

Informed Consent in Psychotherapy

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Objective: The authors sought a rational approach to implementing informed consent within the practice of psychotherapy.

Method: The history of informed consent in psychotherapy was reviewed to define a common synthesis that maximizes the potential benefits and minimizes the potential hazards.

Results: The benefits of informed consent in psychotherapy include fostering a positive treatment outcome through enhancing patient autonomy, responsibility, and self-therapeutic activity; lessening the risks of regressive effects and therapist liability; and helping the practice of psychotherapy extend beyond particular parochialisms by providing checks and balances on therapist judgments. The hazards include the unpredictability of interactional outcomes and the possibilities of replacing positive expectancy with negative sugges-

tion, replacing a therapeutic alliance with a legalistic stance, and misimplying that patients are passive recipients.

Conclusions: Practical implementation of informed consent in psychotherapy must balance such tensions in service of optimal treatment. As a guiding principle, the authors recommend that psychotherapists convey to a prospective patient information that is material to the particular patient's decision. The level of detail needed in informed consent discussions varies directly with the cost and risks of the proposed treatment, the presence of viable alternatives and their relative grounding in scientific data and professional acceptance, and the presence of significant controversy. Unresolved is the question of how to address problematic or controversial psychotherapeutic trends that temporarily enjoy wide professional support.

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“Psychotherapy,” defined simply, is the use of interpersonal influence skills and psychological techniques by trained professionals toward the goal of relieving the signs and symptoms of psychiatric disorder (1). It stands apart from everyday discourse by the extent to which it is defined as a procedure, i.e., medicalized. Psychotherapy is a potent and well-proven tool for both relieving symptomatic distress (2, 3) and lessening the burdens imposed by numerous other ailments (4, 5). It has been ratified as a medical procedure by scientific texts, third-party payers, and the law. With this ratification come legal burdens that constrain all health care practice. Pivotal among these is the duty of caregivers to provide informed consent.

“Informed consent” is a process of sharing information with patients that is essential to their ability to make rational choices among multiple options in their perceived best interest (6). It was founded as a legal standard of care on the principle of individuals' rights over their own bodies and was well established by the turn of this century. It was enforced progressively throughout the past generation: first for surgical procedures, then medical ones, and finally for medication itself. Until recently psychotherapy had largely avoided this burden.

Sound arguments recommending the institution of informed consent for psychotherapy were offered for decades (7, 8) but languished in law library stacks. Several factors traditionally shielded psychotherapy from that

expectation. First and foremost was that therapeutic communications were considered sacrosanct and rarely made available to others in uncensored form. An additional distinction was the fact that psychotherapy is physically noninvasive, with patients being conscious and able to monitor the process themselves. Finally, the multiple uncertainties and complexities that can influence the outcome of treatment for a mental disorder make it very difficult to demonstrate convincingly any specific harm allegedly caused by the psychotherapeutic process itself (9).

During the late 1980s, *Osheroff v. Chestnut Lodge* sparked new interest (10). After a year of intensive inpatient psychoanalytic treatment for major depression, without relief, the plaintiff left a prestigious facility and allegedly responded well to antidepressant medications prescribed elsewhere. Had he been informed of this option in advance, he alleged, he would have salvaged an otherwise wasted year of personal misery and heavy financial burden. Although not setting formal precedent (the case was settled), this case was widely publicized and launched a vigorous published debate. Klerman (11) argued that informed consent standards should be applied rigorously to psychotherapy, whereas Stone (12) maintained that to do so would be highly problematic.

Also during the late 1980s, a few clients began suing third parties for abusive acts allegedly committed in the

distant past on the basis of so-called “recovered memories” that arose during psychotherapy (13). Such legal actions were encouraged by a growing minority of therapists. Other mental health experts (14, 15) and respected journalists (16, 17) came to perceive this trend as a threat to vital social institutions, such as the family and the presumption of innocence. They fought back—with scientific data (citing memory’s vulnerability to suggestion [18, 19]), and through social activism (such as the founding of the False Memory Syndrome Foundation in 1992 [20]). A new spate of litigation began with the *Ramona* decisions of 1994 *et seq.* (21), which held therapists liable for harm allegedly done to third parties. This legal action rapidly gained momentum and represented a 180-degree turn of the litigative trend within only a half decade.

