



# Informed Consent in Psychotherapy: Implications of Evidence-Based Practice

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## Abstract

Evidence-based practice in psychotherapy carries widely unacknowledged consequences for ethical clinical practice. Informed consent to psychological treatments is an ethical imperative in clinical practice, and there is an ethical obligation for psychiatrists, psychotherapists, and clinical psychologists to provide adequate disclosure to patients about treatments. This is codified within the professional guidelines of the American Psychological Association (APA) and the American Medical Association. Given the APA's commitment to evidence-based practice, the objective of this paper is to argue that the provision of information about how treatments work should be based on evidence-based research on psychotherapeutic treatments. Case-based scenarios are used to illustrate a range of ethical issues pertaining to evidence-based practice and informed consent in psychotherapy. This paper argues that informed consent processes in psychotherapy must be commensurate with the latest integrated findings on empirically—supported treatments; process research into psychological treatments; research into therapist expertise; as well as evidence about individual patients' characteristics, culture, and preferences. Our conclusions for practice are challenging: standard ethical interpretations of informed consent to psychotherapy must go further. It is not sufficient for therapists only to describe the specific techniques associated with particular treatment modalities, it is also necessary to disclose information about nonspecific factors. There appears to be consensus among therapists and psychotherapy researchers that these factors are relevant to successful treatment outcome. Our paper aims to launch fresh, serious, pragmatic debate in professional psychotherapy about necessary revisions of ethical codes with respect to information disclosure.

**Keywords** Clinical ethics · Informed consent · Common factors · Evidence-based practice · Empirically-supported treatments

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The importance of informed consent in mainstream health-care is well established. From both ethical and legal standpoints, healthcare practitioners are expected to furnish patients with adequate information to enable individuals to provide informed consent to treatments. Reflecting these ethical imperatives within the context of psychotherapy, informed consent is a professional policy codified by the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (APA 2010). The provision of effective processes for informed consent respects the patient's right to autonomous decision-making about treatments. However, even well-meaning informed consent procedures that fall short of adequate disclosures about the nature of treatments may be paternalistic, and/or put patients' health at risk. Providing adequate informed consent helps to demystify the process of psychotherapy and ensures that patients are better equipped to understand the

significance of factors such as the importance of the therapeutic relationship with their therapist (Blease et al. 2016). Finding appropriate ways to ensure that ethical informed consent is obtained may also lead to greater trust between the patient and psychotherapist, and help facilitate openness in the relationship (Snyder and Barnett 2006).

The APA is now committed to an evidence-based model for the practice of psychotherapy (EBPP), and we argue that the commitment to EBPP also has repercussions for ethical informed consent processes; it obliges therapists to communicate information in an understandable way that preserves patients' autonomy. However, we find that there are reasonable grounds to believe that current practices within psychotherapy are failing to meet this ethical obligation. The goal of the paper is to examine the ethical consequences of EBPP for the process of informed consent. We strongly acknowledge that many outstanding issues remain as to how best to conceive of evidence-based research and its relationship to practice; in this paper we confine ourselves here to the broad themes and recommendations of the 2005 APA Task Force report on EBPP. We argue that it is important that these themes percolate into the APA's future revisions of ethical guidelines. By connecting the APA's Task Force Report on EBPP (2006) with the APA's published ethics guidelines (2010), this paper argues that EBPP yields ethical considerations that require further attention by the APA (and psychotherapy practitioners).

To illustrate the range of relevant ethical concerns associated with informed consent, we follow previous ethical analyses of psychotherapy in employing vignettes derived from composite clinical case studies to highlight potential breaches of ethical informed consent with suggested resolutions (Fisher and Oransky 2008). Our aim is not to provide exhaustive or fully prescriptive solutions; rather it is to reorient, and prompt discussion about the need for revisions in current ethical guidelines.

## Informed Consent: The Moral Responsibilities of Psychotherapists

The APA is very clear that *general ethical principles* are not enforceable rules but rather act as guidelines for psychologists to pursue ethical courses of action (APA 2010). The APA goes further when it comes to what it describes as *ethical standards* (of which it lists eight, in detail), stating that these standards should be interpreted as "enforceable rules". While the APA acknowledges that its description of ethical standards is not exhaustive, its ethics code does mandate these standards as professional duties and not merely aspirational recommendations. The APA's standard of ethical informed consent is the focus of this paper.

