

PAPER

Talking more about talking cures: cognitive behavioural therapy and informed consent

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ABSTRACT

Cognitive behavioural therapy (CBT) has risen to prominence as an orthodox treatment option which is commonly recommended to patients with anxiety and depressive disorders. Mainstream healthcare institutions (including the National Health Service in the UK (NHS) and National Institute for Mental Health (NIMH)) assume that CBT works by helping patients to challenge and overcome 'faulty cognition'. Even if we accept the empirical evidence which shows that CBT (like other forms of psychotherapy) is a beneficial treatment there are still problems with this therapy: mainstream medicine and psychotherapy are continuing to ignore established research that CBT does not work according to its core theoretical tenets. This paper presents evidence that psychotherapy is entrenched in such conventional 'wisdom' and that practitioners are failing to meet their own codified requirement of informed consent. I examine ethical arguments for and against upholding current informed consent procedures and focus, in particular, on the relationship between respect for patient autonomy and the duty of beneficence. I argue that (so far) there are no strong grounds for the claim that patient autonomy undermines therapeutic outcome. The modest conclusion of this paper is that psychotherapy (including CBT) needs to begin to adapt informed consent procedures to comply with ongoing scientific research into its efficacy.

Cognitive behavioural therapy (CBT) has steadily risen to prominence in the USA and UK as an effective mainstream treatment for anxiety and depressive disorders. Globally, a quarter of psychotherapists use CBT; it is also the fastest growing form of psychotherapy worldwide.¹ The rise of CBT in the treatment of mental health disorders makes it ripe for ethical analysis. Americans pay out around \$10 billion every year on psychotherapy treatments.² Meanwhile, in 2007 the British government invested £300 million in the launch of its 'Improved Access to Psychological Treatments' scheme with the goal of training 6000 CBT therapists for access to National Health Service (NHS) patients in England.^{i ii 3}

CBT is the most widely researched and most commonly used psychotherapeutic treatment for

depression and it is often promoted as the most scientifically credible form of therapy. The UK's National Institute for Health and Care Excellence (NICE) Guidelines for Depression recommend that CBT (hereafter 'CBT') is used as a frontline treatment for depression (from subthreshold and low intensity depressive symptoms to severe depressive disorder).⁴ In the USA, the National Institute for Mental Health (NIMH) advises patients that CBT is particularly effective for depression.⁵

In this paper, I assume that studies have demonstrated the effectiveness of CBT—especially for the treatment of depression. Meta-analyses show that around 80% of people who undergo psychotherapy are better off than those who receive no treatment (an outcome ie determined by psychological functioning rating scales such as the Hamilton Rating Scale for Depression).^{6–9} Indeed, there is evidence that CBT is a more enduring treatment than antidepressant medications and that it is a prophylactic.¹⁰ Moreover, patients express a threefold preference for talking cures over medication.¹¹ I take CBT as my focus not because other forms of psychotherapy are better supported by evidence (they are not) nor because there is more scientific support for the theoretical tenets underpinning other versions of therapy (there is not). Rather, I focus on CBT because it is the most researched and widely used form of therapy for depression and has widespread cachet as more 'scientific' than other psychotherapy modalities.^{iii 9}

Even if we accept the evidence for the effectiveness for CBT—evidence which is well known to health professionals—I contend that negligible attention has been paid to scientific research into how CBT (and other versions of psychotherapy) work. This research has massive implications for clinical training, practice and codes of conduct—for doctors no less than for non-medically trained therapists. Indeed, for over 20 years the theoretical explanation for CBT has been called into serious scientific doubt. Today psychologists researching psychotherapy contend that CBT and other versions of psychotherapy do not work according to their highly specific theoretical claims—instead, it appears that the shared 'common factors' explain the beneficial therapeutic effects of different 'talking cures'.⁹ Yet continuing professional development within medicine, and psychotherapy training, continue to ignore these findings. This paper is not the place to investigate why or how training



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ⁱIn the interests of consistency this paper will consistently refer to patients (rather than 'client' or 'health/service user').

