2010

Addressing Negative Effects of Psychotherapy During the Informed Consent Process : the Licensed Psychologists' Perspectives

Neshe Sarkozy
Philadelphia College of Osteopathic Medicine, nsarkozy@yahoo.com

PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE

DEPARTMENT OF PSYCHOLOGY

Dissertation Approval

This is to certify that the thesis presented to us by **Neshe Sarkozy** on the 30th day of July, 2009, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

Committee Members' Signatures:

Virginia Salzer, Ph.D.

Robert DiTomasso, Ph.D., ABPP

Samuel Knapp. Ph.D.

Robert DiTomasso, Ph.D., ABPP, Chair, Department of Psychology

Acknowledgements

The dissertation process is an intensive, creative, and collaborative undertaking that takes place over the course of an extended period of time. I am grateful to my committee members, Virginia Burks Salzer, Ph.D., Robert A Di Tomasso, Ph.D., ABPP, and Samuel Knapp, Ed.D., for their guidance, knowledge and expertise throughout the course of this research project. In particular, I would like to thank Dr. Knapp for his invaluable assistance and for sharing his research in ethics and informed consent with me.

I give special acknowledgement to my grandmother, Barbara Rosen, who has been instrumental in this achievement. You have been the one constant in my life, and for that I thank you and love you. Last, to my siblings, Teresa, Stephen, and Heidi for being supportive through this tremendous undertaking. Your encouragement throughout my entire academic career has been a source of comfort throughout this entire journey.

Abstract

This survey study investigated attitudes and practices of 161 licensed psychologists from a nationwide sample, relative to addressing negative effects of psychotherapy during the informed consent process. Results revealed discrepancies in attitudes toward risk of negative treatment effects in psychotherapy and in addressing risk during the process of informed consent. Information obtained from this study may contribute to research in the area of clinical implementation of the American Psychological Association's Code of Ethics. Implications for clinical practice are discussed. Limitations of the study and directions for future research are also addressed.

Table of Contents

List of Tables

Chapter One: Introduction

Statement of the Problem

Psychotherapy has the potential to produce a plethora of positive and negative effects. Lilienfeld (2007) listed several of these potentially negative effects of psychotherapy, including "symptom worsening, the appearance of new symptoms, heightened concern regarding existing symptoms, excessive dependency on therapists, reluctance to seek future treatment (Boisvert & Faust, 2003), and even physical harm," (Mercer, Sarner, & Rosa, 2003, p.56). Research suggests that a significant minority of clients experience negative effects, including iatrogenic and/or deterioration effects as a result of psychotherapy (Boisvert & Faust, 2002). Data suggest a failure rate that approaches one-third, and a rate of deterioration, with estimates ranging from 3 to 10 percent (Bergin, 1971; Strupp, Hadley, & Gomes-Schwartz, 1977; Mohr, 1995; Stricker, 1995; Lambert & Ogles, 2004; Lilienfeld, 2007). Estimates of client deterioration are higher in the substance abuse literature, averaging about 10 to 15 percent (Ilgen & Moos, 2005; Moos, 2005). Among group psychotherapy, Leiberman and Yalom (1973) reveal "a negative change figure of 16 percent that include 8 percent casualties," in which casualties were defined as "an enduring (8 months or more), significant negative outcome, which was caused by [an individual's] participation in the group" (as cited in Roback, 2000, p. 1). A survey study of negative outcome published in 1981 (Buckley, Karasu, & Charles) revealed that 21 percent of mental health professionals endorsed harmful outcomes as a result of engaging in their own personal psychotherapy. In a review of two meta-analyses, Mohr (1995) found 9 to 13 percent of studies produced negative effect sizes for psychotherapy outcome in the negative direction (Smith, Glass,

& Miller, 1980; Shapiro & Shapiro, 1982), suggesting negative effects as a result of therapy. Results from an international survey of 12 leading psychotherapy outcome researchers concluded that "approximately 10 percent of clients get worse as a result of therapy" (Boisvert & Faust, 2003, p. 512). Considering the number of individuals who engage in psychotherapy every year, this is not an insignificant statistic (Olfson, Marcus, Druss, & Pincus, 2002).

The idea that psychotherapy has the latent ability to produce negative effects has potential implications for informed consent. Due to the multidimensionality of potentially negative effects of psychotherapy, assessing psychologists' attitudes regarding risk toward iatrogenic and deterioration effects may be an important indicator of what is considered material to a client's decision during the informed consent process. Informing clients about the potential risks and benefits of psychotherapy is a fundamental component of obtaining informed consent, analogous to a physician's informing a patient about the risks and benefits of medication or treatment.

The current American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct (2002), (hereinafter, Ethics Code) include broad guidelines regarding the process of obtaining informed consent to therapy. Ethical standard 10.01b states that for some treatments it is also necessary to "inform clients/patients of the developing nature of the treatment, the potential risks involved, [and] alternative treatments that may be available" (APA, 2002, p. 1072). Although "particularly stringent consent procedures," Barden (2001) notes, "should apply to 'treatments' lacking rigorous, empirical evidence of safety and efficacy," all forms of psychotherapy "irrefutably fall within the scope of patient's rights to informed consent"

(p. 160). Psychologists are also ethically obligated to obtain informed consent to psychotherapy "as early as feasible" (APA, 2002, p. 1072). It is consistent with the fundamental concepts of informed consent to discuss with prospective clients that therapy may not work for them and that there is a risk, although somewhat small, of negative effects when engaging in psychotherapy (Boisvert & Faust, 2003; APA, 2002). Risks are thought to be material when a reasonable person in the client's position, "would likely attach significance to the risk or cluster of risks in question in deciding whether or not to forgo the proposed therapy (Canterbury v. Spence, 1972, p. 787)" (as cited in Noll, 1981, p. 915). To neglect potential risk of negative effects during the informed consent process imposes serious ethical and moral questions (Noll, 1981). There is no "normative data for what a reasonable person understands in various consent situations (e.g., high versus low risk with high versus low individual benefit)" (Tymchuk, 1997, p. 58). Although psychologists might occasionally discuss potential negative effects of psychotherapy (e.g., on an as-needed basis) during the informed consent process, they may not be aware of the extent to which this phenomenon exists. Common finding among psychotherapy outcome studies reveal negative responders tend to be embedded in the outcome variance or appear simply not to be reported (Mohr, 1995; Dishion, McCord, & Poulin, 1999). The field of psychotherapy has tended to avoid examining negative outcomes by not reporting them, which Mohr (1995) suggest is problematic and limits the overall potential for the psychological profession. As a result, the lack of accurate information from research, related to negative effects of psychotherapy, may contribute to psychologists' currently held attitudes and beliefs. Research findings suggest that there appears to be a similarity in the reported ethics and belief systems of psychotherapists and in their

subsequent practices (Somberg, Stone, & Claiborn, 1993; Pope, Tabachnick, & Keith-Spiegel, 1987). Therefore, it is important to understand licensed psychologists' current attitudes and practices regarding the informed consent process related to addressing risk of potential negative treatment effects of psychotherapy.

Purpose of the Study

This study examined the general attitudes and practices of licensed psychologists relative to informing clients, during the informed consent process, of potentially negative effects of psychotherapy. In order to better understand the current practices of addressing risk during informed consent, attention needs to be given to attitudes. Although psychologists believe in the general application of informed consent (Somberg, Stone & Clairborn, 1993), little information is available about specific informed consent issues and practices. For example, attitudes about the impact of consent procedures may impact a psychotherapist's decision. Attitudes related to addressing risk of negative treatment effects that are thought; to some degree to affect the therapeutic relationship negatively might change the implementation of informed consent practice (MacDevitt & Acker, 1990). Although there is no evidence, empirically, to support negative expectation (Handelsman, 1990) for informed consent practices, concerns may be present for practicing clinicians.

Information obtained from this survey study could be used to improve clinical guidelines and standards of disclosure for licensed practicing psychologists relating to the process of informed consent. Demographic variables (e.g., age, gender, ethnicity, degree, primary theoretical therapeutic orientation, practice setting, years working as a licensed psychologist, primary population treated, primary therapeutic modality, American Board

of Professional Psychology (ABPP) certification, and post-doctoral training on ethics and informed consent) were examined in relation to licensed psychologists' attitudes and practices related to addressing potentially negative effects of psychotherapy; in addition to this, the relationship between attitudes and practices was studied. The method included a survey questionnaire which was developed by the researcher (see Appendix B). The sample consisted of 161 currently licensed doctoral level psychologists from a nationwide population. Information gathered by this study contributes to the sparse literature related to psychologists' attitudes and practices toward addressing negative effects of psychotherapy during the informed consent process. This study aids psychological, as well as other mental health professionals, gain a more thorough understanding of how the psychological profession implements the APA's Code of Ethics into psychotherapy practice and the process of informed consent.

This study intended to answer several general research questions:

1) Do licensed psychologists address, as part of a conversation of risks, potentially negative effects of psychotherapy during the informed consent process?
2) What are licensed psychologists' general attitudes and practices toward addressing risk of negative effects of psychotherapy during the informed consent process?
3) What are licensed psychologists' general attitudes toward APA's ethical practices and implementation of informed consent procedures?
4) What is the relationship between number of years of formal training as a licensed psychologist and subsequent attitudes and practices toward addressing risk related to negative effects of psychotherapy during the process of informed consent?

5) What is the relationship between licensed psychologists' theoretical therapeutic orientations and attitudes and practices toward addressing negative effects of psychotherapy during informed consent?
6) What is the relationship between licensed psychologists' attitudes and practices toward therapeutic privilege related to addressing risk of negative effects of psychotherapy during the process of informed consent?
7) What are licensed psychologists' general attitudes and practices toward a discussion of alternative treatment and/or procedures during the informed consent process?

Relevance to Cognitive Behavior Therapy

The application of ethical practices to psychotherapy is complex and there is minimal research to illustrate how psychologists generally implement informed consent. Although many professional psychologists view the informed consent process as a means of implementing ethical responsibility to their clients (e.g., Handelsman & Galvin, 1988; Hare-Mustin, Maracek, Kaplan, & Liss-Levinson, 1979; Noll & Haugan, 1985), there is limited explicit recognition or even limited discussion in the literature outlining the need to address risks including potentially negative effects of psychotherapy. Ethical responsibility and the requirement of informed consent are derived from the principle of respect for individual autonomy (Faden & Beauchamp, 1986; Kitchener, 1984). According to this principle, an individual has the right to act as an informed free agent when making a decision (Kitchener, 1984). In order to do so, however, the individual needs information that is relevant to making his or her decision. Informed consent helps maintain an individual's autonomy by ensuring that the individual has received relevant

information, regardless of whether or not he or she intends to use the newly acquired knowledge (Handelsman & Galvin, 1988).

Some therapeutic orientations may lend themselves, in a greater degree, toward encouraging autonomy in their clients. Client autonomy, for example, is a fundamental aspect of Cognitive-Behavioral Therapy (CBT). In their study, Somberg et al. (1993) revealed "therapists of a Cognitive-Behavioral orientation indicated they inform clients more often and consider the issues more important" than therapists from other therapeutic orientations (p. 153). CBT includes a collaborative emphasis with active participation and a team-work approach, in which client and therapist decide together what to do in session and how often to meet (Beck, 1995). The "shared decision making" approach, according to Knapp and VandeCreek (2006), reflects those "mutually agreed upon goals and intervention strategies" as part of the therapist-client collaboration during informed consent (p. 99). With such a strong emphasis on the client's taking an active role in treatment, it seems that psychologists whose primary orientation is CBT would be more likely to encourage client participation and be more likely to inform clients of potential risks during the process of informed consent.

Overview of Literature Review

Presented next is an overview of informed consent, including the various historical, ethical, religious, and legal influences that have shaped its process. Following that, issues related to the application of informed consent, including the risks and benefits of negative treatment effects will be highlighted and discussed. Careful considerations relative to addressing negative treatment effects as a result of psychotherapy are explored. After that, the methodology used for the study and the results of the study are

presented and discussed. A discussion of the conclusions will be presented and explored. Finally, limitations of the survey study and directions for future research are addressed.

Chapter Two: Review of the Literature

Defining Important Terms

Psychotherapy. A classic definition of "psychotherapy" originally defined by Stoudemire (1998) and later articulated by Beahrs and Gutheil (2001), include the "use of interpersonal influence skills and psychological techniques by trained professionals toward the goal of relieving the signs and symptoms of psychiatric disorder" (p. 4). Psychotherapy is defined as a "procedure," similar to that of a medical procedure (Beahrs & Gutheil, 2001). Research concludes that psychotherapy be considered a well-proven, well-researched and effective tool, used to relieve both symptomatic psychic distress and other medical illnesses (Bloom, 1992; Sperry, Brill, Howard, & Grissom, 1996; Gabbard, Lazar, Hornberger, & Spiegel, 1997; Stevenson & Meares, 1992). Despite its widespread use, psychotherapeutic treatment is ambiguous and adds to the complexity of defining potentially negative effects in psychotherapy. The manner of delivery of a psychotherapeutic treatment can be both harmful and helpful and can be applied in a variety of ways, depending on the skill level of the psychologist and the context of the intervention. Scientific texts, the legal system, and third-party payers have impacted the practice of psychotherapy and created significant legal implementations, similar to those found within the medical profession (Beahrs & Gutheil, 2001). One of the most important of these constraints is the duty of mental health professionals to provide clients with informed consent.

Informed consent. An overarching definition of "informed consent" according to Berg, Applelbaum, Lidz, and Parker (2001) includes:

> Legal rules that prescribe behaviors for physicians and other health care professionals in their interactions with patients and provide penalties, under given circumstances, if physicians deviate from those expectations; to an ethical doctrine, rooted in our society's cherished value of autonomy, that promotes patients' right of self-determination regarding medical treatment; and to an interpersonal process whereby these parties interact with each other to select an appropriate course of medical care (p. 3).

Because of the complexity of the term, for the purpose of this proposal, "informed consent" may be thought of, according to Simon (1992) and explicitly described by Beahrs & Gutheil (2001) as "a process of sharing information with patients that is essential to their ability to make rational choices [for psychotherapy] among multiple options in their perceived best interest" (p. 4). As a prerequisite to engaging potential clients in psychotherapy, the Ethics Code (2002, Section 10) mandates a necessary informed consent discussion. The ideal format according to Jensen, McNamara, and Gustafson (1991) for informed consent for psychotherapy must include a discussion between therapist and client of goals, methods, concomitant benefits and risks of psychotherapy, as well as possible alternatives to the proposed treatment.