Section 3.10(a) of its ethical guidelines stipulates that psychologists should obtain the informed consent of patients; the APA also advises that therapists must disclose information about both the nature and course of therapy to be used (APA 2010, 10.01(a)). These requirements encompass the ethical responsibility to practice competently. By keeping up to date with research into psychotherapy and best practices in how to disclose relevant information, practitioners display their professional competence.

## Informed Consent and Respect for Patient Autonomy

Therapists have an ethical duty to provide informed consent and convey in an understandable manner any information that is likely to have a bearing on patients' decision-making about treatments. The purpose of seeking informed consent is to ensure that the patient's right to autonomous decision-making—that is, the right to self-determination with respect to treatment choice—is respected and upheld.

What information might be deemed relevant for autonomous decision-making? As Beauchamp and Childress (2009) point out, disclosure cannot encompass an exhaustive list of information. However, there is broad consensus within both medicine and clinical psychology about the range of information that is morally relevant to autonomous decision-making (Beauchamp and Childress 2009). This includes the patient's diagnosis and prognosis; the range and nature of available treatments for their condition; accurate and representative descriptions of how such treatments work; the timing and duration of treatments; and the effectiveness and risks associated with different treatment options, including the decision to receive no treatment at all.

How should this information be communicated to patients? The APA's ethics code states that psychologists should inform patients as early as possible in forging the therapeutic relationship (APA 2010, 10.01(a)), and that the consent, permission, and assent of patients should be appropriately documented (whether that consent is obtained by written or oral means) (APA 2010, 3.10(d)). In this way, there appears to be much latitude for interpretation about how this consent is both conveyed and obtained. Informed consent to psychotherapy is often conceived as a process rather than a onetime disclosure of information (as it might be understood in biomedical contexts). This is because patients may only come to fully understand how certain aspects of psychotherapy work by undergoing treatment: in this way knowledge of psychotherapy involves a 'know-how' or procedural aspect. However, even if we acknowledge the procedural aspect of understanding psychological treatments this does not provide justifiable grounds for the omission of adequate disclosure of 'know-that' (propositional) knowledge.

Certainly, there is a danger of overwhelming patients when informed consent documents become too complex and dense: in such cases, psychotherapists not only run the risk of them not being read but of patients failing to comprehend the content. As Barnett et al. (2007) argue, in the pre-treatment phase patients ought to be furnished with understandable, written information about treatments (information that they can refer to during later stages of therapy) but this information should be verbally conveyed to patients as well. Consent should additionally be conceived as a process whereby psychotherapists “actively ensure” that patients understand the information that is presented to them, for example, by requesting that patients explain their understanding about what has been disclosed (Barnett et al. 2007). Before we address what ought to be disclosed in ethical informed consent, it is important to reflect on what ‘evidence-based practice’ means in psychotherapy (Table 1).

## Evidence-Based Practice: An APA Policy Commitment

The aims of evidence-based psychotherapy practice are threefold: to integrate the best available evidence about (1) the effectiveness of treatments and their mechanisms of action; (2) the nature of expertise in clinical decision-making; and (3) patient preferences, values, and the sociocultural context of treatment (APA 2015). In this paper, we focus on the APA’s interpretation of evidence, and the consequences of this for clinical ethics.

## Research into Treatments

First, in emphasizing the importance of best available research evidence in psychotherapy, the APA acknowledges that a variety of research contributes to evidence-based practice (APA 2006, p. 274). Indeed it is important to emphasize that the debate over what constitutes ‘evidence’ in psychotherapy is ongoing (and at times fractious). It is impossible to review all of the epistemological issues that this debate raises; however, it is valuable to reflect on key challenges before we investigate the implications of EBPP for informed consent. One fundamental challenge to research is gauging (and comparing) the effectiveness of different versions of therapy. Some proponents of humanistic and psychodynamic therapies argue that these versions of therapy are fundamentally inappropriate for randomized controlled trials (RCTs) (e.g. Garfield 1996). Certainly—as is widely acknowledged—cognitive and behavioral therapies are the most researched forms of therapy: like pharmacological interventions, but unlike psychodynamic and humanistic therapies, cognitive and behavioral therapies operate with a more prescriptive,

manualized approach that is better suited to clinical trials. Even the concept of measuring patient outcomes is persistently challenged by some psychodynamic psychotherapists who argue that their approach does not treat the objectively observable signs and symptoms of mental disorders but instead focuses on the patient acquiring insight and on changing underlying psychological conflicts, which they argue are not directly measurable.