ⁱⁱAlmost 4000 new therapists were trained by the end of 2011 with the goal to train an additional 2000 therapists by end 2014.

ⁱⁱⁱMoreover, different versions of therapy deserve separate ethical analysis.

programmes have managed to disengage from serious scientific research (questions which deserve answers). Rather, the concern of this paper is the ethical implications of promulgating false information to patients.

The paper begins by describing ‘the received view’ of CBT. While fuzziness in classification does exist we can usefully speak of a prototypical, theoretical hard core with respect to CBT which is disseminated in patient literature.^{iv} Second (given the constraints of space) I briefly survey robust scientific research which asserts that it is the incidental factors associated with CBT and not its specific ‘ingredients’ that are responsible for its significant therapeutic effects. Third, in light of this, I examine current ethical regulations for informed consent among psychologists and psychotherapists in respect of CBT. I find that psychotherapy practice is entrenched in conventional wisdom and that practitioners are failing to adhere to their own ethical guidelines. I consider the ethical arguments for and against upholding current informed consent procedures.^{12 13} My modest conclusion is that there are no convincing grounds for maintaining the status quo because these ethical arguments (and research into psychotherapy) thus far demonstrate no tension between respecting patient autonomy and beneficence. I conclude that the profession of CBT (and indeed, other versions of therapy) needs to find ways of adapting informed consent procedures to keep up with the scientific research programme in psychotherapy.

CBT: THE RECEIVED VIEW

The ‘received view’ of CBT amounts to the claim that mental disorders such as depression result from faulty or dysfunctional cognition and behaviour. I take the core principles of CBT to be located in the work of Aaron Beck¹⁴ and published in manualised form by Judith Beck.¹⁵ For proponents of CBT, mental disorders are ‘thinking disorders’. On this view, faulty thoughts cause what Beck dubs maladaptive behaviours. The goal of CBT is to help the patient identify problematic automatic thoughts (what are termed ‘cognitive distortions’), and to help the individual challenge the validity of these thoughts. According to the received view depression arises because of faulty learning: cognitive therapy is an attempt to redress this purported maladaptive learning by helping patients to become ‘realistic’ in their thinking. It is contended that therapists engage patients in a collaborative and experimental process, the outcome of which is purportedly the promotion of healthy and realistic cognitive restructuring. The role of empathy is considered a means to an end in this process: without positive feedback and support, it is contended, the patient will not be sufficiently motivated to become engaged in the therapeutic process which is dubbed ‘collaborative empiricism’.⁹

This view of CBT is propagated in patient literature by leading health authorities in the UK and USA. For example, the NHS’s ‘Health A–Z’ website on CBT explains that, “You and your therapist will look at your thoughts, feelings and behaviours to work out if they are unrealistic or unhelpful and to determine the effect they have on each other and on you”.¹⁶

^{iv}There are numerous versions of psychotherapy that are derivative of CBT (including, for example, Eye Movement Desensitization and Reprocessing (EMDR)) and this has led to questions about how (or whether it is even possible to) classify cognitive-behaviour therapies. The National Association of Cognitive-Behaviour Therapists, for example, asserts that, “The term cognitive-behavioural therapy (CBT) is a very general term for a classification of therapies”. (<http://www.nacbt.org/whatiscbt.htm>, 2014).

Similarly, the NIMH explains that “The therapist helps the patient learn how to identify distorted or unhelpful thinking patterns, recognise and change inaccurate beliefs, relate to others in more positive ways, and change behaviours accordingly”.⁵ In the UK NICE Guidelines also advise that health professionals: “include an explanation of the CBT model, encourage tasks between sessions, and use thought-challenging and active monitoring of behaviour”.^{4*}

COMMON FACTORS RESEARCH

There are major problems with the scientific core of the received view of CBT. This should come as no surprise: its tenets were first formulated nearly 40 years ago.^v While this is not the place to review scientific evidence against the theoretical hard core of CBT we can survey solid scientific research aimed at explaining why psychotherapy is effective.