Negative treatment effects. There are issues in definition about how to label psychotherapy decline. Originally defined by Strupp and Hadley (1976), the term "negative treatment effects" applied to "patients getting worse as a function of the therapeutic influence" (e.g., iatrogenic effects) as opposed to the term "negative outcome" which pertained to a decline in functioning regardless of the original cause(s) (e.g., deterioration effects) (Mays & Franks, 1985, p. 20). Despite the researchers'

classic definition, the term "negative effect" appears to be used interchangeably with "negative treatment effects" within the research literature. For example, Mays and Franks (1985) suggested "negative effect" or "negative outcome" should be applied to patients who got worse, even when there appeared to be no evidence that individuals who became worse was a direct consequence of psychotherapy. In their research, Dies and Teleska (1985), use "negative outcome" to imply that a patient was becoming worse in his or her overall functioning or symptomology, as a result of treatment. Bergin (1963) used the term "deterioration effects" in his research to describe individuals who decline in psychotherapy, when there appeared to be greater variability in the experimental group than in the control group on criterion measures in psychotherapy. In his review of psychotherapy research, Bergin (1963) noted there were a consistently larger proportion of individuals in the experimental groups whose symptoms improved and got worse, than in the comparison groups. The judgment of causality, according to Lieberman et al. (1973), is based on the finding that an individual has "deteriorated in major adult role functioning" (as cited in Roback, 2000, p. 115). Because of the variability in terminology among researchers and clinicians, it is difficult, if not almost impossible, to operationally define negative effects of psychotherapy.

The lack of consensus in existing literature related to what constitutes negative effects of psychotherapy reflects the conceptual complexities in this area. One classic definition states that negative effects occur "when there is no meaningful positive change in a client due to some aspect of the treatment process" (Nolan, Strassel, Roback, & Binder, 2004, p. 311). The most extreme negative effect is related to "client deterioration in functioning that is attributed to the course of therapy" (Nolan et al., 2004, p. 311).

Lilienfeld (2007) utilizes the term "psychological harm" as including "not only deterioration but also a decelerated rate of improvement that is a consequence of psychotherapy" or something that is attributable to the direct effects of psychotherapy (p. 57). Mohr (1995) describes both terms "potential negative effects for treatment" and "potential deterioration" interchangeably in his research (p. 189). The five indicators for "potential deterioration," as a result of interaction between therapeutic techniques, psychotherapists, and clients include, "(a) the role of anticipation of emotional pain and therapeutically induced arousal, (b) client suspiciousness toward the therapist and therapist empathy, (c) level of interpersonal functioning and the focus of treatment, (d) diagnosis and treatment modality, and (e) relaxation therapy and clients' need for control" (Mohr, 1995, p. 187).

Negative treatment effect detection during the course of psychotherapy is similarly complex. Clinical experience is often valued among psychologists as a method to assess treatment progression, including ways to proceed with the course of psychotherapy (Stewart and Chambless, 2007). Research has demonstrated, through the use of empirical and actuarial models, correctly identifying risk for treatment failure are reliably superior to the use of clinical judgment (Kadden, Cooney, Getter, & Litt, 1989; Lutz, et al., 2006; Shulte, Kunzel, Pepping, & Shulte-Bahrenberg, 1992; Stewart and Chambless, 2007).

Because psychotherapy outcome is multidetermined, the question arises about which factors may potentially have the strongest influence on client outcome. Results from research conclude client characteristics "are the most powerful determinants of outcome" (Sachs, 1983; Gomes-Schwartz, 1977). However, it has also been noted by

Luborsky et al. (1980) that "patient characteristics only account for a small proportion of the variance" (as cited in Sachs, 1983, p. 558). According to client-centered theorists, therapist factors are also considered important to overall psychotherapy outcome (Sachs, 1983). Although specific techniques do not seem to have a "differential effect on outcome", personal characteristics of both the client and therapist appear to be the "strongest determinants of outcome" (Sachs, 1983, p. 558). In a research study on characteristics of the therapeutic process (among psychodynamic and experiential therapy), and its relationship to negative outcome, Sachs (1983) revealed that factors shown to be highly related to client outcome were associated with the quality (or lack of quality) of a therapeutic technique.

From the time Sigmund Freud introduced the term "countertransference" (in 1910), there have been insufficient cases in the research literature on "negative therapeutic reaction to describe patients who apparently fail to benefit from psychotherapy or get worse" (Mays & Franks, 1985, p. 21). Although the psychoanalytic literature considers lack of successful treatment regarding both clients (e.g., Freud, 1937/1964) and therapists being primarily related to "countertransference" (e.g., Gorkin, 1987), other examples of failure cases are rare (Rogers, 1954; Stricker, 1995). Strupp et al. (1977) conducted one of the most comprehensive reviews of negative effects of psychotherapy among experts in the field (researchers, clinicians, and theoreticians) from various theoretical orientations. Nearly every one of the 70 prominent psychotherapists who responded to the survey by Strupp et al. (1977) agreed that psychotherapeutic negative effects were problematic and concluded "a worsening of a patient's condition attributable to his having undergone psychotherapy" (p. 91) was what these negative

effects entailed. Strupp et al. (1977) discuss two kinds of negative effects as a result of psychotherapy, "those generally harmful to patient, and those harmful to the attainment of the goals of therapy which may or may not include harm to the patient" (as cited in Mays & Franks, 1985, p. 21). Strupp et al. (1977) reveal that negative effects are associated with a variety of problems related to inaccurate assessment, patient or therapist qualities within the therapeutic relationship, and among techniques or treatment approaches. It appears challenging in psychotherapy research to be able to separate iatrogenic effects from deterioration effects with significant confidence because there could be other factors within the psychotherapeutic process to account for the negative or adverse outcomes (Roback, 2000).

Psychotherapy Failure versus Treatment That May Cause Harm

Therapeutic failure (no clinical improvement). Research is limited regarding decision practice to discontinue psychotherapy when clients fail to make progress. The Ethics Code (2002) dictates that psychologists strive for beneficence and strive to do no harm; however, when psychologists continue to treat clients who appear to gain no benefit from psychotherapy, Stewart and Chambless (2008) note, "This practice in itself can be harmful" (p. 176). In order to achieve clinically significant improvement, Hansen, Lambert, and Forman (2002) suggest treatment duration lasting from 13 to 18 sessions. In a recent study, Stewart and Chambless (2008) surveyed psychologists in independent practice (N=591) regarding treatment failures. Psychologists reported that clients attended psychotherapy for a "median of 12 times before concluding no progress was being made" (p. 179). Specifically, 36 percent of psychologists reported treating clients who were not improving for longer than 19 sessions, and 10 percent reported treating

those clients for longer than 30 sessions before "concluding failure" (p. 180). Psychologists rated "colleague consultation and clinical experience" as primary methods for termination decision, rather than empirical research (p. 179). These researchers reported that psychologists' theoretical orientation impacted the definition of failure and subsequent treatment decision. Specifically, psychologists from a psychodynamic orientation tended to treat clients "significantly longer" than those from cognitive-behavioral and/or eclectic orientations (p. 176). Cognitive-behavioral and other eclectic clinicians tended to use "treatment materials informed by psychotherapy outcome research and refer patients to other clinicians" more often, than those from the psychoanalytic approach (p. 176). In light of evidence-based practice, the tendency to rely on clinical experience alone rather than on empirical research to inform practice is inconsistent with current trends in outcome literature. Therapeutic failure, according to Stewart and Chambless (2008), has both an immediate effect, leaving clients in an "unimproved or even deteriorating state" and the potential to change clients' perceptions of "psychotherapy and make them subsequently less likely to pursue psychotherapeutic treatment" for their difficulties (p. 180). There is a clear distinction between no clinical improvement and psychotherapy failure and a client's becoming worse, as a result of harmful or negative treatment effects.

Treatment that may cause harm. There are methodological issues that complicate defining psychological harm operationally. Research is limited, to date, that outlines how mental health professionals define client improvement or worsening as a result of engaging in psychotherapy. Clients' overall symptomology may improve over the course of treatment; however, use of an alternative (more effective) treatment may

have speeded up the process. It could be argued that psychotherapy, in this regard, could be thought of as harmful because it took the client longer for his or her symptoms to dissipate. It is difficult to know whether or not deterioration effects may have occurred without the intervention, or perhaps participation in treatment may have slowed down the deterioration process. The potential of psychotherapy to cause harm can occur as a result of the psychotherapeutic treatment or decisions made about the treatment (Lilienfeld, 2007). Negative effects that result from harmful treatment are thought to have a causal effect because the outcomes produced are worse than if there were no treatment. There are numerous instances of known psychotherapeutic treatments and techniques that have the potential to cause harm, including: critical incident stress debriefing, facilitated communication, recovered-memory techniques, boot camps for conduct disorder, attachment therapy, dissociative identity disorder-oriented psychotherapy, grief counseling for normal bereavement and expressive-experiential psychotherapies (Lilienfeld, 2007). Potentially problematic psychological treatments, Lilienfeld (2007) notes, that have a tendency to produce both positive and negative effects, should be used with particular caution. Although the prevalence of questionable psychotherapy practices is presently unknown, Lilienfeld (2007) indicates that research-oriented mental health professionals may underestimate how often and when they are utilized.

There is a current lack of consensus within the psychological field regarding harmful treatment detection and subsequent practices. For the purpose of this study, it is noteworthy to make a distinction in definition because failure to provide appropriate treatment that could have improved a client's symptomology is different from providing treatments that cause harm. Related to this are psychological treatments and techniques

that are considered unhelpful (e.g., a client in treatment for depression who commits suicide). The distinction lies between clients experiencing negative effects as a result of having a psychological disorder, and negative treatment effects as a result of engaging in potentially harmful treatment. Although psychological disorders can cause a myriad of harmful negative effects, this study's focus will be on harm that results from psychotherapeutic treatment application, not on harm embedded in the psychological disorder itself. Whittington et al. (2004) assert that psychotherapeutic treatment has the potential to impact a disorder negatively and adversely impact other domains. For example, the use of selective serotonin reuptake inhibitors (SSRI's), as antidepressant medications with adolescents, has been associated both with improvement in depressive symptoms and with a potential to increase risk for suicide (ideation and attempt) (Whittington et al., 2004). Data from empirically-based research suggest exposure therapy is thought to lead to increased levels of distress during implementation (an issue of concern for those who use this method of treatment with post-traumatic stress disorder) (Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002). Nishith, Resick, and Griffin (2002) report a small minority of clients (who engaged in exposure therapy treatment) displayed reliable increases in general anxiety, and others experienced an exacerbation of post-traumatic stress disorder symptoms. Similarly, Neimeyer (2002) suggested clinical concern regarding the use of grief therapy treatment and its potential to interfere with the normal process of recovery from loss, over time. Addler, Craske, and Barlow (1987) suggested that the phenomenon of harmful effects may occur if such effects may be moderated by client characteristics. Although relaxation techniques are

beneficial to the majority of clients, they can also induce panic attacks among a small minority of individuals who engage in this form of psychotherapy treatment.

There are potential problems in not having a consensus of definition both in research and in practice. An operational definition of potentially negative treatment effects (including treatment that does not work and may cause harm) from psychotherapy would aid in understanding the occurrence of these effects, including how they impact the client population. It would also be beneficial to define these problematic effects so that practicing psychologists can address and articulate them during the informed consent process. A lack of terminology consensus suggests that even experts struggle to discern trends in this area of psychotherapy research. It appears unrealistic to expect psychologist practitioners to draw consistent conclusions about negative effects of psychotherapy from literature that does not necessarily lend itself to consistent conclusions.

Informed Consent Underpinning

Informed consent is the process by which clients are informed of their rights regarding psychotherapeutic treatment, as well as the benefits and risks of treatment. The foundation and justification of informed consent derive from various lines of reasoning including philosophy, religion, and the law.

Philosophical support. The origin of informed consent, according to Levine (1995), is derived from the ancient Hippocratic directive "to help, or at least to do no harm" – in which the benefit for seeking information for the client "provides a mechanism for ascertaining what the patient would consider a benefit" (as cited in Emanuel, Crouch, Arras, Moreno, & Grady, 2003, p. 197). Allowing an individual to

decide what is beneficial “is consistent with the perspective affirmed in U.S. public policy that competent persons are generally the best protectors of their own well-being” (as cited in Emanuel et al., 2003, p. 197). However, ensuring adequate consent when potentially negative effects are of concern, appear more complex than acquiring consent when an individual might think that the effects would be beneficial. The requirements for informed consent derive from the principle “respect for persons”, which according to Levine (1995) include two basic “ethical convictions” outlined by the U.S. National Commission for the Protection of Human Subjects of Biomedical Research (hereinafter, NCPHSBR), which ensure individuals be treated as “autonomous agents” with particular emphasis for protection of those individuals “with diminished autonomy... are entitled to such protection” (as cited in Emanuel et al., 2003, p. 197).

Religious support. The Judaeo-Christian tradition is another origin for the requirement of seeking consent. Levine (1995) notes the requirement for consent “is grounded explicitly in the notion of covenant”, and that seeking adequate consent “is an affirmation of the basic faithfulness of care required by the fundamental covenantal nature of human existence” (as cited in Emanuel et al., 2003, p. 197). The notion that human life is a “gift from God and is of infinite and immeasurable worth (the 'sanctity of life')” reflects the religious understanding of how individuals should act toward each other “with respect and not interfere in each other's lives without consent” (as cited in Emanuel et al., 2003, p. 197).

Legal support. Informed consent in the legal context was clarified in by a 1914 New York Supreme Court decision. As part of a response to a medical malpractice suit, Justice Benjamin Cardozo asserted “every human being of adult years and sound mind

has a right to determine what shall be done with his own body" (*Schloendorff v. Society of NY Hospital*, 1914). It is from this principle of "bodily integrity" Levine (1995) notes that the modern idea of informed consent grew within the medical profession. An individual has the right to chose what is done to him or her, and no physician has the right to touch a patient without the person's explicit consent. Failure to obtain adequate informed consent, according to Levine (1995), could result in a charge of battery or negligence for which the plaintiff may claim damages and receive financial compensation (Emanuel et al., 2003). The main purpose of the informed consent requirement, according to Levine (1995), is not necessarily to lessen the occurrence of risk or harm resulting from treatment, but to give an individual the option to chose whether or not to participate (Emanuel et al., 2003).