The APA Task Force statement is clear about recognizing the complexities and disagreements involved in the interpretation of evidence based research, including the difficulties of comparing diverse versions of psychotherapy, which each have different ontological and epistemological assumptions. It advances the importance of going beyond empirically-supported treatments (EST) to consider other desiderata, including the so-called common factors and their role in therapeutic outcome; among the common factors it cites are: the individual psychotherapist, the treatment relationship, and patient characteristics (APA 2006, p. 275). Indeed, the move to endorse EBPP above EST allows for a wider inclusion of varied research evidence, and a move away from a tradition of research bias associated with manualized treatments, such as behavioral or cognitive behavioral therapies over psychodynamic or person-centered approaches (Messer 2004).

The APA also highlights the long tradition of research into the role of common factors as possible mediators of therapeutic change. Interestingly, the APA emphasizes research which shows that the common factors (rather than specific treatment effects) may account for much of the effectiveness in treating a range of problems (APA 2006, pp. 272–274). Indeed, one upshot of research into RCTs comparing psychological treatments has been a renewed support for the so-called ‘Dodo bird verdict’—the claim that every psychotherapy approach or school is equally effective. The common factors hypothesis provides one explanation for the Dodo bird verdict—namely, that it is the factors that are common across therapies rather than specific treatment techniques (e.g. insight-oriented techniques in psychodynamic therapies, or cognitive restructuring techniques in cognitive-behavioral therapy) that are may be most therapeutically relevant to treatment outcome. In further support of the Dodo bird verdict it has been argued that aggregate meta-analyses of process research demonstrate that common factors account for a significantly higher percentage of variability in outcome than specific factors (Wampold and Imel 2015, p. 209). The Common Factors Hypothesis is not without controversy (Marcus et al. 2014). Moreover, when it comes to process research, correlation does not necessarily mean causation, and no evidence so far demonstrates that specific factors (or, indeed, the common factors) are best described as the causal determinants of change in therapy.

**Table 1** Informed consent checklist for therapists

1 Ongoing development of professional knowledge	Keep up to date with research on EBPP including: (a) treatments (e.g., via recommendations on APA's Division 12 website) (b) therapist expertise; and (c) the role of patient characteristics, cultural background, and preferences
2 Evaluation of the patient's capacity to provide full informed consent	If <i>not capable</i> : Strong justification is required It may be determined that the patient is too distressed, lacks capacity, or for reasons of personal preference full informed consent is not appropriate Revisit the possibility of providing fuller disclosure of information in later sessions. Suggest an appropriate psychotherapy, and omit points (3) & (4) below; and provide written material for patient to take away if appropriate
3 Provision of information about the patient's diagnosis and prognosis	Inform patients about their diagnosis and prognosis after initial diagnostic consultation, or as soon as possible
4 Provision of information about treatment options ( <i>Information should be conveyed verbally and in written form</i> )	(a) Disclose the range and nature of EST treatments for the patient's condition regardless of whether the psychotherapist practices every approach (b) Disclose information about the psychotherapists' specialist training, and patient populations (e.g. patients suffering from substance abuse disorders, anxiety disorders, etc) (c) Where applicable provide information about where and how patient might access forms of psychotherapy not practiced by the clinician (d) Provide brief but accessible information about different approaches suitable for the patient: Example: "Some therapies are insight-focused with the goal of better understanding your life experiences including why and how particular experiences have led to problems. Other therapies are more symptom-focused attending to the kinds of thoughts and feelings that may trigger negative and unhelpful beliefs and behaviors." (e) Provide information about the timing and duration of treatments (f) Provide any information on the risks associated with different treatment options, including the decision to receive no treatment at all (g) Ensure that the patient understands this information, through active listening, and asking the patient repeat crucial information in his or her own words
5 Disclosure of common factors ( <i>Information should be conveyed verbally and in written form</i> )	Ensure information about the importance of common factors is disclosed in an accessible way Example: "During these sessions, it is important that you feel comfortable talking to me. You should feel supported and understood. You should also feel that you can readily get on board with the work we will do together in the psychotherapy sessions. If for any reason you feel uncomfortable about the progress we are making, it is important that we talk about that. We can then try to work through these problems, but it may be that a different version of psychotherapy, or even another psychotherapist, may work better for you. While I do not expect this to happen, in some cases another kind of psychotherapy or another psychotherapist might be more suitable for you and that is nobody's fault."
6 Ongoing patient feedback	Implement user-friendly continuous assessment to allow patients to provide feedback on therapeutic alliance, and to track patient progress (e.g. via PCOMS software, see p. 18)

## Research into Therapist Expertise

Second, the Task Force urges that clinicians must embrace an evidence-based conceptualization of expertise. In particular, it emphasizes the need to replace unsystematic biases in clinical judgment with empirically supported findings. In

this context, it highlights established findings that clinical intuitions about the effectiveness of a treatment even among experienced clinicians, can diverge considerably from the evidence (APA 2006, p. 277; also see: Casarett 2016). The APA notes the responsibility of the clinician to incorporate ongoing research findings into clinical practice through

continuing education, emphasizing that clinicians should employ strategies to facilitate self-reflection about practice. The APA recommends the use of peer, academic and real-time patient feedback to improve treatment outcomes (APA 2006, p. 277).

