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The Experiences of Ethical Tensions When Using Harm Reduction with High-Risk Youth

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Abstract

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Keywords

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

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The Experiences of Ethical Tensions When Using Harm Reduction with High-Risk Youth

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Little is known about the ethical experiences of psychologists who work with high-risk youth using a harm reduction approach. We used interpretative phenomenological analysis (IPA) to explicitly explore this phenomenon. In this small exploratory study three participants were interviewed to glean their experiences of ethical tension. Data analysis revealed three superordinate themes (questioning, acting, and holding) within which eight subthemes are subsumed (questioning beneficence, questions from others, self-care, social change, negotiation, consultation and supervision, acceptance, and sitting with tension). The results of this research suggest that context-specific ethical tensions may arise for psychologists who work with high-risk youth using a harm reduction approach, which in turn lead to and necessitate a tailored ethical response. The results also suggest that harm reduction promoters may benefit from increased dialogue with licencing and professional bodies to foster awareness and develop guidelines on promoting ethical practice when using a harm reduction approach with high-risk youth. Future research can profitably be directed towards an increased experiential understanding of some of the central themes of this research, such as "sitting with tension" and "holding."

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Introduction

The provision of counselling services to high-risk adolescent clients is inherently complex and thus requires both clinical and ethical prowess. The term "high-risk" is typically applied to youth involved in behaviours such as substance abuse, sexual exploitation, criminal involvement, running away, and gang involvement (Smyth & Eaton-Erickson, 2009), although a compendium of such behaviours tends to conceal a complex aetiology. Remediating high-risk behavior is notoriously difficult, which is why this population attracts monikers such as "difficult to serve" and "complex needs." Harm reduction, which is an approach that eschews total abstinence as an initial therapeutic goal, has gained increased traction in recent years among those who serve high-risk youth (Jenkins et al., 2017; Midford, 2009). While abstinence may be viewed as a goal, harm reduction serves as a provisional step intended to reduce harm associated with high-risk behaviours (Collins et al., 2012; Kleinig, 2008; Marlatt, 1996). Since its genesis in the early 1980s, harm reduction continues to garner considerable attention, not all of which is positive. Misinformed detractors contend that harm reduction approaches do little more than condone and enable addictive and unlawful behaviours (Hathaway, 2001). While such rhetoric has diminished (Collins et al., 2012), challenges remain, especially when

harm reduction is applied to youth. Practitioners working with youth often cite ethical tensions, such as those related to informed consent, clinical competence, and confidentiality, as challenging features of their practice (Kearney, 1998; Sullivan et al., 2002; Taffel, 2005). Ethical tensions are exacerbated among practitioners who use a harm reduction approach and who provide therapy to high-risk youth. Unfortunately, research in this area is extremely rare (Jenkins et al., 2017). The current research sought to specifically address the experiences of ethical tensions when harm reduction practices are used with this population.

Harm Reduction

Harm reduction is a treatment philosophy that attempts to reduce the risk or harm associated with injurious or problematic behaviours (Collins et al., 2012; Kleinig, 2008; Marlatt, 1996). Although harm reduction arose primarily from the area of substance abuse treatment, it is now applied across a broad spectrum of activities. Harm reduction's cardinal feature is that it departs from an all-or-nothing, abstinence-based, model of treatment (Collins et al., 2012; Larney et al., 2006). Abstinence may be ideal, but it may not always be realistic and is not a mandatory condition for receiving treatment, services, or support. Harm reduction emphasizes personal safety and quality of life for individuals whose current circumstances are incompatible with abstinence (Collins et al., 2012).

Harm reduction practices have garnered considerable empirical support in recent years. For example, a large-scale systematic review of harm reduction and alcoholism by Charlet and Heinz (2017) found dramatic and far-reaching results, leading the authors to emphatically conclude that "the reviewed studies strongly support and emphasize the benefits of alcohol reduction in physical, mental and societal health and life quality" (p. 1154). In their research comparing methadone replacement program with traditional programs, Mattick et al. (2009) found that those who participated in the methadone replacement programs were more likely to enter and remain in treatment, reduce their use of opioids, have less criminal activity, and have lower mortality rates. Finally, safe injection sites have led to decreases in public drug use, safer conditions under which drugs are used, decreases in needle sharing, more referrals to treatment, and quicker medical attention to overdoses (Wood et al., 2006).

