Patient Information on Evidence and Clinical Effectiveness of Psychotherapy

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Abstract and Keywords

This chapter focuses on what information should be provided to patients about the evidence base supporting the clinical effectiveness of psychotherapy. In particular, the authors consider whether research on the relative efficacy of different forms of psychotherapy should be provided to patients, as well as whether patients should be provided with information on the relative importance of common factors versus specific factors as the causal agents of clinical improvement. After a critical review and discussion of the relatively few scholarly papers that have previously addressed this question, the authors conclude that patients should be provided with an honest, transparent, and impartial summary of the evidence related to their treatment options including information about the common factors. The authors offer this conclusion even while acknowledging that considerable controversy persists about how to interpret the psychotherapy research evidence base. Finally, the authors strongly support continued research into these questions, especially given the relatively limited scholarly attention they have received to date.

Keywords: psychotherapy, evidence-based practice, empirically supported treatments, patient autonomy, beneficence, ethics, informed consent, common factors, specific factors

Introduction

Research into psychotherapy is still a source of deep controversy, both in terms of the rationale for it and the methodologies used in clinical trials. When it comes to the evidence base, the myriad difficulties related to conducting psychotherapy research still appear to go under-explored and unappreciated among many clinical investigators and psychotherapists. Yet the empirical and theoretical challenges related to evidence carry deep implications for professionalism including for the processes for delivering informed consent; indeed, the ramifications of the relationship between ethics and evidence in psychotherapy have only recently received scholarly attention (e.g., Blease et al. 2016a, 2018, 2020;

Gaab et al. 2016). Here we focus on questions about what information patients should be provided about the evidence for psychotherapy effectiveness and safety.

Evidence and Ethics

Blease et al. (2016a) identify two ways in which evidence is entwined with the ethical practice of psychotherapy. First, the practitioner has a duty to be educated about, and to keep up to date with, accurate knowledge about the nature of treatments: these obligations are collectively referred to as *epistemic duties* (O'Donohue and Henderson 1999: 10). Epistemic duties carry consequences for the healthcare ethics principles of beneficence (actions which promote beneficial patient outcomes) and non-maleficence ("doing no harm"). Empirical evidence about the absolute efficacy, and relative effectiveness of psychological treatments, as well as their potential risks of harm, are important factors relevant to professional competency, and ultimately to beneficence and non-maleficence.

Second, evidence relates to ethical practice with respect to patient autonomy—specifically, informed consent processes (for the ethics of informed consent for psychotherapy in general, see chapter by McKean, Trachsel, and Croarkin in this volume). Here questions turn on the kind and amount of information that is important to autonomous decision making, the appropriate practice of informed consent processes in psychotherapy, and whether patient understanding about treatments is a moral imperative (Faden et al. 1981; Grisso and Appelbaum 1991; Katz 1977).

To better explore the relationship between ethics and the disclosure of information on psychotherapy evidence to patients, we aim to drill down into the meaning of "evidence-based practice" and review the complexities that have arisen within psychotherapy research.

Commitment to Evidence-Based Practice in Psychotherapy

The American Psychological Association (APA) endorses an explicit policy commitment to "evidence-based practice" (EBP) (APA 2006). It describes EBP as embracing the tripartite goals of integrating scientific findings about: (1) the effectiveness of treatments including evidence about how they work; (2) the nature of clinical expertise; and (3) patient preferences, values, and the sociocultural context of treatment (APA 2015). This suggests a "thick" conceptualization of evidence encompassing a range of basic scientific research into psychotherapy and its practice, in addition to evidence derived from randomized controlled trials (Blease et al. 2016b: 28). In a similar vein, the British Association for Counselling and Psychotherapy (BACP) states: "[The BACP's] *Ethical Framework for the Counselling Professions* values research for 'enhancing our professional knowledge and providing an evidence-base for practice in ways that benefit our clients' (Good practice point 68)" (BACP 2018a); the website further emphasizes, "We take a pluralistic approach to re-

search, including data from trials, practice-based studies and qualitative, theory-building cases" (BACP 2018b).