### Research into Patient Characteristics, Culture, and Preferences

Third, to maximize the potential for therapeutic success, the APA recommends that an evidence-based approach to individual differences, values, and worldviews should be incorporated into clinical judgment. It underscores that EBPP must ensure that systemic scientific evidence about how patient values and preferences, as well as other incidental patient factors, are integrated into psychotherapy practice. Research highlights the importance of adapting psychotherapy to culturally diverse populations, and raises challenging questions about cultural expertise, and sensitivity to the expectations of patients from a range of socio-political and ethnic backgrounds (Bernal et al. 2009).

### The Implications of Evidence-Based Practice for Ethical Informed Consent

A number of significant ethical implications, which relate to patient autonomy, flow from the clinical shift toward evidence-based practice. It is therefore important to illustrate how these clinical priorities present novel ethical challenges for practitioners—challenges that we argue have largely been neglected to date. Previous, detailed analyses of informed consent in psychotherapy have emphasized the importance of such factors as timing of information disclosure and consent-seeking, expected length of treatment, and confidentiality of treatment. These are not of present concern, as they have been adequately addressed elsewhere (cf. Fisher and Oransky 2008). More recent publications have promoted the importance of describing the techniques that the therapist will employ in therapy sessions (Trachsel et al. 2015).

However, there is evidence that psychotherapists still fail to perceive the disclosure of such information as an ethical duty (Dsubanko-Obermayr and Baumann 1998): as Johnson-Greene (2007, p. 183) claims, “[T]he importance of informed consent is probably vastly underestimated by many psychologists.” Qualitative and quantitative studies in the UK and the USA support this claim and also reveal broad variation between psychotherapy traditions, as well as among individual psychotherapists, about the importance and practicability of providing informed consent (Barnett et al. 2007; Somberg et al. 1993). Studies show that psychiatrists and practitioners of insight-oriented therapies are more skeptical about the value and feasibility of informed

consent to therapy (Goddard et al. 2008). One explanation for the failure to provide adequate disclosure has been discussed—some psychotherapists may believe that the procedural nature of understanding psychotherapy practice renders formal consent practices unnecessary. As we have argued, this is not a satisfactory reason to neglect this ethical duty. Even in cases in which therapists do disclose the various techniques involved in psychotherapy (for example, describing the specific techniques of cognitive behavioral therapy), in light of the APA statements on EBPP, a strong case can be made that disclosure processes should be less narrowly interpreted. For example, it has recently been argued that it is imperative to divulge relevant empirical findings about common factors in psychotherapy. In summary, EBPP requires that the techniques involved in different therapy modalities should not simply be taken at face value.

Following earlier seminal studies on clinical ethics (cf. Fisher and Oransky 2008) we restrict the present discussion to issues entailed by EBPP, and use four clinical vignettes to illustrate “red flag” ethical concerns in need of resolution in clinical contexts. Individual case studies in clinical practice are rarely clear-cut. We have therefore constructed composite clinical vignettes derived from a range of case studies that are likely to be widespread in psychotherapy practice. Our purpose is to launch a wider debate about informed consent in light of EBPP: as such, our evaluations are intended to be opening exemplars rather than exhaustive prescriptions about how to adapt and reform practice guidelines. We also recognize that other ethical issues, relevant to informed consent, may emanate from evidence-based practice. For example, we have not included the complex challenges of disclosure in culturally varied or multicultural therapeutic relationships, nor have we explored the issues of working with children, couples or groups of patients, or people with limited cognitive ability. These diverse challenges deserve separate extended ethical exploration and are beyond the scope of the present paper.

