HEDR, LEDR]) ANOVA was completed to explore the influence of years of clinical service and client demographics on diagnoses disclosure ratings. The means and standard deviations are presented in Table 11. ANOVA results are illustrated in Table 13.

This 3 way ANOVA yielded significant interaction effects for condition x years and condition x type, as well as main effects for: years, type, and condition. However, the condition x type x years and type x years interactions did not reveal any significant results. For clarity, the aforementioned 3 Way ANOVA results will be discussed as they relate to each individual Research Question below. Research Question 2 explored how the likelihood of disclosing mental health diagnoses to children varied as a result of the number of years that psychologists have been in clinical practice, while Research Question 3 explored if the conditions of culture, age, and cognitive ability increase or decrease the likelihood of psychologists’ mental health diagnoses disclosure to children practices.
### Table 13

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>F</th>
<th>p</th>
<th>Adj p</th>
<th>η²</th>
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<tbody>
<tr>
<td><strong>Between subjects</strong></td>
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<td></td>
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<td></td>
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<td>Years</td>
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<td>3.45</td>
<td>0.0335*</td>
<td>0.13</td>
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<tr>
<td>Vignette Type</td>
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<td>3.46</td>
<td>0.0331*</td>
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<tr>
<td>Vignette Condition</td>
<td>1</td>
<td>172.99</td>
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<td>Condition X Type</td>
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<td>21.22</td>
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<td>Type X Years</td>
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<tr>
<td>Condition X Years</td>
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<td>Condition X Type X Years</td>
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<tr>
<td><strong>Within subjects</strong></td>
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<td>Simple Effects Test</td>
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<tr>
<td>Simple Effects by Condition</td>
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<td>Low Years</td>
<td>1</td>
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<td>Moderate Years</td>
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<td>&lt;.0001***</td>
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<td>High Years</td>
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<td>&lt;.0001***</td>
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<td>Simple Effects by Years</td>
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<tr>
<td>LEDR</td>
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<td>HEDR</td>
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<td>Simple Effects by Type</td>
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<td>LEDR</td>
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<td>&lt;.0001***</td>
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<td>Post Hoc tests by HEDR Condition</td>
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<tr>
<td>Low and Moderate Years</td>
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<td>0.48</td>
<td></td>
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<tr>
<td>Low and High Years</td>
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<td></td>
<td>0.0171*</td>
<td></td>
</tr>
<tr>
<td>Moderate and High Years</td>
<td></td>
<td></td>
<td></td>
<td>0.0020**</td>
<td></td>
</tr>
</tbody>
</table>

**HEDR Condition Tukey-Kramer HSD Follow Up Test**

| Low and Moderate Years                      | 0.50 |
| Low and High Years                          | 0.30 |
| Moderate and High Years                     | 0.0258*|

*Note: N=47. Years= Years of Clinical Service; HEDR= Higher Expected Disclosure Ratings; LEDR= Lower Expected Disclosure Ratings. *p<.05; **p<.01; ***p<.001
Years of Clinical Experience and Disclosure

(Research Question 2). Research Question 2 explored how the likelihood of disclosing mental health diagnoses to children varied as a result of the number of years that psychologists have been in clinical practice. The means and standard deviations are presented in Table 11. The 3 Way ANOVA (initially described within the section titled Three Way Analysis of Variance: Years of Clinical Experience, Client Demographics, and Disclosure [Research Questions 2 and 3]) yielded two significant effects involving years of clinical experience; the interaction with condition (i.e., HEDR and LEDR) and the main effect for years (i.e., low, moderate, high). The 3 Way ANOVA results fail to indicate that there is an interaction effect between Condition x Type x Years and Type x Years. Results are illustrated in Table 13.

To follow up the years x condition interaction, post-hoc simple effects tests were completed. A simple effects analysis by condition indicated that the means for the low, moderate, and high years of clinical experience were significantly different. Specifically, reported ratings were revealed in the following descending order from most to least likelihood of diagnosis disclosure to children; psychologists with moderate years of experience reported the most disclosure, followed by those with low years, and finally with high.

The simple effects analysis by years indicated that the means for the low, moderate, and high years of clinical experience were significantly different for the HEDR vignette conditions only (which includes the vignettes specifying American culture, high age, and Superior FSIQ). Years of clinical experience did not significantly impact disclosure for the LEDR condition vignettes (which includes the vignettes specifying
Chinese-American culture, low age, and Borderline FSIQ. Post hoc analysis results for the HEDR condition suggest that the disclosure ratings for high years of clinical experience was significantly different from both low and moderate years of service. No significant difference was found when the disclosure ratings for low and moderate years of clinical services were compared. A HEDR condition Tukey –Kramer HSD follow up test further revealed that psychologists with moderate (i.e., between 13-31) years of experience reported more diagnosis disclosure to children, than did participants with 32 years or more of clinical service at the .05 level of significance. The difference between diagnosis disclosure ratings by years of clinical service for the HEDR type vignette conditions (which includes the vignettes specifying American culture, 16 year old age, and Superior FSIQ cognitive ability) is illustrated in Table 13.

Client Demographics and Disclosure

(Research Question 3). Research Question 3 explored how the vignette types (e.g., culture, age, and cognitive ability) and conditions (e.g., HEDR and LEDR), increase or decrease the likelihood of psychologists mental health diagnoses disclosure to children practices. From the literature it was hypothesized that psychologists would be more likely to disclose mental health diagnoses to children described in the HEDR (Higher Expected Disclosure Ratings) conditions, specifically to: (a) children of an American culture than those of a Chinese-American culture, (b) older children (16 years old) than younger (6 years old), and (c) children with an intellectual ability in the Superior Range than those with an IQ in the Borderline Range. The means and standard deviations are presented in Table 11. Consistent with the previous analysis (Research Question 1 Three Way ANOVA), results from the 3 Way ANOVA (initially described
within the section titled Three Way Analysis of Variance: Years of Clinical Experience, Client Demographics, and Disclosure (Research Questions 2 and 3) yielded a significant main effect for condition and interaction effect between vignette condition and type. See Table 13 for results. Figure 1 illustrates the significant vignette condition and type interaction.

This analysis also resulted in a marginally significant main effect for vignette type. The main effect for vignette type (e.g., culture, age, cognitive ability) is not explored further for two reasons. First although the main effect for vignette type was explored in both 3 Way ANOVA’s (see Table 12 and 13), the main effect was only significant in the latter analysis. These inconsistent results suggest that the differences in vignette type means were only marginally significant (See Table 11 for means). Second, this main effect was not of specific interest for the study.

Figure 1. Vignette Type and Condition Interaction
Simple effects analyses were completed to follow up the significant interaction. See Table 13 for follow up test results. A simple effects analysis by vignette type indicated that the means for the HEDR and LEDR vignette conditions were significantly different (See Table 13). A post hoc analysis further revealed that for all three vignette types (culture, age, and cognitive ability) the means of the condition HEDR vignettes were significantly higher than the mean for the condition LEDR vignettes. This suggests that psychologists’ diagnosis disclosure ratings differed based on a client’s presented demographic information. Specifically, psychologists were more likely to disclose to children of an American culture than those of a Chinese-American culture, (b) older (16 years old) children than younger (6 years old), and (c) children with an intellectual ability in the Superior Range than those with an IQ in the Borderline Range.

Open Ended Responses

Responses to the three open-ended questions were independently coded into categories by the lead author and a graduate student. Following independent categorization of the data from all three open-ended questions, the author’s dissertation advisor reviewed all coding. To ensure interrater reliability, a minimum .80 Krippendorff’s $\alpha$ was achieved. Krippendorff’s alpha for Research Questions four, five, and six ranged from .89 to .93 (see Table 6). The coding team then collectively agreed upon six independent categories for participants’ description of the impact that mental health diagnoses, themselves, have on their disclosure practices (e.g., Research Question 4), five categories describing participants’ diagnoses disclosure practices (e.g., Research Question 5), and four categories from participants’ vignette elicited disclosure reasons.
(Research Question 6). After collectively agreeing on these themes, the author corresponded with the coding auditor to review themes.

**Impact of Diagnosis on Disclosure**

**(Research Question 4)**

The themes for Research Question 4, which explored how diagnoses, themselves, impact disclosure decisions, were identified as: No, Child Characteristics, Diagnoses of Common Nomenclature, “Biologically Based” Diagnoses, Less Psychiatric Diagnoses, and Supportive Disclosures (see Table 14 for themes and definitions).

<table>
<thead>
<tr>
<th>Theme</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No</strong></td>
<td>Response indicates that diagnoses themselves have no impact on disclosure practices</td>
</tr>
<tr>
<td><strong>Child Characteristics</strong></td>
<td>References a child’s individual characteristics or demographic factors such as age, diagnosis, IQ, and maturity level</td>
</tr>
<tr>
<td><strong>Diagnoses of Common Nomenclature</strong></td>
<td>Indicates increased disclosure for depression, anxiety, ADHD, and learning disabilities and/or diagnoses that are more present in the media</td>
</tr>
<tr>
<td><strong>“Biologically Based” Diagnoses</strong></td>
<td>Indication that the participant is more likely to disclose a diagnosis that is viewed as having a definitive biological basis including Tourette syndrome, OCD, traumatic brain injury, brain infection, brain tumor, stroke</td>
</tr>
<tr>
<td><strong>Less Psychiatric Diagnoses</strong></td>
<td>Indicates less disclosure for severe pathology or “psychiatric” diagnoses such as schizophrenia and psychosis</td>
</tr>
</tbody>
</table>
When asked to report if there were diagnoses that they were more or less likely to disclose to children and if so to describe, many psychologists indicated that mental health diagnoses, themselves, did not influence their disclosure practices (e.g., Theme of No). For example, one psychologist stated, “There is not a diagnosis that, in and of itself, is off limits from discussing.” While another stated, “I provide information for all diagnoses- at least some information.” Similarly, many participants responded simply “no”. Other participants identified components related to Child Characteristics, particularly age and IQ rather than the diagnosis itself (e.g., “I would share all of them considering ability” and “I think it is an interaction between the age of the individual and the intellectual functioning of the individual to determine whether or not a diagnosis is disclosed and to what extent it is disclosed”).

In addition to child characteristics, participants identified different diagnoses that they were more or less likely to disclose; these responses resulted in three of the six themes (i.e., Diagnoses of Common Nomenclature, “Biologically Based” Diagnoses, Less Psychiatric Diagnoses). Participants also reported that they are more likely to disclose diagnoses, specifically depression, anxiety, ADHD, and learning disabilities, that are of Diagnosis of Common Nomenclature among the lay public. For example, one
psychologist reported, “I'm highly likely to present a diagnosis of normal developmental behavior, ADHD, learning disabilities, anxiety disorders, and depressive disorders”.

While another stated, “It's hard to avoid the popularity in the media of ADHD, so this will often be asked about. Because I don't want to be evasive, I will have more candid discussions about this diagnosis than others.” Similarly, a psychologist reported, “I might be more inclined to disclose diagnoses such as "ADHD" or "learning difference" to a child, as it can help to displace feelings of inadequacy regarding academic struggles. In some cases, particularly with adolescence, I might disclose "depression" or "anxiety" to engage the youth in a dialogue about how best to manage these conditions.”