However, "evidence-based practice" is often associated with a "thinner" conceptualization of evidence—what is more properly (though also, controversially) termed "empirically-supported treatments" (EST) (Wampold and Imel 2015: 27; Goldfried 2013). Maintaining the distinction between these strands of research is crucial because of the significant challenges involved in conducting and interpreting randomized, placebo-controlled trials (RCTs) of psychological treatments: that is to say, of establishing evidence in support of the efficacy of specific treatments. Indeed, pronouncements to one side, in their repositories of resources many professional psychotherapy organizations appear to place greater weight on EST than EBP. For example, in their online resources for practitioners, the APA's Society for Clinical Psychology lists "Research-Supported Psychological Treatments" (APA 2016); similarly, the BACP provides a list of links on its website to studies which primarily investigate the absolute and relative effectiveness of different versions of therapy (EST) rather than links to theoretical appraisals of research, or links to meta-theoretical or process research (BACP 2018a). In light of the emphasis on EST within these curated resources, many practitioners and educators of psychotherapy might well conflate this narrower emphasis on RCTs with EBP, more broadly construed.

Critical Responses to EBP

In spite of the broad policy commitment to EBP among many national clinical psychology and psychotherapy organizations, this move is not universally endorsed by practitioners. Proponents of existential, humanistic, and psychodynamic psychotherapies are especially critical of the movement towards EBP (Goldfried 2013; Tanenbaum 2006) (see also chapter by Krug and Piwowarski on ethical issues in existential-humanistic therapy, chapter by Noyon and Heidenreich on existential philosophy and psychotherapy ethics, and chapter by Drozek on ethical questions in psychodynamic psychotherapy and psychoanalysis in this volume). Certainly, cognitive behavioral therapies (CBT) are the most widely researched types of psychotherapy, in part because their manualized approach renders them more amenable to the format of clinical trials (Garfield 1996). While some versions of therapy (such as CBT) have a greater proportion of evidence in support of them than other modalities, we cannot straightforwardly assume that such treatments are necessarily more effective than other psychological interventions—a point that we will return to.

Some critiques of empirical investigations of psychotherapy raise important questions about what constitutes evidence, including whether patients' presenting complaints are always best classified according to psychiatric pathologies as opposed to "problems in living." Beyond this, there is ongoing debate over the validity of current diagnostic classifications systems in psychiatry and clinical psychology (e.g., Cooper 2014). However, the inference from the premise that the prevailing standards of evidence in psychotherapy (including diagnostic systems) are problematic, to the global conclusion that *all* evidence-based approaches are inherently problematic, is an invalid conclusion: it throws the baby

(the importance of evidence) out with the bathwater (the current standards or conceptualizations of good evidence). Every psychotherapy tradition—even those which do not adhere to conventional diagnostic systems—depends on some interpretation or implied standard of evidence within practice. To illustrate, psychodynamic psychotherapies employ idiosyncratic standards of evidence when it comes to assessing patient outcome (for example, the aim might be for patients to acquire insight or resolve psychological conflicts), but even in these instances, therapists must rely on their observations and evidence to reach clinical judgments. Whether this evidence is clearly articulated or objectively discerned remains a matter of controversy that is not restricted to psychodynamic approaches. As psychotherapy researchers have pointed out, the assumption that practitioners' subjective impressions of effectiveness are reliable is a concern across all psychotherapy modalities: this is because clinical observations about patient improvement are vulnerable to self-serving perspective biases (Casarett 2016; Lilienfeld et al. 2014).

Challenges and Complexities of Psychotherapy Research

Debate about the relationship between psychotherapy and placebos has been sporadic but long-lived, spanning over eighty years (Blease 2015b; Gaab et al. 2016; Grünbaum 1986; Jopling 2008; Rosenthal and Frank 1956). In order to explore the ethics of patient information on evidence and clinical effectiveness, first one should grasp the controversies and debates that surround the evidence. Fundamental to these complexities is how the terms "placebo" and "placebo effect" are defined and used in psychotherapy research. For example, drawing on particular definitions of placebos and on psychotherapy research, some scholars have argued that psychotherapy is vulnerable to interpretation as a "placebo" (Blease 2015a; Gaab et al. 2016; Grünbaum 1986; Jopling 2008). From this perspective, it is claimed that psychotherapy does not work according to its purported "characteristic features"—for example, the specific treatment techniques of particular treatment modalities—but rather depends on its "incidental features" for its effectiveness (e.g., therapist empathy and positive regard) (see related discussion in later subsections "Placebo-Controlled RCTs in Psychotherapy Research" and "Specificity of Treatments and Common Factors"). Others have rejected this line of reasoning, suggesting that in the context of psychotherapy "placebo" is an incoherent concept (e.g., Kirsch et al. 2016). Not all of these intriguing theoretical perspectives survive analysis (Blease 2018b) (see also chapter by Gaab and Trachsel on psychotherapy and placebos in this volume).