Harm Reduction with Adolescents

Most harm reduction programs target adult populations. While harm reduction programs for youth do exist, they remain controversial due to the perception that adolescents are inherently more vulnerable due to various developmental limitations (Wolbransky et al., 2013). Calls for increased presence of harm reduction among adolescent programing comes amidst evidence that typical abstinence-based programs often fail to produce desired results (Kelly, 2012; Marlatt et al., 2001; Poulin, 2006). Although limited in scope, research examining harm reduction programs with adolescents do show promising results. For example, harm reduction programs with adolescents that target alcohol and illicit drug use have shown decreases in substance use and in the harmful/risky behaviours associated with such use (Kelly, 2012; Midford et al., 2014; Poulin & Nicholson, 2005). It is encouraging to see that harm reduction approaches with high-risk adolescents are gaining empirical support. We contend however, that it is equally important to address ethical considerations. Scholarship in this area is extremely rare (Jenkins et al., 2017). Drawing from the broader literature that examines the ethics of working with high-risk youth, it is evident that ethical tensions are unquestionably salient when working with this population. In the section that follows we review areas of ethical relevance when working with high-risk youth.

Ethical Practice with High-Risk Youth

The exploration of ethical tensions[1] experienced by psychologists who work with adolescent populations yields troubling results. Concerns regarding professional competence (Dailor & Jacob, 2011; Kolay Akfert, 2012; Koocher, 2008), informed consent (Koocher, 2008), and confidentiality (Bodenhorn, 2006; Duncan et al., 2012; Rae et al., 2009; Sullivan et al., 2002) figure prominently in this area of practice. The provision of confidentiality is particularly relevant given its ascribed importance to adolescents seeking counselling services (Eyrich-Garg, 2008; Jenkins, 2010; Lehrer et al., 2007).

For example, Kearney (1998) discusses the way ethical tension centered around confidentiality can arise among professionals who provide mental health services to high-risk, gang-entrenched youth. When working with this population, practitioners may find themselves in a position where they learn of impending "hits" on other individuals. In these situations, maintaining confidentiality and forgoing one's duty to warn potential third parties of impending harm, can be ethically precarious due to the potential that others could be harmed. The equivocal nature of confidentiality for adolescent clients compared to adult clients heightens ethical tensions when public safety is juxtaposed with the need to create and maintain a trusting therapeutic relationship. According to Taffel (2005), such ethical decisions, for example in which the practitioner breaches confidentiality, difficult as they might be, can negatively impact the working alliance, sometimes to a point of no repair. The difficulty associated with developing a strong working alliance with high-risk youth in the first place potentiates the resulting ethical tension (Kearney, 1998).

In their survey of 74 pediatric psychologists, Sullivan et al. (2002) found that participants viewed two factors as especially important when deciding whether to breach confidentiality with adolescent clients: the nature of the behaviour and maintaining the therapeutic alliance. Behaviours viewed as dangerous by the psychologists included smoking, alcohol and drug use, sexual behaviour, and suicidal behaviour. Sullivan et al. (2002) found that participants were more willing to breach confidentiality as risk behaviours increased in frequency and duration. However, they also found inconsistencies across practitioner's decisions to breach confidentiality. For example, not all psychologists reported the client's use of tobacco, alcohol, or marijuana, nor did all psychologists report frequent sexual behaviour disclosed by participants. The psychologists did, however, make every effort to maintain the working alliance and were fearful that breaching confidentiality might result in the client's decision to prematurely terminate counselling. Moreover, research participants were also concerned that this rupture in the alliance could deter the client from engaging in future therapy. These concerns are well-founded, as research consistently attests to the value that adolescents place on confidentiality and the diminished likelihood that they will access services if they suspect confidentiality will not be maintained (Boldt, 2012; Eyrich-Garg, 2008; Gustafson & McNamara, 1987; Jenkins, 2010; Kearney, 1986; Lehrer et al., 2007; Rojas et al., 2008; Tigges, 2003).

Research by Rae et al. (2009) attained results like Sullivan et al. (2002). These researchers presented 78 school psychologists with vignettes that contained one or more common areas of adolescent risk-taking behaviours (e.g., cigarette use, alcohol use, illicit drug use, sexual behaviour, suicidal behaviour). Participants were then given information that increased or decreased the intensity, frequency, and duration of the risk-taking behaviour and were asked whether they would breach confidentiality. Not surprisingly, as the frequency and duration of the risky behaviours increased, practitioners became more comfortable with

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[1] The term "ethical tension" is used to broadly encapsulate related but distinct phenomena of ethical uncertainty, ethical distress, and ethical dilemmas (Kinsella et al., 2008).

breaching confidentiality. For example, participants found it easier to justify breaching confidentiality when the client in the vignette reported frequent use of drugs. This also held true for suicidal and sexual behaviour, however, not for antisocial behaviour. Rae et al. (2009) posited that this was likely due to the imminent danger to self associated with self-harm and sexual behavior.