Some psychologists reported that they were more likely to disclose a diagnosis that they viewed as having a definitive biological basis (i.e., “Biologically Based” Diagnoses). One psychologist stated, “I am more likely to discuss ‘biologically based’ diagnoses over which the child has limited voluntary control (Tourette's, OCD) to help the child accept the situation and reduce the child's sense of responsibility and guilt.” Others simply reported diagnoses within this theme such as, “traumatic brain injury, brain infection, brain tumor, stroke.” Some psychologists also identified specific diagnoses or diagnostic categories that were characterized under the theme of Less Psychiatric Diagnoses. For example, one psychologist stated that they were less likely to disclose “‘pure’ or ‘heavy’ psychiatric diagnoses”. Additional diagnoses included in this theme, were responses such as “less psychotic disorders” and “less schizophrenia.”

Finally, psychologists’ responses categorized into the theme of Supportive Disclosures discussed the importance of support from: (1) the psychologist through empathetic and kid-friendly language, (2) parents feelings about disclosure, and (3) peers
and family. Several psychologists acknowledged their use of supportive and kid-friendly language (i.e., “I would not tell them anything that could damage their self esteem or make them vulnerable during their early developmental years when they are trying to develop a self and grounding” and “I may describe characteristics or common issues in a disorder that a child is experiencing. However, some cannot understand and might be frightened by or made to feel hopeless by giving the name of the actual diagnosis”). Others reported the importance of parental preferences for disclosure (i.e., “I find myself disclosing anxiety more than other diagnoses, mostly because parents sometimes want to be the ones who discuss ADHD or LD with their child”). Additionally, psychologists noted the need for general support including “familial/social variables”. For example, one participant stated, “I would share all of them considering ……and support in understanding and overcoming.” Overall, it appeared that psychologists varied on what diagnoses they were more or less likely to disclose. The heterogeneous responses as seen within the six themes that emerged provide evidence to suggest that diagnosis is only one of many considerations that psychologists include in their disclosure decision-making process.

**Diagnoses Disclosure Practices (Research Question 5)**

The categories for Research Question 5, which provided an opportunity for psychologists to describe their current diagnoses disclosure practices, were: Child Characteristics, Supportive Disclosures, Treatment Implications, Child’s Right to Know, and Parent Choice (see Table 15 for themes frequencies).
Table 15

*Themes for Diagnoses Disclosure Practices (RQ 5)*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Characteristics</td>
<td>References a child’s individual characteristics or demographic factors such as age, diagnosis, IQ, and maturity level</td>
</tr>
<tr>
<td>Supportive Disclosures</td>
<td>Contains reference to the need for or importance of support within the disclosure process from either psychologists or other sources (e.g., family, peers) responses may indicate support is needed for comfort or normalization</td>
</tr>
<tr>
<td>Treatment Implications</td>
<td>Includes a discussion of the impact that diagnoses disclosure can have on mental health treatment including treatment prognosis and compliance</td>
</tr>
<tr>
<td>Child’s Right to Know</td>
<td>Reference to a belief that children should have their diagnoses disclosed</td>
</tr>
<tr>
<td>Parent Choice</td>
<td>Reference to the importance of parental preference, consent, or choice in disclosure</td>
</tr>
</tbody>
</table>

This open-ended question encouraged psychologists to describe their mental health diagnoses disclosure practices with children. Similar to the responses in Research Question 4, some psychologists reported child characteristics including age, diagnosis, IQ, and maturity as factors that greatly impact their disclosure decisions. For example, one psychologist reported considering “whether the individual has sufficient good judgment regarding further disclosure of his or her diagnosis to others as this could be damaging to the person (my doctor says I have schizophrenia, etc.)”. Additionally, psychologists often listed some characteristics they consider before disclosure such as the participant who responded, “age, emotional maturity, intellectual maturity, stability, ……, the nature of the diagnosis -what is it.” Also, like Research Question 4, participants
reiterated the importance of Supportive Disclosures. Supportive Disclosures incorporated support from both psychologists, through therapeutic relationship and appropriate language, and external sources (e.g., family, peers). One psychologist reported, “I use language the child can understand - for example I might say things like letters are mixed up, or you have trouble thinking clearly when you are upset based on age and developmental level. I also consider the child's context - is his/her home supportive, is he going to be offered treatment to overcome this. I believe in respect and this includes giving facts and framing it in a recovery context and reality context. It is easier to deal with what you understand and know than ‘making things up’.”

Additionally, participants vocalized the influence of treatment and other long term implications in their disclosure decision making process (i.e., Treatment Implications). For example, one psychologist noted the “relevance of diagnosis for predicting long-term prognosis and treatment decision making.” Similarly, a participant highlighted the implications of disclosure by responding, “when children face possibly life-long problems that will require the development of compensatory cognitive and affective strategies, they may be helped by developing a compensatory motivation and identity.” While another stated, “I think that giving children and adults an accurate picture of the problem is the first step in treating the problem.”

Many psychologists discussed their belief that children should have their diagnosis disclosed in an understandable way (i.e., Child’s Right to Know). For example, one psychologist stated “clients and their parents have a right to be told about their health conditions in ways that are understandable to them so they can make informed decisions about care.” Another reported, “Knowing the diagnosis may provide the child with
comfort and an explanation of their current symptomology. Therefore, I believe disclosing information in an understandable way is key in providing mental health care to children.” Despite reports of a “belief in disclosure to children”, psychologists also highlighted the prominence of parental preference in disclosure decisions within the theme Parents Choice (i.e., “Informing the child is based on parental permission, parental understanding, and delivering the message at a level that the child can understand” and consider “parents desire for a child to know”). In sum, psychologists’ responses to this question underscored many salient factors in their disclosure decisions including individual child characteristics, support systems, and treatment as well as the balance between personal beliefs in child disclosure balanced with parental preferences.

Vignette Elicited Disclosure Reasons

(Research Question 6)

Following each vignette participants were asked to describe the reasons for their disclosure decision that they indicated on the Likert scale. Themes are displayed in Table 16. Vignette elicited open-ended responses were combined across all vignettes for four main reasons: 1) this study sought to explore psychologists’ overall reasons for disclosure, 2) participants provided similar vignette elicited disclosure reasons across vignettes, 3) participants often provided multiple codable responses (e.g., one open-ended answer might consist of data falling within three themes [e.g., child characteristic, support, and treatment benefit]), and 4) pilot data previously provided support for content validity of vignettes. These results should be read with caution as participant’s vignette elicited reasons for disclosure may have been influenced by the order in which the vignettes were presented, which was not varied or randomized. The following four
overarching diagnosis disclosure reason themes were identified by the coding team: Child Characteristics, Supportive Disclosures, Treatment and Benefits, and Child’s Right and Desire to Know.

Table 16

<table>
<thead>
<tr>
<th>Themes</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Characteristics</td>
<td>References a child’s individual characteristics or demographic factors such as age, diagnosis, IQ, developmental and maturity level</td>
</tr>
<tr>
<td>Supportive Disclosures</td>
<td>Contains reference to the need for or importance of support during the disclosure process from psychologists or external sources (e.g., family, peers) to provide normalization, understanding, or comfort</td>
</tr>
<tr>
<td>Treatment and Benefits</td>
<td>Includes a discussion of the impact and/or benefits that diagnoses disclosure can have on mental health treatment including treatment prognosis and compliance</td>
</tr>
<tr>
<td>Child’s Right and Desire to Know</td>
<td>Reference to a belief that children should have their diagnosis disclosed and/or information should be presented when requested by a child</td>
</tr>
</tbody>
</table>

Similar to the responses to Research Questions 4 and 5, the theme Child Characteristics was comprised of several components including age, cognitive ability, diagnosis, individual characteristics, culture, and developmental or functioning level. Participants’ open-ended responses within this theme support their quantitative responses on the diagnosis disclosure Likert scale. For example, some psychologists’ responses indicated
age (e.g., “keep informal because young”), while others stated cognitive ability with answers such as, “higher intelligence suggests that this child can use information about his/her condition.” Some participants indicated diagnosis was a salient disclosure decision factor (e.g., “it depends on what the diagnosis is”), while other participant statements identified other client characteristics such as “guardedness”, “insight”, and “resiliency”. Psychologists’ responses also indicated that a child’s culture (e.g., “I would be more hesitant to provide a label to avoid triggering additional problems due to culture”) or developmental functioning (“developmental level would impact my disclosure decision”) were primary considerations in making diagnosis disclosure decisions. Moreover, psychologists noted both that they would be more and less likely to disclose a mental health diagnosis to a child based on how the aforementioned child characteristics varied. For example, when presented with two vignettes that varied based on age, one psychologist reported “it’s less likely that a 6 year old will benefit from explicit discussions of diagnoses” and “nothing would be held back from a typical 16 year old.”

Also, like Research Questions 4 and 5 participants reiterated the importance of Supportive Disclosures. Psychologists’ responses subsumed under the theme, Supportive Disclosures, was expanded from previous questions to incorporate the following: (1) psychologist support through the therapeutic relationship and appropriate language (e.g., “the explanation must be in simple language and concepts that he or she can understand”), (2) attempts to increase clients’ self-understanding (e.g., “so he/she could better understand her/himself), (3) external sources of support (e.g., “based on his….family support I would give him information”), and (4) to provide normalization
and comfort (e.g., “comforted that other people have the same diagnosis he does and he’s not alone”).

In addition to the theme above, psychologists highlighted possible benefits from disclosure and the impact that disclosure can have on a child’s treatment (i.e., Treatment and Benefits). Specifically, participants’ reports included “participation in the treatment planning process is a vital part of therapy” and “it is most likely that X (child’s name in vignette) will not be able to participate in his treatment by working with the therapist until and unless he understands the nature of the problems we would be working on.” Another psychologist stated, “If presented appropriately, children….benefit from information regarding their mental health condition.”

The final theme identified was Child’s Right and Desire to Know, which included a belief that children should be told their diagnoses as well as the importance of basing the information disclosed on the child’s desire for information. For example, one psychologist stated, “my perspective is that the patient is entitled to understand her or his diagnosis.” While another reported, “I would provide as much information as the child requested.” Altogether, it appears that participants’ reasons for disclosure decisions included child’s characteristics (i.e., Child Characteristics), current support systems (i.e., Supportive Disclosures), and desire to know their diagnosis (i.e., Child’s Right and Desire to Know). Psychologists acknowledged the potential benefits of disclosure for treatment as well as provide a means of providing the child with comfort and normalization as reasoning for telling children mental health diagnoses. Moreover, some psychologists’ belief in a child’s right to know their diagnosis (i.e., Child’s Right and Desire to Know) impacted their disclosure practices. As demonstrated in Tables 15 and
the themes for diagnosis disclosure practices (e.g., Research Question 5) and the vignette elicited reasons for disclosure (e.g., Research Question 6) are very similar. Therefore, the themes for these two Research Questions have been combined for discussion purposes in the next chapter.

Summary of Open Ended Question Results

This chapter investigated mental health diagnosis disclosure practices with children among the study’s 47 participants. The use of concept analysis led to the development of multiple categories. Participating psychologists identified the importance of a child’s specific mental health diagnosis. This sentiment was highlighted among responses that indicate more disclosure for “biologically based” and common nomenclature diagnoses and less disclosure for psychiatric diagnoses. In addition to diagnostic characteristics, results suggest that participants consider many elements in mental health diagnosis disclosure decision making for children including the following: (1) child characteristics and support, (2) benefits and treatment success, (3) child and parent disclosure rights and choices.
CHAPTER V
DISCUSSION

Discussion of Research Findings

The purpose of the current study was to explore psychologists’ current mental health diagnoses disclosure practices with children. The current study collected both open-ended and quantitative data as it employed three methods of exploration: demographic questions, an analogue methodology, and open-ended questions. This approach was chosen because it afforded the opportunity for initial exploration of psychologists’ current practices while simultaneously incorporating findings from related literature, that psychologist (e.g., years of clinical practice and services provided) and client (e.g., culture, age, cognitive ability) characteristics might influence disclosure decision making. This methodology enabled the researcher to maintain high internal validity and experimental control over contextual variables so that they could be isolated, as well as examine a nascent area of research that would ordinarily be both impractical and impossible due to ethical constraints and situational factors.

