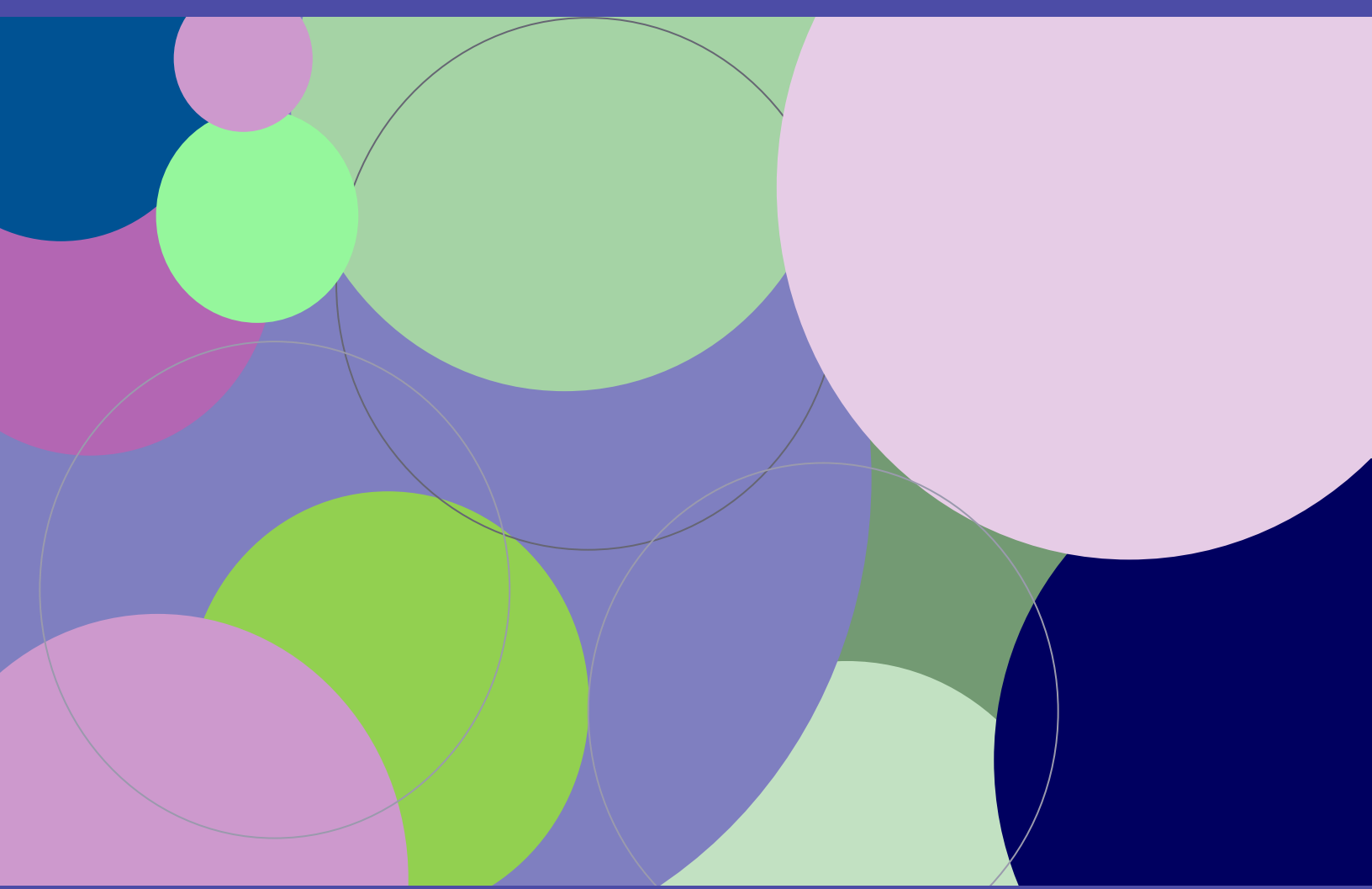


Confidentiality and informed consent in counselling and psychotherapy: a systematic review



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Psychotherapy & Counselling
Federation of Australia

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Suggested citation:

Lamont-Mills, A., Christensen, S., & Moses, L. (2018). *Confidentiality and informed consent in counselling and psychotherapy: a systematic review*. Melbourne: PACFA.

Acknowledgements:

This review was funded by an anonymous philanthropic body and was commissioned by PACFA. The authors thank Nathan Beel and Jens Christensen for their insightful comments on this work, and Alisha Egan for her assistance in the initial review search stages.

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Foreword

PACFA is pleased to present this review on confidentiality and trust in counselling and psychotherapy, one of a series commissioned by the PACFA Research Committee to support PACFA members and member associations in their work. The topic is vital for the professions of psychotherapy and counselling, given that informed consent for therapy and confidentiality are core ethical concepts of our professions, as they are of all health modalities.