What transpired in the psychotherapist’s consulting room became everybody’s business, which threatened the sanctity of doctor-patient confidentiality. One nearly universal complaint, when deeming a particular course of therapy to have been problematic, was that the allegedly negligent therapist failed to inform the patient of alternative therapeutic approaches that could vary in efficacy, time, cost, and social effect.

Informed consent is in the process of becoming mandatory for psychotherapeutic practice because the law says so, under penalty of liability judgments of seven to eight figures (22, 23). The ethics manual of the American Psychological Association (24) explicitly requires informed consent for psychotherapy, while informed consent for psychiatrists practicing psychotherapy is implicitly required in *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*: “A psychiatrist shall not withhold information that the patient needs or reasonably could use to make informed treatment decisions, including options for treatment not provided by the psychiatrist” (25). In other words, the growing expectation is that mandatory informed consent in psychotherapy is a fait accompli.

Exactly how this new expectation is best implemented, however, remains open. Practitioners still retain considerable latitude in defining what constitutes informed consent for psychotherapy, what is optimal, what is the acceptable range of content, and the processes through which psychotherapists provide information and gain consent. The collective charge of psychotherapy professionals is to maximize the benefits, minimize the hazards, and do what we can to shape emerging policies of informed consent toward maximum benefit for our patients, our profession, practitioners, society, and the treatment process itself.

Benefits of Informed Consent in Psychotherapy

The psychotherapeutic benefits of informed consent fall into two broad categories: empowering patients’ self-

therapeutic activity and protecting them against the cult-like information-control elements that are sometimes present within psychotherapy.

Provision of useful information helps patients to become more active agents on their own behalf. It is what patients do for themselves that correlates with therapeutic change, far more so than what therapists say or do, how they rationalize their interventions, or how often they see their clients (2, 26, 27). Granting this premise, the job of therapists is to utilize all of the interpersonal skills in their armamentarium to influence their patients toward more effective self-help (26–29).

One of these skills is educational. Knowledge is power. The most potent antithesis to irrational anxiety is information about where one actually stands: what one faces, what constitutes one’s assets, and what one’s options and their potential consequences are (30, 31). Open discussion of treatment options empowers patients through increasing their useful knowledge and becomes therapeutic in and of itself.

Informed consent lessens the risk of regressive dependency—a risk always present in therapy—which can lead to ineffective treatment and, for particularly vulnerable patients, to destructive outcomes. Experienced analysts have noted that malignant regression occurs more often whenever therapists emphasize their own specialness, thereby influencing patients to perceive them as omniscient or omnipotent (32–34). Such perceptions covertly undermine patients’ already fragile sense of autonomy, thereby increasing their anxiety and perceived dependency as well as the likelihood of acting out against a process that they may sense at deeper levels is intrusive (35, 36). Provision of information about alternative treatments undercuts this pathogenic specialness, supports patient autonomy, increases the patients’ confidence, and thereby mitigates regressive potential.

Through both of the above effects, informed consent shifts liability appropriately from caregivers onto both parties within a working alliance. As patients accept more personal responsibility, therapists are relieved of excessive liability for what is ultimately beyond their purview, i.e., their patients’ voluntary and autonomous actions and their consequences (37). Therapists’ relief from excessive liability accompanies patients’ improved prognosis, and society as a whole benefits from greater clarity as to who is responsible for what, to whom, and at what levels. In other words, considered in this light, informed consent is a win-win-win situation.

Provision of meaningful informed consent expands patients’ treatment options beyond particular therapeutic parochialisms. By “parochialism,” we refer to cult-like elements that may be present to varying degrees in many psychotherapeutic belief systems and methodologies. Parochialism has three components. One is selective indoctrination into the favored system, often referred to unabashedly as “hooking” the patient into the treatment

system, within which whatever subsequently transpires can be explained after the fact in terms of the system's tenets, creating a closed system with its own self-reinforcing momentum (38). The second component is exclusion of potentially contradictory information by ignoring, dismissing, or minimizing it. The third component is ad hominem disparaging of those who offer contrary data or alternative methodologies. Parochialism is fundamentally regressive. By selectively excluding contrary information, it weakens the data base that all human beings need for rational decision making. This weakening, in turn, undermines patients' autonomy and their confidence, thereby again increasing their anxiety and hence their dependence on therapists' expertise. In summary, parochialism is a subtle form of information control—one of the principal methods by which social dominants commonly maintain their control over potential challengers.