This chapter will discuss the implications of the results presented in chapter 4. First, the findings of the six Research Questions will be examined in reference to possible explanations of the findings and their convergence or divergence with previous literature. Next, limitations of the study will be reviewed. Finally, practice, policy, and research implications will be discussed and suggestions for future directions within mental health diagnosis disclosure research will be made.
Mental Health Services and Diagnosis Disclosure

(Research Question 1)

Research Question 1 explored the influence of the setting in which psychologists provide services on the likelihood of disclosing mental health diagnoses to children. In the current study, diagnosis disclosure ratings did not vary across the type of setting services (i.e., counseling, diagnostic evaluations, or both) psychologists provide. Likewise, setting service did not impact disclosure ratings regardless of the changes in client demographics (e.g., vignette types or conditions). Although these findings may indicate that differences in disclosure practices based on services provided are negligible, these results must be interpreted with caution given that there may in fact be a difference between these groups that went undetected due to the limited power of this test.

As examined in the literature review, counseling and diagnostic services have differences. For example, the time present for building therapeutic rapport and working with a family is more limited in a diagnostic evaluation when compared to counseling (Woo & Keatinge, 2008). Despite the differences in services supplied, current findings may broaden support that the diagnostic process is similar in both therapy and assessment.

The lack of significance among services provided may be due to a variety of reasons. First, the similarities in responses across services may be related to sampling, as most participants in this study deliver both counseling and diagnostic evaluations (48.9%), compared to only 25.5% each providing only counseling or diagnostic evaluations. Second, it may be training related, according to the Guidelines and
Principles for Accredited Programs in Professional Psychology psychologists must be trained in both counseling and assessment (APA, 2009). Given that all psychologists in the sample, even those who reported only providing either counseling or diagnostic evaluations, likely received training in both services, it stands to reason that their approaches to disclosure would be similar.

Despite exposure to both counseling and diagnostic evaluation, approaches to diagnostic disclosure within each of these services may differ based on other psychologist characteristics. One study that examined psychologist self-disclosure, found that psychodynamic therapists expressed least willingness to disclose and humanistic the most (compared to CBT and family systems therapists; Bianco, 2007). Since theoretical orientation appears to impact other forms of disclosure, it is logical to assume that these different methods of conceptualizing clients may impact their diagnosis disclosure practices. Theoretical orientation was not examined in this study, but should be considered in future explorations of psychologist characteristics that influence diagnosis disclosure decision-making.

Years of Clinical Service and Diagnosis Disclosure

(Research Question 2)

Research Question 2 explored how the likelihood of disclosing mental health diagnoses to children varied as a result of the number of years that psychologists have been in clinical practice. Previous literature suggested that psychologists with more years of clinical practice would be more likely to disclose mental health diagnoses to children (McDonald-Scott et al., 1992). In contrast to previous findings, the current study results proffer that psychologists with moderate years of experience (14-31 years) reported the
most disclosure, followed by those with low years (0-13), and finally with high (>32). These findings are inconsistent with previous research that suggests psychiatrists’ clinical experience is commensurate with increased diagnoses disclosure to adult patients. Specifically, McDonald-Scott et al. (1992) found that psychiatrists with high years of clinical experience were more likely to disclose diagnoses to adult psychiatric patients that those with low years of experience. Although it was thought that a similar pattern would be found for psychologists, prior to this study no literature was found exploring patterns of diagnosis disclosure to children and psychologists’ years of experience.

One possible explanation for the discrepancy between the literature and the current finding is that psychologists and psychiatrists differ in their disclosure practices, possibly due to training and experiences. Psychiatrists’ experience within medicine may result in a pattern of disclosure more similar to that, which is found in the medical field. Moreover, most participants in the present sample (76.5%) work in non-medical settings. Psychiatrists’ training may also influence their views on mental health diagnoses in general, not just disclosure. Research demonstrates that psychiatrists are more likely to value diagnosis, than psychologists or other mental health workers (Jensen-Doss & Hawley, 2011). This is not surprising, given both medical training and the central role of the American Psychiatric Association central role in creating and disseminating the Diagnostic Statistical Manual (DSM). It stands to reason that with increased time in the field, psychiatrists’ become more solidified in their beliefs and practices regarding diagnosis disclosure, but psychologists do not.

In the vignettes where all participants were more likely to disclose (see Research Question 3 results), the differences between the diagnosis disclosure ratings of
psychologists with moderate and high years of experience were even more prominent. The results revealed that when presented with clients who were either of an American descent, 16 years old, or had an intellectual ability in the Superior Range, psychologists with moderate (i.e., between 13-31) years of experience reported more diagnosis disclosure to children, than did participants with 32 years or more of clinical service. This may be characteristic of the current sample; perhaps, participants had more experience with the populations described in the A condition vignettes (i.e., American decent, 16 years old, Superior IQ). However, because those with low and moderate experience did not significantly differ in their diagnosis disclosure ratings, it may be more indicative of the current movement in psychology toward an egalitarian approach to mental health services (Mehta & Gupta, 2011).

In some empirically supported therapies with children, this egalitarian approach is implemented by the explicit discussion of therapy with patients, including case conceptualizations and the treatment process. For example, transparency in clinical work is a hallmark of cognitive therapy, a treatment model that is increasingly being adopted by child psychologists (Friedberg & Brelsford, 2011). Increased use of these techniques may be more prominent among psychologists with moderate and low experience. It is possible that the low and high experience psychologists have similar disclosure styles because, until recently, the low-experience psychologists were under the supervision of high-experience psychologists. As this movement continues, psychology may see the trend found in McDonald-Scott’s (1992) study of psychiatrists (i.e., disclosure increased with experience) as the younger generation of psychologists gain additional experience and those with high experience retire.
Client Demographics and Diagnosis Disclosure

(Research Question 3)

Research Question 3 explored whether information about the child characteristics, culture, age, and cognitive ability, increase or decrease the likelihood of psychologists mental health diagnoses disclosure to children practices. From previous literature, it was proposed that psychologists would be more likely to disclose mental health diagnoses to: (a) children of an American culture than those of a Chinese-American culture, (b) older (16 years old) children than younger (6 years old), and (c) children with an intellectual ability in the Superior Range than those with an IQ in the Borderline Range. This pattern of findings was soundly supported by results.

Cultural views on mental health diagnoses. First, psychologists’ increased reported disclosure to a vignette describing a child of an American culture than that of a Chinese-American culture, is consistent with previous parent/guardian mental health disclosure literature (Hatton et al., 2003) and adult mental health literature (Hwang, 2008; McDonald-Scott et al., 1992; Yeung & Kam, 2008) that report less disclosure of mental health diagnoses with Asian-American adults. This may be due to worry of greater stigma for patients with traditional illness beliefs (Gupta et al., 2008; Hwang, 2008; Yeung & Kim, 2008).

Age and mental health care. Second, more disclosure corresponding with increased age has been found in medical diagnoses disclosure research examining both cancer (e.g., Claflin & Barbarin, 1991) and HIV (e.g., Abadia-Barrero & LaRusso, 2006; Aiges, 2008). Increased disclosure with age may be related to preparation for adolescent transition to adulthood and the self-management of mental health care.
**Ability and disclosure.** Third, the current finding, that psychologists disclose more information about mental health diagnoses to individuals with superior (vs. borderline) range intelligence, appears to support the previous literature regarding disclosure of medical illness with children being commensurate with cognitive ability level (e.g., Wiener et al., 2007). Additionally, the current results are consistent with preliminary data in one study, which suggest that parents of high ability children are likely to disclose diagnoses of learning disabilities and/or ASD (Allmon et al., 2010).

**Interaction effects.** Analysis of this Research Question also resulted in interaction effects. First, participants’ ratings suggest that they are more likely to disclose diagnoses to a 10-year-old Chinese-American child with average cognitive abilities, than a child (1) who was young (e.g., 6 years old) with average cognitive abilities or (2) with cognitive ability within the Borderline Range who was 10 years old. Thus, a child’s ability to understand, both cognitively and developmentally, may have been a more important consideration and deterrent than possible cultural issues. An alternative explanation for the interaction might be that psychologists did not feel that being Chinese-American with traditional values should prevent or minimize disclosure, when compared to a young or cognitively impaired child.

Second, participants reported higher disclosure ratings for an older child (16 years old) with average cognitive abilities and no cultural information provided, than a 10 year old child who was described either as (1) having average abilities and being from American culture or (2) having superior cognitive abilities and no cultural information provided. There are several possible interpretations of the current findings. First, the results provide support for the idea that disclosure increases with age and that age is an
important consideration in diagnosis disclosure, even more so than culture or cognitive ability (e.g., Aiges, 2008). Second, the increased importance placed on the age of the child, rather than ability, mirrors the literature that many gifted children exhibit social maturity and emotional self-regulation more commensurate with chronological, rather than mental, age (Robinson, 2008). Third, the American culture vignette was likely consistent with the typical client cultural presentation that participants are accustomed to working with in practice. This familiarity may have negated the impact of culture on their disclosure ratings and thus participants based disclosure more on age (10 year old in all vignettes, except the age pair vignettes), even though the child was younger than the highly disclosed to 16 year old. An in-depth assessment of the interaction, between client demographic characteristics (e.g. 16 year old with Borderline FSIQ) may be warranted in order to enhance understanding.

Impact of Diagnoses on Disclosure

(Research Question 4)

The analysis of Research Question 4, which explored how mental health diagnoses themselves influence disclosure practices, unearthed several interesting diagnostic characteristics that influence psychologists’ mental health diagnosis disclosure practices with children. Diagnosis is important part of treatment planning (Jensen-Doss & Hawley, 2011). This sentiment is highlighted among responses that indicate more disclosure for “biologically based” and common nomenclature diagnoses and less disclosure for psychiatric diagnoses. Psychologists’ inclination to disclose “biologically based” diagnoses (e.g., Traumatic Brain Injuries, Tic Disorders) may be due to the view that these diagnoses have a specific and identifiable biological cause, therefore making
them similar to medical diagnoses. Those viewed as analogous to medical diagnoses may encourage diagnosis disclosure by reducing social stigma as well as enabling psychologists to model their disclosure practices after the American Academy of Pediatrics guidelines (AAP, Committee on Bioethics report, 1995). This view that some mental health diagnoses are only, or are more, “biological based” than others negates epigenetic researchers who hypothesize that all mental health diagnoses are no different from medical illnesses and that “the only difference is that the organ of interest is the brain instead of the heart or pancreas” (Weir, 2012, p. 30).