The review was written for PACFA by Andrea Lamont-Mills, Steven Christensen and Lauren Moses from the School of Psychology and Counselling of the University of Southern Queensland. It is intended as a resource for practitioners, students and academics in our profession.

This report presents a systematic review of empirical evidence about client understandings of informed consent and/or confidentiality, and of how therapists obtain informed consent and/or understandings of confidentiality. Findings indicate that client and therapist understandings of confidentiality appear to be context and culture specific, and that there is a significant diversity of communications from therapists in their efforts to enable clients to give truly informed consent for therapy.

The review found no Australian research that fitted the review timeframe, nor research that was directly focused on client understandings, or how therapists obtained informed consent and checked for understandings of confidentiality. And despite the centrality of the concepts of confidentiality and informed consent to our professions, little information was located in the literature reporting therapists' actual practice. The authors advise of the need for further research on the basis of these findings.

The PACFA Research Committee is committed to supporting the most effective practices in counselling and psychotherapy. It recognises the importance of PACFA Members, Registrants and Member Associations having access to recent research evidence that can contribute to the effectiveness of their practice.

We hope that you find this review, and others in this series, useful in your own research, practice and advocacy. We welcome your feedback on this paper, and the submission of further reviews for publication in this series.

Dr Kim Dunphy
Chair, Research Committee
March 2018

Abstract

Ethical behaviour is fundamental to counselling and psychotherapy practice. Two core ethical concepts that transverse all health professions are informed consent for treatment and confidentiality. There are instances where breaches of confidentiality must occur and these need to be clearly articulated to, and be understood, by the client before therapy commences. In counselling and psychotherapy, breaches of confidentiality and the failure to obtain clear consent for therapy are common client complaints. The objective of the current study was to systematically review empirical evidence that examined client understandings of informed consent and/or confidentiality, and to systematically review evidence that examined how therapists obtain informed consent and/or understandings of confidentiality. Academic Search Complete, Informit, PsycARTICLES, Psychology and Behavior Sciences Collection, PsycINFO, and ScienceDirect were searched from January 2007 to May 2017. Studies that contained results relating to client understandings or how therapist obtained informed consent and understandings of confidentiality were included. Seven studies met the inclusion criteria. Client and therapist understandings of confidentiality appear to be context and culture specific. There also appears to be variety in what therapists tell clients that would enable them to give truly informed consent for therapy. No Australian research was located during the search time frame and no studies focused specifically on client understandings or how therapists obtained informed consent and checked for understandings of confidentiality. This neglect suggests research is needed in this area. Whilst the importance of confidentiality and informed consent is widely accepted, actual therapist practice in these areas is unknown.

Keywords: breaches of confidentiality, informed consent, ethics, PACFA

Introduction

According to the Psychotherapy and Counselling Federation of Australia (PACFA) Code of Ethics (Psychotherapy and Counselling Federation of Australia, 2017), gaining and maintaining the trust of clients is critical to best practice. It is the foundation of the therapeutic relationship and must be honoured. Most importantly, this trust is built around informed consent and confidentiality and not surprisingly the code has a number of sections dedicated to these two areas.

Like other allied professional codes of ethics, PACFA's code requires that therapists obtain informed consent to provide therapy with a client. The code recommends that this consent be explicit as implicit consent increases the risk of client misunderstandings of what the client has or has not consented to. This includes clearly informing the client about what the therapy service will entail (e.g., physical touch or holding of the client) as well as respecting client confidentiality and informing the client about limits to confidentiality. As an ethical obligation, maintaining the trust of a client involves sharing all information necessary to enable a client to make informed choices relating to engaging, continuing, and ending therapy (Neukrug, Milliken, & Walden, 2001; Psychotherapy and Counselling Federation of Australia, 2017; Packman, Cabot, & Bongar, 1994). Thus for consent to be truly informed and for therapy to begin, the therapist must be satisfied that the client sufficiently understands what they are voluntarily and rationally consenting to, what is confidentiality, and when breaches of confidentiality may occur.

Whilst therapists are required to ensure that they are attentive to client consent for therapy and its accompanying confidentiality, when to inform clients about these is somewhat ambiguous. Gaining consent for therapy appears to be relatively straightforward. It is self-evident that obtaining client consent for therapy needs to occur prior to therapy starting, although this is not explicitly stated in the Code of Ethics (Psychotherapy and Counselling Federation of Australia, 2017). However for discussions of confidentiality and in particular limits of confidentiality, there is increased ambiguity. There is no clear consensus on when such a discussion should be had, particularly given that confidentiality is seen as "an obligation that arises from the client's trust" (Psychotherapy and Counselling Federation of Australia, 2017 p. 4). Some would argue that such a discussion needs to occur in close proximity to informed consent discussions (Zhao et al., 2012), others would argue that client trust needs to be gained first before such detailed confidentiality discussions are undertaken (Elgera, Handtke, & Wangmoa, 2015). What further complicates matters is that although confidentiality and informed consent feature in codes of ethics (see Australian Counselling Association, 2015; Australian Psychological Society, 2007; Psychotherapy and Counselling Federation of Australia, 2017), what is absent is clarity surrounding how therapists ensure that clients truly understand and give informed consent for therapy. Similarly absent is direction about ensuring that clients understand what confidentiality is and importantly, understand what the limits of such confidentiality are.