A third study of note conducted by Duncan et al. (2012) surveyed 264 psychologists from Australia, all of whom had experience working with adolescent clients. Study participants completed two surveys. The first used vignettes to examine situations in which participants would breach confidentiality with adolescent clients, whereas the second survey focused on factors the psychologists considered when deciding whether to breach confidentiality. Using factor analysis, the researchers arrived at four factors that represented the underlying constructs that participants considered when deciding whether to breach confidentiality. The most important of these was the negative nature of the behaviour and the need to maintain the therapeutic relationship. The researchers found that a key consideration when deciding to breach confidentiality was the intensity of the risk-taking behaviour. The results of the study suggest that the more severe the risk-taking behaviour was, the more willing practitioners were to breach confidentiality. On the other hand, practitioners were worried that in breaching confidentiality, consequences such as the premature termination of therapy, would occur.

Research findings converge on the importance of the therapeutic relationship and how ethical tension increases when client confidentiality is set in competition with heightened degrees of risk behaviour. Ethical practice with high-risk youth is a difficult territory to navigate. When placed in tandem with a harm reduction approach, working in an ethical manner becomes increasingly fraught. As Jenkins et al. (2017) note, programs that use harm reduction approaches with high-risk youth are increasing. Jenkins et al. (2017) further note that research exploring ethical tensions when using this approach with this population is rare. A literature search conducted by the authors of this article yielded no research studies that examined the experiences of counsellors working in this context. Herein, the purpose of this research was to conduct a preliminary qualitative study to help bring an increased phenomenological understanding of ethical tensions experienced by counselors who work with high-risk youth using a harm reduction approach.

Contextual Factors

At the time this research study was undertaken, I, Patricia Owens, was working at a law office with youth who had come into conflict with the law. In my role I became acutely aware of the lack of resources and support available to these youth and their families. Many of the youth I worked with were labelled as "difficult" or "hopeless." Due to my understanding of harm reduction and my experience working with this population, I saw this approach as the natural way to work with this clientele. I noted that despite the best intentions of professionals working with this population, youth would continue to engage in harmful behaviours.

During this time, I was privileged to meet with many individuals (adolescents and adults) that shared with me that the most significant factor that led to their survival and gave them hope, was having one adult who accepted, supported, and believed in them. They each explained that these persons had accepted them fully for who they were: accepted the youth's past and current actions without judgement, supported the youth regardless of what the youth disclosed, maintained the youth's confidence (within measure), and believed in the youth's worth as a human being. These accounts highlighted to me the importance of an approach that meets clients where they are, accepts them unconditionally, regardless of circumstances, and works with the client to make the client's world a little bit better.

As a practicum student (in Counselling Psychology) I struggled with the seemingly adversarial relationship between the duty to protect and my commitment to harm reduction. I suspected that this struggle was not unique to me; and in discussions with my peers, I learned that it was not: many in my cohort appreciated harm reduction and wished to use it in their practice but did not do so, unsure if it constituted as ethical practice according to regulatory guidelines and bodies. I felt that I had to investigate this further. Thus, my research topic was born. I wished to bring to light these tensions or anxiety that new practitioners were facing when trying to reconcile the practice of harm reduction with high-risk youth, because I vehemently saw the value of practicing harm reduction when working with this population.

As second author, I, Simon Nuttgens, provided counselling services to high-risk youth residing in a residential treatment centre for a period of five years in the early 2000s. Soon after this I joined academia with a research interest primarily in ethics, and a methodological approach steeped in the qualitative tradition. I have long been interested in the many inherent tensions that exist within the intersection of counselling youth and ethical practice. Having worked years ago in a harm reduction capacity, I am favourably biased toward this practice approach and thus believe that harm reduction can be carried out in an ethical manner when counselling high risk youth.

Methodology

Interpretative phenomenological analysis (IPA) was used to guide all components of this research. Interpretative phenomenological analysis was developed in the 1990's by Jonathan Smith, who identified a need for a qualitative approach in psychology intended to capture detailed, interpretive accounts of personal experience (Smith, 2004; Smith & Osborn, 2008). In IPA, researchers identify, describe, and strive to understand the phenomenon within a person's world, and then proceed to explore the experiential understandings that a person has toward that phenomenon (Smith et al., 2009). The researcher aims to create a coherent and clear third-party description, which is psychological in nature and attempts to get as close as possible to the participant's lived experience (Larkin et al., 2006). IPA is characteristically descriptive, interpretive, and ideographic, borrowing heavily from the philosophical traditions established by Husserl and Heidegger (Smith et al., 2009) Interpretative phenomenological analysis is best suited for researchers who want to learn about people's perceptions of, their involvement in, and orientation towards the world (Smith et al., 2009). This approach is particularly useful for trying to understand how individuals perceive experiences (Smith & Osborn, 2008). We concluded that IPA was an appropriate methodology to assist in this endeavour. This research study was interested in how participants understood and experienced the ethical tensions. Interpretative phenomenological analysis is especially useful when researchers strive to understand the complexity, process, or novelty of a phenomenon (Smith & Osborn, 2008). This research aims to understand these three qualities. Specifically, the exploratory aims of this research are to understand: (1) the types of ethical tensions practitioners experienced when using harm reduction in their work with high-risk youth, (2) how practitioners personally and professionally experienced these tensions, and (3) how participants personally and professionally managed these ethical tensions.