Concordant with literature among psychiatrists working with adults, participants reported more disclosure of depression and anxiety than schizophrenia (Clafferty et al., 2001; Gantt & Green, 1986; McDonald-Scott et al., 1992; Paccaloni, Moretti, & Zimmermann, 2005; Pinner & Bouman, 2002). The finding that ADHD and LD diagnoses, in addition to the mood disorders present in the existing research with adult psychiatrists, may be related to the fact that these diagnoses are often diagnosed in childhood and have associated school accommodations. Responses conveying high rates of disclosure for ADHD are consistent with its prevalence and increased public awareness. For example, a recent publication by the National Survey of Children’s Health (2010) not only indicate that ADHD has an increasing prevalence trend, but also estimates that 9.5% of children ages 4 to 17 years old are diagnosed with ADHD. Increased prevalence and consequently, public awareness of diagnoses may also make psychologist view them as less stigmatizing. This is commensurate with adult psychiatric literature which has repeatedly found that for certain psychiatric diagnoses, particularly schizophrenia, infrequent disclosure was common due to perceived stigma (Hwang,
Psychologists may also consider the recommendations that interactions (e.g., interventions, demeanor) must be appropriately matched with needs associated with specific diagnoses in their disclosure decisions (Norcross & Prochaska, 1983).

While most psychologists’ responses revealed agreement with the idea that diagnosis provides important information about ability to understand disclosure (Simon, 1988), participants also highlighted the need to consider child characteristics (e.g., age, cognitive ability), social and family support, and the way in which diagnoses are disclosed. In accordance with the medical disclosure to children literature (e.g., Abadia-Barrero & LaRusso, 2006; Chesler et al., 1986; Claflin & Barbarin, 1991; Slavin et al., 1982), psychologists’ responses in the present study insisted that disclosure be commensurate with a child’s level of understanding. Providing ‘kid-friendly’ disclosures including describing the diagnosis in vague terms was highlighted and is similar to findings of language substitutions (e.g., mood instability for bipolar disorder) among the adult psychiatric literature (Lebolt, 2002). Furthermore, social and family support was emphasized when considering disclosure, which is congruent with other studies (e.g., Raskin et al., 2006) that exhort the importance of providing supportive outlets for children with mental health diagnoses.

Incongruous with the previously discussed findings, some psychologists reported that they do not base their disclosure decision on diagnosis in any way. One possible explanation for this finding is that some participants are averse to DSM diagnoses, because in addition to connoting that “no” diagnoses do not impact their disclosure decision, the tone of these responses suggested a negative connotation to DSM diagnoses.
(e.g., “Because I do not trust some DSM-IV diagnoses, I would be less like to emphasize these”). These responses are consistent with the literature that criticizes diagnostic categories for being overly simplistic and pejorative (Simon, 1988). An alternative explanation is that the “no” response may be a function of practice setting, given that the majority of study participants provide services in independent practice or other non-medical settings. This is consistent with previous research that found private practitioners have more negative attitudes towards diagnosis and standardized diagnostic scales than providers working in other areas (e.g., schools, outpatient clinics; Jensen-Doss & Hawley, 2011). Jensen-Doss and Hawley (2011) submit that psychologists within these settings may not have agency mandates or agency culture promoting diagnosis.

Disclosure Practices and Vignette Elicited Disclosure

Reasons (Research Questions 5 and 6)

Research Questions 5 and 6 explored psychologists’ practices of and vignette elicited reasons for diagnoses disclosure. These Research Questions yielded similar themes (see Tables 15 and 16 for themes); as such they will be discussed concurrently. Major findings of the analyses of psychologists’ disclosure decision making practices include the following considerations: (1) child characteristics and support, (2) benefits and treatment success, (3) child and parent disclosure rights and choices.

Child characteristics and support. First, psychologists consistently identified child characteristics that motivate their diagnoses disclosure decisions. The child medical and adult psychiatric literature discussed above seems to suggest that age (e.g., Abadia-Barrero & LaRusso, 2006; Claflin & Barbarin, 1991; Huws & Jones, 2008), cognitive
ability (e.g., Wiener et al., 2007), culture (e.g., Gupta et al., 2008; Hwang, 2008; McDonald-Scott et al., 1992; Yeung & Kim, 2008), and developmental or functioning level (e.g., Aiges, 2008; Dematteo et al., 2002; Kitamura, 2005) impact disclosure decisions. The current findings support these suggestions. These results from open-ended questions also supply added evidence for the quantitative analogue disclosure rating results. Moreover, psychologists’ open-ended responses further reinforce that disclosure increases commensurately with age and cognitive ability. Furthermore, the concern for befitting disclosures based on child characteristics was supplemented by the emphasis on supportive disclosures.

The goal of the supportive disclosures, as derived from open-ended responses, are to provide the child with normalization, comfort, and understanding through the therapeutic relationship, the use of developmentally appropriate language, and external support. These supportive disclosures may include the process of progressive diagnosis disclosure, which occurs when a psychologist gradually tells the patient more information about their condition until the diagnosis itself is disclosed (Byszewski et al., 2007). Psychologists’ desire for supportive and appropriate disclosures based on child characteristics may be related to their desire to not overwhelm the child (Green, 1984). Studies exploring the impact of supportive disclosure with adult psychiatric and child medical patients found that they can render a means of normalization (Finn & Tonsager, 1992; Hwang, 2008), reduce stress (see Kitamura, 2005 for review), and improve patient mood (Fisher, 2000; Holm-Denoma et al., 2008; Hwang, 2008). For example, Huws and Jones (2008) found that diagnosis disclosure offered an understanding of previous
experiences (e.g., classroom experience) for adults diagnosed with Autism Spectrum Disorder.

**Benefits and treatment success.** Second, contrary to fears expressed in the adult psychiatric literature that disclosure of diagnoses might potentially cause harm (Keightley & Mitchell, 2004; McDonald-Scott et al., 1992), psychologists reflected upon the potential for benefits from disclosure. Benefits noted in the child medical disclosure literature include increased social support (Battles & Wiener, 2002) and more cohesive family relationships (Wiener et al., 1998). Additionally, psychologists in the current study noted treatment specific benefits that have been noted across child medical and adult psychiatric research consist of the following: improved treatment cooperation and compliance (Holm-Denoma et al., 2008; Hwang, 2008; Wiener, Mellins, Marhefka, & Battles, 2007), increased opportunities for patients to learn about illness (Hwang, 2008), encouraged patients to be more active in treatment (Hwang, 2008), and provision of additional ancillary treatment options (e.g., support group; Hwang, 2008; MacLeod & Johnston, 2007). Psychologists may surmise that similar benefits occur with mental health diagnoses disclosure due to the chronicity of many mental health diagnoses beginning in childhood or adolescence (Higgins, Raskind, Goldberg, & Herman, 2002; Janepson, 2010; Kessler, Chiu, Demler, Merikangas, & Walters, 2005).

**Child and parent disclosure rights and choices.** Finally, psychologists’ disclosure practices were concerned with parent and child disclosure rights and choices. Some psychologists noted that they consider parental preference in disclosure decisions. Disclosing mental health diagnoses to children may be viewed as a personal choice that differs among parents/guardians (Knussen & Brogan, 2003). Despite the weight of this
responsibility, a study examining parental experience of making the diagnosis disclosure decisions reported that most parents are satisfied with the ability to make disclosure choices (Pearson, et al., 1999). Parent/Guardian satisfaction with the ability to choose may reinforce psychologists’ practice of deferring to parents/guardians for the ultimate diagnosis disclosure decision (Pearson et al., 1999). Complete acquiescence for parent preference begs the question what are the psychologists’ responsibilities in diagnoses disclosure with children?

More prominent than acknowledging parent preference in participants’ responses, was the examination of a child’s desire and right to know their diagnosis. Psychologists reported that disclosure would likely occur if a child expressed a desire for information. Similarly, this desire for understanding is noted among the child medical diagnosis disclosure literature (Ledlie, 1999; Lipson, 1994). The medical community necessitates disclosure if directly inquired by a patient (AAP, Committee on Bioethics, 1995). Beyond a child’s desire to know, some psychologists expressed a belief that children have a right to know their diagnosis. This may be a personal belief, similar to that described by Ross (1974) who stated children who are hospitalized due to mental health concerns are entitled to know why. An alternative explanation for this finding may be that some psychologists believe that it is their ethical imperative to disclose mental health diagnoses to their clients (Brewer & Faitak, 1989).

Results Discussion Summary

The combined results suggest that psychologists consider many factors in their disclosure decision-making process. Quantitative and open-ended question results affirm that psychologists consider the client characteristics, culture, age, and cognitive
ability, derived from adult psychiatric and child medical literature when making disclosure decisions. Open-ended responses adduce the importance of diagnosis, potential benefits of disclosure, psychologists’ belief in clients (both children and their parents) right to make disclosure decisions, and the need for supportive disclosures. Results also suggest that psychologists’ years of clinical experience may impact their disclosure decisions. The results of the current study present a number of interesting implications for future research, practice, and policy development.

Limitations

This study is the first known effort to integrate the children’s medical and adult psychiatric diagnoses disclosure literature in an experimental analogue design exploring psychologists’ mental health diagnoses disclosure with children. As it is grounded in previous research in both of these areas, it may represent an empirical bridge to future research and the initial development of practice guidelines for diagnosis disclosure to children. The use of vignettes helps to incorporate previous literature into a nascent area of research with scientifically controlled work. This study attempted to address several gaps in the disclosure literature primarily by taking into account contextual factors that may influence psychologists’ mental health diagnoses disclosure practices with children. Amidst multiple outcomes, these findings must be understood in consideration of several limitations. First, the analogue design, although convenient for measuring diagnosis disclosure practices to children while incorporating previous research, has limited generalizability (Hill & Knox, 2003). Disclosure interventions with real clients were both impractical and impossible due to constraints of access to disclosure situations with children and the unexplored ethical implications of disclosure (e.g., potential client
benefit or harm). Thus, the research is caught between maintaining an ethical research standard and approximating real world settings. This drawback was addressed in the current study by utilizing a variety of vignettes and open-ended questions. As a result the method used to elicit disclosure practices in the current study involved participants imagining themselves in hypothetical situations described by vignettes. The hypothetical nature of the situations may have somewhat affected the external validity of the study.

Psychologists’ responses were based on one-paragraph vignettes that provided only minimal information about each client. Although heuristically useful, there are limits to the ecological validity of these findings as rarely do clients present with only one salient characteristic that impacts psychological services provided. In actual practice, the psychologist would have far more contextual information about any particular client, and this information could influence disclosure practices in specific ways. Even with more detailed vignettes, the study would still only be an approximation of actual psychologist disclosure behaviors. It is important to note that those who chose to respond to the open-ended questions may not be representative of the population as a whole. However, it is reasonable to assume that they do personify the current sample that took the time to attend to the survey.

The second limitation involves instrumentation: this research relied exclusively on novel self-report disclosure measures without established psychometric properties. Although the validity of these instruments was sound as demonstrated through pilot testing, the reliability of the instruments is indeterminable without further assessments. Given that pilot testing and open-ended findings also suggest the vignettes accurately represent their intended client characteristic, the above limitations should be tempered.
Additionally, the open-ended results for participant’s vignette elicited reasons should be read with caution as they may have been influenced by the order in which the vignettes were presented, which was not varied or randomized. Future research should use randomization of similar materials whenever possible. Third, the survey does not cover all aspects of diagnostic disclosure practices with children. Factors not assessed in the current study, such as psychologists’ theoretical orientation or use of the DSM in practice, may be important predictors of diagnosis disclosure.

Fourth and finally, although the current study used ABPP certified psychologists the sample was small, self-selected, and fairly homogeneous. Additionally, the online nature of the study also presents a number of other sampling problems. The use of the ABPP listserv for survey dissemination made it impossible to ascertain a response rate, and thus the coverage error and response bias of those who did participate may be substantial. This coupled with the small sample size makes generalizability of results difficult. One possible avenue to address this limitation in future studies would be the use of larger samples with known populations (e.g. via mailings for the National Register of Health Service Providers in Psychology or qualitative interviews).