This direction is important because in respect to complaints about therapists, breaches of informed consent and limits of confidentiality are common client complaints in both counselling and psychotherapy. This means that confidentiality and informed consent are issues of possible

contention between clients and therapists. Psychotherapy and Counselling Federation of Australia's own records reveal that confidentiality accounts for approximately 11.4% of all complaints made by clients (Lewis, 2015; Psychotherapy and Counselling Federation of Australia, 2011b). Breaches of ethics, which would include informed consent, accounts for the largest number of client complaints at 39.34% (Psychotherapy and Counselling Federation of Australia, 2011b).

In psychology, Grenyer and Lewis (2012) examined New South Wales Psychology Registration Board complaints from 2003 to 2007. They reported that confidentiality and not gaining informed consent for treatment accounted for 13.3% of all complaints made during this period. This percentage has stayed somewhat stable over the past 10 years with the recent 2015/2016 Australian Health Therapist Regulation Agency Annual report stating that issues relating to confidentiality accounted for 12.7% of all complaints made about psychologists, with informed consent accounting for 0.2% (Australian Health Therapists Registration Authority and National Boards, 2015/2016).

From the above it appears that client understandings of confidentiality and informed consent are not as clearly articulated nor understood as therapists may assume. Indeed a key recommendation from the Grenyer and Lewis (2012) study was that therapists need to take the time to engage clients in an explanatory conversation around limits of confidentiality and informed consent in order to be assured that clients fully understand and consent to therapy, and fully understand what confidentiality entails, and when it may be breached.

This lack of guidance in ethical codes has resulted in some therapists asking clients to sign detailed consent forms (Fitzgerald, Hunter, Hadjistavropoulos, & Koocher, 2010). However this does not immediately mean that clients have fully understood what can be quite complex information that is presented at a time when they may be experiencing high levels of distress. Given this, identifying research on what clients understand informed consent and confidentiality to be and mean, and how therapists obtain this informed consent is paramount to inform best-practice and professional body guidelines.

With this in mind, the objective of the current study was to systematically review empirical evidence that has examined client understandings of informed consent and/or confidentiality, and to systematically review evidence that examined the obtaining of informed consent and/or confidentiality. More specifically, the objectives were:

1. To describe the characteristics of relevant Australian and International published research, their findings and conclusions.
2. To compare and contrast relevant studies and findings to evaluate their strengths and weaknesses.
3. To identify any knowledge gaps in informed consent and confidentiality research.
4. To provide PACFA with recommendations for practice, training programs, and PACFA's Code of Ethics.

Methodology

The search strategy was initially reviewed by a research librarian and a panel of experts, the PACFA research committee, to determine the suitability of proposed search terms and databases. Minor changes to search terms suggested by the research librarian were adopted. The expert panel recommended no changes.

The search was limited to specific databases considered most relevant to the counselling and psychotherapy profession, best suited to the research question under investigation, and that overlapped with previous PACFA systematic reviews (see Evans, Turner, & Trotter, 2015). The databases used were Academic Search Complete, Informit, PsycARTICLES, Psychology and Behavior Sciences Collection, PsycINFO, and ScienceDirect.