Participants

In contrast to some qualitative approaches that draw on large samples (e.g., grounded theory), IPA typically favors smaller samples, with Jonathon Smith proactively asserting that in some situation a single participant could suffice (Smith et al., 2009). For our purposes, and in keeping with IPA's ideographic commitment (Smith et al., 2009), we recruited a small

sample of three participants through purposeful sampling. Eligibility for participation was contingent on the participants' ability to provide a rich and nuanced description of their experiences of ethical tension when using a harm reduction approach with high-risk youth. Participants were recruited from an agency that works with high-risk youth and included a registered psychologist (Karen[2]), and two masters-level counsellors (Maria and Karl). Participants had varying levels of experiences. Karen, for example, was a seasoned psychologist. She had worked with the high-risk population for several years and was well-versed in harm reduction and its application. Maria and Karl were both newer to the field. Maria was a young graduate student and Karl, also a graduate student, had shifted to working as a psychologist, following a change in careers. Due to their regulatory affiliation, participants were required to adhere to the Canadian Psychological Association's Code of Ethics for Psychologists, as well as their provincial standards of practice. All participants identified as having experienced ethical tensions in their work using harm reduction approaches with high-risk youth.

Data Collection

A flexible, semi-structured interview schedule consisting of 11 questions was used for this research. Interviews struck a balance between guiding participants to address specific topics while also allowing latitude for participants to direct conversations to personally relevant content. Additional prompts were used when interview questions were experienced as vague or in some way limiting. Interviews occurred face-to-face, lasted between 60-90 minutes, and were conducted by the first author.

Data Analysis

Data analysis proceeded according to the procedural steps suggested by Smith et al. (2009). In keeping with the ideographic nature of IPA, each participant transcript was analyzed individually prior to the cumulative thematic analysis. Analytic steps were as follows:

1. Transcripts were read and re-read, and audio interviews listened to multiple times.
2. Initial noting was used to identify significant descriptive, linguistic, and conceptual content.
3. Emergent themes were developed through the exploration of connection, interrelationships, and patterns across initial notations.
4. A framework/structure was developed to present and highlight thematic patterns and relationships across cases.
5. A narrative commentary of themes supported by illuminative quotes was developed to afford readers with an accessible interpretive account of the data.

The lead author conducted the initial data analysis, with the second author providing a secondary analysis, followed by comparison and discussion until consensus was reached. Prior to the start of our research, we developed and followed normative ethical protocols to ensure participants were treated with requisite standards of ethical care. Our research received ethical approval from our institution's, Athabasca University, Research Ethics Board prior to

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[2] Pseudonyms are used for all participants.

commencement. It should be noted, as well, that to protect confidentiality in all instance's pseudonyms are used in place of participants' given names.

Results

Use of the IPA data analysis process yielded three superordinate themes: "Questioning," "Acting," and "Holding." Additional subordinate themes were subsumed within each of the superordinate themes (see Table 1 below). In what follows we discuss the results of our analysis using verbatim quotes to reveal a nuanced experiential understanding of ethical tensions when counselling high-risk youth using a harm reduction approach.

Table 1
Superordinate and Subordinate Themes

Superordinate Themes	Subordinate Themes
Questioning	questioning beneficence, questions from others
Acting	self-care, social change, negotiation, and consultation, and supervision
Holding	acceptance, sitting with tension

Questioning

As indicated in our literature review, using a harm reduction approach with high-risk youth inevitably brings to the fore ethical tensions. For our participants, the occurrence of ethical tension was enveloped by forms of questioning that arose in response to marked experiences of uncertainty. Questioning became the focal point of two interrelated lines of inquiry: questioning beneficence and questions from others.