Although the legal basis for an informed consent requirement arose as a result of medical practice litigation, Levine (1995) asserts that there is currently no case law related to "legal standards for consent to research, as distinguished from practice" (as cited in Emanuel et al., 2003, p. 197). If informed consent was not adequately obtained, Levine (1995) notes, it "was traditionally considered as a battery action [where] the law of battery makes it wrong, *a priori* to touch, treat, or do research upon a person without the persons consent" (as cited in Emanuel et al., 2003, p. 198). In recent years, however, malpractice litigation tends to view obtaining insufficient informed consent as "as negligence rather than battery actions" (as cited in Emanuel et al., 2003, p. 198). Similarly, in order to "bring a negligence action, a patient/subject must prove that the physician had a duty toward the patient; that the duty was breached; and that the damage was caused by the breach" (as cited in Emanuel et al., 2003, p. 198). According to the

law, if any information is withheld from the potential patients/clients that would have been pertinent to their decision to give informed consent, it is considered invalid under both the battery and negligence doctrines (Emanuel et al., 2003).

Informed Consent Historical Factors

The concept of informed consent has distant roots in medical ethical principles of beneficence, doing no harm, and helping patients (Faden & Beauchamp, 1986; Chadwick & Mann, 1978). Obtaining patient/client involvement in treatment decisions is somewhat contemporary and has become a more stringent requirement in recent years (Walker, Logan, Clark, & Leukefeld, 2005; Manning & Gaul, 1997). What once was considered good patient overall care, when physicians tended to act on their own authority without informing patients about important treatment decisions, has dramatically changed (Katz, 1999). The previous paternalistic viewpoint tended to focus on whether or not patients would be able to understand or comprehend the information presented to them, which subsequently led to inadequate information obtained about treatment (Katz, 1999). The first evidence of informed consent as a major issue in American medicine was in the late 1950's and early 1960's (Faden & Beauchamp, 1986). Although general medicine began incorporating informed consent, psychotherapy avoided the widespread use of informed consent until the *Osherof f v. Chestnut Lodge* legal case during the 1980's, which raised serious questions about the duty of providers to explain fully, the diagnoses and alternative treatments (i.e., risks and benefits) to clients (Beahrs & Gutheil, 2001; Klerman, 1990). Subsequently, client's rights started to become a priority in obtaining the most effective and efficacious psychological treatment (Klerman, 1990). Although

Osheroff v. Chestnut Lodge case never reached final court adjudication, it started a dialog between mental health and legal professionals (Klerman, 1990).

The last century witnessed multiple cases of unethical and uninformed treatment of human participants under the guise of research. The most notable of these infamous research cases included the Tuskegee Syphilis, Willowbrook, Tearoom Trade, Jewish Chronic Disease hospital, and the Milgram study. In order to understand the natural progression and treatment of syphilis, the United States Public Health Service initiated the Tuskegee Syphilis study in 1932, on 399 lower socioeconomic African-American males who had syphilis, and 201 controls who did not, from Macon County, Alabama (Centers for Disease Control and Prevention [CDC], 2008; Rothman, 1982). No informed consent of any kind was utilized; rather, subjects were coerced into participation through a variety of unethical means. Although penicillin was an accepted and effective form of treatment in 1943, its knowledge and usage was deliberately withheld from study subjects; neither were participants allowed to obtain any other treatment for syphilis (CDC, 2008; Rothman, 1982). Throughout the forty years of the study, 100 subjects died as a direct result of untreated, late stage neurosyphilis (CDC, 2008; Rothman, 1982). Although the study was published in several medical journals, it was never formally, ethically questioned until 1972, when the press reported on it; the result was public outrage. Similarly, the Willowbrook State Hospital study conducted in Staten Island, New York, (from 1963 to 1966), involved a group of children diagnosed with mental retardation who were deliberately infected with the hepatitis virus (Rothman, 1982). Of primary concern was the coercive manner in which the parents were convinced to enroll their children with mental retardation in the study; it was done in

exchange for hospital admission and deliberate infection (Rothman, 1982). In the Tearoom Trade study (1960), a researcher who wanted to study the motivations of men who had public sex in restrooms, posed as a friend by acting as a "lookout" (Warwick, 1973). The researcher then identified the participants by tracking them down by their car license plates and posing as a "health-care worker" in order to visit these men at home (Warwick, 1973). In the Jewish Chronic Disease Hospital study in New York, (1963), chronically ill, cancer-free patients were injected with live human cancer cells (Galietta & Stanley, 2007). Physicians did not inform their patients (in an effort not to scare them) because of the physicians' beliefs that the cancer cells would be rejected (Galietta & Stanley, 2007). Last, in the classic yet controversial behavioral study on obedience, Milgram deceived subjects by misinforming them about the true purpose of the experiment, by making them believe they were administering real electric shocks to real subjects (Milgram, 1974). The study raised serious ethical questions about the use of human subjects in psychology experiments. The lack of informed consent among these studies and other infamous research cases emphasized the need to protect the rights and welfare of human participants in research.

Informed consent in treatment originally developed from the notion of the need for increased protection applied to research with human participants. In fact, the Nuremberg Code, Declaration of Helsinki, and the Belmont Report issued by the NCPHSBR, have declared definitive standards for obtaining informed consent for human participant research, prior to beginning medical experiments or for treatments that might result in harmful or negative treatment effects.

The 1947 Nuremberg Code (Permissibly Medical Experiments, n.d.) arose out of a response to the post-Second World War trials of Nazi doctors who committed heinous crimes against humanity on concentration camp prisoners in the name of biomedical trials and experiments for research. The first sentence of the Nuremberg Code asserts "voluntary consent of the human subject is absolutely essential", which highlights the importance of the consent requirement in research involving human participants (National Institutes of Health [NIH], 2008). In the case of *United States v. Karl Brandt* et al., the Nuremberg Military Tribunal's decision includes what is now called the Nuremberg Code (1947) (Permissible Medical Experiments, n.d). A ten point statement outlining permissible medical research on human subjects is justified only if results are a benefit to society at large, and if it is carried out in accordance with basic principles that maintain allegiance to moral, ethical and legal standards (NIH, 2008, n.p.). Some of those principles include ensuring the rights of human participants in research. The most notable of these directives for human experimentation, according to the Office of Scientific Research, National Institutes of Mental Health (NIMH, 2008) include:

> (a) informed, voluntary consent, (b) research must be purposeful and necessary for the benefit of society, (c) research must be based on animal studies or other rational justification, (d) avoidance and protection from injury, and unnecessary physical and mental suffering, (e) risks to the subject shall not be greater than the humanitarian importance of the problem, (f) investigators must be scientifically qualified, and (g) subject may terminate the experiment at any time (n.p.).

The Nuremberg Code's (1947) requirement for individual consent to participate in research, include four factors outlined by Levine (1995); these are: the ability to exercise

free choice, possess the legal capacity, have sufficient comprehension to make a decision, and have sufficient knowledge to decide (Emanuel et al., 2003). If any of these four conditions are compromised, ethical acceptability of consent itself is imperiled. Levine (1995) argues that the Nuremberg Code's (1947) usage of the term "voluntary consent" rather than "informed consent," indicate primary focus on the notion of "freedom of choice" - rather than on "quality or quantity of information transmitted" (as cited in Emanuel et al., 2003, p. 199). The "free power of choice" objective includes "any element of force, fraud, deceit, duress, overreaching, or other ulterior forms of constrain or coercion" must not be present in obtaining consent (Emanuel et al., 2003, p. 199).

The knowledge or information component of the consent process is what makes it informed. There is much debate over the kind of information potential that research participants need in order for them to make an informed decision. Katz reveals that potential participants "still may fail to understand when a proposed intervention poses uncertain and perhaps significant risks or offers no prospect of therapeutic benefit to them as individual patients" (as cited in Siminoff, 2003, p. 1). Research literature reveals the fact that most research participants have significant gaps in the ability to recall and understand information presented during informed consent; information tends to be relayed in a manner that is difficult to understand, and information from consent forms are frequently hard to read and absorb (Kent, 1996; Tuckett & Williams, 1984; Meade & Howser, 1992; Wu & Perlman, 1988). Siminoff (2003) indicates that patients, "are limited in their ability to assimilate very large amounts of new information quickly", in order to make an informed decision (p. 2). In a large NIMH (1997) study conducted in various locations (large hospitals and outpatient offices) on informed consent, researchers

examined the needs of vulnerable populations (individuals with cognitive impairment and the critically ill), including the quality of consent (forms), the process of obtaining consent, decisions made and recalled, anxiety, proxy decision-makers and other psychosocial outcomes (Siminoff, 2003). Several findings revealed that the importance of the clinical setting and the context of the illness are important factors for informed consent (Siminoff, 2003). Interestingly, individuals whose surrogates made decisions for them, made choices significantly different from the participants themselves; this resulted in a greater "thresholds for risk" when decisions were made by another person (Siminoff, 2003, p. 2). This study underscores the importance of the need to have informed consent research, based on theories of communication and decision-making (Siminoff, 2003).

The Nuremberg Code's (1947) requirement to consent, as outlined by Levine (1995) include both a "legal capacity to consent" (often referred to as "competence") and "sufficient understanding" in order to reach an "enlightened decision" (as cited in Emanuel et al., 2003, p. 199). Levine (1995) argues that within the definitions of competence are elements of comprehension related to an individual's ability to "evaluate relevant information, understand the consequences of action, and to reach a decision for rational reasons" (as cited in Emanuel et al., 2003, p. 199). An assessment for incompetence, according to Levine (1995) includes four basic themes:

> (1) Reasonable outcome of choice. This is highly paternalistic standard because the individual's right to self-determination is respected only if he or she makes the "right" choice – that is, one that accords with what the competency reviewer either considers reasonable or presumes a reasonable person might make; (2) Factual comprehension. The individual is required to understand, or at least be

> able to understand, the information divulged during the consent negotiation; (3) Choice based on rational reasons. Individuals must demonstrate a capacity for rational manipulation of information. They may, for example, be required to show that they not only understand the risks and benefits but also have weighted them in relation to their personal situations; (4) Appreciation for the nature of the situation. Individuals must demonstrate not only comprehension of the informed consent information but also the ability to use the information in a rational manner. Furthermore, they must appreciate the fact that they are being invited to become research subjects and what that implies (as cited in Emanuel et al., 2003, p. 200).

The U.S. Presidential Commission for the Study of Ethical Problems in Medicine and Biomedical Research (2008) (hereinafter, U.S. President's Commission) outlines the requirements for individual capacity to make a decision, "(1) possession of a set of values and goals; (2) the ability to communicate and understand information; and (3) the ability to reason and deliberate about one's choices" (n.p.). Although the U.S. President Commission (2008) endorsed an individual's capacity for assessment, it recommends a balance between well-being and self-determination related to potential consequences of a patient's decision. Specifically, when the consequences for well-being are substantial, there is a greater need to be certain that the patient possesses the necessary level of capacity.

Research on informed consent is inconsistently related to what constitutes appropriate assessment for competence. According to Plaut (1989), the issue of competence related to an individual's ability to give truly informed consent, creates many

ethical dilemmas. Although there are no obvious difficulties at either end of the spectrum, because "the fully conscious, rational patient under no duress can of course give informed consent; the unconscious or totally confused and disoriented patient cannot," Plaut (1989) argues that there exists "a large gray area in between" (p. 436). Interestingly, there appear to be no specific legal cases or precedents to guide research. Although the traditional standards for guardianship and ability to stand trial exist, they do not seem applicable or appropriate to informed consent (Plaut, 1989). Although a determination of incompetence appears relevant for informed consent, it tends to impact very few areas of the ability to make decisions. For example, Levine (1995) argues that an individual who is legally competent may not be functionally incompetent, just as someone who is legally incompetent can be thought functionally competent (Emanuel et al., 2003). Even though lacking legal capacity or comprehension is prohibited for participant research by the Nuremberg Code (1947), this is not the case in all Codes. Most Codes and guidelines discuss obtaining permission for consent from the legal guardians of those individuals lacking the adequate capacity to give consent.

Adequate disclosure to the patient, according to the Nuremberg Code (1947), require as Levine (1995) asserts, the potential participant be told "the nature, duration, purpose of the experiment; the methods and means by which is conducted, all conveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come" (as cited in Emanuel et al., 2003, p. 200). The U.S. Code of Federal Regulations (hereinafter, CFR) have expanded on these codes and regulations to include:

> (1) a statement of the purpose of research and a description of its procedures; (2) a description of foreseeable risks and discomforts; (3) a description of benefits; (4) disclosure of appropriate alternatives, if any; (5) a statement of the extent of confidentiality; (6) an explanation of the availability of medical treatment for injury and compensation for disability; (7) an explanation of whom to contact for answers to questions; and (8) a statement that participation is voluntary and that neither refusal to participate nor withdraw at any time will result in a loss of benefits to which the subjects is otherwise entitled (CFR, 2008, n.p.).

There appears to be no universal agreement on standards for disclosure of information and/or what it takes for a person to have sufficient knowledge to give informed consent (Emanuel et al., 2003). Levine (1995) argues that those who "agree on the need for disclosure of information in a particular category – the risks for example, often disagree on the nature of the information that must be made known" (as cited in Emanuel et al., 2003, p. 201). Levine (1995) suggests, for example, that it is unclear, in the Nuremberg Code (1947) where it describes "explication of hazards 'reasonably to be expected,'" whether this means there could be a "very slight chance of substantial harm, or a substantial chance of a very slight harm" (as cited in Emanuel et al., 2003, p. 201). Similarly, within the legal context, neither the "quality nor the probability of risks to be divulged has been clearly determined" (Emanuel et al., 2003, p. 201).

The Nuremberg Code (1947) failed to produce a broader "legal doctrine protecting individuals against harm induced by scientific practices at large, including not only human beings as subjects of medical experiments but also as consumers and beneficiaries of science's outcomes" (Thieren & Mauron, 2007, p. 1). The Nuremberg

Code (1947) is often thought of as the predecessor of later codes which intend to assure an ethical manner for human participant research. Because the Nuremberg Code (1947) does not address research in patients with illnesses, the Declaration of Helsinki (1964) has been thought to be more preferable ethical guide for patient/client experimentation in research.