Research directly undermines the importance of the ‘cognitive’ components of CBT: it is estimated that most improvement takes place prior to the introduction of cognitive restructuring techniques.¹⁷ More than 300 studies have found that less than 1% of the variability in patient outcome is due to the specific techniques of distinctive treatments.^{18 19 20} An estimated 40% of improvement in psychotherapy is due to external or extra-therapeutic factors (eg, changes in the patient’s social environment).²¹ So what are the common factors responsible for the success of psychotherapy (including CBT)? Surprisingly, research consistently shows that therapists’ allegiance to a particular theory is more important than their adherence to treatment protocols.^{22 23} One estimate puts allegiance effects at around 10% of treatment outcome. Studies even show detrimental effects of adherence: Henry *et al* found that therapists who strictly adhered to treatment manuals were more likely to display negative attitudes such as less approval, less optimism and more authoritarian behaviour towards patients.²³

The most significant factors in treatment outcome appear to be therapist-related. ‘The essence of therapy,’ it is claimed, ‘is embodied in the therapist’.⁹ Comparative studies of therapists who use the same treatment show that 30% of the variability in outcome is attributable to the therapist.²⁴ In other words some therapists are highly effective while others are ineffective, even among experienced and well-trained practitioners.^{9 25 26} The ‘therapist effect’ undermines the received view of CBT where the role of therapist qualities are considered ancillary (‘necessary but not sufficient’)⁹ to the therapeutic process.²⁷ But what exactly should we understand by the term ‘therapist effect’? Research partitions this into: (1) therapist factors such as degree of empathy, encouragement, trust and unconditional positive regard for the patient; and (2) agreement between therapist and patient about the goals of therapy (often dubbed ‘the therapeutic alliance’ or ‘the alliance’). In respect of the latter, alliance is said to encompass the degree of collaboration and

^vFor example, one major problem with the core of CBT is its explicit claim that therapy renders patients’ thinking ‘realistic’. This ignores well-documented findings on the nature of depressive cognition—specifically, on the phenomenon of ‘depressive realism’. There is core scientific agreement that individuals who are mild to moderately depressed (but not severely depressed) are better at evaluating how they are perceived by others: they have more realistic expectations about the future than those whom CBT theorists (and common sense) might declare ‘mentally well’. Judith Beck’s seminal manual of CBT asserts that therapists should be “*realistically optimistic* and upbeat”. In light of depressive realism research this statement does not make sense. In opposition to the key principles of CBT, alleviating depression effectively amounts to restoring positively mild delusions.

commitment to those goals by patient and therapist. It is proposed that agreement about goals helps to harness patient compliance. Indeed, numerous studies show that early assessments of therapeutic alliance between patient and therapist predict outcome with up to 65% of symptomatic relief occurring within one to seven visits.^{28 29} Moreover, contra conventional wisdom, patients are better judges of therapeutic alliance than therapists.^{30vi}

Finally, the patient's *expectation* that the treatment will be effective is also considered to be a key component in outcome. The placebo effect has been defined as an expectancy response whereby the expectation that a treatment will be effective elicits a self-fulfilling therapeutic benefit in the patient.³¹ The placebo effect has been found to be a significant therapeutic effect for a range of conditions (including depression, anxiety and chronic pain).³² In short, the placebo effect is no less relevant in psychotherapy than in pharmacological interventions.³³ Ascertaining the size of the placebo effect in psychotherapy is notoriously problematic not least because double-blinded placebo psychotherapy is not experimentally feasible.³³ Nonetheless expectancy can be assessed without problem and studies show that treatments with cogent rationales are more effective than psychotherapy interventions that have no explanation.

