The Effect of Patient Education on Chinese Adolescent and Parental Beliefs About Counselors' Breaches of Confidentiality

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Abstract

The primary aim of the present study is to explore whether brief education can change Chinese adolescents' and parents' beliefs about when counselors would breach confidentiality. The two secondary aims are to examine whether the brief education (1) increases adolescents' willingness to share private information with their counselor and (2) decreases parents' expectations of the amount of information their child's counselor would divulge to them. Results showed that adolescents and parents who read a brief passage about the limitations of confidentiality were significantly less likely to believe counselors would breach confidentiality in situations where counselors reported they would not likely breach confidentiality. Regarding our secondary research aims, results indicate that education increases adolescents' willingness to share more sensitive information, such as about suicidality and drug use, but it does not change parents' expectations to have most of the information divulged to them by their child's counselor.

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Introduction

Developmental changes during adolescence promote a unique set of challenges, which may leave this population vulnerable to mental health issues. Cross-cultural research provides empirical support linking adolescence to psychological dysfunction, as indicated by increased anxiety, stress, depression, and perceived negative emotions,[1] increased unhealthy and risky behaviors,[2] and psychopathology prevalence rates comparable to those in adults, with many adolescents experiencing clinical symptoms for the first time in their lives.[1] Left untreated, adolescent psychopathology and risk behaviors can result in a range of adverse consequences (e.g., imprisonment, premature death),[3] making it particularly important that this population has access to mental health services and feels comfortable taking advantage of these services.

Unfortunately, despite the presence of effective psychological treatments for adolescents, this age group tends to underutilize mental health services.[4, 5] Studies conducted in the USA report that more than 70% of adolescents with mental health-related problems do not receive care.[6]

According to the World Health Organization, these rates are even lower in non-Western countries.[7] In China, a country that is home to nearly 20% of the world's population and with one of the highest rates of mental illness in the world (17.5%), only 11% of individuals with psychopathology utilized mental health services, with even lower rates in individuals under 35.[8] It is therefore important to identify and address potential barriers that are keeping adolescents from seeking treatment, particularly in non-Western cultures.

Perhaps the most important barriers to adolescents seeking professional mental health services in China are the lack of availability of sufficiently trained providers. For example, according to the Chinese National Health and Family Planning Commission, there are 20,000 psychiatrists (including child psychiatrists) in China and the average doctor-patient rate is 1.49/100,000.[9]

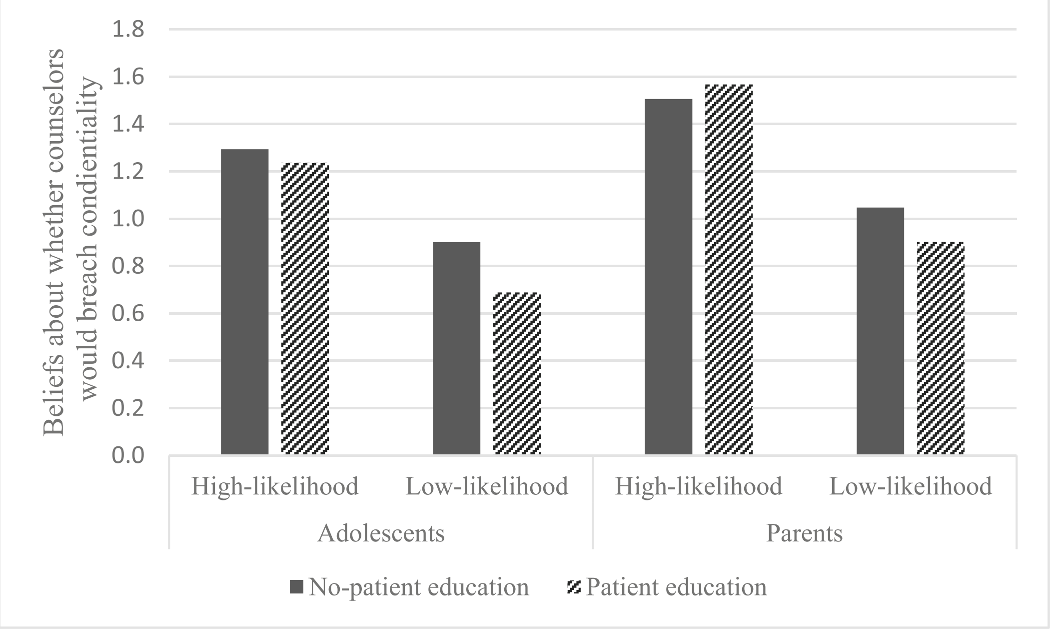
Studies on help-seeking behaviors among young adults in China identified other important barriers, including a lack of mental health knowledge, social stigma, distrust for professionals, and the desire to handle one's own problems.[10–12] Studies also found that younger adolescents, adolescent boys, and adolescents who reported more severe psychological and behavioral problems also reported less positive professional help-seeking attitudes and reported being less willing to seek professional help.[13, 14] One study found that parental knowledge of their adolescents' problems was associated with more positive professional help-seeking attitudes.[11] However, follow-up analyses found that only paternal knowledge of the child's psychological problems mediated the relationship between adolescents' problem severity and their help seeking attitudes. The present study will contribute to the body of literature exploring barriers to Chinese adolescent mental health services utilization by (1) exploring the differences in adolescents' and parents' beliefs about when counselors would breach confidentiality and (2) evaluating the efficacy of brief education in modifying these beliefs, with the hope of increasing adolescent willingness to utilize mental health services (Fig. 1).

