

Paternalism, Placebos, and Informed Consent in Psychotherapy: The Challenge of Ethical Disclosure

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Summary

From a legal as well as ethical point of view, healthcare professionals are nowadays obliged to obtain informed consent of patients. Consequently, paternalism is eschewed in most ethical codes of practice. But what should informed consent mean in psychotherapy? With respect to this question, the claim that psychotherapy may be a placebo may raise grave concerns for its ethical practice. Indeed, almost since the inception of psychotherapy some scholars have claimed that psychotherapy is a sham and/or it may work as a placebo. However, we argue that in clinical biomedicine there is still much conceptual confusion about the terms 'placebo' and 'placebo effect'; moreover, we contend that the term 'placebo', when applied to psychotherapy, may invite more questions than it can easily resolve. Nonetheless, we assert that the core moral debate about clinical placebos raises important themes that are transferable to a psychotherapy context: namely: are therapists providing adequate information to patients about how psychotherapy works, and are they communicating potential risks of unwanted effects? In light of ongoing empirical research into psychotherapy we argue that therapists may be failing to mention key features (so-called common factors) that are relevant to the process of therapeutic change. We assert that current psychotherapy practice appears to exhibit misplaced paternalism in failing to provide patients with this information. We conclude that any justification for paternalism on the grounds of beneficence is unfounded and that adequate disclosure policies are likely to enhance rather than undermine the therapeutic process.

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Schlüsselwörter

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Zusammenfassung

Aus rechtlicher wie ethischer Perspektive ist das Fachpersonal im Gesundheitswesen heutzutage dazu verpflichtet, eine Einverständniserklärung ihrer Patienten einzuholen. Folglich wird Paternalismus den Patienten gegenüber in den meisten Moralkodizes der therapeutischen Arbeit vermieden. Daraus erwächst die Frage nach der Bedeutung der Einverständniserklärung im psychotherapeutischen Kontext. In Bezug auf diese Frage könnte die Behauptung, Psychotherapie sei nichts anderes als Placebo zu tiefgreifenden Bedenken hinsichtlich der ethischen Grundlagen führen. Tatsächlich haben einige Wissenschaftler bereits seit Beginn der psychotherapeutischen Praxis zu bedenken gegeben, dass Psychotherapie mehr Schein als Sein ist bzw. ihre Wirkung eher einem Placebo gleicht. Wir jedoch argumentieren, dass in der klinischen Biomedizin nach wie vor konzeptuelle Unschärfen bezüglich der Begriffe «Placebo» und Placeboeffekt herrschen. Wir sind zudem überzeugt, dass der in der Psychotherapie verwendete Begriff «Placebo» mehr Fragen aufwirft als die Auseinandersetzung damit zu beantworten vermag. Nichtsdestotrotz sind wir sicher, dass die moralisch geführte Kerndebatte über Placebo im klinischen Kontext wichtige Themen berührt, die in den psychotherapeutischen Kontext überführt werden können, nämlich: Informieren Therapeuten ihre Patienten in adäquater Weise über die Wirkmechanismen von Psychotherapie? Legen sie die potenziellen Risiken unerwünschter Nebeneffekte offen? In Anbetracht der kontinuierlichen empirischen Psychotherapieforschung folgern wir, dass Therapeuten ihren Patienten die allgemeinen Wirkfaktoren der Psychotherapie, die maßgeblich den Veränderungsprozessen während der Behandlung unterliegen, nicht hinreichend transparent machen. Somit scheint sich in der derzeitigen psychotherapeutischen Praxis unangebrachter Paternalismus abzuzeichnen. Wir sind davon überzeugt, dass jegliche Rechtfertigung von Paternalismus auf Grundlage von guter Absicht nicht begründbar ist und dass adäquate Grundsätze der Offenlegung eher förderlich als hinderlich für den therapeutischen Prozess sind.

Introduction

The history of medicine has – until the late 20th Century – been a history of paternalism toward patients. For most of medical history, physicians were considered absolute experts not only on the grounds of their medical training but also with respect to medical decision-making. Not merely the gatekeepers of medical knowledge, physicians were viewed as doyens of how to best use medical knowledge as well as the best judges of whether (if ever) such knowledge should be imparted to patients. The medical profession, in turn, expected deference and compliance. Thus within medical practice, paternalism was implicitly justified with the adage ‘doctor knows best’ and the sentiment that a ‘good patient’ follows the ‘doctor’s orders.’ It was not until the post-war period in the late 1950s that medicine became self-aware and self-critical about its paternalistic ways, and began to take the rights of the patient seriously: patients, it was determined, should be truthfully informed about their diagnosis and the nature of available treatments (including harms and risks). In a landmark ruling of 1972, the US Court of Appeals obligated doctors to communicate medical information to the patient in a language that would be readily comprehensible. The result is that today medical doctors in the West are obliged to be open and honest in medical consultations – in short, to respect patient autonomy. The more far-reaching consequence is that healthcare professionals are expected to furnish patients with adequate information about their disorders and available treatments to allow them to reach adequate healthcare decisions. While there is still some dispute about whether medical practice has completely eschewed the mantle of paternalism [Veatch, 2009; Topol, 2015], the ethical norms of truthfulness and respect for patient autonomy have now become established professional commitments in mainstream medical and healthcare codes of practice.