The antithesis to parochialism is expansion of the shared information base to include what is likely to be relevant to problem solving, the essence of informed consent. In order to provide informed consent sufficiently to serve as a natural antithesis to parochialism, therapists need to seek and gain knowledge of other lines of data, extend their understanding beyond favored systems, and become more open-minded to alternative perspectives and models.

Thus, the duty to provide informed consent fosters shifts from indoctrination to information sharing and from paternalism to respect of patients' autonomy. In so doing, we help to access, validate, empower, and challenge our patients' own natural strengths so that they can use these strengths toward more effective self-help, the *sine qua non* of a positive treatment outcome.

Hazards of Psychotherapeutic Informed Consent

At the same time that it can be highly therapeutic, informed consent is problematic to psychotherapy in many regards. Within nearly any psychotherapeutic process, neither party knows at the outset in what directions the therapy might evolve, what information or understanding may unexpectedly emerge, what roadblocks the therapy will need to surmount, or what the final outcome will be. In dyadic interaction, each party influences the other in ways that are both obvious and subtle and operate simultaneously at multiple concurrent levels (39, 40). One does not know what a patient will do in unexpected situations nor how his or her friends and relatives will react and how this will then impact the patient, and so on. All parties, however, can influence the course of treatment profoundly (41, 42). Thus, clear and probable outcomes cannot realistically be stated.

An overly detailed informed consent presentation can stifle the establishment of initial rapport with a suffering individual in crisis, who needs but is already fearful of

therapeutic support. Furthermore, too much emphasis on the pitfalls of psychotherapy could be negatively suggestive, or experienced by the patient as discouraging, thereby leading to more entangled negative therapeutic issues than necessary or desirable. Thus, misapplied informed consent can paradoxically undermine the tenets of good psychotherapy.

Attempting to predict beyond what one can accurately predict, or to control beyond what can reasonably or desirably be controlled, inevitably leads to unintended effects (43, 44). Among these, on a huge social scale, has been the creation of a legalistic climate within which health care providers are caught in a web of competing procedural regulations. These regulations usually arise from well-intended attempts to prevent bad outcomes, but instead, taken en masse, often stifle constructive action altogether (45). A misuse of informed consent doctrine could tighten this legalism.

A more specific hazard is implicit in the litigious climate within which psychotherapy now operates—the risk of covertly reinforcing the victim role by mistakenly implying patients' passivity (46). To mandate a style of informed consent for psychotherapy that is more appropriate for physical procedures, like surgery, could reinforce a widely held misbelief that psychotherapy also is a formal procedure “done to” a passive recipient by an active agent rather than a collaborative process in which patients play a dominating role.

Conflicting Interests and Levels of Complexity

Informed consent in psychotherapy is multidimensional and quite complex, which raises the issues of who it is designed to protect and how this can best be done. Interests of patients, caregivers, and society may diverge. All are relevant to the psychotherapeutic process. Foremost in treaters' obligations are patients and their patients' interests. From the patients' point of view, their perceived interests vary with whether they want to feel better, have life positions validated, enjoy more functional relationships, understand themselves, or enjoy social advocacy and nurturant authority figures upon whom they can lean. Some goals are concealed, conflict with others, and do not correlate with what is needed for a therapeutic result (47, 48). These complexities give therapists wide latitude to influence their patients through selective attention and selective reinforcement (40, 49). This confers the obligation to utilize this potency well. Toward what ends? The patient's interests, but which of his or her many competing interests? These questions become clarified as the clinical relationship develops, necessitating ongoing attention to informed consent rather than dispensing with it at the beginning of therapy.

The values of therapists and those of society are equally relevant. Which values? The medicalization inherent in

how psychotherapy is defined (1) helps to simplify this question. When practitioners accept third-party reimbursement for psychotherapy as a medical treatment, there can be only one legitimate answer: to use our expertise to reverse the symptoms of mental illness as effectively and efficiently as possible (2). Nonmedical goals may be legitimate but are best dealt with explicitly as such (50).