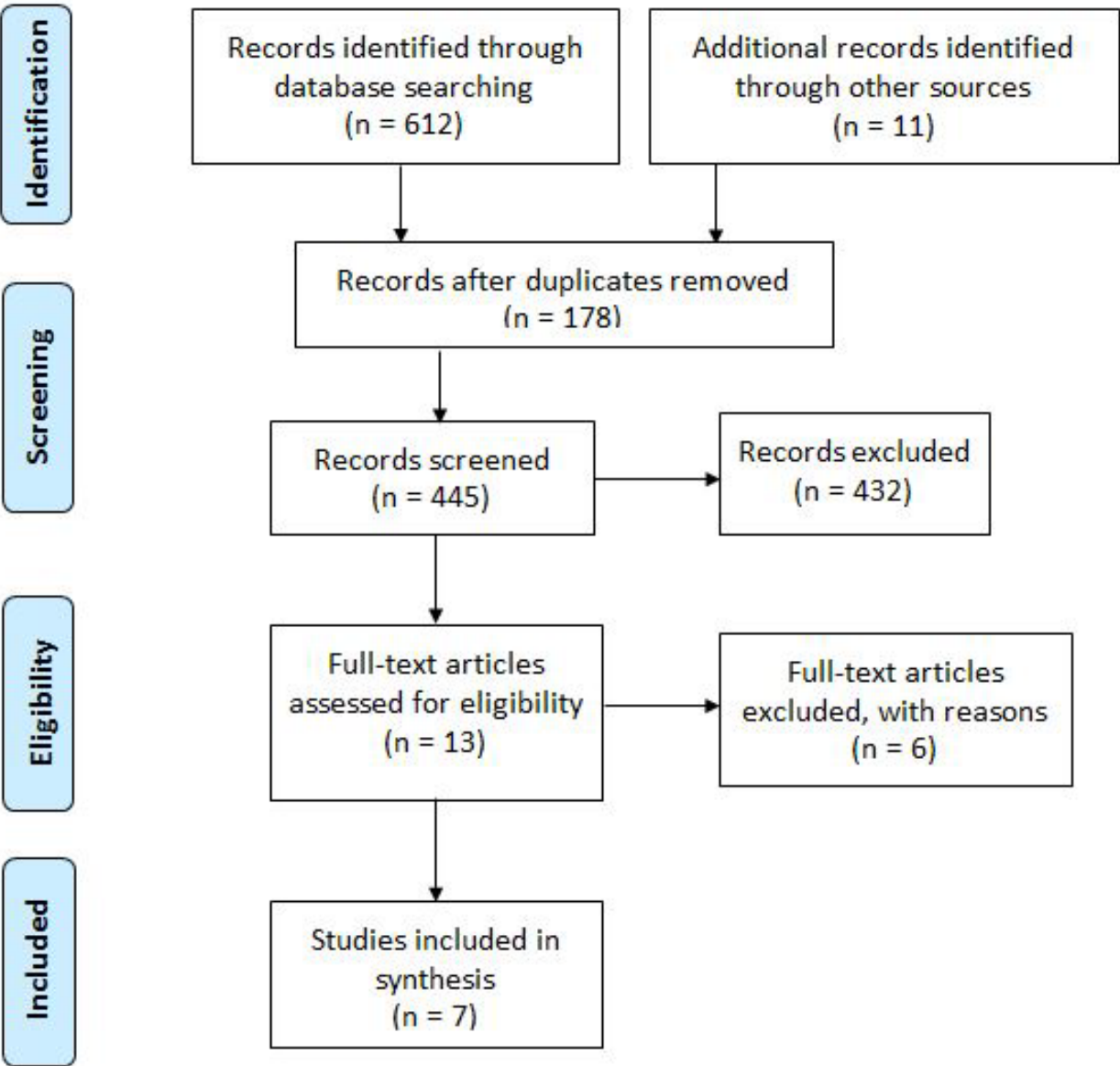
The following search terms were used (counselling OR counseling OR psychotherapy OR therapy) AND (informed consent OR confidentiality OR privileged communication OR ethical issues OR professional ethics OR ethical responsibilities OR ethical decisions OR ethical considerations OR ethical dilemmas) AND (attitude* or understanding*). Two independent reviewers conducted all searches under the guidance of the first author. After each search and exclusion application, search outcomes were compared and any disagreements in returned results were resolved through discussion and consensus.

The following limitations were placed on the initial search. Papers must have been published in peer-review outlets, only English language publications were searched due to limitations on translating articles, only papers published from January 2007 to May 2017 were searched as per funding requirements, and the initial search was limited to title and abstract.

The results from this initial search were then filtered using the following exclusion criteria: expert committee reports, opinion pieces, clinical experiences, essays, or respective authority commentaries. Titles and abstracts were reviewed in the first instance as part of this exclusion process and when this was not possible or these were unclear, the full article was obtained and exclusions were based on that information. The results of this first exclusion were then filtered by participants and any studies that did not include current and/or past counselling/psychotherapy clients, and/or current and/or past counsellors/psychotherapists as participants were excluded from the review by again reviewing titles and abstracts. If this was not possible or these were unclear, the full article was obtained and exclusions were based on that information.

This systematic search resulted in a final list of studies to be included for data extraction. To ensure that no studies had been overlooked the reference list of all potentially eligible articles were searched for additional research articles. Finally, a manual search of key Australian and International counselling and psychotherapy journals was undertaken. After this was completed, one of the independent reviewer's extracted data from these potential studies for final assessment of suitability for inclusion. The first author then reviewed this extracted data against the objectives of the review and excluded six studies as not meeting the broad objectives of the review. This left seven studies to be included. An overview of the search procedure can be found in Table 1.