Nonetheless, as Blease et al. (2016b) argue, the placebo hypothesis presented by Gaab et al. (2016) and other scholars, picks up on a valuable insight: namely, "that the use of clinical placebos, in some way, implies an omission of the disclosure by the clinician of central therapeutic components of the treatment, and that equating psychotherapy to placebos involves the misrepresentation … of fundamental features of the treatment" (Blease et al. 2016b: 26). Further consideration of this intuition brings us to questions about what empirical information ought ethically to be disclosed to patients in psychotherapy.

An additional placebo-related complication is the use of RCTs in psychotherapy research. RCTs are often considered by medical doctors and clinical psychologists to be the gold standard of clinical research (see also chapter by Corre, Bhola and Trachsel on psychotherapy research ethics in this volume) (Locher et al. 2018). Here again, the translation of this standard to psychotherapy trials reveals distinctive challenges that may be further undermined by erroneous conceptions of placebo terminology (Blease 2018b). Yet the quality of psychotherapy RCTs, and the interpretation of this research carry significant implications for professional standards, and therefore, ethical practice.

Placebo Effects and Placebos

Placebos are often understood to be “sham,” “dummy,” or “inert” treatments; however, it has variously been argued that none of these commonly used definitions is accurate (e.g., Kaptchuk and Miller 2015). Indeed, during the last ten to twenty years, the field of placebo studies has crystallized into a mature scientific paradigm (call it the “placebo paradigm”); as such it has been argued that we can identify three nuanced ways in which these terms are now implicitly, if not always explicitly, used by scientists who specialize in placebo research (see Blease 2018a). On the basis of how these terms are operationalized by scientific experts within placebo studies, the stronger, normative case can be made for how these terms ought to be used (Blease 2018a: 415). In the following, we review these three distinctive uses of placebo concepts.

Placebo Effects

First, *placebo effects* are now conceived as specific, beneficial psychobiological effects that are shaped by verbal and nonverbal cues in clinical encounters, as well as by learned responses (Finniss et al. 2010), and which engage specific brain regions. In placebo analgesia these include the prefrontal cortex, anterior insula, rostral anterior cingulate cortex, and amygdala (Finniss et al. 2010; Kaptchuk and Miller 2015). A significant body of scientific research now demonstrates substantial placebo effects for a wide range of self-reported symptoms including pain, depression, anxiety, and episodic migraine headache. *Nocebo effects*, on the other hand, refer to measurable adverse effects which are thought to engage similar psychobiological mechanisms, but which lead to negative outcomes (e.g., increased pain or nausea) (Benedetti et al. 2007).

Placebos as Controls

Second, in the context of clinical trials, placebo scientists conceive of *placebos* as methodological devices for evaluating the effectiveness and specificity of medical treatments (Blease 2018a). Three-armed controlled clinical trials involve the random, “double-blinded” allocation of patients to one of three groups: first, the “verum” treatment (the intervention which is under scrutiny); second, a placebo arm; and third, a waitlist (no treatment, but participants’ symptoms are measured throughout the trial). More typically, however, there are only two arms in clinical trials: the verum treatment, and a control condition, consisting of either no treatment, treatment as usual, or treatment with some

form of placebo. The aim of placebos in this context is to determine whether there is any specific treatment response in the so-called verum treatment.

Strictly speaking, in three-arm trials there are two controls: the placebo and the waitlist. The waitlist controls for the natural history of the illness (what would happen if patients did not receive any treatment), as well as reporting bias, Hawthorne effects (the effect of being observed in a study), and regression to the mean. The placebo condition controls for all of the factors controlled by the waitlist, plus all of the incidental, non-specific features of receiving treatment which may influence patient outcomes, such as the beneficial effect of a warm, empathic, and accepting patient–clinician relationship. These non-specific features of psychotherapy have sometimes been referred to as the *common factors* (Wampold and Imel 2015), but they can also be conceptualized as *placebo effects* (Evers et al. 2018). It is also important to draw a subtle but important distinction between *placebo responses* and *placebo effects*. Placebo responses refer to the total improvement shown by patients treated by placebos, including the improvement that would have occurred in the absence of any treatment at all (i.e., the improvement that typically occurs in waitlist conditions, which includes the aforementioned natural history of the disorder, reporting bias, regression to the mean, and Hawthorne effects). In addition, the placebo response also includes the placebo effect, which refers to "changes specifically attributable to placebo and nocebo mechanisms, including the neurobiological and psychological mechanisms of expectancies" (Evers et al. 2018: 206).