Primum Non Nocere

All interventions must respect the Hippocratic dictum of “*primum non nocere*”: first do no harm. Of what potential harms must patients be informed? The most obvious are excessive cost and improper treatment. Psychoanalysis is very costly in time and resources, and people who request it as a specific treatment need to be informed that alternative treatments are well tested and cost-effective. At the same time, for some otherwise intractable cases, long-term psychotherapy can prove safer and more cost-effective in the long run than overly ritualized brief therapies or medications for cases in which these are not clearly indicated (4, 5). These judgments are often subjective and clearer after the fact than during a course of treatment.

Iatrogenic regression is commonly observed in intensive treatment of clients with disorders widely believed to follow from childhood trauma—e.g., borderline personality and dissociative disorders. Problematic regression remains an open secret: widely recognized by experienced practitioners but, relative to its importance, given sparse attention in the mental health literature (27, 29, 32–36, 43, 49). Patients and therapists at risk need to know that this can occur, that some authorities recommend no treatment at all where regressive potential is high (51), and that cognitive, behavioral, and strategic approaches exist that may help to contain this risk during treatment (27, 52, 53).

Effect of Psychotherapy on Third Parties

Another open question has been the inevitable effects of psychotherapy on third parties. Halleck (54) noted that psychotherapy is inherently political, with a tension between conservative effects (functional adjustment) and radical effects (increased relative status of treated clients). There also is a comparable tension between progressive and regressive effects of psychotherapeutic practice on its greater cultural milieu (55). In recent and current litigation, recovered memory therapists are now being found liable when deemed as threatening such vital social institutions as the family and the presumption of innocence (13, 56). Claims of failure to have informed in advance of contrary data and alternative treatments once again have been major causes of action (57). The size of monetary awards (20–23) indicates clearly that therapists are now being held accountable for the larger scale societal effects of their work.

Informed Consent and Systemic Constraints

Few data are more material to treatment decisions than the systemic constraints against what treatments will be funded and how treatment authorizations are limited in actual practice. However, open discussion is impeded both by overt and covert counterpressures. An example of the former are the “gag rules” imposed by many managed care corporations that explicitly forbid their practitioners from disclosing systemic and financial constraints.

Covert taboos also stifle open discussion. For example, it is politically incorrect to tell a patient or third party that the patient will receive suboptimum treatment because caregivers lack sufficient resources. But often this is exactly the case within heavily managed health care systems. Caregivers and patients are both challenged to make the best use of what is available, and doing so requires that the most relevant limiting realities be discussed openly. In order to support clients and practitioners in the face of such pressures toward information control, psychiatric ethics now mandate explicitly that clients be informed “of financial incentives or penalties which limit the provision of appropriate treatment” (25).

Popular but Untested Psychotherapeutic Trends

Another dominating and unresolved question is how to address problematic treatments that temporarily enjoy wide professional support. The early informed consent landmark case, *Canterbury v. Spence* (57), had already ruled that the professional standard of care could not be misused to justify violations of patients’ autonomy. This question again came to the forefront during the recovered memory movement, in which it is widely believed that the mental health profession as a whole failed to police its practitioners’ excesses and may even temporarily have endorsed them. Despite this professional acceptance at the time, harm was sometimes done, and accused practitioners were often found liable later for failure to provide informed consent about alternatives.

Psychotherapists are thus advised to be alert for warning signs that they themselves may be entrapped within a problematic therapeutic fad: 1) a sense of ungrounded certitude (i.e., a stronger-than-usual conviction in the face of controversial data); 2) a sense of sociopolitical mission to correct some greater social evil (these biases are difficult to recognize in oneself and are, in part, why psychoanalysts require extensive self-knowledge as a prerequisite for treating others [47]); and 3) polarization (38). Knowing that other respectable practitioners oppose one’s views with equal fervor should alert one to consider whether one’s own view might constitute a bias that could later prove problematic (43). These warning signs make it particularly desirable that practitioners inform their patients that reasonable minds disagree—to explain one’s own recommendation and its rationale while abstaining from coercive or excessively suggestive persuasion and honestly respecting patients’ informed choice on how to proceed.

Recommendations

A realistic approach to informed consent in psychotherapy must integrate both clinical and legal aspects of the question. However the process is implemented, it is important that patients understand that multiple options, including no treatment, exist—each with differing rationales, methodologies, and risk/benefit profiles—and that if in doubt patients are encouraged to seek yet more knowledge on their own, either by independent study or seeking a second opinion. This general recommendation applies to somatic therapies as well and to treatments within all medical specialties (6).