Finally, it is important to reiterate that ethical informed consent to therapy is (in part) procedural: adequate information must be provided to patients, but this must be balanced against the risk of confusing or overwhelming patients at any given time. In addition, personal autonomy may even be a goal of psychotherapy treatment. The concept of relational autonomy here is instructive. Relational autonomy is the idea that one’s capacity for autonomous decision-making is dependent on one’s social relationships; in this way, psychotherapy may enhance patients’ “agentic skills” – that is, the ability to engage in the processes of reflection, deliberation, and authentic decision-making (Meyers 2005). Nonetheless, we emphasize that the provision of adequate information is an ethical duty—as such, it ought to be provided to patients as soon as possible and with sensitivity to each individual, with the aim of promoting patient autonomy. We assume that

there are virtually no circumstances under which omission of adequate disclosure is acceptable without careful justification; psychotherapists must find ways to communicate information in understandable ways, against the needs of each patient, and seek to supplement this where appropriate with accessible written material.

### Case 1: Providing Evidence-Based Advice on Diverse Treatment Methods

Ms. P. is a 45-year old who seeks psychotherapy to treat her agoraphobia (i.e., fear of crowded spaces, accompanied by panic attacks). In crowded spaces this manifests in experiences such as pounding heart, trembling, sweating, feelings of choking, and fear of dying. Reading up on the disorder and its treatment, Ms. P. learned that psychotherapy is an effective treatment method and contacted a psychotherapist in her neighborhood. However, as a layperson, she was unaware of the diversity of methods of psychotherapy. During a preliminary consultation, the psychotherapist whose preference was to use applied relaxation techniques informed Ms. P. about his own therapeutic approach. The therapist was unaware that a variety of different treatment techniques were as effective as his own preferred treatment method; and he failed to inform her of the existence of other available EST for treatment of her phobia, such as cognitive restructuring, and exposure techniques.

#### Red Flag

Professional competence in respect of psychotherapy knowledge is entwined with ethical informed consent. And as the APA states, there is a professional duty to maintain competence and to keep up to date with the latest studies on empirically supported treatments (Chambless and Ollendick 2001). As we have noted, it remains controversial whether particular psychotherapeutic treatments are superior for some conditions (Beutler 2002), or whether all treatments are equally effective (Wampold and Imel 2015). Nonetheless, psychotherapists have a professional duty to keep up to date with debates and research on treatment efficacy, as well as with broader (meta-analytical) evidence on treatment effectiveness. In Case 1 the psychotherapist recommended an EST psychotherapy; however, on an EBPP approach there is also a duty to communicate (the matter of fact) that a variety of other approaches may also work, and indeed, that some may work better for different individuals. These considerations take into consideration that patient preferences can influence psychotherapy outcomes. To take another example, in light of the state of current research, it might reasonably be asserted that patients with obsessive–compulsive disorder (OCD) have a right to know that exposure and response prevention is the best-supported intervention for

their condition (Olatunji et al. 2013); they also have a right to know that this treatment can be very distressing for some patients. Some patients suffering from OCD may elect to try a different treatment approach. The point is that patients should be furnished with enough material information to make autonomous, informed decisions about which treatment they may prefer.

In less clear-cut cases—including the treatment of depression—the fact that there is ongoing debate about the relative effectiveness of different treatment modalities for certain conditions (Wampold et al. 2017) might also be usefully conveyed to patients. In open and honest communication, psychotherapists should feel fully able to acknowledge the scientific debate about the effectiveness of treatments (the ethical imperative, we argue, is to keep up to date with that debate). Indeed, just as we would equally expect physicians to disclose such details in respect to the effectiveness of pharmacological treatments and surgical interventions, as well as the risks associated with treatments, and the fact that some patients may respond better to particular treatments than others—so it should be in psychotherapy. Such disclosures should be provided pre-treatment, in a comprehensible manner: following Barnett et al. (2007) we contend that such information might be conveyed verbally but should also be provided in written documentation to allow individuals sufficient time to reflect on treatments and even to investigate them further on their own. Equally, if therapists decide that treatment approaches should change (if for example, there is lack of progress), then new recommendations and options should first be conveyed to patients.

It might be countered that good therapists often have a strong skill set in some areas, and that by attempting to become knowledgeable about different modalities, therapists' expertise and professional competence may suffer as a result. We agree that it is both unrealistic (and probably undesirable) to require or expect therapists to have expertise in practicing a variety of psychotherapy modalities. However, the ability to practice different versions of therapy is quite separate from the obligation to keep up to date with research evidence in the field. Regardless of therapists' competence (or otherwise) when it comes to practicing a variety of modalities, it is still imperative that practitioners keep up to date with research on the effectiveness of specific treatments. Disengaging from challenging debates, we argue, is not an option. Therapists must be professionally knowledgeable about the evidence base as a *precondition* for adequate informed consent to occur.