Importantly, placebos in RCTs should be conceived of as *instrumental* devices or tools and should be understood as a moving category rather than as a specific kind of "thing" (e.g., sugar pills, or saline injections). As such, "their modality, as well as such features as how they look and taste (even their side effects) should mimic and therefore be wholly dependent on the features of the verum treatment under investigation" (Blease 2018a: 424). In short, in clinical trials placebos should ideally be indistinguishable from verum treatments to avoid patients and researchers from "breaking blind"—recognizing which arm of the study they have been allocated to—and thereby unintentionally influencing reported outcomes. So, while it is seductive to think of placebos as particular entities or as nondirective or attention controls in psychological interventions (e.g., talking about hobbies with a clinical researcher), the a priori decision to interpret placebos in RCTs as particular kinds of interventions is mistaken. Instead, as noted, placebos should be interpreted as methodological tools that must, as much as is feasible, mimic the particular verum treatment that is under scrutiny (Blease 2018a: 424).

Placebos as Clinical Interventions

Third, the term "placebo" has a subtly different meaning when it comes to basic research aimed at investigating the nature of placebo effects. Here the term *placebo* refers to an intervention (e.g., a sugar pill) which is used by scientists alongside other socioemotional verbal and nonverbal cues in the patient encounter; these include a confident, empathetic demeanor, and expressions of positive expectations which are intended to reduce patient symptoms by eliciting placebo effects (Blease 2018a). In these circumstances the aim of the placebo is to elicit the placebo effect: this should be contrasted with the use of place-

bos in clinical trials where the aim is to show that the verum is either better, or no better, than the placebo response. Finally, when placebos are transparently disclosed to patients and research participants, they are described as “open-label placebos” (OLPs) (Carvalho et al. 2016; Kaptchuk et al. 2010). The implications of these scientific concepts for psychotherapy research are reviewed below.

Placebo-Controlled RCTs in Psychotherapy Research

Double-blinding poses significant challenges for trial design in psychotherapy because, unlike pharmacological interventions (or even placebo (“sham”) surgery), psychotherapy treatments are dependent on interpersonal interactions. Indeed, research demonstrates that experimenter allegiance to a particular form of therapy can influence therapist behavior, which in turn can impact patient outcomes (Cuijpers et al. 2012; Gerger and Gaab 2016). Moreover, although the patient may be blinded (in the sense that she is unaware of whether she is getting the active or control condition), the patient’s *experience* in therapy is different (i.e., the patient is aware that they are doing cognitive restructuring in CBT, vs. not doing it in the control condition). In contrast, in a medical RCT, the experience for both doctor and patient is mostly identical between the active and placebo conditions (we say “mostly” here because patients in the active treatment are more likely to experience side effects).

A related issue is controlling for the so-called “common-factors” in psychotherapy research. The common factors include therapist characteristics (empathy, positive regard, positive expectations that treatment will succeed); patient characteristics (expectation about therapy, confidence in therapist); as well as factors associated with a strong working alliance including the plausibility of the rationale for therapy and its techniques (e.g., Wampold and Imel 2015). Common factors are distinct from the specific treatment techniques associated with different versions of therapy (see chapter by Flückiger and Wampold on ethical issues with regard to common versus specific factor theories of psychotherapy in this volume). Controlling for common factors presents a major obstacle for RCTs. Yet, problematically, there is wide variation in how the concept of placebo is understood (Gaab et al. 2018; Locher et al. 2018), and placebo controls are variously implemented as *waitlist controls*; *nondirective controls*; and *active controls*. Following our previously described definitions, waitlists are not placebos. Research shows that trials which compare psychotherapy to a waitlist control routinely overestimate the efficacy of specific techniques (Mohr et al. 2014); furthermore, patients on a waiting list can experience worsening of symptoms further contributing to comparative overestimates (Furukawa et al. 2014).

On the other hand, *nondirective* and *active controls* also fall short of meeting ideal standards for placebos. Nondirective controls can include: “relaxation training … leisure reading; and answering questions or talking about hobbies, newspapers, magazines, favorite foods, favorite sports teams, daily events, family activities, football, vacation activities, pets, hobbies, books, movies, and TV shows” (Kirsch et al. 2016: 123). None of these comprise credible “placebos” for the purposes of psychotherapy RCTs. For these and oth-

er reasons, Kirsch et al. (2016) conclude that designing a control condition is impossible for testing the efficacy of the specific elements of psychotherapy. Of further importance, studies show that so-called active controls, which match psychotherapy on factors such as the number and length of treatment sessions, format of intervention, or topics that patients can discuss, lead to a reduction in reported treatment efficacy of psychotherapy (Baskin et al. 2003). In summary, variation in how researchers conceive of and implement placebo controls frequently leads to discrepancies in assessment of the evidence for the efficacy of psychotherapy (Gaab et al. 2018).