In this paper, we address a relatively neglected issue [Blease, 2015a]: Is the current practice of psychotherapy paternalistic? As in mainstream medicine, clinical psychotherapy claims to eschew paternalistic behavior, but we suggest that there is reasonable doubt that prospective psychotherapy patients are not afforded the moral status of autonomous agents. More than this, we argue, there is good reason to believe that patient outcome may be improved if ethical standards of adequate informed consent were met.

The paper begins with a definition of paternalism and an exploration of what this means in the healthcare context. Based on this, we show that paternalism is explicitly (and widely) eschewed in the professional ethics codes of psychotherapy and psychology bodies. After establishing the centrality of informed consent to the professionalism of psychotherapy, we move on to investigate the allegation that ‘psychotherapy is a placebo’. This is a (partly unfounded) charge that has repercussions for informed consent procedures. However, we argue that the terms ‘placebo’ and ‘placebo effect’ have myriad working definitions with current research contexts; moreover, we contend that the application of these terms to psychotherapy is fraught with conceptual and empirical difficulties, many of which take us beyond the reach of this paper [cf. Gaab et al., 2015]. Nonetheless, we argue that the ethical debate about the

role of placebos in healthcare raises pertinent themes which are applicable to psychotherapy practice: What standards of disclosure are being provided in clinical settings? And might professional honesty undermine treatment outcomes? Addressing these questions is the central focus of this paper. Therefore, in foregrounding this discussion, we provide an investigation of what healthcare ethicists understand by the concept ‘informed consent’ before arguing that there is broad agreement in psychotherapy research and practice about the importance of common factors (e.g., therapist effects, the working alliance, and patient expectations) in patient outcome for a range of mental disorders. We avoid the controversial debate about the relative significance of specific factors in different versions of psychotherapy [cf. Wampold and Imel, 2015] and instead assert that there is a widespread consensus that common factors are relevant to therapeutic outcome. This brings us to the key thesis of the paper: We argue that the omission of disclosure of these factors in the informed consent process violates the legal and moral duties of the psychotherapist to respect patient autonomy. Furthermore, contrary to any argument that beneficence may be impeded by honesty, we argue that the therapeutic relationship (and therefore patient outcome) may be enhanced by the provision of adequate informed consent [Blease, 2015a;b; Gaab et al., 2015; Trachsel et al., 2015].

The Concept of Paternalism

In a historical context, deference to the medical profession was assumed to be defensible and indispensable. Undisputedly, doctors are obliged to safeguard patients against harm. Until the middle of the last century this included the duty to protect patients from self-harm if they knew too much about their illnesses, or if they were privy to information that the doctor judged detrimental to the patient’s health or wellbeing. Given that beneficence is still construed as the *ne plus ultra* of medical professionalism, how does this moral imperative balance with the modern healthcare imperative to respect patient autonomy? In order to answer this question, we first need to consider the concept of paternalism in more detail.

Paternalism can be defined as, ‘the interference of a state or an individual with another person, against their will, and defended or motivated by a claim that the person interfered with will be better off or protected from harm’ [Dworkin, 2010]. According to this definition, paternalism always involves a certain degree of constraint on autonomy for particular reasons [Trachsel et al., 2013]. Paternalistic behavior may be characterized as weak (soft) or strong [Engelhardt Tristram, 1989]. According to weak paternalism, ‘a man can rightly be prevented from harming himself (when other interests are not directly involved) only if his intended action is substantially non-voluntary or can be presumed to be so in the absence of evidence to the contrary’ [Feinberg, 1971]. Strong paternalism means that a person is protected, ‘against his will, from the harmful consequences even of his fully voluntary choices and undertakings’ [Feinberg, 1971]; and, ‘whether weakly or strongly paternalistic, the motivation for potentially justifiable paternalism is

usually the prevention of harm (non-maleficence) and/or the benefit to the person whose autonomy is overridden or compromised' [Trachsel et al., 2013]. Since paternalistic actions always involve a violation of the moral principle of autonomy, strong reasons need to be advanced to justify them [e.g., Silber, 2011].