Table 1: Search Strategy and Outcome



Results

What was evident from the final search result is that no studies explicitly examined client understandings of informed consent for therapy, how therapists obtain informed consent for therapy, or how therapists know that a client has understood informed consent for therapy. This was the same for confidentiality. This is not to suggest that researchers have ignored informed consent and confidentiality altogether. There is an abundance of literature that has focused on the importance of informed consent and confidentiality (see Cottone & Tarvydas, 2016; French, 2015; Jenkins, 2015; Harris & Birnbuaum, 2015; Sori & Hecker, 2015). However there is little research that has focused on client understandings of confidentiality and its limits, informed consent for therapy, or how therapists gain such understandings and permissions. Given this, any study that included a result about client understandings of confidentiality or informed consent has been included in this review. Any study that included a result about how therapist obtained informed consent for therapy or client understandings was also included.

Informed Consent

The Code of Ethics (Psychotherapy and Counselling Federation of Australia, 2017) requires counsellors and psychotherapists to obtain informed consent for therapy from clients. Whilst this may be the case, no research was located that had focused specifically on informed consent for therapy. Only one study in the review included information about whether clients had been informed about the risks of therapy and the costs of therapy prior to or in the early stages of therapy (see Zhao et al., 2012). Arguing that the therapeutic relationship is reflective of the social culture in which therapy takes place, Zhao et al. (2012) surveyed 1274 Chinese clients about their perceptions of Chinese psychotherapist ethical practices. Results indicated that approximately 30% of clients reported that their therapist had discussed therapy risks with them and 54% said they were given information about the cost of therapy.

A second study focused on assessing the readability of written therapeutic informed consent forms (see Walfish & Ducey, 2007). The premise of the study was that if information is not presented to clients in a way in which they can easily understand, true informed consent cannot be gained. Whilst not focusing on clients or therapists as participants, the study was included as it focused on one way in which informed consent can be obtained. Examining the readability of informed consent documents used by American psychologists, results revealed that 94% of the documents being used had a reading ease level of difficult and 82% of the documents were assessed as being written at a grade 12 level of understanding. Given that at the time of this study the average reading age in America was Grade 9, the authors argued that the majority of clients who had signed these forms would not have fully understood what they were consenting to.

Confidentiality

Discussing confidentiality, the limits of confidentiality, and gaining client consent for breaches of confidentiality are key professional obligations of counsellors and psychotherapists (Psychotherapy and Counselling Federation of Australia, 2017). Of the seven articles, two studies assessed client familiarity or awareness with confidentiality. Rodriguez, Fang, Gao, Robins, and Rosenthal (2016) explored both client and therapist understandings of the limits of confidentiality. The warrant for the study came from the lack of Chinese guidelines for working with adolescent clients. Analysis revealed that 58% of the adolescents surveyed stated that they were unfamiliar with ethical guidelines relating to confidentiality. Similar findings were reported by Fox and Butler (2007) who aimed to identify adolescent perceptions of school counselling services. Most of the adolescents who were surveyed reported not knowing what therapeutic confidentiality meant.

Knowing what is confidentiality is different to perceptions of whether therapists keep information confidential. Two studies asked clients whether they believed that their therapist had kept their information confidential. Zhao et al. (2012) found that 91% of Chinese clients perceived this to be the case as did the majority of clients in a Nepalese study conducted by Jordans, Keen, Pradhan, and Tol (2007). The Nepalese finding is encouraging given that at the time the study was conducted, Nepal mental health services were poorly resourced, there was no Mental Health Act, and two intensive counsellor training programs had only recently been implemented.

Finally, it appears that some clients are being informed of confidentiality and its limits. This appears to occur most often in the early stages of therapy although in some particular therapeutic contexts this is dependent upon who has requested the therapy. Low (2015) examined Singaporean school counsellor, teacher, and community counsellor perceptions of school counselling in general. When asked about confidentiality, some counsellors expressed a preference for discussions surrounding confidentiality to occur in the first few therapy sessions. However they noted the challenge faced by school counsellors in ensuring the confidentiality of information in a school setting.

The most detailed study to be identified in the search examined breaches of confidentiality in prison settings. There are unique challenges in working with incarcerated clients as there are times when therapists work with clients in non-therapeutic encounters. Elgera et al. (2015) asked 24 German and Swiss mental health professionals who worked in prison settings about their confidentiality practices and found that these practices were context specific. Being asked to give an expert opinion in a judicial setting is considered to be a non-therapeutic encounter. In such cases, all participants reported that they discussed limits of confidentiality in the first session with the individual and they did so by either giving the client a written consent sheet to read and sign, or did this orally with understanding being obtained orally from the client. When seeing a client who has a court order for therapy, the majority of therapists disclosed that they also discussed confidentiality in the first session; although one therapist did not, stating that trust first needed to be built before a discussion of breaching that trust could be had. Client understanding was obtained in writing or orally.

If the client was seeing the therapist voluntarily, therapists stated that confidentiality and its breaches were usually discussed in the first session (Elgera, et al., 2015). An exception was that one therapist stated that such a discussion was not consistent with the underpinning foundations of psychotherapy and that he would often delay such a discussion until the client and therapist had developed sufficient rapport. Again client understanding was obtained either through written or oral means. Despite this, some therapists did not believe that clients fully understood either confidentiality or its limits. In such cases therapist reported revisiting these confidentiality discussions when information was required to be shared.