Specificity of Treatments and Common Factors

Notwithstanding the quality of placebo controls in clinical trials, robust findings show that psychotherapy is highly effective for a wide range of psychological conditions: patients who undergo psychological treatments fare significantly better than individuals who do not (Cuijpers et al. 2006; Goldfried 2013). However, the main purpose of placebo-controlled RCTs is to determine whether specific treatments are effective, and as we have seen, this poses serious challenges for psychotherapy research. One methodology that attempts to circumvent this problem is the use of comparison trials of different psychotherapies (so-called “horse-race” studies). Before we review these studies, it is important to say more about what is meant by *specific treatment techniques* in psychotherapy.

Specific (sometimes referred to as “characteristic”) treatment techniques differ among the various versions of psychotherapy. For example, specific techniques in cognitive behavioral therapy (CBT) involve encouraging patients to identify what proponents of this version of therapy consider to be “cognitive distortions” or “maladaptive thoughts” which are believed to influence individuals’ behavior. The goal is to redress “faulty thinking” by a process of “cognitive restructuring” and as a result to encourage more psychologically healthy thoughts and behaviors (Beck 1976; Beck 1995). In contrast, psychodynamic psychotherapies involve a range of techniques that are aimed at better understanding the individual’s life experiences. Through the lens of distinctive psychological theories, each of which makes reference to particular phenomena (e.g., “complexes,” “repressions,” “defense mechanisms”), the aim of psychodynamic approaches is to guide the patient through a process of “self-exploration.” The purported excavation of the patient’s interior mental processes is theorized to lead to therapeutic insights about the individual’s particular psychological predicaments, predilections, and problems.

While the research is still contested (Marcus et al. 2014), considerable evidence arising from comparative clinical trials suggests that particular versions of therapy (and, it is therefore inferred, the specific factors associated with each type of therapy) are less important for patient outcomes than the common factors. This conclusion about the evidence was famously described by Luborsky et al. (1975) as the “Dodo Bird Verdict” (Luborsky et al. 1975: 1003), which they derived from the words of the Dodo Bird in Alice in Wonderland: “everybody has won and all must have prizes” (Luborsky et al. 1975: 995). It has been proposed that the Dodo Bird Verdict is explained by the common factors hypothesis: in other words, the common factors and not the specific factors have

the most influence on therapy outcome (Wampold and Imel 2015). Nonetheless, as has been pointed out by Blease et al. (2018: 71), “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.” In relation to this, we should underscore the marked lack of progress when it comes to scientific theories about the mechanisms of therapeutic change in psychotherapy (Kazdin 2008). Regardless, a consensus has developed among psychotherapy researchers, at least, that the common factors play a significant role in mediating change in treatment (Cuijpers 2016; Lambert and Barley 2002).

Ethical Debate about Disclosure of Evidence to Patients

Scholarly focus on the ethics of informed consent to psychotherapy is relatively recent (see Blease 2015a, 2015b; Fisher and Oranksy 2008; Trachsel et al. 2015). Here we do not dwell on the wider ethical considerations pertaining to informed consent; instead, our concern is the ethics of disclosure of psychotherapy evidence, where evidence is interpreted in the broadest sense to incorporate insights about EBP as well as EST.

The Nature and Timing of Information Disclosure

Prior to discussing questions about what kind of evidence ought to be disclosed to patients we should highlight the relevance of wider issues—some of which have not yet been substantially addressed in practice guidelines. These issues include the nature of the disclosure process, and when it should occur. Informed consent to therapy is often conceived as a process rather than a one-time disclosure of information to prospective patients (Barnett et al. 2007). Certainly, some aspects of therapy are best understood procedurally—that is, through the process of undergoing treatment. In addition, cultivation of a patient’s sense of autonomy may also be considered a goal of therapy. However, it has been argued by Blease et al. (2018: 70) that “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).” Since the 1960s medical ethicists have argued that strong arguments need to be mounted before health practitioners adopt a paternalistic attitude towards patients. The question then arises about what kinds of information on evidence and clinical effectiveness are morally important for patients.

Up-to-Date, Impartial Disclosure about Treatment Options

Lists of ESTs enumerate treatments that are purportedly effective for particular pathologies. As we have seen, this research is not without controversy since some treatments are more suitable for RCT research, and findings are often dependent on the quality of the placebo conditions employed in trials. Aside from issues of professional competence in the determination of which treatment might be best suited to a patient’s condition, ethi-

cal decisions must be made about what to communicate to prospective patients. At least in principle, open and honest disclosure of information about treatment options may conflict with the principle of beneficence. For example, according to this line of reasoning, presenting patients with too much information—or even too many options—may overburden individuals or confuse them, and a careful balance must be struck to preserve autonomy and maximize the potential for successful therapeutic outcome. Furthermore, one might suggest that when it comes to a range of suitable, evidence-based treatments, some patients might be more comfortable when decisions are made on their behalf; and in some cases, patients may prefer to waive their right to be burdened by such decisions and permit the psychotherapist to "be the expert."