INFORMED CONSENT GUIDELINES

Informed consent procedures for professional organisations such as the British Association for Counselling and Psychotherapy (BACP), the American Psychological Association, are commensurate with General Medical Council (GMC), American Medical Association (AMA) and American Psychiatric Association guidelines. Just like doctors, psychotherapists who are members of organisations such as the BACP and American Psychological Association are duty bound to respect patient autonomy and to provide adequate informed consent to patients. The BACP stipulates, "Clients should be adequately informed about the nature of the services being offered. Practitioners should obtain adequately informed consent from their clients and respect a patient's right to choose..."³⁴ Similarly, the American Psychological Association specifies that psychologists should, "[O]btain the informed consent of the individual"³⁵ and, "inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of the therapy".³⁶ It also stipulates: "Psychologists should seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology". Doctors are required to tell the truth to patients and to obtain informed consent before undertaking any medical intervention: in the UK the GMC asserts that physicians must obtain "consent or other valid authority";³⁷ physicians must "discuss with patients what their diagnosis, prognosis, treatment, and care involve"; in the USA, the AMA states that, "withholding medical information from patients without their knowledge or consent is ethically unacceptable";³⁸ and "The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice".³⁹ Finally, the American Psychiatric Association stipulates that, "A psychiatrist shall not withhold information that the patient needs or reasonably could use to make informed treatment decisions".⁴⁰

How should we understand these ethical dicta? Beauchamp and Childress usefully dissect informed consent into three

phases: (1) preconditions for informed consent (competence and voluntariness of the patient); (2) information (the disclosure material, recommendations, and the patient's understanding of material and recommendations); and (3) consent elements (the patient's decision and its authorisation).⁴¹ This paper focuses on the second cluster of elements since this is most relevant to information disclosure in CBT.

Consider the disclosure of material information. Decisions about what to disclose stems from one fundamental issue: what information is relevant in order for a patient to decide whether to consent to or refuse a treatment? Notice that relevant disclosure need not provide an in-depth account of every material fact about CBT. Disclosure clearly cannot be evocative of Lewis Carroll's cartographer whose maps had 'the scale of a mile to a mile'. Instead, and as a heuristic, practitioners must provide germane information according to what Beauchamp and Childress refer to as a 'reasonable person standard': the facts relevant for a reasonable person to consent to a treatment and to make well-informed choices about that treatment.⁴¹ Furthermore, as Beauchamp and Childress point out, failure to provide representative information through omission, or ignoring patients' false beliefs about treatment, can be said to undermine the disclosure process.

THE FAILURE TO UPHOLD ETHICS GUIDELINES

CBT therapists (and primary care doctors at the referral stage) are not meeting their own ethical standards of material disclosure: NHS, NICE and NIMH guidelines on CBT propagate the received view much as it appears in Judith Beck's manualised account: the goal of the initial session we are told is 'Educating the patient about her disorder, about the cognitive model, and about the process of therapy'.¹⁵ We do not know if CBT therapists are disclosing anything more nuanced and in line with advanced scientific research—the indication that they update their disclosures is not promising given these guidelines.

However, it might be argued that the disclosure accurately describes the procedure of CBT—that the information presented to patients is accurate, even if the outcomes are not due to these specific procedures.^{vii} In response, it not clear that this information does accurately describe the procedure—it may be a description of the *intentions* of therapy but: (1) in practice therapists may routinely stray from rigidly adhering to these techniques;²² and (2) (more importantly) we can contest whether it is even possible to implement these techniques—the phenomenon of depressive realism shows that mild–moderate depressive thoughts are realistic even if they are unhelpful (see footnote^v).⁴² In short, the debate about informed consent in psychotherapy proceeds with the assumption that the various and distinct models of psychotherapy are correct on their own terms. For example, a report on informed consent for the National Register of Health Service Psychologists states that,

[D]epending on their treatment modality psychologists should provide clients with information about the overall approach they will use to treat the presenting problem, and likely techniques that the approach may entail e.g., exposure therapy, dream analysis, detailed developmental history, conjoint family sessions, behaviour contracts, or any other information relevant to making an informed decision to engage in treatment.⁴³

This involves the promulgation of equivocation: it allows patients to assume that the received view of CBT can be taken at face value. Indeed, the report notes—without self-consciousness—"In addition, some therapists choose to inform clients of the

^{vi}That is, patients' judgements of the alliance are comparable to external observers' views (with psychotherapists tending to overestimate the strength and quality of the alliance).