The final therapy setting that was mentioned was when incarcerated clients came to see the therapist of their own free will (Elgera et al., 2015). This was where the most variability emerged in confidentiality practices. Some therapists adopted an approach where confidentiality and its limits, as they relate to the prison setting, were discussed in the first or early sessions. Others took up the position that confidentiality, in such cases, was the same as if they were working with a client who was not incarcerated. In a small number of cases therapists stated that clients knew that confidentiality takes on a different meaning in the prison system, and hence they did not believe that clients need to be systematically informed about confidentiality and its breaches. Informing would be done on a case-by-case basis. Some therapists expressed that it was unproductive to start the therapeutic journey with such discussions and as a result they did not systematically inform clients about confidentiality in voluntary sessions.

Table 2 contains detailed information about the studies included in the synthesis.

Table 2: Studies included in the review

Author/date/location	Study type	Substantive focus	Participants	Measures*	Results/Conclusions/Recommendations*
Elgera, Handtke & Wangmoa (2015) <i>Switzerland</i>	Qualitative, semi-structured face-to-face interviews.	Identification of how mental health therapists inform imprisoned clients about confidentiality and its limits.	24 French and German speaking mental health therapists who were working in Swiss prisons.	Thematic analysis of interview transcripts	<ul style="list-style-type: none"> • Information about confidentiality is context specific. • Expert opinions and court ordered therapy is not bound by traditional confidentiality rules and clients were usually informed this was the case. • Voluntary therapy presented a challenge when informing about confidentiality and different therapists adopted different practices. • Working with vulnerable populations presents particular ethical challenges for therapists and more education about ethical practices in this setting is needed.
Fox & Butler (2007). <i>UK</i>	Mixed methods, survey and focus groups	Exploration of adolescents' perceptions of school counselling.	415 (200 male; 215 female) students recruited from five high schools with a mean age 13.27 years ($SD = 1.54$). 8% reported having seen a school counsellor	Questionnaire that consisted of open-ended questions that assessed understanding of school counselling service and closed-ended questions that assessed awareness of counselling services and perceived usefulness of the service. Developed specifically for the study. Content analysis of focus group transcripts.	<ul style="list-style-type: none"> • Confidentiality was seen as both a facilitator and barrier to attend counselling. • There is shared understanding that counselling is confidential but not what confidentiality actually means • Greater awareness of the confidential nature of the service needed would increase service use. • Early and clear explanations of confidentiality to school counselling clients recommended.

Author/date/location	Study type	Substantive focus	Participants	Measures*	Results/Conclusions/Recommendations*
Jordans, Keen, Pradhan, & Tol (2007) <i>Nepal</i>	Qualitative, semi-structured face-to-face interviews Varkevisser, Pathmanthan & Brownlee (2004) qualitative research framework utilised.	Stakeholder perceptions regarding the benefit of counselling	3 stakeholder groups: clients; managers of human right and violence counselling services; counsellors. 34 clients (26 females, 8 males) mean age 18.6 years (SD = 7.81). 29 were still at school. 23 managers (16 female; 7 male). 30 trained counsellors (they had been trained with funding from the organisation that funded the study), age range 21-42. Sampling was purposive and snowball.	Content analysis of interview transcripts.	<ul style="list-style-type: none"> • Most clients perceived that confidentiality had been maintained by their counsellors. • Those that felt that confidentiality had been breached or would be breached said that this impacted upon their satisfaction with the service. • Culturally specific understandings of confidentiality were raised as an issue where in collectivist cultures, non-disclosure of information is not customary. • Culturally specific counselling services need to extend to confidentiality understandings.
Low (2015) <i>Singapore</i>	Qualitative semi-structured face-to-face interviews	Part of a larger study. Perceptions of key stakeholders regarding school counselling services.	3 stakeholder groups: school counsellors; teachers; and community counsellors. Chain referral sampling was utilised. 19 participants (15 females; 4 males). 7 school counsellors, 6 teachers, and 6 community counsellors. Experience ranged from mean 1.1 years of working for school counsellors, mean 7.3 years for teachers, and 8.4 years for community counsellors. Age range 20-59.	Thematic analysis of interview transcripts using the Braun and Clarke (2006) method	<ul style="list-style-type: none"> • Management of confidentiality perceived as challenging in the School environment • Consent to share information rather than breach confidentiality was encouraged to be obtained in the early stages of therapy. • Developing a common understand and consensus on confidentiality and information transmission is required at management level.