Confidentiality as a Barrier to Adolescent Mental Health Treatment

One key barrier to the utilization of mental health services by adolescents is concern about privacy and confidentiality.[15, 16] Many adolescents struggle with challenges they wish to keep private from their parents, and they may avoid seeking help due to fears that private information they disclose during treatment will be shared with their parents without their consent. Empirical work indicates that 25% of adolescents would forgo treatment if their parents would find out about these challenges.[17] Furthermore, if parental notification was required, only 45% and 20% of adolescents would seek help for depression and drug use, respectively.[18, 19]

Figure 1

. Analysis of the confidentiality belief ratings on high-breach likelihood vs. low-breach likelihood situations: The effect of brief education on adolescents and their parents. Note. Rating code: Would most counselors breach confidentiality in these situations? 2 (most would), 1 (not sure), and 0 (most would not)



This body of work collectively highlights the importance of providing confidential care for adolescents. However, there are also a number of factors that make confidentiality protection more challenging for counselors providing psychotherapy services for adolescents, compared to adults.[16]

Parental and Counselors Beliefs About Confidentiality for Adolescence

One factor that complicates therapeutic confidentiality for adolescents is the involvement of parents/primary caretakers. Parents tend to have some degree of responsibility for initiating and financing treatment for adolescents and may therefore have their own expectations regarding the goals and course of treatment. They may also have beliefs about what types of information counselors should share with them about their adolescents (e.g., when confidentiality should be breached).[20, 21]

There has been some preliminary work investigating parental beliefs concerning adolescent confidentiality in the USA. One study found that 96% of parents endorsed the belief that doctors would share any private conversations that were had with their adolescent children, even if the adolescent specifically asked for it to not be shared with their parents.[21] This is consistent with findings from a study investigating differences between parental and counselor beliefs about confidentiality in mental health treatment for adolescents in China. This study found that Chinese parents reported that they believed it would be ethical to breach confidentiality in each of 36 hypothetical scenarios describing situations one might consider risky. For example, they believed it would be ethical for a counselor to share information regarding smoking cigarettes, watching pornography, or fighting, regardless of the frequency, intensity, and duration of the behavior (Fig. 2).[22] By contrast, Chinese counselors reported that the only situations in which they would find it ethical to breach confidentiality would be in situations related to suicidality and daily drug use. These results suggest there may be a discrepancy between parental and counselor views on confidentiality in China. Furthermore, counselors were significantly more likely than parents to agree that the principle of confidentiality applied to adolescents, with 87% of counselors supporting confidentiality for adolescents.[22]

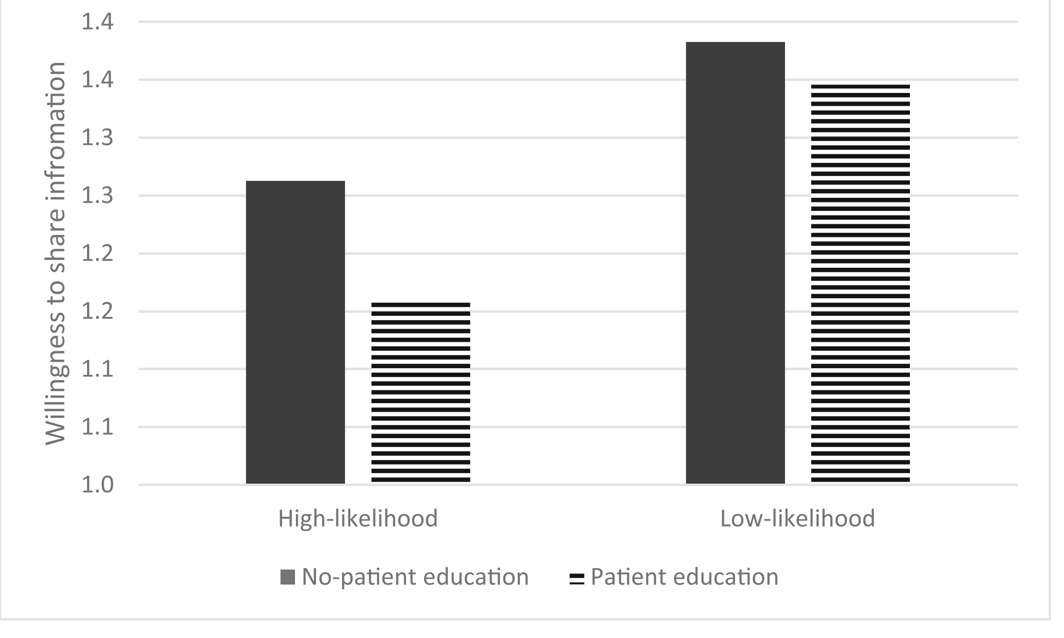
This is consistent with work examining counselor beliefs regarding confidentiality in the USA. For example, pediatric psychologists and school psychologists generally believe it is unethical to break confidentiality when it relates to health risk behaviors that occur infrequently.[23] However, Rae et al. found that counselors reported, almost unanimously, that it was ethical to break confidentiality in certain situations, even at the lowest level of frequency and duration, such as a suicide attempt.[23]

