

Confidentiality and informed consent

[Law](#), [Security](#)



In the article by Martindale, Chambers, and Thompson, we learn that Informed consent and confidentiality. A person should be informed of their right to confidentiality and the treatment they are consenting to in the therapeutic relationship. This study is significantly important because we are shown that there has been not very much previous research done on how well we manage consent, how informed the patient is, how honest they are, and what they actually know about the policies of the provider. Professionals in many settings create and utilize very different techniques of informed consent and confidentiality.

In professions where professionals constantly see people who are troubled. who see the everlasting devastation of grief, pain, and the disparities of people in situations that they can't change, it can be very taxing and wearing on even the most seasoned professional person, but do we actually communicate well to the patient that they have rights? In the article, we see that so many patients are so desperate to receive care that they instantly just "sign papers" so that they can see the psychologist.

If a patient is that desperate, how do we know that mental health professionals are performing to their maximum standards of informing the patient about their care standards and things like who has the appropriate access to their medical information? We, as counseling psychology graduate students and professionals alike, have a strong moral and ethical responsibility to ourselves, our colleagues, and our clients to make sure that we provide appropriate documentation, informing the patients clearly of their rights and responsibilities, so that we do not potentially negatively affect the lives of other people.

In the article by Martindale, Chambers, and Thompson, in the four themes that emerge, "being referred; the participant's feelings, mental health difficulties, and their impact; relationships with workers and carers; and autonomy (Martindale et al, p. 355)", we see that many clients have concerns about continuing care. I think the most difficult and problematic issue to handle there is the patient's mental health and stability. In chapter 5 of the textbook, the ACA Code of Ethics, Section 8.5 on informed consent states: "Responsibility to Clients.

When counseling minor clients or adult clients who lack the capacity to give voluntary, informed consent, counselors protect the confidentiality of information received in the counseling relationship as specified by federal and state laws, written policies, and applicable ethical standards. (Welfel, 2012, p. 142)". It is the professional responsibility of the provider to be aware that the client has good mental standing to be able to know their rights. However, how do we know upon first seeing the client that they are in a good mental standing to be completely informed? This puts providers in a tough situation.

What happens to the clients they counsel who never know of their consent rights and their confidentiality? How can we test for that if we have no idea if the client is being honest with us? How do we know the frequency of occurrence? How do we know it is not happening all the time? That is why it is absolutely imperative to have open and honest communications with the client as often as possible. As graduate students, it is important for us to foster a supportive working relationship with our advisor, so that we are

absolutely sure the client is informed about what comes next in their therapy process.

What if clients are too scared to ask how many sessions they have left? What if they are a "yes" person and can't say no to more or less treatment options? What if they have concerns but are too scared to ask about what is upcoming? I have personally seen a therapist who, after every session, had me fill out a questionnaire about my ability to see things clearly in the session; if I understood what my objectives were, if I understood her clearly, and if there was anything I was personally hesitant to share or anything that bothered me about our last session.

This was extremely problematic for me because I always answered "no problems with last session" for fear that I would disappoint my provider or that she would then bring up the issue that I had experienced a problem with. I always felt uncomfortable, but continued to answer the questionnaires and continue care anyway because I needed it. In Martindale, Chambers, and Thompson's article, there are some limitations to the study. Primarily collected data were from mainly white women.

There seemed to be no measure of marginalized communities, underrepresented populations, or any data from the people who seem to struggle the most: people needing critical care. How would ethnic minorities respond to a provider who may not understand their cultural differences? How do we make sure those people are being informed appropriately? What about marginalized communities who are in crisis and need care? How do we

handle special situations appropriately? What about people who can't consent to appropriate care guidelines?