How to obtain informed consent for psychotherapy: A reply to criticism

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Abstract:
In 'Psychotherapy, Placebos, and Informed Consent', I argued that the minimal standard for informed consent in psychotherapy requires that 'patients understand that there is currently no consensus about the mechanisms of change in psychotherapy, and that the therapy on offer…is based on disputed theoretical foundations', and that the dissemination of this information is compatible with the delivery of many theory-specific forms of psychotherapy (including cognitive behavioral therapy [CBT]). I also argued that the minimal requirements for informed consent do not include information about the role of therapeutic common factors in healing (e.g., expectancy effects and therapist effects); practitioners may discuss the common factors with patients, but they are not part of the 'core set' of information necessary to obtain informed consent.

In a recent reply, Charlotte Blease criticizes these two arguments by claiming they are not supported by empirical findings about the therapeutic common factors. Blease's response is based on serious misunderstandings of both CBT and what the common factor findings actually find. Nevertheless, addressing the reasons for these misunderstandings is instructive and gives us an opportunity to clarify what, exactly, needs to be explained to patients in order to obtain informed consent for psychotherapy.

CBT and the Common Factors:

In the original article, I argue that the common factor findings in psychotherapy are consistent with a theory-specific explanation (specifically, CBT) for the efficacy of therapy.[1] Blease, in her reply, disputes this and claims that my argument wrongly takes CBT 'at face value' and reflects a 'facile approach to evidence based practice'.[2] Blease's reply is based on misunderstandings of both CBT and the common factor findings. Let's start with the common factors.

The so-called 'common factors' are theory-nonspecific ingredients shared amongst different therapy modalities (e.g., the therapist-client alliance, therapist skill in creating and maintaining this alliance, and patient expectations). Blease correctly notes that comparison studies between different therapies 'suggest that the various specific techniques (across psychodynamic, humanistic, cognitive behavioural and other modalities) may be less important for patient outcomes than the common factors'.[2] Put positively, the common factors findings suggest that, at least sometimes, theory-nonspecific ingredients (e.g., therapist warmth) may be more important than theory-specific ingredients (e.g., the theory-specific techniques of CBT) in mediating change.

Blease mistakenly states that these findings show that all psychotherapeutic theories of healing are equally as plausible. According to Blease:

> Focusing on [the relationship between the common factor findings and CBT]…Leder insists: 'the point is that not all forms of psychotherapy are equally as plausible (they are not)'…, on the contrary this *is* the point.[2]

This is not an entailment of the common factor findings. The common factor findings give us information about what techniques and other therapeutic *ingredients* may be salubrious; they do not give us an explanation for *why* these ingredients may be salubrious. Blease correctly notes that the common factor findings 'do not permit inferences about the explanatory truth of specific techniques', but she fails to realize that this does *not* entail that there are no other means to compare the plausibility of different psychotherapeutic theories of healing.[2] There are *many* criteria other than the efficacy of theory-specific techniques from which to judge the plausibility of a theory of healing (e.g., internal consistency, empirical validity, explanatory strength, and so on).

Blease also misrepresents the theoretical basis of CBT. Blease claims that 'therapists [providing CBT and other theory-specific therapies] have, for too long, exhibited a facile approach to evidence-based practice'[2] and, as evidence for this claim, refers the reader to her 2015 paper in which she argues that the common factor findings show psychotherapy (and specifically CBT) to be 'pseudoscientific'.[3] According to Blease:

> 'Psychotherapy [is] continuing to ignore established research that CBT does not work according to its core theoretical tenets….Today psychologists researching psychotherapy contend that CBT and other versions of psychotherapy do not work according to their highly specific theoretical claims – instead, it appears that the shared 'common factors' explain the beneficial therapeutic effects of different 'talking cures'.[3]

This is a mistake. The common factor findings suggest that CBT (and other therapies) do not work only because of the specific *techniques* commonly deployed in cognitive behavioral therapy; these findings do not entail that CBT does not work 'according to its core theoretical tenets'. The common factor findings would only undermine CBT's 'highly specific theoretical claims' if these findings somehow contradicted these claims. This is not the case. Beck's cognitive theory (the primary theoretical basis of CBT), is explicitly technically eclectic.[4] Cognitive theory posits that the efficacy of CBT, and all other effective therapies, is due to the modification of a patient's cognitions and cognitive processes; the theory does *not* postulate that the *techniques* of CBT are necessary to engender change in therapy. For example, according to cognitive theory:

> Cognitive therapy is best defined in terms of the theoretical structure and *presumed mechanism of action* rather than the techniques derived from it…(italics added).[4]