**Implications**

Methodological limitations notwithstanding, the present study makes several notable contributions to the literature. Psychologists’ mental health diagnosis disclosure has received scant empirical attention; as such this is the first empirical investigation to explore psychologists’ current mental health diagnosis disclosure to children. This online analogue study was designed to concurrently provide an initial exploration of mental health diagnosis disclosure practices and include empirical findings from the adult
psychiatric and child medical diagnosis disclosure. Overall impressions as well as implications for research, practice, and policy are discussed below.

**Research implications**

The combined online analogue and open-ended question methodology sought to create rich understanding of current mental health diagnosis disclosure practices with children. It provides the opportunity for initial exploration of psychologist disclosure practices as well as incorporates findings, that psychologist (e.g., years of clinical practice and services provided) and client (e.g., culture, age, cognitive ability) characteristics may influence disclosure decision-making, from related literature.

As evidenced by the results of the current study, it appears that using both quantitative and open-ended measures may yield rich data regarding psychologists’ current practices. Given the study limitations concerning generalizability, it will be important to continue empirical evaluation of diagnosis disclosure practices in order to support the current findings. For example, the use of confederates or videotaped procedures to role-play the scenarios described may, on the one hand, overcome these drawbacks and increase external validity by better approximating the conditions in which diagnosis disclosure may occur. On the other hand, there are drawbacks to this approach, such as the increase risk to confederates. It also particularly important to explore the cutoff points for disclosure practices. For example future research might address questions such as, at what specific age do psychologists increase disclosure of diagnostic information (e.g., 14, 15, 16)? And how have psychologists come to these decisions? Are they based in theory (e.g., Piaget’s Stages of Development; Smith, Cowie, & Blades, 1998)? In addition to further examination of the impact of child characteristics on
diagnosis disclosure, what may be particularly fruitful is investigation into other psychologists’ characteristics that may influence disclosure practices, specifically theoretical orientation. Bianco (2007) found that theoretical orientation appears to impact other forms of disclosure.

Future researchers might also consider a multiple vignette approach, to gain a more general approximation of disclosure practices and overcome potential bias associated with idiosyncratic responding to the context of one particular vignettes. For example, participants might respond to multiple scenarios eliciting disclosure practices to children with each characteristic (e.g., superior range cognitive abilities). Additionally, due to the development of all of the present study’s measures, future research establishing the reliability and validity of the current measure may be appropriate. Samples with large known populations (e.g. via mailings for the National Register of Health Service Providers in Psychology or qualitative interviews) should also be implemented in follow up research so that a response rate and representative sample can be calculated.

Research designs that include long-term disclosure effects (e.g., 6 months, 2 years, 4 years) may yield additional information regarding the impact of diagnosis disclosure with children. For example, do children experience the hypothesized benefits (e.g., social support, treatment adherence) as a result of mental health diagnoses disclosure? Do these benefits vary based on child characteristics, such as age at disclosure? How do children perceive diagnoses disclosure? Because current study participants emphasized the importance of supportive disclosures (e.g., ‘kid-friendly language’), these studies should explore not only the impact of disclosure itself, but also the way in which disclosure occurred.
Given the paucity of research in this area, qualitative investigations may be most appropriate at this juncture. Qualitative interviews might provide specific factors and decision-making steps that psychologists consider in deciding to disclose to children so that practice guidelines may be developed. These guidelines might be used as teaching tools among practicum students and interns, thus creating the potential for consistency across psychologists’ dissemination of information.

Additionally, because the current study’s range of child characteristics was so narrow, the question remains how does the interaction of client features impact disclosure? An important direction will be to explore diagnosis disclosure in the context of children’s multiple intersecting identities. Clients do not exist as a singular characteristic and investigating how to negotiate disclosure competence with clients’ multiple identities would be useful.

In May 2013 the Diagnostic Statistical Manual V is scheduled for release. It is unclear how changes within the DSM (e.g., to diagnostic categories [e.g., Autism Spectrum Disorders]) may influence the results of the current study and future research (American Psychiatric Association, 2012). Despite the mostly modest changes from the DSM IV, there is much controversy over the DSM V (Nature, 2013). The National Institute of Mental Health’s recent launch of the Research Domain Criteria (RDoC) project is an effort to incorporate nosology and move away from using symptom clusters as done in the DSM (NIMH, 2013). Both changes to the DSM and rising research contention with its use, suggest that further research is necessary. Future research should explore how the DSM V impacts current results, particularly to re-examine diagnoses that psychologists may be more or less likely to disclose (e.g., Research Question 4), as well
as explore how this emphasis on nosology influences mental health diagnoses disclosure practices with children. It is hoped that data from this study will inform additional qualitative and quantitative work to describe mental health diagnosis disclosure in terms of both client experiences and psychologists’ practices.

**Practice Implications**

The findings of this study in context with past children’s medical and adult psychiatric disclosure research have significant implications for the practice of mental health diagnoses disclosure to children. Taken as a whole, the results of this study indicate that psychologists rely on child characteristics, diagnosis, potential benefits of disclosure, psychologists’ belief in clients (both children and their parents) right to make disclosure decisions, and the need for supportive disclosures to inform their decisions. Although more research is needed to explore the specific parameters of these findings, it does suggest some possibilities for practice and training. Fortunately, the implications of this study are not restricted to either counseling or diagnostic evaluation, as participants’ responses did not vary based on the services psychologists provide. It is also worth noting that the results adduce that psychologists are aware of not only if they disclose diagnoses to children, but how. Participants’ open-ended responses denoted that considering the use of therapeutic rapport and developmentally appropriate language are imperative.

Psychologists in this study reported that they were more likely to disclose mental health diagnoses to: (a) children of an American culture than those of a Chinese-American culture, (b) older (16 years old) children than younger (6 years old), and (c) children with an intellectual ability in the Superior Range than those with an IQ in the
Borderline Range. It may be necessary for psychologists to consider the possible implications of withholding diagnoses due to client characteristics or other factors. For example, are culture, age, or ability level alone enough to discourage disclosure?

Psychiatrists and psychologists differ in the value they place on mental health diagnoses (e.g., Jensen-Doss & Hawley, 2011). Therefore, it may be important to compare their current disclosure practices. Specifically, this may provide useful information for transfer of client services or clients who have multiple service providers (e.g., social worker, psychologist, psychiatrist).

It is essential that psychologists examine their own mental health diagnoses disclosure practices with children and initiate open collegial discussions regarding these issues. Some psychologists hold a central tenet that children have a right to know their diagnosis, while others believe that parent preference is paramount. Graduate students in training should explore these core values, so that they may respect their personal beliefs, while simultaneously making empirically supported disclosure decisions. These findings coupled with future research lend themselves to the development of continuing education courses with regard to disclosure practices. Because this is the first empirical investigation to explore psychologists’ current mental health diagnoses disclosure practices with children, the development of practice guidelines is premature at this time. However, an initial list of potential considerations for psychologists’ mental health diagnoses disclosure practices with children (See Appendix E), based on the current study’s findings, is appropriate. The present list was modeled after Foley Nicpon et al.’s (n.d.) proposed diagnostic disclosure discussion points for mental health professionals working with parents. These potential diagnostic disclosure considerations are to be used
by psychologists to increase awareness about their own practices and encourage
discussion surrounding diagnoses disclosure with children. It is hoped that future research
findings will be incorporated into this initial list.

Policy Implications

An important contribution of this study that extends previous literature and
theoretical understanding of diagnosis disclosure is that it provides initial understanding
of current disclosure practices and thus, a starting point for the development of practice
guidelines. The majority of the literature has neglected to explore psychologists’
disclosure practices. This study augments the current literature by providing preliminary
factors for reflection in disclosure to children including: (1) child characteristics (i.e., age,
culture, cognitive ability, maturity, developmental and functioning level), (2) support
(social, peer, therapeutic relationship), (3) personal beliefs about disclosure, (4)
diagnostic characteristics (e.g., prevalence, stigma), (5) how to provide a supportive
disclosure (e.g., kid friendly language), and (6) potential disclosure benefits.

Johnson, APA’s 2012 president, wrote a column encouraging APA’s involvement
in the Evidence Based Guidelines movement (Johnson, 2012). Her article chronicles the
explosion of the medical communities guidelines beginning in the 1980’s to aide
physicians in maintaining current practices based on the expanding clinical research and
literature. By 2011, the Guidelines International Network database had 3,700 guidelines
and the National Guidelines Clearinghouse had 2,700 (IOM, 2011). Psychology has
begun to follow in the footsteps of the medical community with the American
Psychological Associations publication of Criteria for Evaluating Treatment Guidelines
(APA, 2002), which is consistent with the Institute of Medicine’s eight standards for
empirically based guideline development (IOM, 2011). As psychology continues to move towards the infusion of mental health services in primary care (Ward-Zimmerman & Cannata, 2012), it will be important for the field to develop its own evidence based guidelines for practices such as diagnosis disclosure that may at times overlap with medical services.

Practice guidelines exist to offer a compilation of the relevant psychological literature and likely benefits and harm, not mandate a uniform disclosure policy (IOM, 2008). The primary goal of disclosure guidelines would be to enable psychologists to provide the best care to children with mental health diagnoses. Before this goal can be achieved more empirical evidence is needed to replicate previous findings, explore patient subgroups and preferences (e.g., parent disclosure preference or children’s desire to know information), and examine the implications of disclosure (IOM, 2008). Ensuring that psychologists have empirically grounded guidelines will bring more evidence to bear on diagnosis decision-making. Thus, practice guidelines can aid psychologists and parents in making diagnoses disclosure decisions with and for children with mental health diagnoses.

**Conclusion**

The current study investigated ABPP psychologists’ mental health diagnoses disclosure practices with children. Utilizing a combined online analogue and open-ended question method, it was found that psychologists consider the following factors in their decision to disclose diagnoses: (1) child characteristics (i.e., age, culture, cognitive ability, maturity, developmental and functioning level), (2) support (social, peer, therapeutic relationship), (3) personal beliefs about disclosure, (4) diagnostic
characteristics (e.g., prevalence, public familiarity, current biological evidence, stigma), (5) how to provide a supportive disclosure (e.g., kid friendly language), and (6) potential benefits. Psychologists’ years of clinical experience also significantly predicted their disclosure practice. Psychologists with between 13-31 years reported more diagnosis disclosure to children than did participants with 32 years or more of clinical service when presented with a client who was of an American decent, 16 years old, or had an intellectual ability in the Superior Range. Finally, results suggest that psychologists, like psychiatrists and pediatricians, are more likely to disclose diagnoses to: (a) children of an American culture than those of a Chinese-American culture, (b) older (16 years old) children than younger (6 years old), and (c) children with an intellectual ability in the Superior Range than those with an IQ in the Borderline Range. It is hoped that this manuscript can be a small part of the evidence based guidelines movement, providing the initial exploratory research of current practices that can eventually lead to the development of guidelines for the disclosure of mental health diagnoses to children.
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APPENDIX A: PILOT STUDY INVITATION EMAIL

Dear Student/Psychologist,

I am a Counseling Psychology Ph.D. student in the Department of Psychological and Quantitative Foundations at the University of Iowa. I am currently in the process of completing my dissertation. The purpose of this research study is to explore current mental health diagnosis disclosure practices to children. I invite you to participate in a research study. The study will consist of a 20-30 minute online survey exploring current mental health diagnoses disclosure practices. To be eligible for participation you must be a graduate student or psychologist who currently works with individuals who are under the age of 18 and have a mental health diagnosis.