The Impact of Patient Education on Beliefs Regarding Confidentiality

Given that the majority of counselors *do* support confidential care for adolescents, except in very specific situations, adolescents' concerns about confidentiality may reflect inaccurate understanding of the nature of confidentiality in psychotherapy and/or an exaggerated perception of situations in which counselors would breach confidentiality. If these inaccurate perceptions are contributing to their concerns about confidentiality, providing education about confidentiality assurances (e.g., information shared in therapy will remain between the adolescent and the counselor, and will *not* be shared with anyone else, including their parents) and the specific situations in which counselors

Figure 2

Two-way analysis of variance of adolescents' willingness to share information with counselors. Note. Rating code: Yes = 1 and No = 2



would breach confidentiality (e.g., risk of serious harm to self or others, physical or sexual abuse) may help to assuage some of their fears concerning confidentiality.

Prior research provides evidence that accurate knowledge about confidentiality has the potential to impact adolescent treatment seeking. For example, confidentiality assurances have been shown to increase the likelihood that adolescents will both seek and return for mental health care and provide more accurate, complete, and candid information about sensitive concerns (e.g., substance abuse, fighting, carrying a weapon, risky sexual behaviors, and suicidality).[16, 18, 19]

However, addressing adolescents' perceptions alone, without also challenging parental views on confidentiality, may render the intervention less effective. For example, it is possible that parental expectations that counselors will divulge private information shared by the adolescent may contribute to adolescent concerns about confidentiality. Additionally, discrepancies between parental, adolescent, and counselor beliefs about confidentiality and situations in which confidentiality should be breached could potentially undermine the process of therapy and create conflict when parental expectations are not met. Thus, in order to maximize the likelihood that adolescents receive quality, confidential mental health treatment, it is important to promote consistency among parental, adolescent, and counselor beliefs surrounding confidentiality.

There is some evidence to suggest that education is effective in changing not only adolescent perceptions on confidentiality but also parental perceptions as well. One study investigated the efficacy of a brief education on modifying parental knowledge relating to teen privacy and risk-taking behaviors in a medical setting.[20] Results from this study indicate that both written and face-to-face education were effective in increasing parental beliefs that adolescents can have private information and the right to see a doctor privately without parental presence.[20]

Current Study

Building upon this work, the current study sought to investigate whether a brief education could effectively modify adolescent and parental opinions concerning confidentiality in the context of psychotherapy in China. Specifically, it was hypothesized that the brief education would (1) change beliefs of parents and adolescents about when confidentiality should be breached, (2) lead to increased reported willingness from adolescents to share sharing sensitive information with counselors, and (3) lead to reduced parental expectations that counselors will share confidential information divulged by adolescents.

Methods

Participants

Adolescent participants ($N=245$) were primarily female (63%), with an average age of 16.9 years ($SD=0.90$). Their grades in school were as follows: 33% ($N=79$) were 10th graders, 54% ($N=131$) were 11th graders, and 12% ($N=29$) were 12th graders. Only 14 (6%) of the students endorsed ever having received psychological counseling or therapy services for any reason.

Parent participants ($N=216$) were primarily female (60%), with an average age of 43.8 years ($SD=3.33$). Their educational composition was as follows: 13% completed junior high school or less, 22% completed high school, 18% completed the Chinese equivalent of an associate's degree, 36% had a bachelor's degree, and 11% completed some form graduate school. Only 7 (3%) of the parents indicated their child had ever received psychological counseling.

Measures and Procedure

An 18-item questionnaire was developed for this study to assess participants' views about therapeutic confidentiality breaches with adolescents. The 18 hypothetical clinical situations were adapted from a similar measure developed by Rae et al.[23] For each item, subjects were given a hypothetical piece of information an adolescent client might share with his/her counselor about his/her specific behaviors, including skipping school, cheating on exams, watching pornography, fighting with peers, stealing things from stores, smoking, being drunk, being depressed, suffering from eating disorders, having a romantic relationship, wanting to have sex with his/her partner, having protected sex with his/her partner, having unprotected sex with their partner, being worried about contracting sexually transmitted diseases, being gay/lesbian, using drugs, having suicidal ideas, and attempting suicide.