It should be pointed out that there need not be a conflict between respect for autonomy and beneficence but where there is a perceived tension, arguments for paternalism must first invoke the notion that the ethical imperative of beneficence clashes in a morally significant way with respect for patient autonomy; second, the case must be made that the right to self-determination could be seen as (in some particular circumstance) of lower moral value than beneficence. In summary, the structure of such moral conflicts entails that – independent of the final decision made – one of these two moral principles of healthcare ethics is overridden [Beauchamp and Childress, 2009].

First, however, it is important to examine the ethical codes of conduct of professional psychotherapists.

Paternalism is Eschewed in Ethical Codes of Practice and Informed Consent

In Germany, psychotherapy is practiced by specialist physicians for psychiatry, psychosomatics, and psychotherapy or by specialist psychologists for psychotherapy by law. The ethical code of practice by the German Federal Chamber of Psychotherapists entails an article on informed consent (§7). It states that before the initiation of a psychotherapeutic treatment the patient needs to be provided with the following timely information enabling her or him to give well-considered informed consent: information on psychotherapy type, scope, procedure, expected effects, the risks as well as its necessity, urgency, and prospects for successful outcome. Other factors, such as session duration, frequency, and estimated total time of the treatment, should also be discussed.

Similar rules are stated in the Ethical Principles of the German Psychological Society (DGP), in the Association of German Professional Psychologists (BDP), and in the Code of Conduct of the Association of German Professional Psychologists:

'Psychologists must inform their clients/patients about all key measures taken and the course of treatment provided and must ensure that they have obtained such persons' consent. If therapeutic treatment is provided, psychologists must draw individuals' attention to the risks involved and the alternative treatments available. This duty to inform also encompasses issues relating to fees and the reimbursement of costs.' (D.I.2.)

In Switzerland the code of conduct of the Federation of Swiss Psychologists reads as follows:

'Members shall sufficiently explain, comprehensibly and realistically, to their patients or their legal representatives in particular: a) the planned procedure or methods and the setting, b) any risks involved in the treatment and alternative treatments, c) the financial conditions, namely the fee or payments from the basic or additional voluntary insurance, and how missed sessions will be in-

voiced, d) professional secrecy. [...] They shall in particular clarify with patients the intended goals and the estimated duration of the treatment. [...] Members shall mention if they are working for a doctor on a delegated basis.'

Meanwhile, in the USA, the American Psychological Association (APA) specifies that psychologists should '[o]btain the informed consent of the individual' (3.10, [APA, 2010]) and 'Psychologists should seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology.' Similarly, the Ethical Framework for Good Practice of the British Association for Counseling and Psychotherapy (BACP) states that practitioners should, 'ensure accuracy in any advertising or information given in advance of services offered; seek freely given and adequately informed consent... The principle of autonomy opposes the manipulation of clients against their will, even for beneficial social ends' [BACP, 2013].

In the USA and UK where psychotherapy is practiced by licensed doctors (usually psychiatrists), they must obtain the 'consent or other valid authority' of the patient (UK) [GMC, 2010] and are under strict guidance that 'withholding medical information from patients is ... ethically unacceptable' [AMA, 2006].

Thus, when it comes to respect for patient autonomy in clinical practice professional organizations are consistent in their normative guidelines: practitioners are expected to be honest and have a duty to provide adequate information to patients. Respect for patient autonomy trumps the ethical imperative of beneficence: healthcare ethics codes oppose paternalism and uphold the principle of respect for autonomy. In short, in order to act beneficently, practitioners must first obtain permission to do so.

In respect of the specific content of informed consent guidelines in psychotherapy, what ought to be conveyed to patients? Before we examine classical bioethical considerations on the standards of disclosure, it is worth highlighting what psychotherapy guidelines advise. In the USA, a report conducted on behalf of APA by the National Register of Health Service Psychologists [Fisher and Oransky, 2008a] 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'.

The report adds that, 'In addition, some therapists choose to inform clients of the empirical evidence guiding their treatment choice'. The addendum suggests that providing evidence for the effectiveness of a treatment modality (whether it is a version of psychodynamic therapy, cognitive behavioral therapy, etc) is not necessary for informed consent: What matters is that the therapist discloses the nature of the treatment (e.g., whether it involves the techniques of cognitive therapy, exposure, or tracking family history, etc). Indeed, at this juncture it should be noted that the suggestion that evidence might (or might not) be provided to patients seems to indicate some equivocation over whether or not forms of

treatment ought to be evidence-based. On a charitable reading it might be assumed that all treatments being offered to patients are evidence-based and that the therapist has an option to inform patients about the treatment that they would like to use, with the patient and the evidence supporting this decision.