The Declaration of Helsinki's (1964) original document, much like the Nuremberg Code (1947) was written in response to the unethical medical experiments of the Nazi physicians during the Second World War. While the publication has been revised several times by the World Medical Association (WMA), the latest version asserts that "the well-being of the human subject should take precedence over the interest of science and society" (WMA, 2000). Physicians are expected to both act in their patients' best interest and to view an individual's heath and overall well-being as priority. The main principles of this document are incorporated in a great number of national research regulations and guidelines. The most recently revised declaration asserts the following regarding informed consent:

> In the treatment of a patient, where proven prophylactic, diagnostic and therapeutic methods do not exist or have been ineffective, the physician, with informed consent from the patient, must be free to use unproven or new prophylactic, diagnostic and therapeutic measures, if in the physician's judgment it offers hope of saving life, re-establishing health or alleviating suffering. Where possible, these measures should be made the object of research, designed to evaluate their safety and efficacy. In all cases, new information should be recorded and, where appropriate, published (WMA, 2000, n.p.).

In 1947 the National Research Act was passed by the United States Congress. Although both international codes, the Nuremberg Code (1947) and the Declaration of Helsinki (1964) were generally used as guides for researchers conducting experimentation with participants, the United States government continued to sponsor unethical human experimentation (Zimmerman, 1997). The NCPHSBR, created by the National Research Act (1947), included professionals from ethics, science, and the law, who made recommendations to the Department of Health and Human Services (hereinafter, DHHS). One of the Commission's statements was *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*, or commonly referred to as the Belmont Report (1979). Although the Belmont Report (1979) never officially endorsed many of the recommendations, it became the basis for subsequent DHHS laws. The United States Congress enacted both, titled Protection of Human Subjects (FDA regulation 21 CFR Part 50 and PHS regulation 45 CFR Part 46; FDA regulation 21 CFR Part 56 [Institutional Review Boards]); however, there are still, surprisingly, no national policies to outline protection of human research participants (Zimmerman, 1997). Zimmerman (1997) notes that the DDHS mandates appear too "restrictive and inflexible to be used as a dynamic foundation for evolving biomedical ethics" (n.p.). Despite the lack of endorsement by United States Congress and DHHS, the Belmont Report (1979) remains widely recognized as an international guideline for protecting individuals in clinical trials research.

As a result of the Belmont Report (1979) principle, "respect for persons", potential participants were no longer considered "passive objects for scientific investigations or trials but were to be seen as having an inviolable autonomy" (Walker et

al., 2005, p. 244). Potential research participants were given the opportunity to decide to participate through adequate information, assessment of comprehension, and most important, as true and actual volunteers. It was necessary that adequate information relative to informed potential participants' understanding be given, that "research is neither necessary for their well being nor are the effects of the research fully known or understood," and that "if a direct benefit to subjects is expected, they should clearly understand the range of risks" (Zimmerman, 1997, n.p.).

The ethical principles outlined in the Belmont Report (1979) were designed to aid in establishing guidelines for the development of biomedical and behavioral research with human participants. Respect for persons, beneficence, and justice are the three fundamental ethical principles that underlie human participation and informed consent (Walker et al., 2005; NCPHSBBR, 1979). Embedded within these principles are corollary applications to psychotherapy treatment practices and informed consent. For example, respect for persons implies that individuals be "treated as autonomous agents" (Walker et al., 2005, p. 244) and assumes two ethical presumptions. The first assumption is that people must be treated as autonomous individuals, capable of making their own decisions by possessing the capacity for self-determination. The other presumption assumes that not every individual is capable of self-determination; rather, "some individuals may lose the capacity for self- determination because of physical illness, mental disabilities, or situations that restrict personal freedom" (Zimmerman, 1997, n.p.). Beneficence relates to the idea or practice of "doing good" in order to improve an individual's overall well-being, and justice dictates that during the treatment process, every individual must be treated in a manner that is fair and equal (Zimmerman, 1997,

n.p.). Respect for persons, beneficence, and justice outlined by the APA's Code of Ethics are embedded in the foundation of informed consent.

Informed Consent Functions

Katz and Capron present an overview of the functions of informed consent; these are, "to promote individual autonomy; encourage rational decision making; avoid fraud and duress; involve the public; encourage self-scrutiny by the physician-investigator; and reduce the civil and or criminal liability of the investigator and his or her institution" (as cited in Emanuel et al., 2003, p. 198). Information transmission is at the core of obtaining informed consent (Siminoff, 2003). Informed consent is a moral, ethical, and legal obligation in medical, psychiatric, and psychological treatment and research (Berg et al., 2001; Faden & Beauchamp, 1986). Human participant research is regulated by both federal law (CFR, Title 45, Part 46, 1994) and university or agency Institutional Review Boards (IRB). These IRB's monitor, design and ensure that informed consent is consistent with the federal regulations, guidelines and ethics.

There is a clear distinction articulated by researchers between "genuine informed consent" related to the communication process, and the "bureaucratic trappings" of a consent form and signature (Emanuel et al., 2003, p. 189). According to Levine (1995), "genuine informed consent is supposed to serve the rights and welfare of potential participants in research", whereas the use of consent forms "largely serves the legal and financial interests of researchers and their institutions" (as cited in Emanuel et al., 2003, p. 189). Although the "negotiations for informed consent are designed to safeguard the rights and welfare of the subject," Levine (1995) asserts, "documentation that the negotiations have been conducted properly safeguards the investigator and institution" (as

cited in Emanuel et al., 2003, p. 198). Although the actual consent signature obtained on a form for research is advantageous for the investigator, Levine (1995) argues it could result in privacy and confidentiality violations, resulting in the "net effect" construed as "harmful to the interests of the subject" (Emanuel et al., 2003, p. 198). Levine (1995) asserts that, "federal regulations permit wavers of the requirements for consent forms when the principal threat to the subject would be a breach of confidentiality and the only record linking the subject and the research would be the consent document" (as cited in Emanuel et al., 2003, p. 198). This exception, however, does not pertain to the informed consent process. Federal regulations appear to focus primarily on the consent form itself, rather than the process as a whole (Emanuel et al., 2003). Information about what is included and what is excluded on consent forms (both in research and practice) remains an area of debate. Levine (1995) views informed consent as "a discussion or negotiation"; Katz, on the other hand, "envisions consent as a searching conversation" (as cited in Emanuel et al., 2003, p. 198). Researchers generally agree, however, that informed consent should be viewed as a continual process rather than as a one-time event (such as obtaining a signature on a consent form).

Although research consent is primarily geared toward "the fulfillment of a scientific aim," Roberts, Geppert, and Baily (2002) indicate, "clinical consent is oriented toward the patient benefit" (p. 292). There is a debate whether or not informed consent to research should be conducted by a different standard or set of criteria, than informed consent in psychology practice (Emanuel et al., 2003). Some authors argue it is unnecessary to negotiate the informed consent process formally when the "interests of research and practice are conjoined"; however, others argue that there should be "higher

requirements for informed consent... imposed in therapy...particularly when an honest experimentation is joined with therapy" (Emanuel et al., 2003, p. 198). These researchers point out that "patients are entitled to the same degree of thoroughness of negotiations for informed consent as are subjects of research" (Emanuel et al., 2003, p. 198). Although the bioethics literature and CFR appear to impose more demanding research requirements, Levine (1995) argues "both patients and research participants should be afforded the same rigorous protection in this regard" (as cited in Emanuel et al., 2003, 189).

There is, however, with the exception of clinical trials research, no immediate oversight or monitoring of the informed consent process for psychotherapy practice (Smith, 2001). As a consequence, there are no clear stated standards or clinical guidelines on informed consent implementation into the everyday clinical practice. Although it is generally understood that potential clients should be informed, prior to engaging in psychotherapy, about the "relative efficacy, efficiency, and safety of the recommended treatment and its primary alternatives as well as the likely consequences of no treatment" (Beahrs & Gutheil, 2001, p. 8), the specifics related to informed consent content and practice appear to be decided on an as-needed basis, depending on the needs of the client. What constitutes sufficient and appropriate fully informed consent in clinical practice remains unclear.

The Ethics Codes

In searching for standardized criteria or for guidance about implementation of informed consent, a review of the major mental health profession's ethics codes and

guidelines suggests that there are few common elements among the ethics codes related to understanding and implementation of informed consent.

The medical model. In the precedent setting case, *Canterbury v. Spence* (1972), the United States Court of Appeals asserted the following regarding the standards of informed consent:

> (a) that consent is the informed exercise of a choice; (b) that every adult human being of sound mind has a right to determine what shall be done with his/her body; (c) that the doctor must disclose all "material risks" based on the "prudent patient" test; and (d) that the doctor can withhold information from the patient concerning the risk only if it can be shown that the disclosure would result in serious adverse psychological consequences to the patient (n.p.).

Judicial decisions have primarily determined standards of disclosure from informed-consent proceedings (Jensen et al., 1991). Knapp and VandeCreek (2006) note "malpractice courts have used the 'reasonable person' standard to determine what information should be given to patients" prior to agreeing to undergo a medical procedure (p. 100). As a guide for physicians, the American Medical Association's (AMA) Code of Medical Ethics (2006 - 2007) (hereinafter, AMA Ethics Code) has undergone many revisions since its inception in 1847, and continues to set the standard for practicing medicine for physicians and health care providers. The AMA Ethics Code asserts that part of overall good medical practice includes the physician's obligation to his or her patient to make sure all medical facts are accurately presented in order to be able to make a treatment decision. With the recent changes in general social policy, the previously held paternalistic view, whereby physicians tended not to present patients with alternative

treatment options, in order to ensure patients remaining in treatment, are no longer valid. There are few, if any, specific guidelines, however, advising physicians about what to include during informed consent (AMA Ethics Code).

The psychiatric model. Since the first edition of American Psychiatric Association's (APA) *Principles of Medical Ethics* (1973), the APA's Board of Trustees and Assembly have determined numerous editions to these principles; the most recent include changes in 2001 to the principles. The basic medical-ethical principles of physician-patient contact are the same; however, the psychiatric profession added some specific ethical issues. *The APA Principles of Medical Ethics* (2008) assert "a physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law" (APA, 2008). In regard to providing informed consent, the APA (2008) notes:

> Psychiatrists have a long and valued tradition of being essential participants in organizations that deliver health care. Such organizations can enhance medical effectiveness and protect the standards and values of the psychiatric profession by fostering competent, compassionate medical care in a setting in which informed consent and confidentiality are rigorously preserved, conditions essential for the successful treatment of mental illness.

Although informed consent in psychiatric practice includes the aforementioned contractual arrangement between the patient and the physician which is to be "rigorously preserved", there is no specific reference regarding informed consent to undergo psychotherapy or pharmacological treatment as part of establishing the treatment contract (APA, 2008). The APA (2008) briefly mentions ethics regarding presentation of a case

to a scientific meeting, during which the physician must ensure "dignity and privacy - with truly informed consent," which includes maintaining patient confidentiality during presentation (n.p.).

The psychological model. The psychological profession, as a whole, views informed consent as one of the primary ways of protecting both the self-governing and the privacy rights of clients. Informed consent is also seen as helping to maintain a "culture of safety" (Knapp & VandeCreek, 2006, p. 100). The current Ethics Code (2002) includes broader informed consent requirements, than previous editions, both in structure and in content (i.e., 1992 edition limited informed consent to research and therapy). The 1992 Ethics Code marked the first distinction in separating aspirational from mandatory ethics. The current Ethics Code (2002) reflects the recent societal changes of moving from a rather paternalistic manner to a more autonomy-based view in which both professional and scientific ethics are concerned (Fisher, 2003). Fisher (2003) notes "for the first time clear distinctions were made between aspirational principles that articulated foundational values of the discipline and specific decision rules articulated in 180 distinct ethical standards that would be subject to enforcement by the APA, other organizations, and licensing boards that adopted them (Canter, Bennet, Jones, & Nagy, 1994)" (p. 6). The Ethics Code (2002) provides specific guidelines for informed consent in order to undergo assessments, treatments and research, including provisions for assent among persons who have limited ability to provide assent. The Ethics Code (2002) dictates enforceable rules or ethical standards for conduct among psychologists. The following are outlined by the Ethics Code (2002) regarding minimum standards of informed consent to therapy:

> (a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers.
>
> (b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation (Ethical standard 10.01, p. 1072).

In practice, psychologists are obligated to ensure that potential clients have been given sufficient information in order for them to make an informed decision prior to engaging in psychotherapy. An informed consent discussion not only protects the rights of client autonomy and self-direction, but it is thought also to enhance subsequent participation and responsibility of engaging in psychotherapy (Coyne & Widiger, 1978). The Ethics Code (2002) indicates that in order to increase client autonomy, psychologists "obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons" (Standard 3.10, Informed Consent, p. 1065). In order to ensure adequate comprehension, careful consideration regarding an individual's capacity to understand, includes language at a level the individual can understand and absorb. If the consenter does not comprehend or understand information presented to him or her, the informed consent becomes invalid (Zimmerman, 1997). An implementation of informed consent procedures has been mandated as an ethical

responsibility for psychologists; however, guidelines concerning the content are vague and open to individual interpretation. For example, in a discussion of therapeutic risks and benefits (see Section 10.01b) regarding informed consent, according to the Ethics Code (2002), appears merely to be implied. An implied discussion allows practicing psychologists a substantial amount of leeway regarding those topics to be included as part of a conversation about risks, resulting in significant variation within informed consent practices.

Informed Consent and Implementation

Research suggests various models to help define the direction of informed consent and to understand its implementation into the clinical setting (Lidz, Appelbaum, & Meisel, 1988; Walker et al., 2005). The "event model" is thought of as a onetime event during which informed consent is given at one specific point in time, usually at the beginning of treatment; this has its roots in legal doctrine. Because of an emphasis on the idea that information is more important than the individual's understanding, a consent form is often used with this model (Braaten & Handelsman, 1997). Lidz et al. (1988) note some advantages for using this model, including a clear outline of potential client goals; however, this model is problematic for psychotherapy. The information presented is often "too complex for the patient to understand without reflection and dialog, and frequently constitutes a formalistic effort to comply with the law, at the expense of the real collaboration" (Lidz et al., 1988, p. 1388). Braaten and Handelsman (1997) reveal "Patients with certain disorders, such as major affective disorders, may be competent to consent to treatment but may need to be provided with different information once their symptoms abate" (p. 313). Other problems with this model include the assumption that

psychotherapy involves only a one-time decision, separate from the process of informed consent. Not only is this model paternalistic, Braaten and Handelsman (1997) noted "It provides a poor model for many clients who are seeking treatment in order to regain a sense of power and autonomy in their lives" (p. 313).