Adolescents' instructions were to imagine they were currently receiving counseling and that each item represents a hypothetical piece of information they shared with their counselor. Parents' instructions were to imagine their child was currently receiving counseling and that each questionnaire item represented a hypothetical piece of information their adolescent child shared with his/her counselor. For each item, parents and adolescents answered the following question, "Do you believe most counselors would share this information with (you or your parent)?" Response options included the following: 2 = *most would* (breach confidentiality), to 1 = *not sure*, to 0 = *most would not*. They were also asked to answer another question for each item. Parents were asked: "Do you expect the counselor to divulge this information to you?" Adolescents were asked: "Are you willing to tell this information to your counselor?" Response options for both questions included the following: 1 = *yes* and 2 = *no*.

In a previous study, 36 Chinese counselors were surveyed using the same 18-item questionnaire.[24] They were asked to imagine they were treating a 15-year-old adolescents and then rated if they would breach confidentiality and divulge it to their clients' parents if their clients informed them of this specific piece of information. Counselors rated their responses using a 3-point Likert scale, where 3 = *I would share this information with parents* (i.e., breach confidentiality), 2 = *I am not sure*, and 1 = *I would not share this information with parents* (i.e., maintain confidentiality). Two subtests were calculated based on this prior study: *high-breach* and *low-breach likelihood*. There were five items where at least 50% of counselors indicated that they would breach confidentiality. These items were then identified as *high-breach likelihood* items. The high-breach likelihood items were "being depressed," "having an eating disorder," "having suicidal thoughts," "trying drugs," and "attempting suicide." For the other 13 items (i.e., *low-breach likelihood*); at least 75% of counselors indicated they would not breach confidentiality. The low-breach likelihood items were related to skipping class, cheating on a test, smoking, viewing pornography, having consensual sex, drinking, and stealing.

Brief Education and Manipulation Check

Participants in the no-education condition only completed the questionnaire. Participants in the brief education condition first read a passage before completing the questionnaire. The educational passage was introduced as being a "hypothetical explanation of the conditional assurance of confidentiality that a counselor may share with a patient during the first counseling visit." It read as follows:

> As a general rule, I will keep the information you share with me in our sessions confidential. This means that what we talk about is just between you and me, and that other people, including your parents, will not find out about it unless you want them to know. There are, however, important exceptions to this rule that are important for you to understand. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. The situations when confidentiality cannot be maintained include: (1) When

you tell me you plan to cause serious harm or death to yourself or someone else who can be identified; (2) when you tell me you are being or have been abused physically or sexually; and (3) when you are involved in a court case and a request is made for information about your counseling.

After reading the passage, a manipulation check was conducted in order to ensure that participants read the passage carefully. Participants were asked to answer the following question: "According to the passage above, which of the following are exceptions to the confidentiality agreement? Check all that apply." Response options included the following: (1) *Adolescent client was the victim of sexual abuse*, (2) *any behavior or activity that parents would definitely disapprove of*, and (3) *the client plans to commit suicide*. In order to pass the manipulation check, participants needed to check both items 1 and 3, but not 2. Any other response combination resulted in a failure to pass the manipulation check.

Participant Recruitment, Randomization, and Inclusion Criteria

In the present study, a convenience sample of 341 pairs of high school students and their parents were recruited from six cities in China. High school teachers ($N = 11$) handed out questionnaires to their students who then delivered questionnaires to one of their parents. Students were instructed to return the questionnaires and signed consent forms to their teacher within 1 week. In order to be considered valid, parent questionnaires and consent forms had to be returned in a closed envelope, signed across the seal. All questionnaires were completed on a voluntary basis. Students and parents received a small gift for their participation. Students received a notebook (with a leather-like cover) and a ball-point pen with Fudan University logos printed on both items. The value of both items was approximately US$3.00. This study received permission from the Research Ethics Committee of Fudan University. Informed consent was obtained from all participants and their parents.

Of the 682 questionnaires that were distributed to adolescents and parents, 638 (94%) were returned, and 615 (96%) were valid. Reasons for being invalid included the following: incomplete questionnaires (i.e., 50% of items were left unanswered; $N = 9$), parent-surveys returned in unsigned envelopes ($N = 12$), and signatures screened by teachers as having been obviously forged by the student ($N = 2$).

Of the 316 valid adolescent questionnaires, 163 were for participants in the *no brief education* (no-BE) condition and 153 were in the *brief education* (BE) condition. However, only 82 (50%) of the adolescents in the BE condition passed the manipulation check. Participants in the BE condition who did not pass the manipulation check were not included in future analyses. Of the 299 valid parent questionnaires, 152 were in the no-BE condition and 147 were in the BE condition. However, only 64 (43%) of the parents in the BE condition passed the manipulation check and were included in future analyses.