In response, assumptions about such purported ethical dilemmas between beneficence and patient autonomy in the disclosure of information about treatment options have been strongly challenged (Blease 2015a; Blease et al. 2018). Here we stress that no empirical evidence has thus far been marshaled to support the claim that patients fare worse if treatment options are communicated to them. Gaab et al. (2016: 189) also point out evidence showing that when patients are offered a choice of therapy as opposed to having been provided with no choice, significantly fewer patients drop out of treatment (see also Swift et al. 2011). Furthermore, another important reason to dissuade patients from conferring paternalistic status to therapists is that patients who are more actively involved in decisions about therapy will likely be more inclined to take responsibility for what happens during therapy sessions. In short, we suggest that respect for patient autonomy when it comes to describing treatment options may lead to greater mutual trust between patients and therapists (Blease et al. 2018), which in turn may enhance treatment outcomes (Birkhäuer et al. 2017).

Equally, as we've seen, characterizations about the specificity of treatment modalities, and assertions that some treatments are superior for certain conditions and psychopathologies, are claims that are subject to ongoing debate (Beutler 2002; Wampold and Imel 2015; Wampold et al. 2017). Notwithstanding, when it comes to communication about ESTs a straightforward ethical case can be made—on the grounds of both beneficence and respect for patient autonomy—that patients presenting with certain symptoms should be advised about the treatment(s) appropriate for their condition. For example, Blease et al. (2016a: 3) have suggested that "patients suffering from obsessive compulsive disorder (OCD) have a right to know that exposure and response prevention is the best-supported intervention for their condition – and hence a front-line treatment." Even where the evidence is subject to disagreement among experts in psychotherapy research (such as in the treatment of depression) (Fonaghy et al. 2015; Hollon et al. 2002), therapists have a duty to keep up to date with these disputes and to communicate the truthful matter of fact that scientists debate which modality works best for the patient's condition (Blease et al. 2018).

In order to ensure that honest, transparent, and impartial communication of evidence is presented to patients about treatment options, some scholars have urged that clinical psychologists and psychotherapists must disclose their own expertise to prevent inten-

tional and unintentional bias in the quality of disclosures, and thereby to prevent possible professional conflicts of interest (Blease et al. 2018). In short, to maintain the integrity of evidence-based informed consent, practitioners must be upfront about their own training, specialties, and experience in treating different patient populations (Blease et al. 2018). Furthermore, because therapists are not typically trained in all versions of psychotherapy, a stronger case has been made that patients should be referred to therapists skilled in evidence-based treatments not offered by the practitioner (Blease et al. 2018).

Finally, criticisms about diagnostic classification systems also have a bearing on treatment disclosures. Even when assuming the classifications upon which ESTs are based are valid, questions arise about suitable treatment options for treatment of subthreshold psychopathologies, and for "problems in living." Again, for the reasons given, one might argue that even in such instances, patients should be made aware that a range of different treatment modalities exist.

Disclosure of Information about Specific and Common Factors

When it comes to psychotherapy research and patient disclosures, one might conclude that there is a neat distinction between evidence about *what* works versus evidence about *how* therapy works. In light of our review of the evidence, this distinction cannot be easily supported. A robust body of research shows that common factors appear to play an important role in mediating therapeutic change. Less clear is whether the common factors serve as vehicles for other unidentified factors which improve patient outcome, or whether the common factors directly lead to psychotherapeutic benefit. Therefore, the case has variously been made by psychotherapy researchers and ethicists that one should not just disclose the so-called specific factors in therapy, but also to "go open" and disclose information about common factors to prospective patients (e.g., Blease 2015a; Blease et al. 2016a; Gaab et al. 2016; Trachsel and Gaab 2016). Elsewhere, Blease, Kelley and Trachsel argue 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" (Blease et al. 2018: 76). Indeed, Blease has proposed that failure to communicate common factors may render patients vulnerable if therapy fails: "It may be, for example, that if there is a lack of progress, patients erroneously blame themselves … 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 2015a: 753). Moreover, a recent experimental study of informed consent to cognitive behavioral therapy concluded that disclosures could usefully be augmented to encompass information about common factors (Blease and Kelley 2018). Given that drop-out rates for psychotherapy are substantial—approximately 20 percent of patients (Swift and Greenberg 2012)—communication of information about common factors may carry considerable weight by informing patients about the value of seeking out alternative therapeutic approaches and/or therapists. Such information should inform patients that these factors may differ according to the therapist and the treatment provided. Formulations for how to communicate information about common factors have been suggested by Blease et al. (2018); however, further research is needed in how to refine and com-

municate these factors most effectively. Finally, Gaab and colleagues claim there is strong ethical justification for disclosure about common factors (Gaab et al. 2016; Trachsel and Gaab 2016).