The "process model" on the other hand, addresses informed consent, "as an integral and continuous part of the relationship between patients and physicians embedded in the treatment process," with clients providing active participation in their treatment decision-making, over time (Lidz et al., 1988, p. 1385). Consent is seen as a dynamic process which happens within the "context" of the provider-client relationship (Childress & Fletcher, 1994). The process portion of consent is a "systematic disclosure of information to the client over time"- over the course of psychotherapy (Reamer, 1987, p. 428). There is also an element within consent which remains part of the personal process and tends to be specific to each individuals treatment (Arboleda-Florez, 1987). The informed consent process provides a more substantial effect on the therapist-client relationship. Clients are seen to have an active role in the process; this enhances the interaction between therapist and client, allowing clients the opportunity to make treatment decisions. This may not only enhance client autonomy and further treatment goals, it can also "help therapists monitor the course of treatment and, perhaps, provide therapists with information about their own effectiveness" (Braaten & Handelsman, 1997, p. 313). Lidz et al. (1988) concluded that the emphasis on the need for participation is beneficial for the client and "contributes to therapeutic outcomes" (p. 1388).

Most current research view informed consent as a process to be conducted over time (e.g., Dyer & Bloch, 1987; Hass, 1991). Hass (1991) recommends beginning the

informed consent process with more general and universal aspects of the proposed treatment and then moving toward more specific descriptions of procedures and implications on an as-needed basis. Manning and Gaul (1997) note that when an individual is experiencing an "emotionally traumatic experience it is difficult to capture and retain what has been said, let alone the meaning of what has been said" (p. 108). These authors suggest an "opportunity to reflect, ask more questions that stimulate the need for specific information" regarding their proposed treatment leads clients to a more highly informed decision over time (Manning & Gaul, 1997, p. 108).

The phrase "as early as feasible" in ethical standard 10.01a (APA, 2002, p. 1072) suggests that there may be times when obtaining informed consent during the first meeting may not be appropriate. Studies suggest that psychotherapy should not be "an all-or nothing" experience; rather, it should be an on-going process conducted over time (Pomerantz, 2005). For example, O'Neill (1998) has suggested that potential problems change in psychotherapy over time, resulting in a need to change a treatment approach; therefore, a one-time consent presented before these changes occur does not adequately reflect treatment changes or the consent itself. Stone (1990) regarded informed consent as a process and not a single set "formula regardless of the actual situation" (p. 425). Knapp and VandeCreek (2006) suggest "psychologists can sometimes *titrate* the information given to patients", whereby "they present the patient with a limited amount of information, determine how well the patient is able to understand and integrate that information, and then provide additional information as needed" (p. 103). Hass (1991) recommends informed consent be treated as both a prerequisite to engage in psychotherapy and as part of the ongoing treatment process. Pomerantz (2005) asserts

that informed consent to psychotherapy "is better conceptualized as a process that evolves with psychotherapy rather than as single even that precedes it" (p. 352).

Faden and Beauchamp (1986), as outlined by Walker et al. (2005), describe two requirements for informed consent. First they reveal that informed consent is an actual "authorization of treatment by an informed and intentional patient", whereas the second is "more of an institutional one that observes the correct legal means for obtaining consent" from individuals seeking psychotherapy (Walker et al., 2005, p. 244). With the second one there is a greater emphasis on meeting the legal requirements, which include the consent signature being a "defining moment of the consent process" (Walker et al., 2005, p. 244). Rather than merely signing a consent form, these researchers assert that "clients should more than simply comply with treatment: they should actively authorize it as autonomous agents or take the opportunity to exercise control over their decisions" (Walker et al., 2005, p. 244). Dyer and Bloch (1987) viewed the clinical informed consent process as occurring "within the framework of a fiduciary relationship whereby therapists identify specific needs of patients and respond individually without the use of written contract or forms" in which this "fiduciary relationship is one based on mutual trust, confidence, and openness" (as cited in Braaten & Handelsman, 1997, p. 313).

The manner in which informed consent is obtained in research has significant application to the informed consent process in practice. Obtaining informed consent to undergo research and treatment in clinical trials, "has become a routine expectation as a way to promote self-determination and autonomy" (Walker et al., 2005, p. 243). Although informed consent procedures among research settings has received a significant amount of attention and has resulted in formal consent procedures (regulated by IRB in

academic settings), there is less evidence for protection of clients either by completed procedures or by guidelines among clinical practice settings. In fact, Hare-Mustin, Marecek, Kaplan, and Liss-Levinson (1979), reveal that in their opinion, the primary motivating factors for the use of informed consent procedures for psychotherapy were therapist's protection from malpractice lawsuits and as a way to safeguard psychology from outside regulation. Regardless of the rationale, Handelsman, Kemper, Kesson-Craig, McLain, and Johnsrud (1986) emphasize the importance of providing written information to clients at the onset of psychotherapy. Knapp and VandeCreek (2006) suggest the "content of informed consent procedures is intended to anticipate questions that most reasonable patients would have and to prevent future misunderstandings and disappointments" (p. 100). The ultimate goal for these consent procedures (provided correct implementation) consists of "open exchanges between psychologists and their patients" (Knapp & VandeCreek, 2006, p. 100).

The ethical responsibility of psychologists to practice informed consent is clear; however, there is little consensus regarding procedures related to the use of oral or written consent forms for psychotherapy (APA, 2002; Everstine et al., 1980; Hare-Mustin et al., 1979; Morrison, 1979; Schwitzgebel, 1976). Muehleman, Pickens, and Robinson (1985) note that no more than one-third of practicing psychologists use verbal consent from their clients for psychotherapy. Authors have advocated that written forms include a description of goals, procedures, risks, and benefits for psychotherapy (Hare-Mustin et al., 1979; Handelsman & Gavin, 1988; Morrison, 1979). Handelsman and Gavin (1988) advocate for a combination of an informed consent format which includes an initial written section in which clients indicate information that interests them, with concerns

subsequently addressed orally by the therapist before initiation of therapy. These authors present a written format that includes open-ended questions that a client has the right to ask upon entering psychological treatment. An open-ended format "has several advantages over narrative forms: it preserves clients' right to refuse information; it is less overwhelming; it fosters conversation between therapist and client, and it is readable" (Handelsman & Gavin, 1988, p. 223).

Research is varied regarding the use of consent forms. For example, in a survey study of psychologists in private practice, 28 percent of those who responded (53 percent) endorsed using an informed consent form; the primary reason for not using a form is a preference for oral informed consent (Handelsman et al., 1986). Results from this study reveal forms from psychotherapy practice generally dealt with fees and not "information that satisfies the requirements of informed consent, such as risks of treatment and alternative treatments" (Handelsman et al., 1986, p. 514). Among the 19 consent forms collected in their study, only one mentioned possible risks, and none of the consent forms outlined "benefits or risks to be expected of alternative treatments, or prognosis without treatment" (Handelsman et al., 1986, p. 516). Although Handelsman et al. (1986) note that they do not necessarily endorse using a consent form, they articulate "increased sensitivity to the issues involved", including the fact that the potential risks are of primary importance (p. 516). Hare-Mustin et al. (1979) argue strongly for information related to risks involved and for alternative treatment to be included, at the onset of psychotherapy, in any informed consent procedure.

Handelsman et al. (1986) note that because consent forms do not necessarily guarantee informed consent, more sensitivity to the issues involved is warranted.

Croarkin, Berg, and Spira (2003) note "state psychological associations have examined these procedures and recommend that patients be offered documents at the outset of treatment" (p. 399). Researchers suggest presenting clients with "a patient's rights form, treatment-contract form, and an informed-consent form" at the beginning of treatment (Croarkin et al., 2003, p. 399). Giving a client these forms, according to Horowitz (1984), not only emphasizes the voluntary nature of engaging in psychotherapy, but also that there are inherent risks which clients need to know about. Addressing risks, including potentially negative treatment effects during the informed consent process appears consistent with these fundamental goals of informed consent, as part of creating a dialog or exchange between clients and psychologists.

Informed Consent and Risk

One of the main responsibilities of psychologists is to ensure the informed rights of their clients relative to potential risk (Hare-Mustin et al., 1979). Handelsman and Gavin (1988) assert "therapists still must judge whether a given risk or alternative is so important that a particular client absolutely needs to know, they must answer the questions objectively and clearly, and they must ensure that clients understand and are satisfied with the material presented" (p. 224). One of these responsibilities includes providing individuals with the knowledge of potentially negative effects as a result of psychotherapy. Information regarding what constitutes risks or negative indirect effects is essential in order for a client to be able to weigh the benefits and risks upon entering treatment (Hare-Mustin et al., 1979). The psychology profession has been "more proactive in regard to establishing informed consent for psychotherapy as a standard of care" (Croarkin et al., 2003, p. 399); however, there is considerable variability among

practices regarding addressing risk during the informed consent process (Handelsman et al., 1986; Noll & Haugan, 1985).

Although there is published literature suggesting informed consent content, less is known about clinicians' actual informed-consent procedures. Most of the research in the area of informed consent consists of surveys reporting alleged informed consent content among consent forms. Although there is clear responsibility on behalf of psychologists to inform their clients fully about potential risks related to psychotherapy, an adequate, outlined procedure appears to be lacking. Subsequently there appears to be little agreement about what those potential risks should include. In their study examining opinions and practices of psychotherapists, Croarkin et al. (2003) reveal that practices for informed consent vary with the characteristics of the therapists. Results from content analyses of written consent forms reflect a wide variation of information used by psychologists (Handelsman et al., 1979). In their study, Talbert and Pipes (1988) conducted a content analysis of 40 consent forms used by psychological services. Results indicated inconsistent content, and only 1 of the 40 forms mentioned possible risks of engaging in psychotherapy. However, Somberg et al., (1993) surveyed psychotherapists' attitudes and beliefs regarding informed consent, including potential risks of psychotherapy. Data revealed that 48 percent of clients were informed about risks (Somberg et al., 1993). Noll and Haugan (1985) reported similar results, indicating that approximately 40 percent of psychologists inform their clients about potential risks (e.g., confidentiality issues). However, a discussion of potential risks by the clinician, according to Noll and Haugan (1985), was more highly preferred when relevant situations presented during the course of psychotherapy. One reason for delayed

presentation of possible risks of therapy, Noll and Haugan (1985) hypothesize, is that clinicians may feel information of risks could potentially overwhelm possible clients and deter them from engaging in psychotherapy. Results from a study conducted on a German speaking population, Dsubanko-Obermayr and Baumann (1998) found that a higher percentage (68 percent) of clients were informed of risks during informed consent when compared with the results of Stomberg et al. (1993) and Noll and Haugan (1985). A possible reason for the apparent difference, according to Dsubanko-Obermayr and Baumann (1989), may be "explained by a different comprehension of the term 'risk' (e.g., family changes, straining periods, failure of therapy, stigma, and so on)" (p. 243). Although addressing risks in therapy may be considered generally relevant, more research is needed regarding psychologists' attitudes and practices related to addressing potential negative effects of psychotherapy during the informed consent process.

As part of the information process, Hare-Mustin et al. (1979) assert the need to include, as part of a conversation of risk, potential negative effects as a result of engaging in psychotherapy (Hare-Mustin et al., 1979). Braaten and Hadelsman (1997) found both current and former therapy clients wanted information about confidentiality, risks of alternative treatments and inappropriate therapeutic techniques as opposed to information such as therapist personal characteristics and professional training, which were rated as least important. Similarly, in their study looking at what client's considered preferable information during informed consent, Jensen et al. (1991) surveyed 173 parents of elementary school-aged children regarding potential psychotherapy for their children. The parents placed a stronger emphasis on disclosure of information related to iatrogenic risks then did the therapists (Jensen et al., 1991). Prior to the onset of psychotherapy, 95

percent of the parents wanted information about therapeutic risks (Jensen et al., 1991). In an earlier study conducted by the same authors (Gustafson, McNamara, Jensen, 1988), child clinical psychologists were surveyed and rated iatrogenic risk as only moderately important information to include during informed consent. Interestingly, however, there appeared to be a high correlation among these child psychologists between therapeutic risk-benefit importance ratings and their reported frequency of discussion of such issues with their clients (Gustafson et al., 1988). In a national survey study on psychotherapy outcome, Boisvert (1999) found respondents to be "either incorrect about research findings on iatrogenic effects (i.e., they tended to underestimate the frequency of negative outcomes) or simply indicated that they were unaware of research in this area" (as cited in Boisvert & Faust, 2002, p. 247). Dsubanko-Obermayr and Baumann (1998) concluded, as a consequence of clients not being well informed of risks within the first five sessions of therapy, consent to psychotherapy was deemed insufficient. Pomerantz (2005) surveyed licensed psychologists regarding the timing of informed consent; they asked what the psychologists felt, specifically, was the earliest point in time at which they could provide information regarding specific aspects of therapy, including risks and alternatives. The general consensus among psychologists include requiring "about one full session of psychotherapy to feel capable of addressing the many important aspects of psychotherapy" including risks (Pomerantz, 2005, p. 356). In another study Sullivan, Martin, and Handelsman (1993), instructed participants to rate their initial impressions of therapists that use either oral or written informed consent procedures, including information related to risk or benefits of treatment, or of therapists that use no informed consent. Participants gave higher ratings to those therapists who used an informed

consent procedure and were more willing to recommend the therapist to a friend and go to him or her for therapy (Sullivan et al., 1993). Psychology professionals who used an informed consent procedure were rated as more "expert and trustworthy" then those who did not (Sullivan et al., 1993, p. 160).