Results

Descriptive Statistics

Table 1 provides a summary of participants' descriptive statistics and mean ratings for high- and low-breach likelihood items. Among both participant groups (adolescents vs. parents), item type (high- vs. low-breach likelihood situations) and study condition (brief education vs. no education), parents who received brief education rated the high-breach likelihood items as most likely to be disclosed ($M = 1.57$, where two represents the belief that most counselors would breach confidentiality). In contrast, the lowest rating were for the low-breach likelihood items when rated by adolescents who received brief education ($M = 0.69$, where 0 represents the belief that most counselors would not breach confidentiality).

Table 1

Descriptive statistics and participants' mean ratings for high- and low-breach likelihood items

	Adolescents		**Parents**	
	No brief education, *N* = 164	**Brief education*, *N* = 82**	**No brief education, *N* = 152**	**Brief education*, *N* = 64**
Mean age (*SD*)	17 (0.94)	17 (0.80)	44 (3.38)	43 (3.11)
Female, *N* (%)	95 (60%)	56 (68%)	88 (60%)	37 (58%)
High-breach likelihood, mean (*SD*)	1.29 (0.67)	1.24 (0.56)	1.51 (0.56)	1.57 (0.44)
Low-breach likelihood, mean (*SD*)	0.90 (0.59)	0.69 (0.51)	1.05 (0.58)	0.90 (0.46)

High- and low-breach likelihood scores were based on the following question and rating scale, "Would you (or most counselors) breach confidentiality in this situation?" 2 = most would (i.e., breach confidentiality), 1 = not sure, and 0 = most would not (i.e., maintain confidentiality)

*Only participants who passed the manipulation check

Effect of the Brief Education on Attitudes Toward Confidentiality

The present study explored whether a brief education (i.e., reading a passage about the limitations of confidentiality) would change adolescents' and parents' beliefs about when counselors would breach confidentiality. To examine this question, a general linear model (GLM) analysis was first conducted to examine the confidentiality belief ratings for high-breach likelihood vs. low-breach likelihood items, using subject type (parents vs. adolescents) and condition (BE vs. no-BE) as the grouping variables. Two categories *high-breach* and *low-breach likelihood* items were calculated based on a prior study.[24] There were 5 *high-breach likelihood* items (i.e., situations where at least 50% of counselors indicated that they would breach confidentiality) and 13 *low-breach likelihood* items (i.e., situations where at least 75% of counselors indicated they would not breach confidentiality).

The three-way interactions were not significant, $F(1, 457) = 0.245$, $p = .621$, as well as the two-way interaction between the subject type and the ratings of high- vs. low-breach likelihood items, $F(1, 457) = 3.026$, $p = .083$. Results revealed a significant two-way interaction between condition and ratings of high vs. low breach likelihood items, $F(1, 457) = 11.730$, $p = .001$, as well as a significant main effect of high-breach likelihood vs. low-breach likelihood items, $F(1, 457) = 381.474$, $p < .001$. There was also a significant main effect for the subject type, $F(1, 457) = 19.487$, $p < .001$. The main effect of the condition was not significant, $F(1, 457) = 2.984$, $p = .085$, as well as the two-way interaction effect between the condition and the subject type, $F(1, 457) = 0.245$, $p = .621$.

Further independent sample t test analyses showed that, for both parents and adolescents, as for ratings of the high-breach likelihood items, there was no significant difference between the BE condition ($M = 1.38$, $SD = 0.54$) and no-BE condition ($M = 1.40$, $SD = 0.63$), $t(325.66) = 0.256$, $p = .789$. As for the low-breach likelihood items, the mean breach of confidentiality belief ratings was significantly lower for the BE condition ($M = 0.78$, $SD = 0.59$) than for that of the no-BE condition ($M = 0.97$, $SD = 0.59$), $t(459) = 3.370$, $p = .001$. This result indicated that BE would be able to change adolescents' and parents' beliefs about when counselors would breach confidentiality only for those situations rated as low-breach likelihood by counselors. Besides, for both parents and adolescents, their ratings for high-breach likelihood items ($M = 1.40$, $SD = 0.03$) were significantly greater than that for low-breach likelihood items ($M = 0.88$, $SD = 0.03$). Finally, in general, parents' confidentiality belief ratings ($M = 1.26$, $SD = 0.38$) were significantly higher than adolescents' ratings ($M = 1.03$, $SD = 0.034$), indicating that parents were more likely to believe that counselors would breach confidentiality regardless of specific situations.

A series of two-way between-subjects ANOVAs were conducted using condition (BE vs. no-BE) and item type (*high*- vs. *low-breach likelihood*) as the grouping variables, in order to investigate whether a brief education would (1) increase adolescents' willingness to share private information with their counselor and (2) decrease parents' expectations about what information would be divulged by their child's counselor.