The BACP in the UK advocates similar advice in its ethical code of conduct:

'All practitioners are encouraged to share their professional knowledge and practice for the benefit for their clients and to promote awareness of counseling and psychotherapy in the public through providing information and education'.

The guidelines continue:

'All training in counseling and psychotherapy should model standards and practice consistent with those expected of practitioners in the role for which training is being provided' [BACP, 2013].

This latter statement suggests that good practice involves disclosure of information about the specific treatment that the therapist practices; just as in US guidelines, this involves taking the validity of psychotherapy theories at face value.

In Summary

Disclosure, according to professional ethics codes of psychology and psychotherapy organizations, is disclosure about the techniques in which the practitioner has been trained and has the necessary skills that need to be applied. Whether such disclosure occurs in practice is another matter [see e.g., Dsubanko-Obermayr and Baumann, 2010]. In addition, there also appears to be an optional stipulation that therapists may decide whether to provide supporting evidence for their treatment choice. Before we address the content and particulars of information disclosure in psychotherapy in the next section, we discuss an issue of particular relevance to informed consent to psychotherapy: The question of the relationship between psychotherapy and placebo.

The Content of Disclosure: Psychotherapy and the Placebo

Hypothesis

In scientific literature, there is a growing body of empirical research as well as a lively discussion about the mechanisms of change in different forms of psychotherapy. Almost from the inception of talking therapies until the present day, the charge that talking cures are 'pseudo-scientific', 'sham', or 'placebos' have also been leveled at psychotherapy [Rosenzweig, 1936; Rosenthal and Frank, 1956; Frank 1991]. This charge is significant not just to the empirical evaluation of the effectiveness of psychotherapy – today, psychotherapy is clearly very effective for various forms of mental disorders [Lambert, 2013] – but to our present concern, namely its ethical status.

In order to appraise the claim that 'psychotherapy is a placebo' and the repercussions of this for informed consent it would first be necessary to arrive at satisfactory definitions of 'placebo' and 'pla-

cebo effect'. We argue that there are wide-ranging conceptions of 'placebo' and 'placebo effect', and we contend that non-controversial definitions neither exist nor (therefore) can easily be applied to psychotherapy. In this section we suggest that many present definitional confusions in relation to the terms 'placebo' and 'placebo effect' amount to what Turner describes as 'lumping a disparate range of elements together' which is 'in essence, like mixing paint colors to get brown' [Turner, 2012].

Placebos are often conceived as 'inert substances' but recent empirical research complicates matters because placebos (defined as fake treatments) are not necessary to elicit the placebo effect since verbal and non-verbal socio-emotional cues of practitioners are also hypothesized to trigger the placebo effect [Kaptchuk et al, 2008; Jensen et al., 2012]. This has led some to define placebos as 'context effects' – 'effects deriving from patient-practitioner relationships' [Di Blasi and Harkness, 2001]. In turn, this definition has been criticized because it overlooks other incidental features of verum treatments (e.g., branding, modality, expensiveness, the manner in which the treatment is administered by a practitioner), which also influence the size of the placebo effect [Kaptchuk et al., 2000]. Indeed, if we were to define the placebo effect as 'practitioner effect' as Di Blasi and colleagues propose [2001] and as Kirsch has pointed out [Kirsch, 2005], this results in a default or a priori definition of psychotherapy just as a placebo.

Others have attempted to circumvent these contextual problems by claiming that placebos are non-specific care effects and that it is the specificity of a treatment that determines whether it is a placebo: In this way, Shapiro and Shapiro [1997] propose, '[The placebo effect] is primarily the nonspecific psychological or psychophysiological therapeutic effect produced by a placebo...'. To de-mystify the placebo concept and open the door to further research on its components and mechanisms, Castonguay and Grosse Holtforth [2005] have gone further by proposing that the term refers to 'not-yet-specified' effects. Finally, Grünbaum [1981; 1986] has argued that placebos are treatments whose 'characteristic features' are not remedial for the target condition under scrutiny. In light of the afore-mentioned empirical research, these definitions are problematic because they conjugate placebo(s) and placebo effect(s); they problematically assume that the terms are 'moveable categories' since the definitions are relativized to particular therapeutic theories [Greenwood, 1997].

Amidst this panoply of theoretical definitions of placebos and the placebo effect in biomedical contexts, the job of translating these terms to psychotherapy has proven even more challenging. Take the idea of comparing psychotherapy to a so-called placebo treatment in randomized controlled trials: Psychotherapeutic treatments are sometimes compared to 'attention placebo control groups' (which are often labeled as the 'placebo'). These so-called placebos are typically interpreted as treatments that match the amount of time and attention as the verum treatment under evaluation. The key problem is that it ignores the epistemological concern that controls ought to mimic every aspect of a treatment except for the specific ingredient under scrutiny [cf. Howick, 2011;

Turner, 2012]. In biomedical contexts this is a (relatively) easier task compared with psychotherapy clinical trials, since decomposing the specific ingredients in psychotherapy is a much more multifaceted and complicated endeavor. In addition to the difficulties in conceptually and procedurally separating a ‘true’ intervention from a so-called placebo condition, also a key standard for minimizing experimental biases, i.e. double blinding, is impossible in psychotherapy research, simply because therapists will always know what they are doing.