Another ethical consideration is whether communicating false information to patients may add potency to treatments. Gaab and colleagues (2016: 189) formulate the line of reasoning as follows: “it might seem that we should present to the patient whatever kind of rationale for psychotherapy makes sense to them, rather than concern ourselves with the validity of that rationale.” Similarly, Blease describes the counterpoint as, “the idea that truthful disclosure would significantly undermine the magic of treatment” (Blease 2015a: 753).

Again, however, any purported clash between the two ethical principles of beneficence and autonomy does not withstand scrutiny. To begin with, there is no empirical evidence to indicate that invented rationales for therapy fare better than accurate ones, either in terms of enhancing trust, or in enhancing patient outcome. Moreover, while there is evidence that therapist allegiance can enhance therapeutic outcome (Cuijpers et al. 2012; Gerger and Gaab 2016), this does not provide justification for misinforming therapists as a means to such an end. There are two reasons for this. First, in some countries or regions where training demands are less rigorous, duping therapists or omitting education about other versions of psychotherapy on the grounds that their current allegiance to a particular modality improves patient outcomes, suggests a conservative, even parochial perspective of the profession, including training. Therapists who become better engaged with the evidence base would likely maintain a strong—or even stronger—allegiance to the effectiveness of psychotherapy. Second, such a laissez-faire stance risks jeopardizing long-term trust in the profession among both psychotherapists and patients (Blease 2015a; Gaab et al. 2016).

Disclosure of Harms

To date there has been little research on the potential harms of psychotherapy. Unlike pharmacology, no regulatory authority exists which requires investigators to analyze the risks and harms of talking therapies before they are recommended for clinical use (Duggan et al. 2014; Markowitz and Milrod 2015). A recent study found that around 5 percent of patients who undergo psychotherapy report negative long-term effects of treatment (Crawford et al. 2016). Earlier findings suggest that approximately 10 percent of patients experience worsening of symptoms following long-term treatment, but the reasons for this are unclear as the study did not include controls (Lilienfeld 2007). To enhance patient autonomy and to minimize the risk of harms arising in therapy, we suggest that further research and required reporting on the potential risks of psychotherapy is overdue (Blease et al. 2016a).

Patients as Sources of Evidence

A final consideration is that evidence may also be conceived as “bottom-up” (from patient to psychotherapist) as well as “top-down” (from psychotherapist/researcher to patient) (Blease et al. 2018). Research shows that practitioners tend to have “therapeutic blind spots” (Rousmaniere et al. 2014: 1091) when it comes to accurate assessments about therapeutic progress. Session-by-session feedback from patients provides real-time evidence for psychotherapists that has been shown to improve patient outcome (Whipple et al. 2003).

Conclusions

Ethical codes of conduct to one side, there may be a default tendency among psychotherapy practitioners to adopt their own personal approach towards evidence, which in turn influences individual standards of practice (e.g., Blease et al. 2020). From an ethical as well as best-practices perspective, this stance has been criticized as unacceptable (e.g., Blease et al. 2016a). Undoubtedly, research in psychotherapy is beset with serious conceptual and empirical challenges, yet substantial engagement with these issues is necessary to properly fulfill the ethical duties of professional competence and respect for patient autonomy (see Table 1 for recommendations). Indeed, there is evidence that fuller and more transparent disclosure processes strengthen the therapeutic alliance, leading to improved patient outcomes (Boswell et al. 2015). Further research is required on how psychotherapists might better communicate information about evidence to patients, including the ways in which such information may affect the therapeutic process.