### Case 2: Communicating Impartial Clinical Judgments about Treatment Options

Mr. D. is a 25-year old married technician with two young children in partial remission from a moderate recurrent

major depressive disorder. From colleagues, Mr. D. knows that psychotherapy can be of help in treating his depression. Like Ms. P., Mr. D. is unaware of the existence of diverse treatment approaches. Unlike the therapist in Case 1, the psychotherapist Mr. D. approaches is fully aware of the variety of EST available to a patient suffering from depression, including interpersonal therapy, psychodynamic therapy, and cognitive-behavioral therapy. However, the therapist's principal training is cognitive-behavioral and without due consideration to patient preferences, characteristics or history, she informs the patient in the preliminary consultation session that CBT is the best way to treat depression. The therapist reaches this conclusion on the basis of her own clinical experience about effective psychotherapy and fails to give due consideration to the weighting of clinical studies and patient preference.

### Red Flag

Personal bias must not interfere with clinical judgment: cherry picking or misrepresentation of evidence undermines informed consent, which must be evidence-led. Here, the therapist understands the importance of EST but exhibits bias (which differs from the therapist's lack of knowledge about EST in Case 1), and therefore she fails to fully embrace EBPP. It should be pointed out that in the case of CBT there is continued debate about whether this is the most effective version of therapy for major depression (cf. Fonagy et al. 2015). The patient was not provided with information that other forms of therapy might be equally beneficial and thereby provided with the option of treatments (and specific treatment techniques) that he or she might have preferred.

This scenario should also be distinguished from those cases when patients firmly establish with therapists that they wish them to "be the expert"—that they would prefer the therapist to make treatment decisions on their behalf. Patients in psychotherapy are a heterogeneous population with diverse and particular information requirements. In some circumstances, it may be more appropriate for psychotherapists to make early treatment decisions on behalf of some individuals: for example, patients are distressed in first sessions, and/or judged to be incapacitated in reaching autonomous treatment decisions. However, even in these circumstances patients may still be furnished with suitable information to help them to gain a better understanding about psychotherapy, and the therapeutic process. We also urge that the occasions whereby patients provide explicit *authorized* consent for the psychotherapist to act in their interests (e.g., in selecting from empirically-supported treatments) should be rare, and must be fully justified (for example, on the grounds that the patient is distressed, or incapacitated in making a treatment decision). Finally, there are good reasons to dissuade patients from conferring

paternalistic decision-making on psychotherapists, and for psychotherapists from assuming control in respect to all decision-making processes: it is likely that patients who are actively involved in decisions about treatment options will also be more actively engaged, and bear greater responsibility for their contributions during the tasks and activities of psychotherapy. It is also likely that greater trust will be enhanced as a result of psychotherapists respecting, and conferring greater autonomy on patients, which may in turn lead to improved outcomes.

Psychotherapists should also disclose information on their psychotherapy training, and previous fields of work (e.g., psychiatric inpatient clinic, outpatient services, or private practice). Information on treated patient populations (e.g. whether the psychotherapists specializes in affective disorders, or substance disorders, etc) may also better help prospective patients to reach decisions about whether to undergo sessions with particular individual psychotherapists. Finally, there may be geographical, financial or insurance constraints with respect to treatment choice: not every evidence-based form of psychotherapy may be available to prospective patients. We argue that this is still not a justification for failure to disclose information about the best evidence-based treatments. In medical contexts, patients expect to be informed about the variety of therapeutic options that are available, including options that the physician they are consulting with does not provide. Regardless of potential insurance limitations or geographical constraints that may reduce psychotherapy options, it is not for a doctor or a psychotherapist to decide or second-guess patients' decisions. Psychotherapists should be prepared to be transparent in their disclosure of the range of evidence-based treatment options for patients, while being prepared to work within particular constraints. For example, if there is moderate to weak support, or controversial support, for a therapeutic modality for a particular condition, then psychotherapists have a duty to communicate this to patients. We also argue that, in some circumstances, there is an ethical obligation on psychotherapists to recommend practitioners or healthcare providers who may be better equipped to help patients. Other options—such as videoconferencing psychotherapy—may provide another possible solution for patients facing barriers to effective psychotherapies (Backhaus et al. 2012).