Questioning Beneficence

Beneficence rests as the keystone principle of ethical practice. Indeed, it is difficult to argue the contrary: that one should _not_ act in ways that minimize suffering and maximize the health and well-being of our clients. While both our ethical codes and moral predilections align with his imperative, in the realm of harm reduction it might feel as if we are sitting idly by while our clients take a turn for the worse. Maria captures this feeling when she says:

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

Here two cardinal features of harm reduction (honoring client choice and assuming a nonjudgmental stance) are set in opposition to Maria's moral value of care. Maria questions whether the harm reduction approach is ethically defensible amidst the reality of her client's high-risk choices. The resulting dissonance leads to considerable emotional discomfort. For Karl, beneficence came into question when wrestling with the decision to breach informed consent. In his example he questions whether beneficence is better served through upholding client autonomy at the potential expense of public safety:

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

Fidelity to harm reduction implores Karl to respect and protect his client's autonomy, believing that doing so will ultimately align with the client's best interest. However, non-interference in this regard runs counter to utilitarian ethical assertion that actions ought to bring the greatest good to the greatest number. The ethically significant question in this instance asks whether beneficence, extended in service of the harm reduction philosophy, can be ethically defended when other lives are at risk.

Questioning from Others

The participants in this research questioned whether they were extending beneficence to their clients. Doubt, uncertainty, and dissonance fueled these questions which inevitably led to imagining how others might perceive how they braided together harm reduction and ethical practice. It was if the participants mused, "If I'm questioning beneficence, then so, too, will others – especially those whose counselling philosophy and approach reside outside the borders of the harm reduction approach." Karen succinctly conveys this when describing instances where a client of hers could be apprehended and placed in group care because child protective services either do not understand, or do not agree with, the harm reduction approach:

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

Karl similarly wondered whether his commitment to harm reduction would lead others who subscribe to alternative "ideals of practice" to question his ethics:

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

Such wondering initiated feelings of anxiety and urgency for Karl. Maria struggled similarly when her allegiance to harm-reduction led her to break from convention and provide her cellphone number to a client. Karen took "questioning from others" a step further, speculating on how her regulatory body would perceive a harm-reduction-informed-decision not to obtain parental consent:

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

Those faithful to the harm reduction approach realize that some of their practices will be deemed ethically questionable because they reside beyond the scope of normative ethics.

Acting

The second superordinate theme, "acting," captures the participant's tendency to confront their questions as responsive agents; this can be contrasted with the "questioning" theme which was decidedly reflective. Subordinate themes within the "acting" theme include "self-care," "social change," "negotiation," and "consultation and supervision."

Self-Care

Self-care is commonly viewed as an essential feature of ethical practice. When self-care suffers, so does our ethical comportment. Not surprisingly, the participants in this research referenced self-care as integral to their ethical work with high-risk youth. For example, maintaining a boundary between her "private and professional life" was key to Maria's deliberation when deciding whether to provide her cell-phone number to a young female client. For Karl, self-care meant knowing when to disengage from what he viewed as an unsolvable ethical situation:

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

Karen was the most explicit when discussing her approach to self-care. In her interview she flagged typical self-care strategies and framed these as a necessity if one is to have longevity in their work with high-risk youth using a harm reduction approach:

Karen: I exercise on a regular basis, I work out three times a week with a trainer, and I've had the same trainer for 15 years, I physically move. Umm…I have a very strong group of folk around me who are very big-picture folk, right? So, people who see…who are involved politically. You know, they're people who do things…I think you have to have a big, deep, rich network to do this for the long haul.

Social Change

Counselling high risk youth from a harm reduction approach inevitably illuminates larger macro social forces that give rise to and shape the lives of youths at the micro level. For two participants the existence of ethical tension at the micro level became the motivation to make changes at the macro level. As a seasoned counsellor, Karen is acutely aware of the impact that high risk behaviours, such as drug abuse and prostitution, have on the lives of young people. It would be easy to experience resignation or defeat in the face of such enduring problems. Karen, however, can starve off such sentiment through turning her actions toward

initiating change at a broader social level. While this did not eliminate current tension related to high-risk youth and harm reduction, it did afford a sense of agency which in turn fostered hope:

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

In her interview, Maria relates a similar commitment, although through a different genesis. Rather than "take home" specific client struggles and concerns, she instead redirects her focus on supporting macro change:

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

Negotiation

The lines that demarcate the ethics of harm reduction practice are, by their very nature, mutable and context dependent. This means that variant features of the harm reduction approach will often involve negotiation, both between counselor and client and between counsellor and other agencies and institutions. Karl describes his approach to negotiating a harm reduction position with schools:

> Karl: Even if the harm reduction-oriented group home has a requirement to not bring substances on the premises, or to be intoxicated on the premises. And schools, the public schools have a very strict policy that if you're found to be in possession of a substances, that you'll be suspended or expelled… There seems to be some very large agendas at stake in those kinds of rule settings. So, negotiating a position of harm reduction within those contexts has varying levels of difficulty, but is extremely important.