Informed Consent Biases

Knapp and VandeCreek (2006) assert that the "standards of informed consent were developed primarily from physical medicine or surgery, and the degree to which they apply to mental health treatment is controversial" (p. 100). As one of the most arguable components of informed consent, the APA's Code of Ethics (2002) briefly mentions the ethical need to inform clients of the benefits and risks of treatment. Although this is a clear standard of practice when psychotropic medications are involved (due to pharmacological side effects), it is less clear when it comes to psychotherapy. Plaut (1989) notes "the apparent trade-off between, on one hand, increased autonomy, reduced dependency and increased participation by the patient and, on the other hand, decreased trust in the physician, is a difficult one" (p. 436), and continues to produce ethical dilemmas for clients, psychologists and attorneys. Although "informed consent is not an optional process," Braaten, Otto, and Handelsman (1993) reveal "client preferences are not the final determining factor in what information psychologists provide" (p. 569). These authors reveal that "the fundamental functions of informed consent, to promote individual autonomy and to encourage rational decision making are paramount" and "psychologists need to follow the disclosure guidelines mandated by ethics codes and state laws" (p. 569), Braaten et al. (1993) conclude that if the

psychological profession follows only what is "absolutely required they may be missing the opportunity to provide the most good for clients" (p. 569).

Ethicists and researchers agree that informed consent is at the core of moral practice in both medicine and treatment; however, it may be perceived as less important in clinical practice settings then in treatment setting for a several reasons (Pellegrino & Thomasma, 1993). Practicing psychologists may have a limited understanding of the informed consent process because they have insufficient training for providing fully informed consent (Walker et al., 2005). There may also be an attitude bias among psychologists toward the client's level of competence to give accurate, informed consent to engage in psychotherapy. For example, the literature on competence tends to focus more closely on severe mental illness impairment (i.e. mental retardation, dementias, severe cognitive impairment); depending on the circumstances, these impairments could make it difficult for clients to give their full consent to psychotherapy (Grisso & Appelbaum, 1998; Elliott, 1997). According to Grisso and Appelbaum (1998), the criteria for a client to make an informed decision include the ability to express his or her choice, understand relevant information, appreciate the significance of the situation and the choices, and reasonably weigh options (see also *Historical Factors of Informed Consent*). In research, however, clients with depressive disorders (with the exception of psychotic depression) are typically considered competent to give consent to undergo research involving medical treatments (Appelbaum, Grisso, O'Donnell, & Kupfer, 1999). In their study of moderately depressed, outpatient women with major depressive disorder, Appelbaum et al. (1999) found participants "performed quite well on a measure of their decision-making capacities related to research" (p. 1383). These authors note that few

participants "manifested difficulties with understanding, appreciation, or reasoning to a degree that would raise suspicions about their capacity to make an informed choice...the extent of depressive symptoms did not seem to affect the level of performance" (Appelbaum et al., 1999, p. 1383). Researchers find that participants who suffer from severe mental illness (i.e., schizophrenia and bipolar disorder) have also been found competent to understand and retain informed consent information; however, when compared with medically ill participants, they are reported to have less understanding of consent information (Flory & Emanuel, 2004; D. Wirshing, W. Wirshing, Marder, Liberman, & Mintz, 1998). In clinical practice settings, an individual entering into psychotherapy should be thought of as being able to understand and to give their fully informed consent to treatment, regardless of their subsequent mental illness or current diagnosis, as defined in the APA Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR).

Meisel, Roth, and Lidz (1977) indicate that "if all risks and possible consequences of the procedure in question, and all alternative procedures are presented to the patient and the patient has given evidence that the presentation was understood" then consent is thought to be informed (as cited in Widiger & Rorer, 1984, p. 508). However, some authors recount that it may not always be appropriate to disclose all relevant and important information when a client, according to Morse (1967), is experiencing "instability, distress, [and] confusion" (as cited in Widiger & Rorer, 1984, p. 508). Meisel et al. (1977) note, "if disclosure of certain information-especially the risks of treatment is likely to upset the patient so seriously that he or she will be unable to make a

rational decision, then the physician has the 'therapeutic privilege' to withhold such information" (p. 282).

Other potential biases regarding informed consent implementation, according to Braaten and Handelsman (1997), include therapist's concern over the impact on the therapeutic relationship, the client's view of the therapist's ability to help him or her, resulting in the possibility of client drop-out. These authors suggest that because the modal length or therapy is one session (Talmon, 1990), and studies reveal drop-out rates for psychotherapy to be within the first three to five sessions (Garfield, 1986), therapists may not be presenting adequate "useful information at the beginning of counseling" (Braaten & Handelsman, 1997, p. 313). However, the "promotion of autonomy and rational decision making is thought to enhance and help define the relationship between client and therapist" (Braaten & Handelsman, 1997, p. 312); it should not negatively impact it.

Beahrs and Gutheil (2001) recommend an integration of clinical aspects of informed consent along with the legal requirements; this might be done verbally, with documentation of the client's "level of interest and understanding in the written record" (p. 8). Although the written consent meets, more closely, a legal criterion, Beahrs and Gutheil (2001) assert "written contracts with patients run the risk of sacrificing clinical rapport so essential to positive therapeutic outcome and fail to address new questions that emerge" (p. 8). Although the "burden of the therapist to provide informed consent varies with the particular client, the clinical problem at hand, and the social context", Beahrs and Gutheil (2001) assert, "these burdens increase directly with the costs and risks of the recommended treatment" (p. 8). Beahrs and Gutheil (2001) note that regardless of how

"the process is implemented, it is important that patients understand that multiple options, including no treatment exist - each with different rationales, methodologies, and risk/benefit profiles" (p. 8).

There are no guarantees that all clients will fully comprehend and understand potential negative effects of psychotherapy; however, having clinical guidelines for informed consent would help ensure clients and therapists be provided with the best available knowledge of these matters. Boisvert and Faust (2003) note "if therapists are unfamiliar with the domain of knowledge in psychotherapy research, the information provided on these types of matters [negative treatment effects] pertaining to informed consent is likely to be personal opinion and may not align with the research evidence" (p. 512). Similarly, "if a therapist's views deviate from consensus opinion among experts, clients should be informed of both positions and the strength of the evidence on which each rests" (Boisvert & Faust, 2003, p. 512). Ensuring that the client gives truly informed consent for psychotherapy is an essential part of psychologists fulfilling the ethical obligations and legal requirements of informed consent.

Approximately 400 studies in the last decade have addressed information on informed consent (Sugarman et al., 1999). However, a review of informed consent literature related to risk reveal that there have been few published studies related to psychologists informing clients of potentially negative effects of psychotherapy during informed consent processes. All the previously mentioned studies looked at the problem of negative treatment effects, general informed consent procedures, and information related to what clients and clinicians considered important. There is a need to survey doctoral-level, licensed psychologists on negative treatment effects and to inquire how

they practice fully informed consent. This current survey study has intended to assess licensed psychologists' attitudes toward and practices pertinent to, addressing negative effects of psychotherapy during informed consent process. Because of the considerable research on negative effects of psychotherapy, licensed psychologists were surveyed on attitudes and subsequent practices toward these negative treatment effects related to informed consent practices.

It has been hypothesized that addressing negative effects of psychotherapy during informed consent may have negative implication for treatment. In their study, Braaten and Handelsman (1997) surveyed patients, former patients, and non patients on attitudes toward informed consent and the importance of being informed about the risks of psychotherapy. These researchers found former clients "placed more of an emphasis on risk of counseling than did one or more of the other groups, possibly because they had more experience with some of the potential problems inherent in counseling" (p. 323). These authors point out "that although it has been suggested that clinicians may withhold information about treatment risks because of concerns about potential negative effects on clients (Handelsman et al., 1986; Noll & Haugen, 1985), people who have been through the therapy process value the information" (p. 323). Jensen et al. (1991) point out those psychotherapists might "curtail disclosure about therapeutic risks, fearing such information might deter potential clients from engaging in therapy" (p. 168). This "attitude," the authors reveal, "may particularly reflect clinicians' tendencies to systematically underestimate the importance of discussion of certain issues, particularly therapeutic risks, in informed-consent contexts" (Jensen et al., 1991 p. 168). The authors note that some potential psychotherapy clients might "not only tolerate this type of

discussion, they might welcome such disclosure" (Jensen et al., 1991 p. 168). Other studies suggest that consumers of psychotherapy value a risk-benefit discussion, even if the information disclosed is not necessarily used in their treatment decisions (Denney, Williamson, & Penn, 1976; Faden & Beauchamp, 1980; Gustafson, 1988).

Informing clients of the potential risks of engaging in psychotherapy, including the fact that treatment might not work for everyone, is a fundamental part of obtaining truly informed consent. The potential risks of negative treatment effects (including iatrogenic and deterioration effects) might appear initially less severe with talk therapies; however, they are just as important as the potential risks of psychopharmacological side effects. Informing clients in full regarding risks and benefits to treatment, not only gives them the option of choice, but it also helps them recognize the importance of being part of their own treatment and therapy. More information is necessary in order to understand how psychologists comprehend and implement informed consent in their own psychotherapy practices. Although it is clear that most psychologists receive education on ethics and informed consent in graduate school and post-doctoral studies, guidelines that outline the application of the Ethics Code (2002) appear vague and incomplete. More research is sorely needed so that psychologists may better understand these issues in clinical practice. Because there is such little information on the clinical practice related to addressing potential negative treatment effects of psychotherapy during the process of informed consent, this survey study is somewhat exploratory.

Chapter Three: Hypotheses

Specific Hypotheses and Questions

The research question for this study was based on informed consent research and theory from the past several decades (e.g., Bergin, 1971; Strupp et al., 1977; Mohr, 1995; Stricker, 1995; Boisvert & Faust, 2003; APA, 2002), establishing the notion of informing clients of potential risk as being integral to the informed consent process. The informed consent doctrine mandates that discussion of potential negative effects directly resulting from psychotherapy is a necessary component of informed consent (Jensen et al., 1991). The hypotheses for this survey study presume that licensed psychologists obtain, at some point prior to beginning psychotherapy, informed consent from their potential clients. A relative standard of disclosure and lack of specific clinical guidelines regarding informed consent indicate a need for research investigating the attitudes and practices of currently licensed psychologists. Empirically supported, informed consent is currently recommended for psychotherapy; however, the question of informing clients as part of a discussion of risks, potential negative effects associated with psychotherapy, remains unclear. The following research hypothesis was proposed:

Hypothesis 1. Licensed psychologists who acknowledge the significance of potential negative effects associated with psychotherapy are more likely to inform their clients of risks associated with negative treatment effects.

Rationale. Research findings suggest there appear to be similarities in the reported ethics and belief systems of psychotherapists and their subsequent practices (Somberg, Stone, & Claiborn, 1993; Pope, Tabachnick, & Keith-Spiegel, 1987). Therefore, licensed psychologists who endorse congruent scores on the survey related to

the occurrence of negative treatment effects as a result of psychotherapy are expected to subsequently inform clients of potential risk regarding negative treatment effects.

Hypothesis 2. The second area of investigation posed the question: Are licensed psychologists hesitant to address negative effects of psychotherapy due to the belief that it will negatively impact the therapeutic alliance and subsequent psychotherapy outcome? It was hypothesized that licensed psychologists will rate the addressing of potentially negative treatment effects associated with psychotherapy as less important if they believe that it will negatively affect the therapeutic alliance and psychotherapy outcome.

Rationale. Braaten and Handelsman (1997) discuss potential biases that psychologists hold relative to informed consent implementation. There is concern among practicing psychologists relative to addressing potential negative effects of psychotherapy, concerning how this might impact the therapeutic relationship, the client's view of the therapist's ability to help him or her, and subsequent client drop-out (Braaten & Handelsman, 1997). Braaten and Handelsman (1997) note that providing useful and relevant information at the beginning of the informed consent process may improve psychotherapy outcome. Research reveals a discrepancy concerning what clients and clinicians rate as important information to be included during informed consent. In their study of parents seeking therapy for their children, Jensen et al. (1991) revealed that therapists rated a discussion of informed consent issues, particularly therapeutic risks, less important than did parents. Therefore, it is expected that licensed psychologists who endorse greater risk of negatively impacting the therapeutic alliance and subsequent treatment outcome, will be less likely to inform clients of potential negative effects of psychotherapy, during informed consent.

Hypothesis 3. The third area of investigation poses the question: Are certain demographic characteristics (degree, theoretical therapeutic orientation, career setting, clinical experience, and post-doctoral ethics training) among licensed psychologists related to attitudes and/or practices of informed consent procedures? It was hypothesized that the number of years of clinical experience, post-doctoral ethics training, and a Cognitive-Behavioral orientation, would positively correlate with licensed psychologists' attitudes regarding the importance of including risks of potential negative effects of psychotherapy during the informed consent process.

Rationale. Psychologists who have more experience in the practice of psychology are also presumed to have more contact with clients and subsequent ethical situations. Similarly, those psychologists who have attended post-doctoral ethics training are presumed to have received information on the process of informed consent and disclosure of risks. The Cognitive-Behavioral orientation lends itself toward encouraging autonomy in their clients. In fact, Somberg et al. (1993) revealed in their study "therapists of a Cognitive-Behavioral orientation indicated they inform clients more often and consider the issues more important" than therapists from other therapeutic orientations (p. 153). With such a strong emphasis on the client's taking an active role in treatment, it seems that psychologists whose primary orientation is Cognitive-Behavior Therapy (CBT) would be more likely to encourage client participation in a discussion of risks during the process of informed consent. However, whether or not licensed psychologists from a CBT orientation inform clients of potential risks of negative treatment effects as a result of psychotherapy, during the process of informed consent, remains unknown.

Chapter Four: Method

Overview

The present study focused on licensed psychologists' attitudes and practices related to addressing potential negative effects of psychotherapy during the informed consent process. This research study included a nationwide sample of licensed psychologists' attitudes and practices toward many of the issues raised in the literature regarding risk and the ethical implementation of informed consent procedures.

Design and Design Justification

A survey research design strategy was used for the proposed investigation. No identifying information was collected. The study utilized a survey-based research design (questionnaire format) in order to assess licensed psychologists' attitudes and practices related to addressing potential negative effects of psychotherapy during the informed consent process.