### Case 3: Disclosing Information about Common Factors

During a preliminary consultation with a prospective patient (Ms. R.), the therapist explains a range of treatments that may be suitable for dealing with the patient's generalized anxiety disorder, including worry, rumination about perceived untoward outcomes, irritability, fatigue, and muscle tension. The therapist describes some therapies as

insight-focused with the goal of better understanding the patient's life experiences including why and how particular life experiences can lead to psychological problems. She also explains that other therapies are more symptom-focused, attending to the kinds of thoughts and feelings that may trigger negative and unhelpful beliefs and behaviors. The therapist explains that there is good evidence that both kinds of therapies will be helpful in treating this individual's problems. The therapist is also very careful to describe, in understandable terms, the distinct techniques used in different treatments for depression and anxiety. The patient decides to try a form of cognitive behavioral therapy, as these techniques (as described to her) seem more plausible than approaches that range over her life history. Under the therapist's guidance, and with the patient's consent, they embark on a course of cognitive behavioral therapy.

### Red Flag

Psychotherapists may assume that, by informing patients about different empirically-supported treatment options and describing the differing techniques involved, they have provided full ethical disclosure: while both of these are necessary for provision of informed consent they are not sufficient in an EBPP ethical framework. Psychotherapists have a professional duty to keep up to date with meta-analyses of treatment modalities and with research findings on successful treatment outcomes. Although there is still controversy among researchers over the Common Factors Hypothesis and the value of specific techniques in psychotherapy, there is a strong consensus among psychotherapists—quite aside from this debate—that common (or non-specific) factors (e.g. the working alliance, psychotherapist empathy, and positive regard for patients) are strongly correlated with successful treatment outcome. We believe that the research evidence and the strong consensus among psychotherapists provide strong reasons to communicate to patients the importance of the common factors in psychotherapy. The APA—the largest association for psychologists in the world—emphasizes the wealth of research indicating that the 'common factors' may play a role in mediating therapeutic change. In light of the evidence base, and process research, the disclosure of these factors appears at least as justified as the disclosure of specific factors to prospective patients. Moreover, important ethical concerns flow from the disclosure of common factors; for example, it may be that when patients ignore common factors (and place a premium on specific factors) they may undervalue the importance of a trusting relationship with their therapist. It is also conceivable that, if patients decide to discontinue therapy, they may come away with the false impression that the treatment (e.g. CBT) is "not for me" rather than reflect on the role of other factors such as their relationship with the therapist, or their

expectations about the treatment, that may have influenced their outcome.

It is eminently feasible that common factors can be communicated in an understandable, straightforward, and simple way to patients; and in a manner that does not undermine the effectiveness of these factors. For example, in the scenario above, the therapist might advise the patient: "During these sessions, it is important that you feel comfortable talking to me. You should feel supported and understood. You should also feel that you can readily get on board with the work we will do together in the therapy sessions. If for any reason you feel uncomfortable about the progress we are making, it is important that you feel able to communicate this to me. We can then try to work through these problems, but it may be that a different version of therapy, or even another therapist, may work better for you. While I do not expect this to happen, it is important that you know that therapy need not fail: in some cases, another kind of therapy or even another therapist might be more suitable for you, and that is nobody's fault" (Blease et al. 2016). We concede that the suggested formulation for disclosures is likely to require refinement, the key point is that discussion about how disclosures might best be formulated, presented, and discussed with patients, must now begin in earnest (Gaab et al. 2016).

Finally, it might be argued that the disclosure of 'non-specific' factors goes beyond what is common practice in medicine. There are three reasons why this criticism misses the mark. First, we reiterate that while there is still disagreement about the role of specific effects in the treatment of different psychopathologies and conditions, there appears to be broad agreement that common or 'non-specific' factors play a therapeutically relevant role in psychological treatments (Wampold and Imel 2015). Second, there also exists a large body of literature on the clinical ethics of placebo effects or 'non-specific' effects in biomedical contexts. Therefore, when placebo effects are therapeutically relevant in clinical biomedical practice, the case can also be made that clinicians should advise patients of these effects; research into so-called open-label placebos demonstrates that disclosing placebogenic aspects of treatment may not negate the effectiveness of those very factors (Charlesworth et al. 2017). Third, we argue that widespread practices within medicine do not provide strong justifications for criticism of the debate about improving ethical practice in psychotherapy. This is because standard ethical practices in medicine may themselves be found wanting.