^{vii}I thank one anonymous reviewer for urging clarification on this point.

empirical evidence guiding their treatment choice". This ambiguity—the notion that some therapists *choose* to provide scientific support for their therapy but others can (by intimation) choose not to justify *their* treatment choice inverts the very rationale for disclosure. Informed consent procedures are not about tailoring information to the therapist but to the patient. Therapists are therefore failing to inform patients about common research factors: (1) the importance of the patient 'getting on board' with the goals and aims of the treatment; (2) the importance of therapist attributes (such as empathy and support); and (3) that the patient is the best judge of the quality of the bond between the therapist and him or herself.^{viii}

Do these failures to meet informed guidelines constitute an *ethical* failing in the clinical practice of psychotherapy, and specifically, CBT?

BENEFICENCE VERSUS AUTONOMY: A FALSE DILEMMA IN CBT?

The challenge in informed consent is to disclose to the patient information that is pertinent to treatment choice and autonomous decision-making. It might be argued, however, that therapists do indeed provide adequate information to their patients—furthermore, regardless of the conventional (yet pseudoscientific) explanation for *how* CBT works there appears to be scientific evidence that it *does* work. Isn't this science enough for maintaining the status quo when it comes to informed consent? Thus, if a patient asks, "How does CBT work?" and the therapist responds, "In these sessions we use various techniques that will help you to overcome your depression" it might be claimed that such a response is ethically justified on the grounds that sufficient information has been disclosed to warrant the designation 'informed consent'. On this line of reasoning, the various techniques in CBT form the 'vehicles' for treatment and it is the collaborative agreement over these techniques that carry the causal therapeutic effects: thus, it might be argued, the therapist has met the requirement of respecting patient autonomy.

Take the first claim: the claim that CBT is effective is not a robust defence for disclosing false theories to patients. Indeed, it might be contended that patients with CBT would fare even better (regardless of the ethical issue of respecting individuals' self-determination) if they were equipped with adequate information. Moreover, the fact that a treatment works does not license doctors or therapists to disclose whatever they choose in respect of that treatment. Second, in response to the claim that therapists merely describe the vehicles of treatment which (it is argued) transmit the causally effective factors in CBT, we might retort that (at best) this is something of a sleight of hand. Certainly, the therapist has thereby described the *intended practice* of therapy but they have not answered the relevant question of the causal explanation for the effectiveness of therapy. We can concede that the plausibility of the form of therapy to the patient (including the techniques involved) is relevant to outcome but it is *this* factor that needs to be conveyed to patients. It is not sufficient to say, 'CBT works because of cognitive restructuring techniques aimed at changing unhelpful or faulty cognition'; rather, truthful disclosure would involve: 'CBT uses techniques based on a theory about cognitive restructuring. *But the evidence shows that it works best for those patients who can readily commit to the theory and techniques*

behind the treatment.' Indeed, as noted, this is one factor among others that patients should be informed about since research shows that the therapeutic alliance is the most significant factor in outcome and patients appear to be the best judges of this.

It might be countered, however, that current disclosure policies maximise the therapeutic effect of treatment. On this view, the duty to be open and honest about treatment clashes with beneficence. Some might consider the evidence for the significance of patient expectations about particular treatments and the cogency of the rationale of the therapy for patients as supporting the idea that truthful disclosure would significantly undermine the 'magic' of treatment.

But this stance ignores other findings that may support the opposite conclusion. For example, although open placebo studies are still in their infancy they^{ix} have begun to yield promising results which suggest that practitioner deception may not be necessary to elicit placebo effects: similarly, it may be that the effectiveness of CBT will not be undermined by improved disclosure. Furthermore, we already know that some therapists put a misplaced premium on the techniques of CBT in their adherence to treatment (of which more, later). Thus, it is certainly possible that the impediment of informed consent may even produce negative health consequences for some patients. So far empirical studies have found: "[C]lients approach therapy with expectations regarding the nature of therapeutic interview and the roles they and their counsellors/therapists will assume...[C]lients' expectations may either facilitate or hinder the communication process and the process and the effectiveness of therapy. For instance, expectancies influence the choice of help giver... Expectancies may be related to persistence in therapy, and a client's decision to discontinue therapy".⁴⁴ It may be, for example, that if there is lack of progress patients erroneously blame themselves for the failure of CBT to work. If (as a consequence) they drop out of therapy the outcome may be clinically harmful and it may negatively affect patients' future trust in therapy, therapists and even referring doctors. Patients may come away with the false impression that 'psychotherapy is not for me' rather than the clearer perception that (for example) CBT may not have been the best treatment for them, or even that their therapist may not have been suitable for their particular needs.^x Thus, the claim that CBT is effective and that this is sufficient defence for upholding current practices can be challenged: again, CBT may have the potential to be even more effective for more people, when aligned with adequate informed consent policies.