In her interview, Karen artfully described her "layered" and negotiated approach to balancing demonstrable care with respect for client autonomy:

> Karen: We have safety plans; we talk about layers and layers and layers. And so, sometimes we will negotiate with the youth umm… for quite a while before we make a report. Like a week, right? So, you start doing the... "It's not an investigation, but it's a layering of support" and start breaking down resistance, so that the relationship has a chance of surviving. Cause what we don't want is a betrayal. So that's an important piece.

Karen makes clear that negotiation and collaboration is inherent to navigating ethical tensions.

Consultation and Supervision

As highlighted in the "questioning" theme, dissonance, emotional discomfort, and uncertainty were prominent within the experiential landscape of our participants. When faced with ethical tensions, all participants repeatedly emphasized the importance of engaging in consultation or supervision. This was the case with Maria who, when confronted with a vexing ethical dilemma, sought advice and reassurance from a seasoned and trusted supervisor.

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

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

For Karen, consultation with other agencies was vitally important, though it was also strategic. In the excerpt below she shares she would carefully vet her consultants as to help ensure that she can "depend" upon them to understand and accept a harm reduction approach:

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

Holding

The final theme, "holding," captures the participants' experience of slowing down, or pausing while during an ethical tension. In such instances, participants were still aware of the tension, and felt its effects, yet remained in a "holding pattern," as Maria notes, where no attempt was made to change or influence component parts of the tension. This is not to be viewed as indifference or being incapacitated by trepidation; rather "holding" is about suspending action. Two subordinate themes, "acceptance" and "sitting with tension" help elucidate this experience of holding.

Acceptance

Acceptance refers to the participants' understanding and acknowledgement regarding the limits of their ability to resolve an ethical tension. For Maria, acceptance flows from the confluence of uncertainty related to her place of employment, personal beliefs, and the covert

actions of the youth she cares for. At one point in her interview Maria uses the word "complicit" to describe the tension she experiences when extending beneficence through a harm reduction approach while simultaneously feeling that she is condoning her client's harmful behavior. The excerpt below betrays how reluctance is fused with her acceptance, as though she is, in a sense, directed by forces beyond her control toward a place of acceptance:

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

Karl's experience of acceptance centers on a client's refusal to consent to participate in counselling, despite this youth posing significant risk to self and others. Karl evocatively equates acceptance with the metaphorical quality of "ripening," suggesting that one must wait until conditions are right before acting. However, before acceptance can be exercised, he must also be confident that all that can be done has been done to ensure safety:

> Karl: My response is fairly consistent in those situations, or in situations, is to simply accept what I cannot do and move on from that situation, ensuring that others and myself are as safe as can possibly be made. Considering the risks that are involved. And there has to be a further ripening, or maturing of that situation, I guess, aging/ripening of that situation before action is taken. And that…that's all that I can do…that acceptance is, it's fueled by a number of things. It's fueled by what I feel is an assessment of what I can and cannot do. Both from the perspective of capability and from the perspective of ethics.

For Karen, the experience of acceptance arrived from the recognition that there will always be unsolvable social ills that no amount of goodwill or policy can displace. Acceptance, in this instant, is the salve for Karen's "outrage" that allows her to continue her work in bettering the lives of youth, knowing that sometimes there will be nothing more she can do:

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

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

Sitting with Tension

Whereas "acceptance" captured the participants' understanding that certain limitations will in some situations prevent them from fully executing their desired harm reduction approach, "sitting with tension" reveals the way in which participants co-exist with ethical tension. In this respect, participants seemed to externalize their experiences of ethical tension, using anthropomorphic language to elucidate their relational position with tension. For example, both Karl and Maria used a "sitting" metaphor to describe the way in which they lived alongside tension. Maria referenced the tension regarding the ongoing drug use by her clients. Maria was torn between wanting to implement harm reduction approaches, which emphasized acceptance, and her reporting obligations. The excerpt below highlights Maria's process through this ongoing tension.

> Maria: I've just kinda accepted it and I'm kinda sitting in it, but I'm like, I don't feel like I've solved anything, for a lack of a better way to talk about it.

For Karl, the very essence of the harm reduction approach involves sitting with tension, which in some respects is contrary to our natural impulse to relieve it. Karl suggests that non-harm-reduction approaches align more with a natural impulse insofar that decisions and actions are undertaken to quickly and efficiently fix or solve a challenging client situation.

> Karl: Since harm reduction is based upon duration, it requires the ability to sit with tension. I think the practices that are contrasted with harm reduction arise from the inability to sit with tension. In other words, "I'm gonna incarcerate that person, I'm gonna force them to stop doing something, or they should stop doing something immediately, because if they stop doing something immediately, I no longer have any tensions about it, right?" The problem is solved. Practicing harm reduction involves the ability to sit with tensions. It involves the ability to sit with tension in one's own life.