Effect of Brief Education on Adolescents' Willingness to Share Sensitive Information

Adolescents' willingness-to-share-sensitive-information ratings were subjected to a two-way analysis of variance having two levels of item type (high-breach likelihood, low-breach likelihood) and two levels of condition (BE, no-BE). Willingness ratings ranged from 1 (*would be willing*) to 2 (*would not be willing*). Results revealed a significant main effect of item type, $F(1, 242) = 82.87$, $p < .001$. There was marginally significant main effect of condition, $F(1, 242) = 3.763$, $p = .054$. The interaction effect was marginally significant, $F(1, 242) = 3.759$, $p = .054$.

Further analysis showed that, as for high-breach likelihood situations, adolescents who received a brief education ($M = 1.16$, $SD = 0.25$) were more willing to share the sensitive information with counselors than those who did not receive the brief education ($M = 1.27$, $SD = 0.31$), $t(244) = 2.59$, $p = .01$. As for low-breach likelihood, no difference was found between the two groups, $t(242) = 0.935$, $p = .351$.

Effect of Brief Education on Parents' Expectations for Counselors to Share Sensitive Information

Parents' expectations-for-counselors-to-divulge-sensitive-information ratings were subjected to a two-way analysis of variance having two levels of item type (high-breach likelihood, low-breach likelihood) and two levels of condition (BE, no-BE). Mean *expectation* ratings ranged from 1 (*would expect*) to 2 (*would not expect*). Results revealed a significant main effect of item type, $F(1, 212) = 89.74$, $p < .001$, indicating that parents' mean *expectation* rating was significantly greater for high-breach likelihood items ($M = 1.11$, $SD = 0.02$) than for low-breach likelihood items ($M = 1.30$, $SD = 0.025$). However, the interaction effect and the main effect of condition were non-significant, $F(1, 212) = 1.04$, $p > .05$ and $F(1, 212) = 0.148$, $p > .05$, respectively.

Discussion

The present study is the first to examine the effect of education on perceptions of counselor confidentiality among parents and adolescents in China. Specifically, we explored (1) whether a brief education (i.e., reading a description about the limitations of confidentiality) would change adolescents' and parents' beliefs about when counselors would breach confidentiality, (2) whether this patient education would increase adolescents' willingness to share private information with their counselor, and (3) whether the brief education would change parents' expectations about what information would be divulged by their child's counselor.

Results revealed that for *low-breach likelihood* items identified by a group of counselors in an earlier study, a brief education was associated with a lower likelihood for adolescents and parents to believe that counselors would breach confidentiality.[24] For the *high-breach likelihood* items, a brief education was not able to produce any effect on both parents' and adolescents' attitudes about confidentiality. Considering the fact that for five situations identified as high-breach likelihood situations, they all could be interpreted as situations where adolescents were under the great risks of self-harm; these results suggest that the education given to parents and adolescents were able to provide them with a more accurate knowledge on the issue of confidentiality.

Regarding the effect of patient education on adolescents' self-reported willingness to share sensitive information with their counselor, adolescents in the BE condition reported that they would share a significantly greater number of *high-breach likelihood* items. In other words, education seemed to increase adolescents' willingness to share more difficult and alarming information about themselves. One way to interpret this result was that adolescents were drawn to the idea of confidentiality messages in general, rather than the specific contents.[25] Adolescents who read the passage in this study may have expected absolute confidentiality from counselors so they were more willing to share more sensitive and difficult information about themselves. Another possibility was that by understanding more about the principle of confidentiality and its importance, adolescents may develop more trust in the professionals, thereby making them more willing to share more sensitive information. However, it was also worth noting that adolescents were in general less willing to share information that was less likely to result in the breach of confidentiality, as identified by counselors themselves. As indicated by their ratings on the likelihood of breaching confidentiality, adolescents did seem to understand that counselors were less likely to breach confidentiality for those less risky situations. Therefore, it might indicate that there were perhaps many reasons for adolescents to choose to share certain information. Their understanding of confidentiality might be only one of them.