Data Reporting and Entry. The survey questionnaire utilized a Likert-type scale. Responses were placed in a numerical format for analysis. All data from completed on-line survey questionnaires using SurveyMonkey were subsequently entered into a spreadsheet database for final analysis, using Statistical Software for the Social Sciences (SPSS 16.0). Descriptive statistics were examined including frequency, distribution, mean, median, standard deviation, and standard error. A correlational analysis (using a Pearson product-moment correlation coefficient) was the preferred means to determine the relationship between general attitudes toward negative treatment effects of psychotherapy and addressing those risks during the process of informed consent. Between-group comparisons were conducted by means of one-way analyses of

variance (ANOVA) in order to assess for group differences. An analysis was conducted on demographic data in order to ascertain correlations on attitudes regarding informed consent practices and negative treatment effects.

Participants

The nationwide sample consisted of 161 completed surveys from licensed psychologists. Qualified participants included male and female licensed psychologists, defined as mental health professionals who apply scientifically validated procedures to help people change their thoughts, emotions, and behaviors (APA, 2008). For the purposes of this study, psychotherapy, according to the APA (2008) was defined as, "treatment of emotional or behavioral problems by psychological means" (p. 1-5). It includes a collaborative effort between an individual and a psychotherapist and provides a supportive environment to talk openly and confidentially about concerns and feelings. For this study, psychologists were included in this sample provided they were: 1) licensed to practice psychology in the state where they practice or in some other state; 2) hold a Doctoral degree in a mental health related field, and 3) have an available electronic mail address.

Notice for participant recruitment was sent out through electronic mail obtained on various websites over the World Wide Web; these included: National Directory of Psychologists, The Association of Black Psychologists, and graduate school psychology programs listed on the APA directory. Participation in this study was on a voluntary basis. Participants gave consent by choosing to accept the prompt NEXT at the beginning of the on-line questionnaire presented in Appendix A and B. Participants in the study were free to withdraw from the study for any reason, at any time and were

treated in accordance with the Ethics Code (2002). Participants were excluded if they 1) did not hold a Doctoral level degree, 2) were not licensed to practice psychology in a state where they practice or in some other state, and 3) did not have an available electronic mail address.

Measures

The instrument used in this survey study was a questionnaire developed specifically for this study, designed to capture attitudes and practices that licensed psychologists hold regarding informed consent practices, specifically related to risks of informing clients of potential negative effects of psychotherapy. The survey included definitions from research regarding potential risk of negative effects (iatrogenic and deterioration effects) attributable to psychotherapy. These definitions included: no positive meaningful change, worsening of a symptom/condition, appearance of new symptoms, heightened concern regarding existing symptoms, excessive dependency on therapists, reluctance to see future treatment, the abuse or misuse of psychotherapy by the client, the client "overreaching" himself or herself , and physical harm (Lilienfeld, 2007; Boisvert & Faust, 2003; Nolan, 2004; Mercer, Sarner, & Rosa, 2003). The questionnaire consisted of 27 questions in total. The initial section of the questionnaire included self-report questions (dependent variables) on attitudes and practices related to informing their clients of potentially negative treatment effects during the informed consent process. The latter portion of the survey included demographic characteristics (independent variables): (a) gender, (b) age, (c) ethnicity, (d) number of years working as a licensed psychologist, (e) populations served, (f) practice location, (g) theoretical therapeutic orientation, and (h) post-doctoral ethics training, etc. These variables have been studied

in relation to a variety of ethical issues (e.g., Borys & Pope, 1989; Pope, Tabachnick, & Keith-Speigel; Somberg, Stone, & Claiborn, 1993). Responses on the questionnaire were rated by using a response key on a 7-point Likert scale (i.e., Strongly Agree=1, to Strongly Disagree=7; and Very Unimportant=1, to Very Important=7), true of false, and options from a drop down menu.

Procedure

After an extensive literature review (conducted using PsycINFO) on informed consent and psychotherapy, it became apparent that there was a significant gap in both the research and clinical literature related to the clinical implementation of informed consent procedures using the APA's Ethics Code. Although studies on informed consent and risk are available, addressing potential negative effects as a result of engaging in psychotherapy did not appear to be emphasized. Further, there are limited guidelines and implementation procedures, about when or how to inform clients of potential negative effects as a result of psychotherapy. Research is lacking relative to information on practicing psychologists' attitudes regarding their own informed consent procedures, and relative to whether or not they address potential negative effects as a result of some aspect of psychotherapy with their clients.

The questions on the survey were chosen in order to capture licensed psychologists' attitudes and practices of the informed consent process, specifically related to potential negative effects as a result of psychotherapy. Participants were instructed to respond to the survey questions regarding each of the 27 items. The next step was to pilot the questionnaire on a small number of psychology faculty at the Philadelphia College of Osteopathic Medicine (PCOM). The questionnaire was

examined for clarity, grammatical errors, and order of questions. Efforts were made to enhance the presentation, the attractiveness, and the appeal of the questionnaire, because this has been found to entice the respondent to complete it (Dommeyer, 1988). In addition, both positively and negatively worded items were included to eliminate potential acquiescence bias (Smyth, Dillman, Christian & Stern, 2007; Nunnally & Bernstein, 1994).

Surveys were distributed to 2,148 currently licensed psychologists through professional psychological associations and societies using their electronic mail address; through this method, 161 completed surveys were obtained. The electronic mail included a brief description of the study and website address that directed potential participants to the questionnaire on SurveyMonkey over the World Wide Web (Appendix A). The participants were able to give their consent to participate in the study by clicking on the NEXT button at the beginning of the on-line questionnaire. No personal identifying information was collected and steps were taken to protect participant's anonymity.

Chapter Five: Results

A nationwide sample of 2,148 potential participants was solicited through their electronic mail address to participate in the survey. A total of 161 doctoral level psychologists chose to participate in the study. The overall response rate was 7.5% for completed on-line questionnaires. The survey contained a total of 27 items. The initial part of the survey contained questions related to licensed psychologists' attitudes and practices of obtaining informed consent, specifically related to addressing potential negative treatment effects of engaging in psychotherapy (Appendix B). These first 14 questions were measured through various scales including a seven-point Likert scale; this was coded from 1 to 7 on agreement (Strongly Agree=1, Moderately Agree=2, Slightly Agree=3, Neutral=4, Slightly Disagree=5, Moderately Disagree=6, Strongly Disagree=7), and 1 to 7 on importance (Very Unimportant=1, Moderately Important=2, Slightly Unimportant=3, Neutral=4, Slightly Important=5, Moderately Important=6, Very Important=7), Yes or No, and last, by picking an option from a list of multiple choice items. The second half of the questionnaire captured demographic information from participants. The latter portion contained 13 questions coded on a multiple choice or drop down menu format. Every item on the survey questionnaire was calculated for percentages.

Demographic Information on the Study Sample

The majority of the sample was Caucasian (90.2%) and evenly split between males (49.6%) and females (50.4%). The age of the participants varied, with 26.7% between the ages of 59 and 74, 38.3% between the ages of 44 and 59, and 35.0% between the ages of 31 and 44. The majority of the participants hold a Ph.D. degree (82.8%), with

the rest possessing a Psy.D. degree (15.7%) and Ed.D. degree (1.5%). The majority of participants have a primary emphasis in clinical psychology (85.1%), with the rest endorsing counseling (7.5%), and other (7.4%) areas of emphasis. The most frequently endorsed orientation was Cognitive/Behavioral (46.9%), with Psychodynamic (16.9%) and Interpersonal (13.1%) following next. The least endorsed orientation was the Behavioral (10.0%); the rest endorsed other areas of emphasis (13.1%). Most of the participants (93.9%) do not hold an American Board of Professional Psychology (ABPP) specialty certificate. The majority of the sample has practical experience working with an adult (75.8%) and older adult (28.9%) population, with adolescent (44.3%) experience next and working with the child (28.2%) population somewhat less frequently. It should be noted that participants were able to endorse more than one population. The most frequent therapy modality reported was with individual (76%) clients, with families (10.1%), groups (8.5%); couples (54%) was rated less frequently. It should be noted that participants were able to choose more than one modality; however, 32 participants chose not to answer the question. Half of participants (50.4%) reported primary work in academic settings (college or university), with solo independent practices (41.4%) rated next, group practices (12.0%); research (10.5%) was somewhat less frequent and community mental health centers (8.3%) and hospital setting (8.3%) were the least frequently reported. It should be noted that participants were able to pick more than one modality and 28 participants chose not to answer the question. Participant work experience in the field of psychology is categorized into three groups: more than 30 years (20.2%), 5 to 10 years (23.4%), and 11 to 15 years (16.9%). The demographic data

obtained are similar to results obtained from a nationwide survey (see page 90). (Table 1 presents the demographic characteristics in detail.)

Table 1

Demographic Characteristics of the Sample

Demographic	Percentage
Gender	
Male	50.4
Female	49.6
Ethnicity	
Caucasian	90.2
African American	2.3
Hispanic	2.3
Native American	0.8
Asian/ Pacific Islander	2.3
Multi-Racial	2.3
Education	
Ph.D.	82.8
Psy.D.	15.7
Ed.D.	1.5
ABPP*	
None	93.9

*American Board of Professional Psychology specialty certificate

Table 1-cont.

Demographic Characteristics of the Sample

Demographic	Percentage
Age	
Between age 59- 74	26.7
Age 44 – 58	38.3
After age 31 – 44	35.0
Doctoral Degree Emphasis	
Clinical	85.1
Counseling	7.5
Developmental	3.0
Educational	1.5
School	2.2
Social	0.7
Orientation	
Cognitive/Behavioral	46.9
Behavioral	10.0
Psychodynamic	16.9
Interpersonal	13.1
Systems	13.1

Table 1-cont.

Demographic Characteristics of the Sample

Demographic	Percentage
Primary Population Served*	
Child	28.2
Adolescent	44.3
Adult	75.8
Older Adult	28.9
No. Years Working in Psychology	
Less than 5 years	4.8
5 to 10	23.4
11 to 15	16.9
16 to 20	9.7
21 to 25	13.7
26 to 30	11.7
More than 30 years	20.2

*Participants were able to rate more than one choice.

Table 1-cont.

Demographic Characteristics of the Sample

Demographic	Percentage
Therapy Modality*	
Individual	76.0
Family	10.1
Group	8.5
Couple	54.0
Primary Work Setting*	
Academia	50.4
Solo Independent Practice	41.4
Research	10.5
Community Mental Health	8.3
Group Practice	12.0
Hospital	8.3
Treatment facility	2.3
School	2.3
Correctional facility	1.5
Administration	1.5

*Participants were able to rate more than one choice.

Frequent Attitudes Endorsed in the Study Sample

Data describing attitudes related to informed consent practices, specifically toward potential harm from engaging in psychotherapy, include the following: general ethics and informed consent practices, risks and potential negative treatment effects, therapeutic treatment techniques, clinical judgment, negative patient/client reactions, alternative treatment procedures/techniques, and methods frequently used for obtaining informed consent. (Tables 2, 3, 4, and 5 present psychologists' attitudes in detail.). Descriptive statistics that demonstrated commonly endorsed attitudes and practices related to addressing negative treatment effects of psychotherapy during informed consent are as follows:

An overwhelming majority of participants (97.1%) agreed that there are potential risks to clients in engaging in psychotherapy (Strongly Agree=24.3%, Moderately Agree=34.0%, and Slightly Agree=36.1%). It should be noted that 12 participants chose not to answer this question. However, they completed the remaining demographic questions; therefore, they were retained in the study. Similarly, the majority of participants (90%) agreed that some psychotherapeutic treatment techniques produce a greater probability of potentially negative treatment effects than others (Strongly Agree=35.7% and Moderately Agree=38.6%). Participants' attitudes related to the use of clinical judgment (evoking therapeutic privilege) toward negative treatment effects were somewhat varied, with one-half (50%) reporting disagreement with its use and significantly less (23.1%) in agreement (Moderately Disagree=26.9%, Strongly Disagree=23.1% and Slightly Agree=15.7%, Moderately Agree=6.7%, Strongly Agree=0.7%). A small portion (14.9%) remained neutral and 23 participants chose not to answer the question. More

than one-half of the participants (66.9%) reported no known negative reactions from clients, relative to the informed consent process as a whole (Strongly Disagree=40.4%, Moderately Disagree=26.5%). Twenty-one participants chose not to answer the question. More than half (68.6%) of participants agreed that addressing potentially negative treatment effects of psychotherapy during the informed consent process does not negatively impact the therapeutic alliance and subsequent treatment outcome (Strongly Agree=34.3%, Moderately Agree=34.3%, and Slightly Agree=12.4%). Twenty participants chose not to answer the question. The majority of participants (89.4%) agreed that a discussion of the risk, including potentially negative treatment effects during informed consent, is of ethical importance (Of note, this was a negatively worded question) (Strongly Disagree=69.9%, and Moderately Disagree=19.5%). Twenty-four participants chose not to answer the question. The majority of participants disagreed (53%) and a somewhat fewer number agreed (39.5%) that symptomology, personality, and overall functioning impacts the therapeutic decision to address negative treatment effects in psychotherapy (Strongly Agree=6.7%, Moderately Disagree=13.4%, Slightly Agree=19.4%, and Strongly Disagree=19.4%, Slightly Disagree=20.9, Slightly Disagree=12.7%). Twenty-three participants chose not to answer the question. Similarly, participants' attitudes were almost evenly split (48.6% endorsing disagreement and 43.8% noting agreement) regarding informing clients at the onset of psychotherapy, that therapy might not work for them and that they could become worse as a result of engaging in psychotherapy (Strongly Agree=5.4%, Moderately Agree=14.6%, Slightly Agree=23.8%, and Slightly Disagree=16.2%, Moderately Disagree=16.2%, Strongly Disagree=16.2%). Twenty-seven participants chose not to answer the question.

Interestingly, of 161 responses to the statement, "10 percent of clients get worse as result of psychotherapy", 41% endorsed a neutral attitude and 25 participants chose not to answer this question.