To take the survey click on the following link or cut and paste it into your web browser: https://uiowa.qualtrics.com/SE/?SID=SV_1M61QhCBNi51wri

If you have any questions about the research study, please contact Allison Allmon (912-432-0159; allison-allmon@uiowa.edu) or John Westefeld, Ph.D. (319-335-5562; john-westefeld@uiowa.edu).

Thank you very much for your consideration.

Sincerely,

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John Westefeld, Ph.D.
Professor
Dissertation Chair
Department of Psychological and Quantitative Foundations
The University of Iowa
APPENDIX B: PILOT STUDY SURVEY

We invite you to participate in a research study. The purpose of this research study is to pilot test a survey exploring mental health diagnosis disclosure to children. If you agree to take part in this study, your responses will be used to improve the online survey questions so that we may better explore psychologists' current mental health diagnosis disclosure practices to children.

We are inviting you to participate in this research study because you are a graduate student or psychologist who currently works with individuals who are under the age of 18 and have a mental health diagnosis. Approximately 15 people will take part in the pilot study at the University of Iowa. This will include approximately 10 graduate students and 5 local psychologists. After the pilot study is complete, approximately 100 psychologists will take part in the main study.

If you agree to participate, we would like you to complete a 20-30 minute online survey. This online survey will include demographic questions (e.g., gender, age), scenarios and rating-scale questions, and open-ended questions about your current mental health diagnosis disclosure practices. Additionally, it will provide an opportunity to provide feedback on the online survey. Participants may skip any questions that they prefer not to answer. Additionally, the survey may be ended at any time by clicking the "Save and exit" button in the upper left-hand corner of each survey screen.

We will keep the information you provide confidential, however federal regulatory agencies and the University of Iowa Institutional Review Board (a committee that reviews and approves research studies) may inspect and copy records pertaining to this research. To help protect your confidentiality, no personally identifiable information will be obtained from you during your study participation. If we write a report about this study, we will do so in such a way that you cannot be identified.

There are no known risks from being in this study, and you will not benefit personally. However, we hope that others may benefit in the future from what we learn as a result of this study.

You will not have any costs for being in this research study.

You will not be paid for being in this research study.

Taking part in this research study is completely voluntary. If you decide not to be in this study, or if you stop participating at any time, you won't be penalized or lose any benefits for which you otherwise qualify.

If you have any questions about the research study itself, please contact Allison Almon (912-433-0159; allison.almon@uiowa.edu) or John Westefeld, Ph.D. (319-335-5562; john.westefeld@uiowa.edu). If you experience a research-related injury, please contact Allison Almon (912-433-0159; allison.almon@uiowa.edu) or John Westefeld, Ph.D. (319-335-5562; john.westefeld@uiowa.edu). If you have questions about the rights of research subjects, please contact the Human Subjects Office, 105 Hardin Library for the Health Sciences, 600 Newton Rd, The University of Iowa, Iowa City, IA 52242-1098, (319) 335-6564, or e-mail info@uiowa.edu. To offer input about your experiences as a research subject or to speak to someone other than the research staff, call the Human Subjects Office at the number above.

Thank you very much for your consideration. Completing the online survey will indicate your willingness to participate in the study.

Sincerely,

Allison Almon, B.A.
Doctoral Candidate, Counseling Psychology
The University of Iowa
allison-almon@uiowa.edu

John Westefeld, Ph.D.
Professor
Dissertation Chair
Department of Psychological and Quantitative Foundations
The University of Iowa
By clicking the Next button you are agreeing to participate in the study.

Background Information Form for Pilot Testing

I am a licensed psychologist?
- Yes
- No

I am a graduate student at The University of Iowa?
- Yes
- No

What is your terminal degree?
- Ph.D.
- Psy.D.
- Ed.D.
- M.D.
- MD/Ph.D.
- Other academic or equivalent degree:

I currently work in a setting where I diagnose children (individuals under the age of 18 years old) with mental health diagnoses?
- Yes
- No

What is your primary work setting?
- University Setting
- Four-Year College
- Medical School/Academic Medical Center
- Other Treatment Settings
- Schools and Other Educational Settings
- Independent Practice
- Hospital
- OTH
- Other Human Service
- Other Public Sector
- Government
- Other
At the setting in which I diagnose children (individuals under the age of 18 years old) with mental health diagnoses I provide which of the following services?

- [ ] Counseling Services
- [ ] Diagnostic Evaluation
- [ ] Both Counseling Services and Diagnostic Evaluations

Please indicate the number of years you have provided clinical service (include only those years after internship).

[ ]

Please indicate your American Psychological Association membership(s). Please choose all that apply.

- [ ] General Psychology
- [ ] Teaching of Psychology
- [ ] Experimental Psychology
- [ ] Evaluation & Measurement
- [ ] Behavioral Neuroscience & Comparative
- [ ] Developmental Psychology
- [ ] Personality & Social
- [ ] Aging
- [ ] Applied Experimental & Organizational
- [ ] Rehabilitation Psychology
- [ ] Consumer Psychology
- [ ] Forensic & Philosophical
- [ ] Behavior Analysis
- [ ] History of Psychology
- [ ] Community Psychology
- [ ] Psychology & Aging
- [ ] Social Psychology
- [ ] State, Provincial, & Territorial Psychological Association Affairs
- [ ] Homeland Security
- [ ] Intellectual & Developmental Disabilities
- [ ] Environmental & Population Studies
- [ ] Conservation Psychology
- [ ] Counseling Psychology
- [ ] Psychology of Women
- [ ] Psychology of Aging
- [ ] Child & Family Policy & Practice
- [ ] Health Psychology
- [ ] Psychoanalysis
- [ ] Clinical Neuropsychology
- [ ] Psychology Law-Social
- [ ] Psychology in Independent Practice
- [ ] Family Psychology
- [ ] Lesbian, Gay, Bisexual, & Transgender Issues
- [ ] Ethnic Minority Issues
- [ ] Media Psychology
- [ ] Exercise & Sport Psychology
- [ ] Sport Psychology
- [ ] Group Psychology & Group Psychotherapy
- [ ] Addictions Psychology
- [ ] Men & Masculinity
- [ ] International
- [ ] Clinical Child and Adolescent Psychology
- [ ] aerospace Psychology
- [ ] Advanced Practice
- [ ] Pharmacology
- [ ] Trauma Psychology

What is your Gender?

- [ ] Male
- [ ] Female
- [ ] Other/Prefer Not to Specify
What is your Race/Ethnicity?
- American Indian
- Asian
- Black
- Other
- White
- Mixed heritage
- Multicultural
- Other

Base Vignette

Diagnosis Refers to Mental Health Diagnosis

Please Read the Following:

Sam is a 10-year-old child who is referred to you for current concerns experienced both at home and school. His/Her parents and teachers have expressed that Sam is experiencing difficulties impacting their behavior and academic performance. Sam currently lives with his/her mother, father, and two younger brothers. Sam has a positive relationship with his/her family. You have access to a recent evaluation that includes Sam's WISC-IV profile, which suggest that Sam has a full scale IQ of 102. Sam's presentation in your context with WISC-IV is also consistent with a mild functioning at the Average Range. After working with Sam you conclude that neither symptoms are consistent with a mental health diagnosis.

What would you tell Sam? Please respond using the following rating scale.

- 10: I would tell Sam that I am not familiar with any information about the diagnosis or the name of the diagnosis.
- 9: I would tell Sam that I am familiar with the diagnosis but I do not know the name of the diagnosis.
- 8: I would tell Sam that I am familiar with the diagnosis and name of the diagnosis.
- 7: I would tell Sam that I am familiar with the diagnosis and give a thorough explanation of it (e.g., treatment procedures).
- 6: I would tell Sam that I am familiar with the diagnosis and name of the diagnosis.
- 5: I would tell Sam that I am familiar with the diagnosis.
- 4: I would tell Sam that I am not familiar with the diagnosis.
- 3: I would tell Sam that I am not familiar with the diagnosis.
- 2: I would tell Sam that I am not familiar with the diagnosis.
- 1: I would tell Sam that I am not familiar with the diagnosis.

Why did you make your diagnosis disclosure decision for Sam?

Please provide the rationale for your disclosure decision here.

Which of the following is the most salient factor presented in this vignette?
- Emotion
- Ability
- Age
- Culture
- No Problem exists in this example/ vignette
Any Additional Comments about this Vignette?

Culture Vignette #1

Diagnosis Refers to Mental Health Diagnosis

Please Read the Following:

Riley is a 10-year-old Caucasian child who is referred to you for current concerns expressed by his mother and school. His teachers and peers have expressed that Riley is experiencing difficulties in his behavior and academic performance. Riley’s family holds traditional American values. Riley currently lives with his mother, father, and two younger brothers. Riley has a positive relationship with his father. You have access to a recent evaluation that includes Riley’s WISC-IV profile, which suggest that Riley has a full scale IQ of 112. Riley’s presentation in your context with his mother is also consistent with a child functioning in the Average Range. After working with Riley, you conclude that his symptoms are consistent with a mental health diagnosis.

What would you tell Riley? Please respond using the following likert scale.

1. Don’t mention. I would not tell
2. Tell him any information about the diagnosis or the name of the diagnosis
3. 4
4. 5
5. 6
6. 7
7. 8
8. 9
9. 10

Why did you make your diagnosis disclosure decision for Riley?

Please provide reasoning for your disclosure decision here.

Which of the following is the most salient factor presented in this vignette?

- Cognitive Ability
- Age
- Culture
- No Factors

In the space below please provide any suggestions for ways in which to alter the vignette to make the factor, Cultural, more clearly stand out as the basis for making a diagnosis disclosure decision.

5 of 12
Any Additional Comments about the Vignette?


Culture Vignette #2

Diagnosis Refers to Mental Health Diagnosis

Please Read the Following:

Jordan is a 15-year-old Chinese-American child who is referred to you for current concerns experienced both at home and school. His mother and teachers have expressed that Jordan is experiencing difficulties impacting his behavior and academic performance. Jordan's family holds traditional Chinese values. Jordan currently has two younger brothers, an older sister, and two younger sisters. Jordan has a positive relationship with his/her family. You have access to a recent evaluation that includes Jordan's WISC-JV profile, which suggests that Jordan's Full Scale IQ of 100. Jordan's presentation in your contact with him/her is also consistent with a child functioning in the Average Range. After working with Jordan you conclude that his/her symptoms are consistent with a mental health diagnosis.

What would you tell Jordan? Please respond using the following Likert scale.

5. Even if asked, I would not tell
I would tell either the name of the
I would tell either the name of the

Why did you make your diagnosis disclosure decision for Jordan?

Please provide the reasons for your disclosure decision here:

Which of the following is the most salient factor presented in this vignette?

- Cognitive Ability
- Age
- Culture
- No Factor thor to the Example Vignette
In the space below please provide any suggestions for ways in which to alter the vignette to make the factor, Culture, more clearly stand out as the basis for making a diagnosis disclosure decision?

Any Additional Comments about this Vignette?

Age Vignette # 1

Diagnosis Refers to Mental Health Diagnosis

Please read the following:

Robin is a 6-year old child who is referred to you for current concerns experienced both at home and school. Her parents and teachers have expressed that Robin is experiencing difficulties impacting her behavior and academic performance. Robin currently lives with her mother, father, and two younger brothers. Robin has a positive relationship with her father. You have access to a recent evaluation that includes Robin’s WISC-V profile, which suggests that Robin has a full scale IQ of 102. Robin’s presentation in your contact with him/her is also consistent with a child functioning in the Average Range. After working with Robin you conclude that her symptoms are consistent with a mental health diagnosis.