Additional problems arise in psychotherapy where placebos (and placebo effects) are conflated with the factors that are considered to be common to different forms of psychotherapy. For example, it has been argued that the following common factors can be labeled placebos on the grounds that they constitute non-specific or not-yet-specified components of treatment: the therapeutic alliance, therapist factors (such as positive regard, empathy, trustworthiness), the expectation that the treatment will be effective (on the part of patients and therapists), the provision of explanations for patients’ problems [Frank and Frank, 1991; Jopling, 2008].

Finally, some scholars have gone so far as to contend that the placebo concept does not make any sense in the context of psychotherapy:

‘[t]he placebo effect in medicine is produced by factors other than the physical properties of the treatment. However, the effect of psychotherapy is – by definition of the term psychotherapy – produced by something other than the physical properties of the treatment. Therefore, using the medical definition of placebo, the effects of psychotherapy are ipso facto placebo effects, and psychotherapy is ipso facto a placebo’ [Kirsch et al., 2015; Kirsch, 2005].

We argue that this *reductio ad absurdum* confuses ontological concerns (the issue about what placebos and the placebo effect might be) with epistemological issues (the use of placebo controls in clinical trials as a means of evaluating treatment efficacy).

Thus, while we contend that there may yet be utility in appraising experimental and clinical ethics using also a placebo framework, we submit that deployment of these terms in our current ethical evaluation of psychotherapy takes us beyond the scope of this contribution [Gaab et al., 2015]. Nonetheless, we do identify a common underlying intuition in both the conceptualization and ethical analysis of placebos that we take to be a central concern of this paper. This is the idea that the use of clinical placebos, in some way, implies an omission of the disclosure by the clinician of central, therapeutic components of treatment, and that equating psychotherapy to placebos involves the misrepresentation (perhaps on the grounds of beneficence) of fundamental features of treatment [Bleese, 2015c]. Therefore, we concentrate on the latter, tangible notion – that psychotherapy may involve omissions of relevant material disclosure to patients. In the next sections we focus on evidence that psychotherapists may, in some non-trivial way, be engaging in routine failures of disclosure to patients. Before we turn to this issue, however, it is necessary to say more about the ethical standard that any disclosure should meet.

Motivating a Standard for Informed Consent in Psychotherapy

In part due to inherent time constraints, we cannot expect the therapist exhaustively to disclose all treatment-relevant information to prospective patients. Therefore in clinical practice, informed consent must be restricted to those fundamental aspects of the treatment that enable the patients to consent (or dissent) to a treatment [Beauchamp and Childress, 2009, p. 117]. The classical biomedical understanding of informed consent is owed to Beauchamp and Childress who decompose it into three main components: (1) threshold or preconditions for informed consent to occur; (2) information elements; and (3) consent elements. How might these components map onto psychotherapy?

Take the first set of criteria – the preconditions for consent. Psychotherapists deal with individuals suffering from a wide range of mental health conditions and problems. However, strong arguments must be made if therapists are to presume incapacity to consent on such grounds. It is important to emphasize that even in cases where mental-health specialists determine that an individual’s mental functioning is impaired, this does not entail that the individual lacks the ability to make informed decisions about his or her treatment. Indeed, the UK’s Mental Capacity Act of 2005 [UK Department for Constitutional Affairs, 2005] states that there must not only be a presumption of capacity to make treatment decisions but the burden is on health professionals to take steps to show that a patient lacks any such capacity:

‘[T]he Act’s first key principle is that people must be assumed to have capacity to make a decision or act for themselves unless it is established that they lack it. That means that working out a person’s best interests is only relevant when that person has been assessed as lacking, or is reasonably believed to lack capacity to make the decision in question or give consent to an act being done.’

Presumably, then, in order to avail of the kind of dialogue and exchanges involved in different psychotherapy modalities, patients must demonstrate an ability to engage in substantive discussion and reflection, commit to regular treatment appointments, and undertake homework. In addition, many patients may exhibit sub-threshold symptoms for mental disorders. Therefore, in this paper we assume that adult patients have both the capacity to understand information provided in psychotherapy disclosures, and thus exhibit voluntariness in reaching decisions on that basis.