But is informed consent too tall an order for therapists? Does it place impossible demands on clinicians in requiring them to relay scientific research on psychotherapy to patients? It might even be argued that professional psychotherapists should not be expected to grasp the science behind psychotherapy. This defence of the status quo is unconvincing. Relevant information about the nature of the treatment can certainly be representative of current scientific knowledge without being exhaustive. This need not be an onerous demand: indeed, it is a standard expectation for other treatments in orthodox medicine. Furthermore, when it comes to training psychotherapists we might add that

^{viii}Moreover, CBT disclosure routinely peddles misinformation: depression is not caused by 'faulty cognition'—this constitutes a deep misrepresentation of what is currently understood about depressive cognition (arguably, including severe depression).

^{ix}In open placebo studies patients are informed that they are receiving a placebo.

^xNor, of course, does it necessarily mean that the therapist has failed. Some patients may be particularly challenging for many therapists. The key issue is that the weakest therapists appear to lack crucial interpersonal skills, and patients (and practitioners) need to be fully cognizant of the key importance of empathy and the therapeutic bond as *causally* implicated in outcome.

the science of psychotherapy is not more challenging than CBT theory. Indeed, we might rhetorically turn the criticism on its head and respond: should we expect psychotherapists to ignore the evidence base for their professional activities, because: (1) therapists might not understand the evidence; and/or (2) it is too much effort to present the science in a digestible, understandable manner to trainees? Deceiving therapists about current scientific understanding about their treatments may even jeopardise the future status of the profession by risking distrust and scepticism among therapists, and ultimately patients. As we've seen therapists' allegiance to a form of therapy is more effective than their adherence to the protocols of that therapy (and some evidence shows that adherence is detrimental to patients): therefore, the justification for inculcating misinformation to therapists as a means to a beneficent end for patients is risky and (on the grounds of evidence) unpersuasive. Indeed, on consequentialist grounds, we might reach the opposite conclusion: previous controversies such as the landmark informed consent case Osheroff versus Chestnut Lodge (1980) arguably contributed to the demise and diminished reputation of psychoanalysis as a preferred treatment option.^{xi 45} Lessons need to be heeded lest CBT (and other effective versions of psychotherapy) are challenged in the future on the basis of research into the science of psychotherapy and the ways in which this challenges informed consent.

CONCLUSION

Any ad hoc claim that adequate disclosure clashes with the duty of beneficence in CBT has not yet been convincingly made. There are still unresolved issues and open questions about how we might improve informed consent in CBT but, in light of scientific research, debate about these very questions needs to begin. The ultimate ethical goal, I urge, is to find ways of enhancing disclosure procedures to enable patients—and therapists—to better harness (and even improve) the therapeutic effectiveness of CBT and other psychotherapy modalities. In addition, ongoing research into psychotherapy needs to pay attention to how and why ethical concerns should be embedded in treatment provision. It is certainly possible that this will result in modifications to existing versions of psychotherapy as well as the emergence of new talking therapies.

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^{xi}The lawsuit of Osheroff vs Chestnut Lodge involved a psychiatric patient who had undergone a year of psychotherapy for major depression without improvement. The plaintiff claimed a case of negligence against Chestnut Lodge because he was not offered antidepressants either in conjunction with therapy or as an alternative. He claimed that when he received antidepressants they alleviated the symptoms of his depression. The case was settled out of court.

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