Karl's final words in this excerpt are perhaps telling and instructive. For Karl, the ability to "sit" with tension extends to "one's own life" thus alluding to the expansive nature of ethical tension. It exposes itself not only in the confines of one's counselling practice, but in one's life in general, and thus co-existence is not solely a choice, but a necessity.

Karen drew upon yet another metaphor to illuminate her co-existence with tension. In the following excerpt she describes "holding her breath" in response to a client's high-risk behavior. We, as humans, hold our breath as an expectancy bound by uncertainty. We exhale when we realize that danger has passed. Knowing that responsive action on her part would not be possible, or likely helpful, Karen's only recourse was to pause and sit with the tension.

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

harm reduction. So, I have to be very careful to not think that I am smarter than her about survival on the street, or that I can fix anybody.

Discussion

This research explored ethical tensions when working with high-risk youth using a harm reduction approach. The analysis of the interviews revealed three superordinate themes and eight subordinate themes which in sum, afford an expanded understanding of the phenomena under investigation.

The findings of this study align with existing scholarship detailed in the literature review. Informed consent and confidentiality are among some of the concerns for psychologists working with high-risk youth. All the three participants recounted ethical tensions pertaining to confidentiality; and two of the three participants disclosed ethical tensions relating to obtaining informed consent. Concerns with maintaining the working alliance were also prevalent. The participants in this study wanted to maintain the best interests of their clients while adhering to their ethical obligations. Research by Sullivan et al. (2002) and Duncan et al. (2012) support the finding of this study that maintaining the working alliance is a significant factor for psychologists who work with adolescents. While there were no previous studies canvassed that explored the lived experiences of psychologists working with high-risk youth and using harm reduction methods, there were similarities in the types of ethical tensions identified in the literature.

The superordinate theme, "questioning," exposes what might rightfully be viewed as a central experiential feature of ethical practice: uncertainty. Uncertainty is bound to the very nature of ethical tensions and dilemmas and though often experienced as uncomfortable, should not be viewed a grievous. While there may be strong temptation to quell uncertainty to alleviate discomfort, doing so divests ethical reason from ethical action. The uncertainty experienced by our participants centered on questions of beneficence, an ethical principle that has long been considered essential to ethical practice (Beauchamp & Childress, 2008). For most counsellors in most situations, there is little or no need to question whether one is extending beneficence as this principle seamlessly aligns with the personal values that led them to the profession in the first place. This moral predilection is thrown askew, however, when maximizing benefit is cast as a "long game" that requires acceptance of immediate harm. It is thus not surprising that at times our participants questioned their implementation of a harm reduction approach. Such questioning is perhaps a phenomenological cousin to the angst that parents feel when impending adolescence leads them to shift their orientation from parenting to protect, to parenting to prepare. In both instances the impulse to prevent harm rubs uncomfortably against the desire to do what one believes will, in the long run, optimize growth and well-being. In both instances, as well, a positive outcome is in no way guaranteed. A leap of faith is required, and the leap feels much longer and perilous when the life of a high-risk adolescent client hangs in the balance.

Our participants, of course, looked before they leapt. By this we mean that they were not cavalier in their implementation of harm reduction and did not take lightly a corresponding responsibility to ensure that their decisions were well-reasoned and defensible. Our participants achieved this through consultation and supervision, two pillars of ethical practice. However, even these two pillars of ethical practice become entangled with "questioning" as our participants wondered whether others would understand and accept their harm reduction-informed approach. This led to a double jeopardy of sorts, wherein angst at wondering whether one is extending beneficence met with second dose of angst at wondering potential consultants will be receptive to the harm reduction ethos. If those who practice from a harm reduction approach question whether they are extending beneficence it is unsurprising that they would

then suspect others, outside of the harm reduction approach, would as well. Whether real or imagined, questions from others inevitably expose either our own vulnerability (Am I doing the right thing?) or frustrations (Why don't others understand the benefits of harm reduction?).

Questions of receptivity lead naturally to the necessity of negotiation. As seen in our results, participants at times used negotiation to maximize the fit between clients' needs and desires and a harm-reduction approach. However, negotiation was also instrumental in shaping the way in which harm reduction was proffered to institutional setting, as was the case with Karl who sought to render harm reduction more palatable to the school he was collaborating with. And Karen betrays a commitment to negotiation when she coyly confesses to strategically choosing which child welfare worker she approaches. Negotiation is an apt compliment to the vigilance, cognitive agility, and foresight that is required when traversing this ethical landscape.