> A common denominator of the various systems is the ascription of cognitive mechanisms to the process of therapeutic change…[I]mprovement in the clinical condition is associated with changes in cognitive structuring of experience *irrespective of the type of therapy* (italics added).[5]

According to the 'theoretical claims' of CBT, if *any* therapeutic ingredient is salubrious (be it a common factor or theory-specific technique), its efficacy is explained by its role in engendering cognitive change. This explanation may be wrong (I argue elsewhere that it likely *is* wrong),[6-7] but it is not wrong *because* CBT is incompatible with empirical findings about the therapeutic common factors. And this distinction is important. Patients require accurate information in order to provide informed consent, and Blease's argument that the common factor findings show CBT to be 'factually wrong' misrepresents both the common factor findings and the empirical standing of CBT.[8]

Therapy and Informed Consent

Blease and other 'go open' advocates claim that therapists have a moral duty to 'go open' to patients about the role played by the common factors in psychotherapy.[9-10] According to Blease, the common factors show that CBT and other theory-specific explanations to the 'How does it work?' question are 'phony stories' and 'therapeutic fictions'.[9-10] In the original paper, I argue that this 'go open' argument has the potential to harm patients by misinforming them about how therapy works. Blease, in her reply, disputes this by posing a question. Blease states:

> 'there is compelling agreement across diverse psychotherapy traditions that…[the common factors] play a significant role in treating clients…This invites the question about why it would be problematic – epistemically worse- to disclose information about these factors, in an understandable way, to prospective patients'.[2]

The answer to this question is made explicitly in the original paper that Blease is responding to. There, I state: 'this paper is not arguing that therapists ought to withhold this information from their patients. Practitioners should discuss the mediators of change in therapy with patients to whatever level of specificity that they choose…as long as they do so *accurately'* (italics added).[1] The problem, here, is accuracy; it is inaccurate to claim that the common factor findings show all theory-specific therapies to be 'phony' and equally as plausible, and it is inaccurate to claim that 'common factors explain the beneficial therapeutic effects of different [therapies]'.[3] These findings do not *explain* why therapy is salubrious; they identify *what* ingredients may be salubrious. The 'go open' argument is based on fundamental misunderstandings about the relationship between the common factors and the mechanisms of change in psychotherapy. These factors may be mediators of change (i.e., they are statistically correlated with treatment effects), but they are not necessarily mechanisms of change (i.e., mechanisms that causally *explain* therapy's efficacy). And, as I argue in the original paper, there are many mechanistic explanations on offer. CBT's cognitive theory is but one.

So, what should therapists tell patients about how therapy works? The minimal standards for informed consent require that patients are informed about how a proposed therapy is hypothesized to work. The problem, here, is that there is currently no consensus about mechanisms of change in psychotherapy. I argue in the original paper that therapists need to inform patients of this and that patients need to be informed that 'the therapy on offer (including cognitive therapy) is based on disputed theoretical foundations'.[1] Patients also need to be informed that theory-specific techniques are not necessary for healing (and are based on a disputed theory of healing). All of this is consistent with the delivery of theory-specific therapy. Theory-specific therapies should be presented to the patient as hypotheses about the mechanisms of change in therapy, and patients should be able to use this information to attempt to make informed treatment choices.

Psychotherapy and Placebos:

Finally, Blease raises a terminological issue about placebos and psychotherapy. Blease, and the other 'go open' advocates that I cited in the original paper, are all explicit in proclaiming that psychotherapy is, or is likely to be, a placebo. For example, here is Blease and colleagues in 2016:

> '[Psychotherapy] can best be described as either a superplacebo or a superverum'.[10]

Note that 'superplacebo' refers to a placebo treatment delivered by a practitioner who does not know that the treatment is a placebo, while a 'superverum' refers to a treatment that it 'substantially augmented or exceeded' by placebogenic factors.[10] Blease is not direct in her reply but implies that she no longer endorses her previous 'placebo' claim. Blease suggests that the 'go open' argument may be best served by avoiding 'placebo' language altogether, because it 'may invite more questions than it can easily resolve'.[2] I think that dropping the 'placebo' language is wise, however Blease gives no indication that this terminological shift reflects a change in the substance of her argument. Blease still argues that the common factor findings show that psychotherapy is 'failing patients' by improperly informing them about how therapy works.[2] And, as noted in the original paper, this argument is mistaken. It is important to be clear about why this matters. There is a great deal we don't know about therapy. We should be careful not to add to this by disseminating a mistaken understanding about how therapy works.

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