What would you tell Robin? Please respond using the following Likert scale.

1 = Even if asked, I would not tell
2 = I would tell any information about the diagnosis or the name of the diagnosis
3 = I would tell the name of the diagnosis and give a thorough explanation of (e.g., treatment, procedures)

Why did you make your diagnosis disclosure decision for Robin?

Please provide reasons for your disclosures, division here:

Which of the following is the most salient factor presented in this vignette?

- Gender
- Age
- Culture
- No Factor—this is the Example Vignette
In the space below please provide any suggestions for ways in which to alter the vignette to make the factor, Age, more clearly stand out as the basis for making a diagnosis disclosure decision?

Any Additional Comments about this Vignette?

Age Vignette #2

Diagnosis Refers to Mental Health Diagnosis

Please read the following:

Jamie is a 10-year-old child who is referred to you for current concerns experienced both at home and school. His/text his parents and teachers have expressed that Jamie is experiencing difficulties impacting his/her behavior and academic performance. Jamie currently lives with his/her mother, father, and two younger brothers. Jamie has a positive relationship with his/her family. You have access to a recent evaluation that includes Jamie's WISC-IV profile, which suggests that Jamie has a full scale IQ of 102. Jamie's presentation in your contact with him/her is also consistent with a child functioning in the Average Range. After working with Jamie, you conclude that his/her symptoms are consistent with a mental health diagnosis.

What would you tell Jamie? Please respond using the following Likert scale:

1 – I would explain it to Jamie in a way that he/she could understand
2 – I would tell Jamie the name of the diagnosis and give a thorough explanation of it (e.g., back-of-the-hand explanation)

Why did you make your diagnosis disclosure decision for Jamie?

Please provide three reasons for your disclosure decision here:

Which of the following is the most salient factor presented in this vignette?

- Gender
- Age
- Gender
- No Factor is the most salient

Please select one:
In the space below please provide any suggestions for ways in which to alter the vignette to make the factor, Age, more clearly stand out as the basis for making a diagnoses disclosure decision?

Any Additional Comments about this Vignette?

Cognitive Ability # 1

Diagnosis Refers to Mental Health Diagnosis

Please read the following:

Dominique is a 10-year-old child who is referred to you for current concerns experienced both at home and school. His/her parents and teachers have expressed that Dominique is experiencing difficulties impacting his/her behavior and academic performance. Dominique currently lives with his/her mother, father, and two younger siblings. Dominique has a positive relationship with his/her family. You have access to a recent evaluation that includes Dominique's WISC-IV profile, which suggest that Dominique has a full scale IQ of 120. Dominique's presentation in your contact with her/him is also consistent with a child functioning in the Superior Range. After working with Dominique you conclude that his/her symptoms are consistent with a mental health diagnosis.

What would you tell Dominique? Please respond using the following Likert scale:

1. Do not mention, I would not tell him/her any information about the diagnosis or the name of the diagnosis.
2. 3. 4. 5. 6. 7. 8. 9. 10. I would tell him/her the name of the diagnosis, and give a thorough explanation of it (e.g., symptoms, procedures).

Why did you make your diagnosis disclosure decision for Dominique?

Please provide the reason(s) for your disclosure decision here.

Which of the following is the most salient factor presented in this vignette?

- Cognitive Ability
- Age
- Gender
- No factor stands out in this example vignette
In the space below please provide any suggestions for ways in which to alter the vignette to make the factor, Cognitive Ability, more clearly stand out as the basis for making a diagnoses disclosure decision.

Any Additional Comments about the Vignette?

Cognitive Ability # 2

Diagnosis Refers to Mental Health Diagnosis

Please read the following:

Taylor is a 10-year-old child who is referred to you for current concerns experienced both at home and school. Her her parents and teachers have expressed that Taylor is experiencing difficulties impacting her behavior and academic performance. Taylor currently lives with her mother, father, and two younger brothers. Taylor has a positive relationship with her family. You have access to a recent evaluation that includes Taylor’s WISC-IV profile, which suggest that Taylor has a full scale IQ of 79. Taylor’s presentation in your contact with him/her is also consistent with a child functioning in the Borderline Range. After working with Taylor you conclude that his/her symptoms are consistent with a mental health diagnosis.

What would you tell Taylor? Please respond using the following Likert scale.

10: I would tell her the name of the diagnosis or the name of the disorder, with or without explanation of it (e.g., treatment provided).
9 8 7 6 5 4 3 2 1 0

Why did you make your diagnosis disclosure decision for Taylor?

Please provide reasons for your decision below.

Which of the following is the most salient factor presented in this vignette?

- Cognitive Ability
- **Not**
- Experiences
- Yes Factor other than the Example Vignette
In the space below please provide any suggestions for ways in which to alter the vignette to make the factor, Cognitive Ability, more clearly stand out as the basis for making a diagnosis disclosure decision.

Any Additional Comments about this Vignette?

Diagnosis Question

Are there mental health diagnoses that you are more or less likely to disclose to children? Please describe.

Open Ended Question

Please provide information (e.g., considerations for disclosure or non-disclosure, your decision making process) about your mental health diagnosis disclosure practices with children.

Please provide information about your diagnostic disclosure practices here.

Overall Content Validity Suggestions

Overall Comments and Suggestions about the Study

In the space below please provide any overall suggestions or comments about the vignettes.

In the space below please provide any additional suggestions or comments about the study.

End of Survey
Thank you for your cooperation! Your time and attention is greatly appreciated, and your participation in this study is highly valued.

Please contact us if you have any questions or concerns.

Allison Almon, B.A.
Doctoral Candidate, Counseling Psychology
The University of Iowa
allison-almon@iu.edu
(312) 432-0150

John Weisefeld, Ph.D.
Professor
Dissertation Chair
Department of Psychological and Quantitative Foundations
The University of Iowa
john.weisefeld@uiowa.edu
(319) 335-2562
Dear Psychologist,

I am a Counseling Psychology Ph.D. student in the Department of Psychological and Quantitative Foundations at the University of Iowa. I am currently in the process of completing my dissertation. I would like to invite you to participate in a research study that I am conducting as part of my dissertation. The purpose of this research study is to explore psychologists’ current mental health diagnosis disclosure practices to children. The study will consist of a 15-20 minute online survey exploring current mental health diagnoses disclosure practices. To be eligible for participation you must be a psychologist who is certified by the American Board of Professional Psychologists (ABPP) and currently works with individuals who are under the age of 18 who have a mental health diagnosis.

To take the survey please click or cut and paste the following link into your web browser:
https://uiowa.qualtrics.com/SE/?SID=SV_efzG1wYavuGnG6g

If you have any questions about the research study, please contact Allison Allmon (912-432-0159; allison-allmon@uiowa.edu) or John Westefeld, Ph.D. (319-335-5562; john-westefeld@uiowa.edu).

Thank you very much for your consideration.

Sincerely,

Allison Allmon, B.A.
Doctoral Candidate, Counseling Psychology
The University of Iowa
allison-allmon@uiowa.edu

John Westefeld, Ph.D.
Professor
Dissertation Chair
Department of Psychological and Quantitative Foundations
The University of Iowa
APPENDIX D: FINAL STUDY SURVEY

Informed Consent

We would like to invite you to participate in a research study that is being conducted at the University of Iowa. The purpose of this research study is to explore psychologists' current mental health diagnosis disclosure practices to children.

We are inviting you to participate in this research study because you are a psychologist who is certified by the American Board of Professional Psychology (ABPP) and currently works with individuals who are under the age of 18 who have a mental health diagnosis. Approximately 100 psychologists will take part in the study.

If you agree to participate, we would like you to complete a 15-20 minute online survey. This online survey will include demographic questions (e.g., gender, age), scenarios rating-scale questions, and open-ended questions about your current mental health diagnosis disclosure practices. You may skip any questions that you prefer not to answer. Additionally, the survey may be ended at any time by clicking the "Close" button in the upper left-hand corner of each survey screen.

We will keep the information you provide confidential; however, federal regulatory agencies and the University of Iowa Institutional Review Board (a committee that reviews and approves research studies) may inspect and copy records pertaining to this research. To help protect your confidentiality, your personally identifiable information will be obtained from you during your study participation. If we write a report about the study we will do so in such a way that you cannot be identified.

There are no known risks from being in this study, and you will not be harmed personally. However, we hope that others may benefit in the future from what we learn as a result of this study.

You will not have any costs for being in this research study.

You will not be paid for being in this research study.

Taking part in this research study is completely voluntary. If you decide not to be in this study, or if you stop participating at any time, you won't be penalized or lose any benefits for which you otherwise qualify.

If you have any questions about the research study itself, please contact Allison Almon (912-432-0159, alison.almon@iowae.edu) or John Westedfeld, Ph.D. (319-355-5562, john.westedfeld@uiowa.edu). If you experience a research-related injury, please contact Allison Almon (912-432-0159, alison.almon@uiowa.edu) or John Westedfeld, Ph.D. (319-355-5562, john.westedfeld@uiowa.edu). If you have questions about the rights of research subjects, please contact the Human Subjects Office, 105 Karden Library for the Health Sciences, 600 Newton Rd, The University of Iowa, Iowa City, IA 52242-1098, (319) 353-6564, or e-mail info@uiowa.edu. To offer input about your experiences as a research subject or to speak to someone other than the research staff, call the Human Subjects Office at the number above.

Thank you very much for your consideration. Completing the online survey will indicate your willingness to participate in the study.

Sincerely,

Allison Almon, D.A.
Doctoral Candidate, Counseling Psychology
The University of Iowa
alison-almon@uiowa.edu

John Westedfeld, Ph.D.
Professor
Dissertation Chair
Department of Psychological and Quantitative Foundations
The University of Iowa

By clicking the Next button you are agreeing to participate in the study.
Background Information Form

What is your Gender?
- Male
- Female
- Transgender

What is your Race/Ethnicity?
- African American
- Asian
- Black
- Hispanic
- Other
- White
- Native Hawaiian
- Other racial/ethnic group:

Please indicate which of the following American Board of Professional Psychology (ABPP) certification(s) you currently hold. Please choose all that apply:

- Clinical Child and Adolescent Psychology
- Clinical Health Psychology
- Clinical Neuropsychology
- Clinical Psychology
- Cognitive and Behavioral Psychology
- Counselling Psychology
- Couple and Family Psychology
- Forensic Psychology
- Group Psychology
- Organizational and Business Consulting Psychology
- Police and Public Safety Psychology
- Psychologist in Psychology
- Rehabilitation Psychology
- School Psychology

I currently work in a setting where I diagnose children (individuals under the age of 18 years old) with mental health disorders:
- Yes
- No
What is your primary work setting?
- University Settings
- Four-year Colleges
- Medical Schools/Training/Research Center
- Other Academic Settings
- Schools and Other Educational Settings
- Independent Practice
- Hospital
- Other
- Other Human Service
- Business & Industry
- Government
- Other

At the setting in which I diagnose children (individuals under the age of 18 years old) with mental health diagnoses I provide which of the following services?
- Counseling services
- Diagnostic Evaluation
- Both Counseling Services and Diagnostic Evaluations

What is your terminal degree?
- PhD
- PsyD
- EdD
- MD
- Masters
- Other (describe or identify type and equivalent)

Please indicate the number of years you have provided clinical service (include only those years after internship)

I am a licensed psychologist:
- Yes
- No

Culture Vignettes and Questions
Diagnosis Refers to Mental Health Diagnosis

Please read the following:

Riley is a 10-year-old Caucasian child of European descent who is referred to you for current concerns experienced both at home and school. His/her parents and teachers have expressed that Riley is experiencing difficulties impacting social behavior and academic performance. Riley's great-grandparents immigrated to the United States and his/her family resided in the United States since that time. Riley's family holds traditional American values. Riley currently lives with his/her mother, father, and two younger brothers. Riley has a positive relationship with his/her family. You have access to a recent evaluation that includes Riley's WISC-IV profile, which suggests that Riley has a full-scale IQ of 102. Riley's presentation in your contact with him/her is also consistent with a child functioning in the Average Range. After working with Riley you conclude that his/her symptoms are consistent with a mental health diagnosis.