Perhaps the most striking finding in our research revolves around the "holding" theme. As noted earlier, "holding" can be viewed as a form of inaction, wherein participants resisted the moral impulse to act to reduce or eliminate ethical tension. Such an impulse is understandable given, as noted earlier, our predilections toward beneficence. The urge to act also comes from the way in which we are taught ethics and the way in which we are instructed by ethical decision-making models. In both instances ethical action rests as an implied or implicit imperative. The American Counselling Association's guide to ethical decision-making is prototypical in this regard. After negotiating three information-gathering steps, counselors are then enjoined to "brainstorm as many potential courses of action as possible. Be creative and list all of the options you can think of, even ones that you are not sure will work" (Forester-Miller & Davis, 2016, par 19). Once acted upon, ethical tension tends to dissipate because, for better or worse, the decision has been made. Those who experience ethical tension when using a harm deduction approach with adolescents may not always be afforded the luxury of a tidy and final resolution. Rather, as detailed in our results, what is required is the ability to coexist with tension while remaining committed to the tenets of harm reduction despite the inevitable questioning that occurs and the very visible and real struggle of our clients.

In the absence of an imminent final resolution, what might therein offer solace to the harm reduction counsellor who is sustained in a hold? The answer likely points toward our theme, social change. With little or no means to eliminate ethical tension and its concomitant discomfort, our participants sought a more circuitous agentive path. What they could do, irrespective of ethical tension and all that fuels it, was take steps, even if small, to support macro level changes aimed at reducing the conditions and forces that give rise to high-risk behaviour in the first place. Even though this locus of control stretches gossamer thread thin, it nonetheless assumes a meaningful function in the experiential landscape of a harm reduction counsellor on hold.

This research provides a small, yet important look into the lived experiences of psychologists who experience ethical tensions because of working with high-risk youth while adhering to a harm reduction approach. A notable finding of this research is the idea that an immediate ethical response might in some circumstances give way to a form of coexistence with ethical tension. This is especially significant for professionals who work in environments where ethical tensions are common, and resolutions are hampered by philosophical and practical constraints.

Implications for Practice and Further Research

The findings of this study contribute to ethics and psychology in several ways. Firstly, as intended, our findings afford new insights into how practitioners experience ethical tensions when working with high-risk youth using a harm reduction model. Such insights can help

normalize the experiences for new psychologists who may feel isolated and unsure when confronted with ethical tensions born of their work with high- risk adolescent using a harm reduction approach. The findings of this study also raise awareness about the types of ethical tensions practitioners working with high-risk youth experience when incorporating harm reduction approaches.

Secondly, this research encourages discussion around ethical standards and education as they relate to harm reduction approaches. In her interview, Karen indicated her belief that her regulatory body may not understand or accept harm reduction as an ethical practice when used with youth. This, of course, undermines harm reduction as a viable and ethical treatment approach, while also leaving harm reduction practitioners feeling that they are working outside the bounds of ethical practice. For example, Karen described feeling obligated to obtain guardian informed consent prior to providing psychological services to a young client, even though this, in her view, was not immediately in the best interests of her client. Ultimately, Karen decided to proceed without obtaining guardian consent, as per harm reduction strategies, because she believed beneficence was best served through forgoing normative standards for obtaining consent.

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

Two of the central themes that emerged in this study were the experiences of "acceptance" and "sitting with tension." Adding these discussions to undergraduate and post-graduate ethics courses might foster students' ability to navigate ethical tensions when no viable ethical action can be exercised. Future research is needed, however, to more fully expose the ways in which this can be accomplished. For example, it would be helpful to know how "sitting with tension" is learned and cultivated over time, or even whether this ought to be viewed as a learned skill. It may also be the case that "holding" as a theme is a relevant ethical posture for all practitioners, not just those who work with high-risk youth using a harm reduction approach.

The experience of ethical tensions seemed to differ according to experience in the field. Maria, who had the least amount of professional practice, experienced a greater degree of anxiety and concern about implementing a harm reduction approach. Karen, on the other hand, who is a more seasoned psychologist, experienced much less anxiety. It is unclear if this is best explained by level of experience, personality type, or a combination of both. Additional research is needed to confirm and clarify the intimations noted in our research.

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

Limitations

There are several limitations present in this study. Though Smith et al. (2009) endorse and promote the use of small sample sizes, it remains true that a larger sample would likely bring greater breadth to our analysis, thus increasing confidence in the validity of the revealed themes. In addition, the role and impact of the place of employment might have altered the findings of this research. All the participants in this study were employed by the same agency. Having participants from different agencies, and perhaps even different cities, could lead to important nuances with respect to this study's findings. Furthermore, one cannot help but wonder how the findings may have differed had participants worked for an agency that did not endorse harm reduction approaches.

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