As for parents, although education was associated with a lower likelihood for parents to believe that counselors would breach confidentiality for *low-breach likelihood* items, it seemed to have no significant effect on how they would expect their child's counselor to divulge, regardless of the nature of the information. These findings were different from previous research, which demonstrated improvements in parental attitudes about confidentiality.[20] Results from the present study might reflect certain cultural norms for child-parent relationships in Chinese culture, where a child's autonomy is usually not emphasized and a more enmeshed, hierarchical parent-child relationship is favored. In Shuzo Shiga's famous book on traditional Chinese family laws, he summarized beautifully the essence of traditional parental relationships in China, on both the legal and social levels, as "father-son unity," in which fathers (parents) and sons (children) are mutually dependent and are part of each other.[26] Parents are thought to be the providers for their children and have the right of supervisor-ship even after their children reach adulthood. Likewise, if their children fail or behave improperly, their failure or mistakes also reflect failures or mistakes of their parents and are considered as disgrace for the entire family. Although the traditional Chinese family systems have been changing rapidly in contemporary China, parents are still heavily influenced by these traditional values.[26] There is an ancient Chinese saying (言知之易, 行之难; to know is easy, but to do is difficult) which speaks too how it is hard to put into practice what is known (i.e., "cool knowledge"), particularly when new knowledge conflicts with personal beliefs and cultural norms (i.e., "hot expectation"). Therefore, this inconsistency between knowledge and expectation among parents in the current study highlighted the difficulty of providing effective education to parents, which may be important for improving the mental health service delivery among adolescents. As these results suggest, Chinese parents might still expect professionals to disclose everything their children say in therapy based on the "father-son unity" norm, despite the fact that they are given clear and formal information that professionals are bound to confidentiality in mental health service and that confidentiality is important for a good working alliance. In a sense, this inconsistency could be interpreted as a clash between the more collectivistic Chinese culture and the more individualistic Western culture which underlies modern psychological counseling.

Another possible related factor contributing to this knowledge-expectation conflict is the stigma associated with mental health problems and disorders in China.[11] The stigma surrounding mental health problems and disorders might prevent adolescents from revealing their problems to professionals as well as their parents or caregivers. On the other hand, the concern of stigma could increase adolescents' sensitivity as well as their demands for confidentiality in treatment.[27] As for their parents, the social stigma (e.g., the fear for losing face because of the potential psychological difficulties experienced by their children) as well as the anxiety about the potential negative consequences of these difficulties on their children's future might contribute to their desire and expectations to know every detail of their children's treatment. Unfortunately, few empirical studies have explored parental factors that hinder or enhance children's help-seeking behaviors. However, Wu et al. found parents' knowledge about their children's psychological and behavioral problem—particularly the fathers' knowledge—enhanced positive help-seeking attitudes among Chinese adolescents.[13] Accordingly, future research could explore different ways to educate parents (especially fathers) about mental health services for their children, including the limitations and benefits of confidentiality. For instance, besides simply delivering the information about privacy and confidentiality to parents, emphasizing the benefits of confidentiality and counselors' shared goal of helping their child, it would be also helpful for professionals to take the time to understand the parents' beliefs, expectations, and concerns related to their children's difficulties and treatment. These discussions could also help professionals to make more effective decisions about confidentiality when they are faced with ethical dilemmas.

There are several limitations when considering the results of this preliminary study. First, the present study used a non-random sample of urban dwelling students. More than half of Chinese people live in the countryside; however, the students and parents in this study were all recruited from large cities, from high schools in five of China's ten largest cities. Moreover, participants were all volunteers, rendering the sample vulnerable to self-selection bias. Perhaps this is why both students and parents of choice were primarily female, because more female students volunteered to complete the surveys and they chose to request their mothers to complete the survey more often than their fathers. As a next step, larger studies are needed to explore potential relationships between beliefs about confidentiality and factors such as religious background, family income, and urban vs rural schools. Second, although we collected data from pairs of parents and adolescents, we did not match individual students with parents during the data collection process. Third, this study also did not collect data related to adolescents' own risky behaviors, so it is unclear the degree to which the scenarios in the questionnaire were considered relevant to adolescents in China. Previous research suggests adolescents in China engage in fewer risk-taking behaviors than their Western counterparts. Future studies should sample treatment seeking adolescents and families engaged in family therapy. Fourth, the high manipulation failure rate of the participants was a limitation of the study. Perhaps future studies should implement an easier or more intuitive manipulation check. Finally, the present sample includes participants with and without mental health symptoms and risky behaviors, but information about participants' mental health and risky behaviors was not collected. It is not possible to know how adolescents' own mental health and risky behaviors influenced their responses.

Implications for Behavioral Health

Although results are preliminary and need to be replicated among clinical samples, this study suggests that brief patient education increases adolescents' willingness to share sensitive information and leads to greater agreement among the counselor-adolescent-parent triad regarding when confidentiality should be breached. These findings point to the importance of developing and evaluating practices of implementation and communication of confidentiality for adolescents and their parents before the start of treatment.

Compliance with Ethical Standards

This study received permission from the Research Ethics Committee of Fudan University. Informed consent was obtained from all participants and their parents.

Conflict of Interest The authors declare that they have no conflict of interest.