What would you tell Riley? Please respond using the following Likert scale.

1 2 3 4 5 6 7 8 9

On what basis did you make your diagnostic decision for Riley?

Please provide the reasoning for your diagnostic decision here.

Diagnosis Refers to Mental Health Diagnosis

Please read the following:

Tu Su Li is a 10-year-old Chinese-American child who is referred to you for current concerns experienced both at home and school. Tu Su Li is regarded to be told by his/her American name, Jordan, for the purpose of your work together. His/her parents and teachers have expressed that Jordan is experiencing difficulties impacting his/her behavior and academic performance. Jordan's great-grandparents immigrated to the United States from China and his/her family has resided in the United States since that time. His/her family holds traditional Chinese values. Jordan currently lives with his/her mother, father, and two younger brothers. Jordan has a positive relationship with his/her family. You have access to a recent evaluation that includes Jordan's WISC-IV profile, which suggests that Jordan has a full-scale IQ of 102. Jordan's presentation in your contact with him/her is also consistent with a child functioning in the Average Range. After working with Jordan you conclude that his/her symptoms are consistent with a mental health diagnosis.
What would you tell Jordan? Please respond using the following Likert scale.

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<tr>
<td>Even I asked, I would not tell him/her any information about the diagnosis or the name of the diagnosis.</td>
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<td>I would tell him/her the name of the diagnosis and give a thorough explanation of it (e.g., treatment procedures).</td>
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On what basis did you make your disclosure decision for Jordan?

Please provide the reasons for your disclosure decision here.

Age Vignettes and Questions

Diagnosis Refers to Mental Health Diagnosis

Please Read the Following:

Robin is a 6-year old child who is referred to you for current concerns experienced both at home and school. Her parents and teachers have expressed that Robin is experiencing difficulties impacting her behavior and academic performance. Robin is currently in the first grade. Robin currently lives with her mother, father, and two younger brothers. Robin has a positive relationship with her father. You have access to a recent evaluation that includes Robins WISC-IV profile, which suggest that Robin has a full scale IQ of 112. Robin’s behavioral presentation in your contact with her is also consistent with a child functioning in the Average Range. After working with Robin you conclude that her behavior symptoms are consistent with a mental health diagnosis.

What would you tell Robin? Please respond using the following Likert scale.

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<td>Even I asked, I would not tell him/her any information about the diagnosis or the name of the diagnosis.</td>
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<td>I would tell him/her the name of the diagnosis and give a thorough explanation of it (e.g., treatment procedures).</td>
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On what basis did you make your disclosure decision for Rob?

Please provide the reasons for your disclosure decision here.

Diagnosis Refers to Mental Health Diagnosis
Please Read the Following:
Jamie is a 16-year-old child who is referred to you for current concerns experienced both at home and school. His/her parents and teachers have expressed that Jamie is experiencing difficulties impacting his/her behavior and academic performance. Jamie is currently in the tenth grade. Jamie recently lived with his/her mother, father, and two younger brothers. Jamie has a positive relationship with his/her family. You have access to a recent evaluation that includes Jamie's WISC-IV profile, which suggests that Jamie has a full scale IQ of 102. Jamie’s presentation in your contact with him/her is also consistent with a child functioning in the Average Range. After working with Jamie, you conclude that his/her symptoms are consistent with a mental health diagnosis.

What would you tell Jamie? Please respond using the following Likert scale:

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<td>Not at all</td>
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<td>Moderate</td>
<td>Significant</td>
<td>Very Significant</td>
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On what basis did you make your disclosure decision for Jamie?
Please provide the reasoning for your disclosure decision here.

Cognitive Ability Vignettes and Questions

Diagnosis Refers to Mental Health Diagnosis

Please Read the Following:
Dominique is a 10-year-old child who is referred to you for current concerns experienced both at home and school. His/her parents and teachers have expressed that Dominique is experiencing difficulties impacting his/her behavior and academic performance. Dominique is currently in Talented and Gifted Programming in school. Dominique currently lives with his/her mother, father, and two younger brothers. Dominique has a positive relationship with his/her family. You have access to a recent evaluation that includes Dominique’s WISC-IV profile, which suggests that Dominique has a full scale IQ of 120 (Percentile Rank: 95, 95% Confidence Interval 114-124). Higher WISC-IV Index Scores are the following: Verbal Comprehension Index = 119, Perceptual Reasoning Index = 117, Working Memory Index = 115, Processing Speed Index = 112. Your contact with Dominique is consistent with a child functioning in the Superior Range. After working with Dominique, you conclude that his/her symptoms are consistent with a mental health diagnosis.

What would you tell Dominique? Please respond using the following Likert scale:

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<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Some</td>
<td>Moderate</td>
<td>Significant</td>
<td>Very Significant</td>
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On what basis did you make your disclosure decision for Dominique?

Please provide the reason for your disclosure decision here.

Diagnose Refers to Mental Health Diagnosis

Please read the following:

Taylor is a 10-year-old child who is referred to you for current concerns experienced both at home and school. His/her parents and teachers have expressed that Taylor is experiencing difficulties impacting his/her behavior and academic performance. Taylor has an Individualized Education Plan in order to receive appropriate support and accommodations in school. Taylor currently lives with his/her mother, father, and two younger brothers. Taylor has a positive relationship with his/her family. You have access to a recent evaluation that includes Taylor’s WISC-IV profile, which suggests that Taylor has a Full Scale IQ of 79 (Percentile Rank=8), 95% Confidence Interval: 65-85), and Higher WISC-IV Index Scores are the following: Verbal Comprehension Index: 83; Perceptual Reasoning Index: 84; Working Memory Index: 83; Processing Speed Index: 83. Your contact with Taylor is consistent with a child functioning in the Borderline Range. After working with Taylor you conclude that his/her symptoms are consistent with a mental health diagnosis.

What would you tell Taylor? Please respond using the following 10-point scale:

1 = Do not inclusion of the diagnosis or the name of the diagnosis.
2 3 4 5 6 7 8 9 10 = Would include the name of the diagnosis and its etiology.

On what basis did you make your disclosure decision for Taylor?

Please provide the reason for your disclosure decision here.

Open Ended Questions

Are there diagnoses that you are more or less likely to disclose to children? Please describe.
Please provide information (e.g., considerations for disclosure or non-disclosure, your decision-making process) about your mental health diagnoses disclosure practices with children.

Please provide information about your diagnostic disclosure practices.

End of Survey

Thank you for your cooperation! Your time and attention is greatly appreciated, and your participation in this study is highly valued.

Please contact us if you have any questions or concerns.

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APPENDIX E: POTENTIAL DIAGNOSES DISCLOSURE CONSIDERATIONS

<table>
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<tr>
<th>Potential Considerations for Psychologists’ Mental Health Diagnoses Disclosure to Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychologist Self Reflection</strong></td>
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1. **What are my beliefs about diagnoses disclosure with children?**
   a. Do I hold strong beliefs about a child’s right to know their diagnoses? Or parent choice?
   b. How do these beliefs influence my diagnoses disclosure decisions?
   c. How do my beliefs impact my diagnoses disclosure practices with children?
   d. How might I reconcile potential differences between my disclosure beliefs and those of the families with whom I work?
   e. How have the beliefs evolved? Have they changed over time?
   f. What are my beliefs/values about diagnoses?
      i. How do these values influence my diagnoses disclosure decision making?
      ii. How do these values impact my diagnoses disclosure practices with children?
      iii. Where do these values come from? How have they evolved?

2. **What are my current diagnoses disclosure practices?**
   a. How might I describe my decision making process?
      i. To a colleague? To a parent? To a client?
   b. How have I made diagnoses disclosure decisions with children in the past?
   c. What do I base these decisions upon?
      i. What child and family characteristics do I consider?
   d. Are there diagnoses I am more likely to disclose or not disclose?
      i. What are they?
      ii. Why?
   e. Who could I speak with about my experiences with and feelings about diagnoses disclosure with children?
      i. Colleague? Supervisor?

| Client Characteristics and Support |

1. **What characteristics of this child may influence their ability to understand the diagnosis?**
   a. Consider the impact of the child’s:
      i. Age
      ii. Culture
      iii. Cognitive ability
      iv. Developmental Level
      v. Maturity
      vi. Other individual characteristics that might impact disclosure decision making
vii. Interaction of child characteristics on disclosure decision making
   b. Consider the impact of the child’s specific diagnosis?
      i. What treatment is child likely to receive?
      ii. How might the diagnosis’ prevalence, public awareness, or social stigma influence disclosure?
         1. How familiar is the child and family with this diagnosis?

2. Consider the impact of the child’s current support?
   a. How might therapeutic rapport with both the child and family impact disclosure?
   b. What type or external support does the child already have in place (e.g., family, peers)? How might this impact disclosure?

3. Do the child’s parents/guardians have diagnosis disclosure preference?
   a. What are they?
   b. Are they commensurate with my own decision making? If not, how will this be reconciled?

4. Has the child expressed a desire to know their diagnosis?
   a. If so, how might I address or help the family handle this situation?
   b. If not, how might this be handled in the future?

Potential Implications of Diagnoses Disclosure Decision

1. What are the potential benefits of disclosure?

2. How might disclosure impact treatment options or success?
   a. Are there other supportive outlets that are available due to disclosure (e.g., support groups, group therapy)?
   b. Are there other providers involved in the client’s treatment (e.g., psychiatrist)? How might this influence my disclosure decision?

3. What are the potential negative implications of disclosure?

4. What are the ethical implications of my disclosure decision?

Diagnoses Disclosure Practices

1. If the decision is made to disclose the diagnosis to the child, consider the act of disclosure itself.
   a. What is the goal for disclosure with this child?
      i. Normalization? Explanation of services? Responding to a child’s question?
   b. When will the disclosure take place?
   c. Where will the disclosure take place?
   d. How will the disclosure take place?
      i. How can I make the disclosure discussion commensurate with child’s
understanding?
ii. What type of language will I use?
   1. How can I make this language kid-friendly and developmentally appropriate?
iii. Will I use the actual name of the diagnoses?
   1. What are the positive and negative implications of disclosing the name of the diagnosis?
   2. If not, what will you say?
      a. If an evaluation was completed will I discuss in terms of areas of strengths and weakness?
iv. Is progressive disclosure most appropriate? How might I use this form of gradual disclosure to benefit the client and family?
e. Who?
   i. Who will relay the information to the child? Parents? Psychologist? Both?
   ii. Who will be present during the disclosure?

2. If a non-disclosure decision is made, what might this mean for the future?
   a. Consider helping the family address potential future questions from the child (e.g., why do I see a therapist?)
   b. How and when might the disclosure decision change in the future?

*Note: This list was modeled after Foley Nicpon et al.’s (n.d.) proposed diagnostic disclosure discussion points for mental health professionals working with parents*