Several heuristics have traditionally been employed to determine the content and extent of such information elements. Beauchamp and Childress [2009, p 122] identify three ‘competing’ measures of disclosure that have helped to direct normative standards: The professional practice standard, the reasonable person standard, and the subjective standard.

The professional practice standard is the view that ‘professional custom establishes the amount and kinds of information to be disclosed’. On this view, healthcare practitioners should proceed at their own discretion and as tradition dictates. This normative standard was customary in healthcare contexts until paternalism was explicitly eschewed by medical ethics codes. The second meas-

ure of disclosure described by Beauchamp and Childress – the reasonable person standard – promotes the heuristic that practitioners should disclose the kinds of information that a reasonable person would require in a hypothetical treatment situation. Thus, this normative standard works backwards from a conception of ‘the reasonable patient’ to speculate about the kinds of information that patients would desire to know about their treatment options. Finally, Beauchamp and Childress propose the subjective standard which they describe as the provision of information with reference to the unique requirements of the patient: ‘Persons may have unconventional beliefs, unusual health problems, or unique family histories that require a different informational base than the reasonable person needs’ [Beauchamp and Childress, 2009, p. 123].

How do these different heuristics compare? Consider the first one, the notional assumption that doctors (or other health professionals) have the expertise to discern patient preferences in regard to treatment options. On empirical grounds, this claim is unsubstantiated: Evidence shows that doctors are poor judges of patient preferences [e.g. Street and Haidet, 2011]. But perhaps more importantly, as Beauchamp and Childress [2009, p. 122] assert, ‘the professional practice standard subverts the right of autonomous choice’. Therefore, even if healthcare professionals somehow intuited or knew patients’ preferences for treatments, satisfying their preferences would not be the same thing as respecting patients’ treatment choice [Barnhill and Miller, 2015]. Thus, dependence on the paternalistic heuristic that health professionals can (and should) make decisions on behalf of patients is profoundly problematic both on moral and empirical grounds.

Regarding the second heuristic, the reasonable person standard, Beauchamp and Childress [2009, p. 123] argue that there are practical problems in envisaging what material information a reasonable person may require – that the conceptualization is much too abstract to be workable. While there are problems related to the feasibility of healthcare practitioners reliably conceiving of ‘idealized rational patients’ (including whether such patients even exist), we believe that the core sentiment behind this standard is defensible, i.e. it is likely that there is empirically determined treatment-specific information that patients may routinely require in order to reach informed decisions about treatments. The case may be made that heuristics should not be deployed but, instead, specific guidelines with respect to disclosure practices should explicitly be incorporated into disclosures for both therapists and patients.

In this way, the ‘subjective person standard’ is likely to play an important role in disclosure practices. Indeed, Beauchamp and Childress [2009, p.124] contend that this third heuristic is ‘the preferable moral standard of disclosure, because it alone meets persons’ informational needs.’ They concede, however, that in practice dependence on this standard is too demanding: ‘We cannot reasonably expect a doctor to do an exhaustive background and character analysis of each patient to determine the relevant information’.

Certainly, we argue that some admixture of reasonable person and subjective standards must inform disclosure practices. But we go further and argue that patient standards should not be the only

influence on informational disclosure: This is because patients are not experts in deciding whether information is trivial or fundamental for making the best possible decision [Blease, 2015c]. For example, studies show that how patients conceptualize their disorder (e.g. depression) can negatively influence their long-term healthcare behavior [Blease, 2014]. This conceptualization may strongly depend on what information they are provided with by their therapists. Furthermore, there is considerable evidence from healthcare psychology that how information is provided to patients influences decision-making as well as relief of symptoms [Gigerenzer, 2007; Alfano, 2015; Blease, 2015c]. Therefore, it is not just the content of disclosures that may influence patients’ health decisions (including information that patients may incorrectly deem irrelevant to their choices), but also how that information is disclosed that may be germane to adequate disclosure.

While it is impossible to provide a full a priori prescriptive list of material information that helps an individual to consent or refuse to treatment, certain key factors will be relevant to disclosure. These will include information about diagnostic findings, the disorder itself (psychopathology), the (differential) indication for the treatment, and characteristics of the proposed treatment such as aims/goals, expected procedures and course, expected benefits and risks, and expected duration of the therapy. In addition, how such disclosure is provided to patients must be balanced against beneficence (the potential to improve patient outcome), and this should be factored into any appraisal of informed consent to psychotherapy.

Does Psychotherapy Uphold Its Own Ethical Principles?

Given the foregoing discussion, is there evidence that psychotherapists routinely fail to provide adequate informed consent to psychotherapy patients? While it is difficult to ascertain (in clinical practice) what therapists are disclosing to patients, we contend that there are good reasons to believe that patient autonomy is not being fully respected and that therapists are not completely fulfilling their own ethical standards. In light of the empirical evidence into the effectiveness of psychotherapy we argue that therapists may be omitting fundamental information about the mechanisms of change of psychotherapy.