### Case 4: Providing Feedback on Patient Progress and Attitudes to Treatment

A psychotherapist carefully explains to Mr. G. the range of empirically-supported psychotherapy options for treatment of his posttraumatic stress disorder, which includes severe

sleeping problems, nightmares, flashbacks, and hypervigilance. The psychotherapist adequately describes the techniques used in different kinds of therapy, as well as the role of common factors across all modalities. Mr. G. is aware that a good working relationship with his therapist, as well as an open attitude, and positive expectations about the treatment, are very important for the success of psychotherapy. Despite consenting to a specific form of desensitization therapy and attending sessions each week, the patient struggles to feel comfortable with his psychotherapist and knows that this is affecting his ability to work through the sessions. However, the patient feels awkward about communicating these worries to his therapist for fear of upsetting him, and rather than addressing the problem, the patient eventually drops out of therapy.

### Red Flag

The psychotherapist invites honest and open feedback but in this circumstance the patient feels unable to give it. Some patients may resist or refrain from communicating their worries about how psychotherapy is progressing (including any perceived discomfort with their psychotherapist) for fear of upsetting or even disappointing their psychotherapist. By the same token, research has revealed that psychotherapists tend to be overconfident in clinical judgments, and that patients are better judges of the therapeutic alliance (Lambert et al. 2003). In short, a “therapeutic blind spot” may prevent psychotherapists from reaching accurate assessments about patient progress, and the state of the therapeutic alliance (Rousmaniere et al. 2014). While the psychotherapist should aim to create the conditions under which open communication is possible, mechanisms must exist for individuals to express their experiential knowledge and perceptions of therapeutic alliance.

Research into continuous patient monitoring systems demonstrates the value of providing session-by-session feedback to psychotherapists (e.g. Lambert et al. 2003). Recall that informed consent to psychotherapy is—in part—a process: it requires ongoing, bidirectional feedback between patients and psychotherapists about how psychotherapy is progressing. In Case 4, the psychotherapist and patient could benefit from the implementation of continuous assessment software such as the Partners for Change Outcome Management System (PCOMS) which incorporates two short, four-item self-reporting instruments which each take less than a minute to complete (Miller et al. 2005): the Outcome Rating Scale (ORS)—which is a shorter version of the Outcome Questionnaire-45 (Lambert et al. 1996)—assesses change in patient functioning; the Session Rating Scale 3.0 provides the patients’ assessment of the quality of the therapeutic and working alliance (Miller et al. 2005). Both measures

have demonstrated reliability and validity (Miller et al. 2005). The PCOMS provides psychotherapists with real-time feedback of patient progress; it also makes patients’ concerns about the therapeutic alliance more visible. As a result, this feedback system affords psychotherapists an opportunity to open up dialogue with patients about the nature of treatment and the therapeutic process. This process is proven to yield superior outcomes, and better identify patients at risk of terminating psychotherapy; furthermore, when the PCOMS is combined with clinical support tools (which provides psychotherapists with a decision-tree of recommendations and resources), research indicates that patients show significantly better and more rapid improvement, with significantly fewer patients dropping out of treatment (Whipple et al. 2003). Continuous assessment can thereby promote ongoing feedback between patients and psychotherapists about how psychotherapy is progressing: such software allows quick, user-friendly methods of data collection, as well as tools for analyzing patient feedback, and helpful recommendations for enhancing patient outcomes (Rousmaniere et al. 2014).

### Conclusions

Ethical informed consent to psychotherapy is dependent on, and must be sensitive to, developments in evidence-based practice—in this respect it is no different from medicine. However, there is still a widespread default tendency in clinical psychology and psychotherapy to assume a paternalistic attitude towards informed consent. We strongly recommend that psychotherapists find ways to adapt their informed consent practices to maintain the ethical responsibilities and high standards of care that are conferred with clinical licensure and the duties it bestows. The vignettes in this paper are presented as a prelude to a finer debate about how psychotherapists might better adapt and update their ethical practice. In Table 1 we provide a checklist of practical, user-friendly strategies that might be implemented to facilitate ethical, EBPP informed consent. We conclude that the quality of the information provided to patients depends on psychotherapists keeping up to date with research into psychotherapy and clinical expertise, and on their receptivity to patients’ cultural milieu and personal preferences. Diverging from the evidence base is ethically indefensible: it undermines the professional competence of the psychotherapist, as well as the duty to respect patient autonomy. Finally, there is evidence that promoting honest dialogue between psychotherapists and patients about the nature of psychotherapy improves both the therapeutic alliance and patient outcomes (Boswell et al. 2015).

## Compliance with Ethical Standards

**Conflict of interest** The authors declare that they have no conflict of interest.

**Research Involving Human and Animal Participants** This article does not contain any studies with human participants or animals performed by any of the authors.

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