We believe this information sharing is best done verbally, documenting the patient's levels of interest and understanding in the written record. Because so many individuals misinterpret or forget informed consent discussions and new dilemmas arise, the process is strengthened by ongoing attention to patient choices and their potential outcomes—with more supporting documentation as therapy progresses.

While written consent might best meet formal legal criteria, it is our opinion that written contracts with the patients run the risk of sacrificing clinical rapport so essential to positive therapeutic outcome and fail to address new questions that emerge. Where written forms are required, nonetheless, they should be constructed with therapeutic intent, be relatively simple and straightforward, be framed in ordinary language without jargon, cover the key contractual business parameters and differential responsibilities, note the relevant uncertainties, and summarize general principles and specific emergency resources for what to do whenever the therapist is unavailable (58). Optimally, they also should mention the necessary role of patients' self-therapeutic activity, which in certain cases can be elaborated to include voluntary abstinence from specific problem-maintaining behaviors such as abuse of controlled substances. Personalizing written informed consent forms has been shown to foster rapport and more constructive patient expectations (59). Finally, written forms should not be considered a substitute for ongoing verbal consent.

We advise against being overly or obsessively comprehensive, only partly in order to avoid a legalistic climate. When practitioners attempt to be comprehensive, paradoxical outcomes accrue: it becomes ever more likely that some low-probability undesirable event may occur, which, because not discussed in advance, will be experienced as a violation or overt betrayal (43, 44). The relevant question is materiality.

When in doubt over what to disclose, and how, we recommend that therapists return to the basic principle from which informed consent doctrine arose: that patients know their options and these options' rationales well enough to make reasonable treatment decisions in their own perceived interest—as defined by themselves. The

overarching question for therapists is “What data are ‘material’ to this particular patient's decision?”

Therapists are also advised to share uncertainty at the outset, which can be an important component of the informed consent process. Gutheil et al. (60) noted that “the real clinical opportunity offered by informed consent is that of transforming uncertainty from a threat to the doctor-patient alliance into the very basis on which an alliance can be formed.” Informing of uncertainty is particularly relevant in exploratory psychotherapeutic approaches in which therapists play a less directive role and uncertainty is intrinsically greater than in procedure-based treatment. How general and how specific the information should be depends on other factors that vary with the particular patient and the context.

The burden of the therapist to provide informed consent varies with the particular patient, the clinical problem at hand, and the social context. These burdens increase directly with the likely costs and risks of the recommended treatment, the presence of viable alternatives with potentially lower cost or greater benefit, the controversial nature of the recommended treatment, and the existence of alternatives that are demonstrably effective, efficient, and safe.

The burden of providing informed consent also increases when treatment alternatives enjoy wide professional support, even when those alternatives are problematic in themselves. For example, if unnecessarily regressive treatments are the de facto standard of care within a given community, one who disagrees with this trend is advised to inform carefully of what the treatment is and its rationale, as well as why one opposes it.

The burden of informed consent is most stringent within highly polarized therapeutic arenas in which opposing factions are heavily invested in their own methodologies, make strong claims about their efficacy, and denigrate those who disagree. Finally, even when fully informed consent is provided, it is unlikely that courts will exonerate a therapist who knowingly does damaging treatment, even if this was asked for, agreed upon, or even coerced emotionally by the client.

Conclusions

In summary, informed consent is now recommended for psychotherapy, just as it is for other medical and surgical procedures and for the same reasons. Its content depends primarily on what is material to clients' decisions. Consent always includes basic parameters of the treatment contract. Clients should be informed about the relative efficacy, efficiency, and safety of the recommended treatment and its primary alternatives as well as the likely consequences of no treatment. Patients should understand these parameters and be competent to give informed consent (6).

Much of the question of just what constitutes sufficient and appropriate informed consent remains unresolved. This fact gives the psychotherapy profession considerable latitude in helping to shape a still unfolding process. Wherever the informed consent process is potentially problematic, as in the risks of a legalistic climate, this malleability confers both the opportunity and the obligation on us psychotherapists to do all that we can so that the emergent doctrines will be maximally therapeutic for our clients, foster a salutary climate for our practice, and serve a constructive role in helping to shape society.

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