It should be noted that the very concept of evidence-based practice (EBP) is still divisive especially among adherents of psychoanalytical psychotherapy who argue that the use of measurements is both seriously limited and unnecessary [Tanenbaum, 2003]. However, it has been increasingly argued that evidence-based research is of the utmost relevance to the clinical practice of psychotherapy [e.g. Wampold and Imel, 2015], yet surprisingly little has been said about how these research findings might ethically be conveyed to patients. Moreover, even among the majority of psychologists who accept the importance of an evidence-based approach to psychotherapy there is still controversy over how to define this research agenda. APA defines EBP as ‘the integration of the best available

research with clinical expertise in the context of patient characteristics, culture, and preferences' [APA Presidential Task Force on Evidence-Based Practice, 2006]. This suggests a thick concept of evidence – namely, the integration of 'scientific results related to intervention strategies, assessment, clinical problems, and patient populations in laboratory and field settings as well as to clinically relevant results of basic research in psychology and related fields' [APA Presidential Task Force on Evidence-Based Practice, 2006]. In addition, however, the more commonly deployed notion is the narrower conception of Research-Supported Psychological Treatments. This conception refers to a narrow medical model of evidence, deploys a similar framework as the US Food and Drug Administration's drug criteria, and focuses primarily on clinical trials which compare (and purport to show) the differences among various treatments for different psychopathologies [Wampold and Imel, 2015, p. 27; Goldfried, 2013]. For example, the BACP's website provides a repository of links to psychotherapy research which primarily lists those studies aimed at investigating the absolute efficacy of therapy and the effectiveness of specific therapies for particular conditions, rather than research aimed at investigating the relative efficacy of common factors within psychotherapy [BACP, 2015]. Similarly, the webpage of APA's Society for Clinical Psychology provides a comprehensive list of 'Research-Supported Psychological Treatments' for specific disorders: again, these studies do not survey meta-theoretical research aimed at assessing the comparative effectiveness of different versions of psychotherapy or research aimed at de-compositional analysis of common factors [APA, 2015].

It is how one interprets 'evidence' that matters. For example, and perhaps most prominently, Wampold et al. [1997; Wampold and Imel, 2015] have argued that evidence shows that the specific techniques involved in different versions of psychotherapy (e.g., cognitive restructuring in cognitive behavioral therapy, or accessing repressed memories in versions of Freudian psychoanalysis) are irrelevant to outcome and account for less than 1% of the effectiveness of therapy. Others have disputed this interpretation, arguing for the therapeutic significance of specific techniques [e.g. Lambert and Barley, 2002]; indeed Marcus et al. [2014] confirmed the findings of Wampold et al. [1997].

In this paper we avoid engagement in this important debate; instead we highlight the shared (non-controversial) consensus that there are common factors in therapy which are significant and relevant to patient outcome. These factors include the therapeutic alliance, goal consensus between therapist and patient, therapist factors (positive regard, empathy and genuineness) as well as patient factors (the expectation that the treatment will be effective). While there remains scholarly disagreement over the size of the therapeutic effectiveness of each of these common factors in therapy, it seems reasonable to state that there is professional and scholarly agreement as well as empirical support for these factors playing a major role in therapeutic change [e.g. Beck, 1995; Lambert and Barley 2002; Norcross, 2011; Wampold and Imel, 2015].

Against the ongoing debate about empirical evidence in psychotherapy we suggest that there is room for improvement in regard to

two features of informed consent. First, we argue that therapists may currently be failing to provide sufficiently tailored disclosure to patients: we suggest that therapists may be failing to describe the specific techniques involved in different versions of psychotherapy, regardless of the empirical status of these techniques. This is an argument that has been made elsewhere:

'[T]he content of an informed consent statement may be quite different for more insight-oriented psychotherapy than for a more symptom-focused treatment. Symptom-focused psychotherapies, such as exposure treatment for specific phobias, primarily aim to reduce the symptoms of the disorder, while the main focus of insight-oriented psychotherapies is to achieve a new understanding of oneself and one's relationships with others. Accordingly, in a symptom-focused psychotherapy, goals, risks, and procedures are more concretely nameable beforehand, whereas the goals of an insight-oriented psychotherapy need to be more openly formulated. Consequently, due to the less foreseeable course of an insight-oriented therapy a more complex and contingent IC [informed consent] may be required at intake, whereas a more straightforward IC may be pursued for symptom-focused psychotherapy that more closely resembles ICs for pharmacological treatment.' [Trachsel et al, 2015].