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References

1. Lee FS, Heimer H, Giedd JN, et al. Adolescent mental health—opportunity and obligation. *Science*. 2014; 346(6209): 547–549.
2. Steinberg L. Risk taking in adolescence: What changes, and why? *Annals of the New York Academy of Sciences*. 2004; 1021: 51–58.
3. Bijl RV, de Graaf R, Hiripi E. The prevalence of treated and untreated mental disorders in five countries. *Health Affairs*. 2003; 22(3): 122–133.
4. Gulliver A, Griffiths KM, Christensen H. Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC Psychiatry*. 2010; 10(1): 1–9.
5. Zachrisson HD, Rödje K, Mykletun A. Utilization of health services in relation to mental health problems in adolescents: a population based survey. *BMC Public Health*. 2006; 6(1): 1–7.
6. Chandra A, Minkovitz CS. Factors that influence mental health stigma among 8th grade adolescents. *Journal of Youth and Adolescence*. 2007; 36(6): 763–774.
7. World Health Organization. *Mental Health Atlas*. Geneva: WHO Press, 2011.
8. Phillips MR, Zhang J, Shi Q, et al. Prevalence, treatment, and associated disability of mental disorders in four provinces in China during 2001–05: an epidemiological survey. *The Lancet.* 2009; 373(9680): 2041–2053.
9. Cyranoski D. China tackles surge in mental illness; psychological examinations to be added to selection procedure for government officials. *Nature*. 2010; 468(7321): 145–146.
10. Jiang GR, Xia M. A study on help-seeking propensity of Chinese undergraduates. *Chinese Journal of Clinical Psychology.* 2003; 11(3): 180–184.
11. Xia M, Jiang GR. Relationship among attribution, self-efficacy, perceived social acceptance and help seeking behaviors. *Acta Psychologica Sinica*. 2007; 39(5): 892–900.
12. Zhao J, Jiang GR, Wang Y. Correlation between trust of counseling and professional help seeking in college students. *Chinese Mental Health Journal*. 2011; 25(4): 249–253.
13. Wu MX, Liu CY, Fang XY, et al. Adolescents' mental and behavioral problems and professional help-seeking attitudes: The mediation effect of parental knowledge. *Journal Psychological Science*. 2014; 37(1): 94–100.
14. Xie QH, Fang XY, Liu CY, et al. Relationships among psychological problems, help-seeking attitudes and help-seeking willingness of adolescents. *Chinese Journal of Clinical Psychology.* 2012; 20(3): 413–416.
15. Ford C, English A, Sigman G. Confidential health care for adolescents: position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health*. 2004; 35(2): 160–167.
16. Ford CA, English A, Dowshen N, et al. Confidentiality in Adolescent Health Care. In MR Korin (Ed). *Health Promotion for Children and Adolescents*. New York: Springer, 2016, pp. 347–370.
17. Lehrer JA, Pantell R, Tebb K, et al. Forgone health care among US adolescents: associations between risk characteristics and confidentiality concern. *Journal of Adolescent Health.* 2007; 40(3): 218–226.
18. Kerwin ME, Kirby KC, Speziali D, et al. What can parents do? A review of state laws regarding decision making for adolescent drug abuse and mental health treatment. *Journal of child & adolescent substance abuse.* 2015; 24(3): 166–176.
19. Santoro KL, Schoenman J, Speedling C, et al. *Protecting confidential health services for adolescents & young adults: Strategies & considerations for health plans*. National Institute for Health Care Management Foundation Issue Brief. Washington, DC: National Institute for Health Care Management, 2011. Available online at: www.nihcm.org/images/stories/NIHCM-Confidentiality-Final.pdf. Accessed on October 15, 2017.
20. Hutchinson JW, Stafford EM. Changing parental opinions about teen privacy through education. *Pediatrics*. 2005; 116(4): 966–971.
21. Lyren A, Kodish E, Lazerbnik R, et al. Understanding Confidentiality: Perspectives of African American Adolescents and Their Parents. *Journal of Adolescent Health.* 2006; 39: 261–265.
22. Rodriguez MA, Lin J Y, Qian MY, et al. When should confidentiality be breached to report adolescent risk-taking behavior? A comparison between parents and psychologists in China. *Chinese Mental Health Journal.* 2011; 25(9): 655–657.
23. Rae WA, Sullivan J R, Razo NP, et al. Breaking Confidentiality to Report Adolescent Risk-Taking Behavior by School Psychologists. *Ethics and Behavior.* 2009; 19(6): 449–460.

24. Rodriguez MA, Fang C, Gao J, et al. Perceptions of the limitations of confidentiality among Chinese mental health practitioners, adolescents and their parents. *Ethics and Behavior*. 2016; 26(4): 344–356.
25. Ford CA, Thomsen SL, Compton B. Adolescents' interpretations of conditional confidentiality assurances. *Journal of Adolescent Health*. 2001; 29(3): 156–159.
26. Peng XZ, Hu Z. The Changes of Contemporary Chinese Families and the Reconstruction of Family Policies. *Social Sciences in China*, 2015; 12: 113–132.
27. Wilkinson B, Shah-Arora K. A Systematic Review on Confidentiality, Disclosure, and Stigma in the United States: Lessons for HIV Care in Pregnancy From Reproductive Genetics. *The New Bioethics.* 2015; 21(2): 142–154.