Author/date/location	Study type	Substantive focus	Participants	Measures*	Results/Conclusions/Recommendations*
Rodriguez, Fang, Gao, Robins, & Rosenthal (2016). <i>China</i>	Survey	Identify when it is appropriate to breach confidentiality and compare responses across different groups.	3 groups: therapists, parents, and adolescents of which only 7% had seen a counsellor before. Convenience sampling used.	Questionnaire developed specifically for the study. Consisted of 18 hypothetical clinical scenarios that the authors adapted from previous researchers. T-tests and one-way ANOVA used to assess for group differences.	<ul style="list-style-type: none"> • Most of the adolescents and half of the parents reported a lack of familiarity with Chinese ethical guidelines. • Guidelines regarding how to communicate confidentiality and breaches of confidentiality to adolescents are needed.
Walfish & Ducey (2007). <i>United States</i>	Evaluation	Assessment of the readability of written informed consent forms used by psychologists.	N/A	Flesch-Kincaid Grade Level formula and the Flesch Reading Ease scores.	<ul style="list-style-type: none"> • Forms have been written using language that is targeted at Grade 12 reading level and a level of high difficulty. • Psychologists who are using forms to gain written consent may be at risk of clients not understanding the information on the form and thus not truly giving informed consent for therapy or understanding of the limits of confidentiality. • Forms need to be reviewed from the client's perspective rather than from the therapist's.

Author/date/location	Study type	Substantive focus	Participants	Measures*	Results/Conclusions/Recommendations*
Zhao, Ji, Tang, Du, Yang, Yang, Hou, & Zhang (2012) <i>China</i>	Cross-sectional survey	Client perceptions of psychotherapists ethical practice	1274 participants (722 females; 522 males). The response rate was 80%. Age range was 12-74 years with a mean age of 29.84 years (<i>SD</i> = 11.47). The majority of clients had a college degree or below level of education (<i>n</i> = 772)	Questionnaire developed specifically for the study. Frequency distributions reported. Gender comparisons made using chi-squared tests	<ul style="list-style-type: none"> • Confidentiality was perceived as not being breached by the majority of participants. • Only half of clients had been informed of the fees relating to therapy. • About a third of clients stated that their therapist had discussed the risks associated with therapy appropriately with them, with about a half reporting that the treatment plan had been discussed. • Clients most likely do not understand what confidentiality and informed consent mean. • Confidentiality and informed consent are grounded in cultural understandings, thus cross-cultural therapists need to be aware of this if they wish to work effectively with Chinese clients.

Notes: * Only measures/outcomes and results/conclusions relating to informed consent or confidentiality were included in the table.

Concluding Comments

The purpose of this review was to evaluate empirical evidence that has examined client understandings of informed consent and/or confidentiality, and to systematically review evidence that examined the obtaining of informed consent and/or confidentiality by therapists. It is clear from the search results that limited empirical research has been conducted in these areas. This is not to suggest that there is a dearth of literature on these topics. Quite the contrary, there is a substantial body of scholarly opinion or professional statement literature that reiterates the importance of informed consent and discussions of confidentiality or provides reflections based on author experience (see Fisher & Oransky, 2008; Venier, 1998). What is missing is an exploration of client understandings of informed consent and confidentiality, how therapists obtain such understandings, and how therapists know that clients do understand.

Given this, the reviewers undertook to include studies that contained a result that was in some way related to the review objectives. Even with this, limited research was identified. No Australian research was located that was within the search parameters. This meant that the review consisted of International studies with the majority of these being conducted in South-East Asia, and those remaining focused on European or American contexts. Just over half of the studies had been published in the last five years, with the remainder being published 10 years ago. Most of the studies adopted qualitative research frameworks utilising either content analysis or thematic analysis as the analytic approach. For those studies that used surveys, each study had developed their own survey.

The methodological quality of the studies included in this review is variable. What is particularly problematic is that when surveys are developed explicitly for a study, comparisons across studies become difficult. This then limits what we can say about confidentiality and informed consent practices. Whilst some of the qualitative studies followed clearly established analytic processes (see Low, 2015), most did not. Given that qualitative research is often criticised for its 'anything goes mentality' (Silverman, 2015), ensuring that analysis is robust and rigorous is critical to ensuring the integrity of the analytic observations.

Findings from the review suggest that confidentiality is culture and context specific. That is, the context in which the counsellor or psychotherapist is working influences whether what the client says during therapy remains confidential. In some contexts, confidentiality cannot be protected, however it appears when this is the case therapists inform the client of this. One of the clear conclusions to emerge from the review is the cultural nature of confidentiality and informed consent understandings. Whilst there is much focus on culturally appropriate counselling (see Collins & Arthur, 2010), what is absent is an extension of this cultural lens to confidentiality and informed consent practices. That is, Western understandings of confidentiality and informed consent do not always take into account the social understandings of culturally diverse groups and this is potentially problematic if keeping trust is to be maintained. For example, in more collectivist orientated cultures, privacy and keeping information confidential is not as valued as it is in Western cultures (Jordan et al., 2007).