For example, a survey on informed consent among practicing psychotherapists in the USA revealed similarity and variability between individuals as well as between adherents of theoretic approaches in beliefs and practices regarding confidentiality, risks, treatment length, treatment procedures, and alternatives [Somberg et al, 1993]. In particular, psychodynamic therapists seem to voice skepticism regarding the value and feasibility of informed consent in therapeutic practice [Goddard et al, 2008]. We contend that furnishing patients with proper information about the techniques involved in therapy sessions has the potential to demystify and thereby reduce the fear of psychotherapy [Fisher and Oransky, 2008b; Boswell et al, 2015].

Second (but arguably an even more substantive and pressing issue) is the importance of disclosing information about fundamental non-specific/not-yet-specified or common therapeutic factors in therapy. In light of the broad consensus in the empirical research that certain common factors in therapy are relevant to outcome and given the foregoing discussion on minimal standards of adequate disclosure, we argue that these factors should be communicated to patients in an understandable manner [Bleas, 2015a,b; Gaab et al., 2015]. In summary, if patient autonomy is to be respected, the following information should be conveyed to patients: (i) agreement about the goals and tasks of therapy is relevant to successful outcome; (ii) the alliance with the therapist is important for good psychotherapy processes and outcomes and patients should feel supported, encouraged and understood; and (iii) patients should be aware that their own attitude and expectations about therapy are also fundamentally relevant to the success of therapy [Bleas, 2015b].

What might this mean in practice? Take the example of cognitive behavioral therapy (CBT) – it has recently been argued that, '[i]t is not sufficient to say, "CBT works because of cognitive re-

structuring 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. [Blease, 2015b]

Therapists should inform the patient that if they feel unable to commit to the therapy or the sessions it may be that another version of psychotherapy would be more appropriate. In addition, we propose that therapist factors (such as empathy, genuineness, and positive regard) and factors relating to the therapeutic alliance might be relayed to potential patients in the following manner: ‘During these sessions you should feel supported by me and encouraged to discuss your problems. If, for any reason, you feel uncomfortable about the progress we are making, please feel able to discuss this with me or with your doctor. We will try to work through these issues but it may also be that another therapist or another version of therapy would work better for you. This does not mean therapy has failed or that we cannot find a more appropriate treatment or therapist for your needs’. While such disclosures may seem unorthodox, or may discomfit the practitioner, these are not sufficient reasons to preclude raising such fundamentally important information. As a complementary measure we also suggest that third-party mechanisms may be an important method of communicating this information to patients and keeping track of patient progress without terminating therapy prematurely: e.g., Lambert [2007] has successfully pioneered a patient tracking system which showed that ‘integrating treatment response research into routine mental health care reliably improved positive outcomes and reduced negative outcomes’ [see also Lutz et al., 2011].

In summary, we argue that there is no evidence to support the view that adequate disclosure policies would undermine the effectiveness of psychotherapy. Rather, we assert that the opposite is likely to be the case; and while we acknowledge that this is an empirical matter and one to be determined by ongoing research, we contend that thus far the evidence supports the view that there is more to be gained from patients being treated as autonomous agents, privy to augmented understanding of the mechanisms of change of psychotherapy rather than being treated as passive recipients of paternalistic care.

Conclusion

Informed consent is not only a moral duty it has various advantages for the patient. In this paper we acknowledge that there are still outstanding issues about how to interpret evidence within psychotherapy. However, we urge that appropriate informed consent procedures are important for augmenting mutual trust, and thus, are the basis for a strong therapeutic relationship that is one of the most important factors for good psychotherapy outcomes [e.g., Lambert and Barley, 2002]. It has been argued that informed consent may also prevent undue harm or dropout rates among patients:

‘It may be, for example, that if there is lack of progress patients erroneously blame themselves for the failure of... [therapy] 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.’ [Blease, 2015b].

Further, informed consent in psychotherapy – just as is standard in other healthcare contexts – should meet the challenge of how best to inform patients about potential risks and harms of psychological treatments [Lilienfeld, 2007; Ladwig et al, 2014]: this is still not standard practice in psychotherapy. Finally, adequate disclosure serves the empowerment of patients: ‘Informed consent procedures emphasize the patient’s role in making treatment decisions, increasing a sense of ownership over the process’ [Fisher and Oransky, 2008b, p. 576; Beahrs and Gutheil, 2001], and to date research shows that this improves psychotherapy outcome [e.g., Pope and Vasquez, 2007; Lambert, 2007; Lutz et al., 2011]. The broad goal of this paper is to remind psychotherapists of their legal and ethical obligations in maintaining their own stated standards of informed consent. It is the modest conclusion of this contribution that these goals can be met with reasonable and unobtrusive modifications to current practices.

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