Table 1. Recommendations for patient information about evidence and clinical effectiveness

Recommendation	Description	Phase of therapeutic encounter	Allocated time*
1. Ongoing development of professional knowledge	Psychotherapists should keep up to date with research on evidence-based practice in psychotherapy including findings from clinical trials and evidence of therapist expertise.	(Ongoing)	Not applicable: requires ongoing continued professional development.
2. Provision of information about the patient's diagnosis and prognosis	Patients should be informed about their diagnosis and prognosis as soon as possible. If condition or symptoms are subthreshold for a diagnosis, or amount to a "problem in living" this should also be disclosed. *(Where applicable: information about diagnosis and prognosis should be disclosed both orally and in written form.)*	By end of patient evaluation which should be made no later than second or third session.	10–15 minutes
3. Provision of information about the proposed treatment and other treatment options	Disclose information about the psychotherapist's specialist training, and patient populations who are known to benefit from the respective approach (e.g., patients suffering from anxiety disorders, etc.).	First session: provide information about (a)–(e).	For points (a)–(e), allocate 15–20 minutes.

	Where applicable provide information about where and how the patient might access forms of psychotherapy not practiced by the clinician. Provide brief but accessible information about different approaches suitable for the patient (e.g., insight-focused vs. more symptom-focused psychotherapy). Provide information about the timing and duration of treatments. Provide any information on the risks associated with different treatment options, including the decision to receive no treatment at all. Provide patients with an honest, transparent, and impartial summary of the evidence related to their treatment options. Disclose the range and nature of EST treatments for the patient's condition regardless of whether the psychotherapist practices every approach. Ensure that the patient understands this information, through active listening, and asking the patient to repeat crucial information in his or her own words.	After (2) is completed, provide information about (f)–(g). During first to third sessions. Revisit (h) depending on progress in relation to patient feedback: see (6).	For (f) and (g), depending on variety of treatment options, allocate 15–20 minutes. Further time should be taken to check patient understanding.

	(Information should be disclosed both orally and in written form.)		
4. Disclosure of common factors	Ensure information about the importance of common factors (e.g., the therapeutic relationship) is disclosed in an accessible way. *For a concrete example, see Appendix* 1.	During first session	5 minutes
5. Disclosure of advice about harms	Advise patients that a small percentage of individuals report long-term worsening of symptoms as a result of psychotherapy. While the risk is likely to be low, patients should also be advised that they may experience fluctuations in symptoms, including worsening of symptoms as therapy proceeds. However, patients should also be informed that if the treatment is going well, they should experience progress as the course of psychotherapy proceeds. Implementation of (6), below, is especially relevant to this disclosure. *For a concrete example, see Appendix* 2.	During first session	5 minutes

6. Ongoing patient feedback	Implement user-friendly continuous assessment to allow patients to provide feedback on the therapeutic alliance, and to track patient progress. These assessments should help to avoid potential harms as treatment progresses, and decrease patient dropouts from psychotherapy.	Initiate after second session.	Not applicable: patient provides feedback in his or her own time.

Adapted from Blease, C., Kelley, J. M. and Trachsel, M. (2018), "Informed Consent in Psychotherapy: Implications of Evidence-Based Practice," *Journal of Contemporary Psychotherapy* 48(2): 69–78, https://doi.org/10.1007/s10879-017-9372-9. Copyright © 2017, Springer Nature.

(*) These times are presented as a guide only: they are contingent on a number of factors, such as level of patient understanding, and number of patients partaking in therapy sessions. However, we urge that even among patients judged to be well educated, adequate time should be taken to follow through these points, and ensure the patient understands what is communicated.

Appendices

Appendix 1: Disclosure of Common Factors

Recommended statement that might be communicated orally and in written form:

> Because a good relationship between the patient and the therapist is known to be an important factor for a successful psychotherapy outcome, it is important that you feel comfortable talking to me during these sessions. You should also feel supported and understood, and feel like you can readily get on board with the work we will do together in these sessions. If for any reason you feel uncomfortable talking to me, or feel worried about the progress we are making, it is important that we address those issues. We will try to work through any problems, but it may be that a different version of psychotherapy or a different therapist may work better for you. While I do not expect this to happen, in some cases another kind of

psychotherapy or therapist might be more suitable for you. If that happens it is nobody's fault. My aim is for us to make progress together.

(Adapted from Blease et al. 2018)

Appendix 2: Disclosure of Harms

Recommended statement that might be communicated orally and in written form:

It's important to know that you'll experience lots of different emotions during and after our therapy sessions. This is a very normal part of treatment. However, a very small percentage of patients may not make progress or may feel worse and want to drop out of therapy. While this is unlikely to happen, it's very important that you let me know if you are feeling this way so that we can try to address the problem, or find alternative solutions. I will do my best to pick up on how you might be feeling, but I really encourage you communicate your thoughts on how we're progressing. If you feel uncomfortable expressing this to me face to face, you can also email me or use the independent feedback portal [if this is available]. That way, I can better assess how things are going.

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