A number of gaps in the literature are evident from this systematic review. There is a clear need for Australian based research that has as its substantive focus client understandings of informed

consent and confidentiality. There is a similar need for Australian research that examines how therapists obtain understandings of informed consent, confidentiality and its limits, and how therapists know that clients have actually understood these ethical practices. Benchmarking of current therapist practices would be a good starting point for this research. Including questions relating to how informed consent is obtained and how clients are informed about confidentiality and its limits could be incorporated in PACFA and other counselling organisation membership renewals as an interim measure.

Perhaps what is most needed is an actual examination of therapist ethical practices in situ. Research has found that engaging in discussions of informed consent and confidentiality can positively contribute to the therapeutic relationship (see Beahrs & Gutheil, 2001; Kerby, 2010). It does so in that client and therapist are seen as working toward a common endpoint. The discussion encourages the client to take ownership of the therapeutic process, and client anxiety about the therapeutic process may be reduced as a result. What we know from this review is that therapists do not always discuss all aspects of informed consent and issues of confidentiality with clients, and that when they do then the manner of how this discussion is enacted differs according to therapist and practice setting. Keeping trust is central to professional practice and the therapeutic relationship; yet despite this emphasis the process by which informed consent is obtained, and how clients display understanding of limits of confidentiality has not been examined as a lived practice.

Research is needed that examines client-therapist discussions of informed consent and confidentiality as it occurs in consultations in-order to increase empirical knowledge of the lived practice of informed consent and limits of confidentiality. Given that informed consent and confidentiality are prescribed by ethical codes as occurring in interaction, it is important to actually examine this interaction. Lamont-Mills and Christensen (2010) have done this by examining how limits of confidentiality were discursively negotiated in a real-life psychological consultation. They found that the discursive practices used by the psychologist had the effect of limiting the client's opportunities to ask questions or clarify components relating to limits of confidentiality. The psychologist made it interactionally difficult for the client to ask questions about the conditions under which confidentiality breaches would occur. Lamont-Mills and Christensen concluded that whilst the psychologist satisfied her ethical obligation to inform the client about the limits of confidentiality, she had simultaneously restricted the client's opportunities to clarify aspects of confidentiality. This made it unclear as to what the client had agreed at the end of the discussion. It is acknowledged that informed consent was not explicitly examined in this study; however the above findings raise questions about the level of clarity that may surround client displays of informed consent and therapist acknowledgements of this informed consent.

Given the limited empirical evidence found in this review, it is premature to suggest that any changes to PACFA educational or training programs are required. Any such changes need to be grounded in data and thus research first needs to be conducted. If the opportunity presents, some further clarity around informed consent and confidentiality should be embedded into PACFA's Code of Ethics (Psychotherapy and Counselling Federation of Australia, 2017). For example, clarity around what is adequately informed consent (see page 2); informing clients of

their right to confidentiality (see page 2); obtaining informed consent (see page 8); and explaining the limits to confidentiality (see page 9) means may assist in ensuring that clients truly give informed consent and truly understand what confidentiality means and what are its limits. In an increasing litigious society such clarity is warranted.

What could be included in PACFA's Code of Ethics is a statement about the culture specific nature of confidentiality. Counsellors and psychotherapists who work with culturally diverse groups may need to take additional time when discussing confidentiality and its limits with such groups to be assured of client understandings. Based on the research reviewed, it appears that Western understanding of confidentiality would most likely be at odds with some clients' social and cultural understandings.

What may also assist counsellors and psychotherapists is a PACFA developed written informed consent template. Such a template needs to be carefully developed taking into consideration the average reading age in Australia. It may be that different templates can be developed for different groups of clients (i.e., adolescents, culturally and linguistically diverse), all with a careful consideration of how the document is constructed. These points aside, more research is needed to ensure that counsellors and psychotherapists are truly gaining informed consent and clients truly understand confidentiality and its limits.

Recommendations

In summary, we recommend:

- Australian research that focuses on client understandings of informed consent and confidentiality be conducted.
- Australian research focusing on how therapists obtain such understandings and, importantly, how do therapists ensure that clients have understood is also required.
- This research must be methodologically rigorous. Future quantitative research studies must use psychometrically sound measures. Just as future qualitative research must follow well developed analytic procedures.
- Research that explicates informed consent and confidentiality as real-world practices is vital. Therapists need to be willing to have their therapy sessions recorded and examined just as doctors, psychologists, nurses, dentists, speech and occupational therapists have done.
- Culturally and linguistically diverse client and therapist groups be included in this research to allow for cross-cultural explorations of confidentiality and informed consent.
- Sections of PACFA's Code of Ethics where confidentiality and informed consent are explicitly mentioned be re-written to ensure that therapists clearly understand what adequately informing clients about informed consent and confidentiality means.
- A statement in the Code of Ethics relating to the cultural specific nature of confidentiality is required.
- PACFA develop written informed consent templates that reflect the average Australian reading age, cultural background, and age group.

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