When asked how important it was to address potentially negative effects of psychotherapy during informed consent, almost half (48.3%) agreed about its importance, but significantly fewer (19.6%) did not (Very Important=28.0%, Moderately Important=23.1%, Slightly Important=18.2%, and Very Unimportant=10.5%, Moderately Unimportant=6.3%, Slightly Unimportant=2.8%). (See Table 2). It should be noted that 14 participants chose not to answer this question. A discussion of alternative treatment/procedures (including no treatment) was rated important during informed consent by 41.2% participants, and somewhat less important by 18% of the sample (Very Important=28.0%, Moderately Important=24.5%, Slightly Important=14.7%, and Very Unimportant=9.8%, Moderately Unimportant=10.5%, Slightly Unimportant=7.7%). (See Table 3). Fourteen participants chose not to answer this question. Approximately one-third (34.1%) of the sample reported beginning the discussion of informed consent prior to the first session of psychotherapy; more than half (58.0%) reported starting the discussion during the first session, and significantly fewer (6.5%) reported a discussion of informed consent on an as-needed basis or not at all. Nineteen participants chose not to answer this question (See Table 4). Finally, the most common methods of assessment for overall progress in psychotherapy include: use of outcome measures and questionnaires (84.0%), asking the client directly (72.5%), and giving and receiving feedback (65.1%) (See Table 5 for details). It should be noted that more than one category could be rated

for this question; therefore, some participants rated more than one method of assessment and 23 participants chose not to answer this question.

Table 2

Frequent Attitudes Endorsed on the Survey Questionnaire

Attitudes	Percentage
There are potential risks to clients engage in psychotherapy.	
Strongly Agree	24.3
Moderately Agree	34.0
Slightly Agree	36.1
Neutral	1.4
Slightly Disagree	0.0
Moderately Disagree	2.8
Strongly Disagree	1.4
Some psychotherapeutic treatment techniques produced a greater probability of potential negative effects than others.	
Strongly Agree	35.7
Moderately Agree	38.6
Slightly Agree	15.7
Neutral	4.3
Slightly Disagree	1.4
Moderately Disagree	4.3
Strongly Disagree	0.0

Table 2-cont.

Frequent Attitudes Endorsed on the Survey Questionnaire

Attitudes	Percentage
There are times when my judgment about a client prevents me from addressing negative effects of psychotherapy during the informed consent process.	
Strongly Agree	0.7
Moderately Agree	6.7
Slightly Agree	15.7
Neutral	14.9
Slightly Disagree	11.9
Moderately Disagree	26.9
Strongly Disagree	23.1
My clients have reacted negatively during the informed consent process.	
Strongly Agree	0.0
Moderately Agree	2.2
Slightly Agree	9.6
Neutral	12.5
Slightly Disagree	8.8
Moderately Disagree	26.5
Strongly Disagree	40.4

Table 2-cont.

Frequent Attitudes Endorsed on the Survey Questionnaire

Attitudes	Percentage
Addressing potential negative effects of psychotherapy during the informed consent process does not negatively impact the therapeutic alliance and subsequent treatment outcome.	
Strongly Agree	34.3
Moderately Agree	34.3
Slightly Agree	12.4
Neutral	10.2
Slightly Disagree	2.9
Moderately Disagree	2.9
Strongly Disagree	2.9

Table 2-cont.

Frequent Attitudes Endorsed on the Survey Questionnaire

Attitudes	Percentage
During the informed consent process, a client's current symptomology, personality, and overall functioning, impacts whether or not to address potentially negative effects of engaging in psychotherapy.	
Strongly Agree	6.7
Moderately Agree	13.4
Slightly Agree	19.4
Neutral	7.5
Slightly Disagree	12.7
Moderately Disagree	20.9
Strongly Disagree	19.4

Table 2-cont.

Frequent Attitudes Endorsed on the Survey Questionnaire

Attitudes	Percentage
It is unethical to include a discussion of risk of potential negative effects of psychotherapy during the informed consent process.	
Strongly Agree	0.8
Moderately Agree	0.8
Slightly Agree	0.0
Neutral	2.3
Slightly Disagree	6.8
Moderately Disagree	19.5
Strongly Disagree	65.9

Table 2-cont.

Frequent Attitudes Endorsed on the Survey Questionnaire

Attitudes	Percentage
At the onset of therapy I always tell my clients not only the therapy might not work for them, but that they could become worse as a result of engaging in psychotherapy.	
Strongly Agree	5.4
Moderately Agree	14.6
Slightly Agree	23.8
Neutral	7.7
Slightly Disagree	16.2
Moderately Disagree	16.2
Strongly Disagree	16.2
Approximately 10% of clients get worse as a result of engaging in some aspects of psychotherapy.	
Strongly Agree	2.3
Moderately Agree	12.1
Slightly Agree	13.6
Neutral	41.7
Slightly Disagree	9.1
Moderately Disagree	11.4
Strongly Disagree	9.8

Table 3

Frequent Attitudes Endorsed on the Survey Questionnaire

Attitudes	Percentage
How important is it to you to address potential negative effects of psychotherapy during the informed consent process?	
Very Unimportant	10.5
Moderately Unimportant	6.3
Slightly Unimportant	2.8
Neutral	11.2
Slightly Important	18.2
Moderately Important	23.1
Very Important	28.0
How important is it to you to inform clients of alternative treatment/procedures (including no treatment) during the informed consent process?	
Very Unimportant	9.8
Moderately Unimportant	10.5
Slightly Unimportant	7.7
Neutral	4.9
Slightly Important	14.7
Moderately Important	24.5
Very Important	28.0

Table 4

Frequent Attitudes Endorsed on the Survey Questionnaire

Attitudes	Percentage
At what point during the therapeutic process do you usually began a discussion of informed consent?	
Before the First Session	34.1
During the First Session	58.0
During the Second Session	0.7
During the Third Session	0.7
After the Third Session	0.0
On an “As Needed” Basis	5.1
Never	1.2

Table 5

Frequent Attitudes Endorsed on the Survey Questionnaire

Attitudes	Percentage
What methods do you most commonly use to assess your patient/clients' overall progress in therapy?*	
Questionnaires	43.0
Outcome Measures/Assessments	51.0
Asking the Client	72.5
Giving and Receiving Feedback	65.1

*Participants were able to rate more than one choice.

Results of Hypotheses Testing

It was predicted that licensed psychologists would be more likely to inform clients of risk associated with potentially negative treatment effects as a result of engaging in psychotherapy, if they acknowledge the significance of those negative effects. The first hypothesis stated there would be a correlation between attitudes toward negative treatment effects and acknowledgement of the potential risks to clients involved. A two-tailed Pearson product-moment correlation was used. Results failed to support this hypothesis as an inverse relationship, $r(141) = -0.254$, $p < 0.01$, two tailed, was found. Licensed psychologists are less likely to address negative treatments of psychotherapy if they acknowledge the existence of those risks.

It was also predicted that licensed psychologists might be hesitant to address potentially negative effects of psychotherapy due to the belief that it will negatively affect therapeutic alliance and subsequent therapy outcome. The second hypothesis stated that attitudes toward addressing negative effects would be rated less important if it was perceived to adversely affect therapeutic alliance and subsequent treatment outcome. A one-tailed Pearson product-moment correlation revealed an inverse relationship, $r(136) = -0.228$, $p < 0.01$, one tailed. Results failed to support this hypothesis because attitudes toward negative effects are rated as being important to address during informed consent; however, they are not thought to impact therapeutic alliance and treatment outcome negatively. Further, there was an inverse correlation found relative to the importance of addressing potentially negative treatment effects of psychotherapy during informed consent and to informing clients of the potential of therapy ineffectiveness and/or becoming worse, $r(128) = -0.283$, $p < 0.01$, two tailed. These results suggest a

discrepancy between attitudes toward informed consent procedures and implementation during the informed consent process.

The third hypothesis predicted that years of clinical experience, post-doctoral ethics training, and a Cognitive-behavioral orientation, respectively, would correlate with attitudes related to informed consent practices, specifically with regard to discussion of risks related to negative treatment effects.

Clinical experience and attitudes. It was expected that years of clinical experience as a licensed psychologist would correlate with attitudes and practices related to addressing risk during informed consent; however, results of a two-tailed Pearson product-moment correlation revealed no significant findings.

Post-doctoral ethics training and attitude. It was expected that those who received post-doctoral training in ethics and informed consent, would be more likely to include a discussion of risk of potentially negative treatment effects as part of informed consent practice. A one-way between subjects analysis of variance (ANOVA), at the $p<0.05$ level, revealed a difference between the mean score of those who received post-doctoral ethics training ($M=1.95$, $SD=1.07$) and mean score of those who did not ($M=2.54$, $SD=1.47$), $F(1, 120) = 4.99$, $p = 0.027$, in support of the hypothesis. Participants who received post-doctoral ethics training are more likely to agree that some therapeutic treatment techniques produce greater probability of risk of negative effects than others. A marginally significant relationship was found, using a one-way between subjects analysis of variance (ANOVA), at the $p<0.05$ level, between mean score of those who received post-doctoral ethics training ($M=6.65$, $SD=0.85$) and mean score of those who did not ($M=6.25$, $SD=1.11$), related to attitude toward ethical importance of a

discussion of risk of potential negative treatment effects during the informed consent process, $F (1, 119) = 3.70$, $p = 0.056$. Results suggest that those who receive ethics training are more likely to agree with the ethical importance of addressing negative treatment effects during informed consent.

Orientation and attitudes. It was expected that therapeutic orientation, specifically Cognitive-behavioral orientation, would be related to attitudes and practices toward addressing negative treatment effects during informed consent; however, results of a one-way between subjects analysis of variance (ANOVA), at the $p<0.05$ level, revealed no significant findings. Licensed psychologists from a Cognitive-behavioral orientation were no more likely to rate the importance of addressing negative treatment effects during informed consent than those from other therapeutic orientations.

Although no original hypothesis were made, a one-way between subjects analysis of variance (ANOVA), at the $p<0.05$ level, was run to find out if degree (Ph.D. versus Psy.D.), or if gender, and age were related to attitudes and practices of informed consent, specifically related to importance in addressing negative treatment effects as part of a discussion of risk.

Degree versus attitudes and practice. A significant result was found between means of those who hold a Ph.D. degree ($M=4.74$, $SD=2.07$) versus Psy.D. degree ($M=5.71$, $SD=1.61$) in regard to attitudes and practices of informing clients of alternative treatment/procedures (including no treatment) during the process of informed consent, $F (1, 129) = 4.18$, $p = 0.043$. Those licensed psychologists who hold a Psy.D. degree rated informing clients of alternative treatments/procedures (including no treatment), during the process of informed consent, as more important than those who hold a Ph.D. degree.

Gender versus attitudes and practice. A significant correlation was found between means for licensed psychologist males (M=2.19, SD=1.47) and licensed psychologist females (M=1.69, SD=1.68) related to attitudes and practices toward the initial discussion of informed consent in psychotherapy, $F(1, 129) = 5.88$, $p = 0.017$. Results suggest that licensed psychologist females are more likely to begin the discussion of informed consent before or during the first session, but licensed psychologist males begin the discussion between the first and second session of psychotherapy.

Age versus attitudes and practice. Analysis for age and attitudes and practices of informed consent procedures revealed no significant findings, which suggests that a licensed psychologist's age does not correlate with attitudes and practices related to informed consent practices.

Chapter Six: Discussion

Summary of the Study Rationale

The current survey study investigated the relationship between attitudes and practices toward addressing risk of potential negative treatment effects of psychotherapy during the process of informed consent. Because of the potential of psychotherapy to produce risks of negative treatment effects, there are implications in clinical practice for informed consent procedures (Bergin, 1971; Boisvert & Faust, 2003; Lambert & Ogles, 2004; Lilienfeld; 2007; Mercer, Sarner, & Rosa, 2003; Mohr, 1995; Stricker, 1995; Strupp, Hadley, & Gomes-Schwartz, 1977). The rationale for this study is rooted in the Ethics Code (2002), which includes broad guidelines for obtaining informed consent to psychotherapy, including informing clients early on of the dynamics of treatment, potential risks, and of alternative treatments that may be available. Although the Ethics Code (2002) refers specifically to the importance of informed consent with treatments that lack evidence-based efficacy, it is ethically and morally consistent with the fundamental concepts of informed consent to include a discussion of potential risk of negative treatment effects associated with psychotherapy (Barden, 2001, Boisvert & Faust, 2003; APA, 2002). It is known that clinical research tends to have more stringent criteria to abide by the Ethics Code (2002); however, little is known about practicing psychologists' attitudes and subsequent clinical practices related to addressing risk of negative treatment effects. Because research is not well developed in this area, a survey design was used for the study. Further, the study intended to explore general questions related to ethics, attitudes and practices in addressing risks of potential negative treatment effects of psychotherapy, including whether or not alternative treatments and/or

procedures are used, during the process of informed consent. The relationship between years of formal training, theoretical therapeutic orientation, and invoking therapeutic privilege (use of clinical judgment) during informed consent was also assessed. Findings for the current study suggest that opinions and practices regarding the application of informed consent, specifically related to addressing potential risk of negative treatment effects associated with psychotherapy, vary with characteristics of licensed psychologists. This is the first study known to quantify the attitudes and practices of licensed psychologists on this subject. Several significant findings were discovered from the data analysis.

Demographic Information

It is noteworthy that the demographic data obtained for the current survey study is a close match to a nationwide sample (N=272) of licensed practicing psychologists (Greenbury & Jesuitus, 2002). In their survey study, primary ethnicity was Caucasian (93.2%), almost evenly split male (48.5%) and female (50.7%). The majority held a Doctor of Philosophy degree (Ph.D.=77.5%, Psy.D.=13.9%, Ed.D.=0.04%), with primary emphasis in clinical psychology (50-57%), with counseling (4-7%) rated significantly less. Both primary and secondary orientation included, Cognitive/Behavioral (57%), Interpersonal (14%), Psychodynamic (11%), and somewhat fewer, Behavioral (6.5%). Primary work setting included Human Services (70%) and Educational/School (15%). Finally, 93% reported that they did not hold an American Board of Professional Psychology specialty certificate (Greenbury & Jesuitus, 2002). Because the demographic information was closely matched to a national sample, it could be inferred that the results of this study are representative of practicing psychologists in the United States.

Relationship between Attitude and Practice

Research revealed that licensed psychologists, who recognize risks of potential negative treatment effects from engaging in psychotherapy, are less likely to address potential risk during the informed consent process. These findings reveal a discrepancy between attitudes toward informed consent procedures and the implementation of informed consent practice. It should be noted that potentially negative treatment effects occur as a result in engaging in psychotherapy and does not mean clinical incompetence. Although licensed psychologists in this study generally agreed that potential risk of negative treatment effects are important enough to be discussed during informed consent, there is little evidence to support adequate implementation into the clinical setting. The majority of licensed psychologists shared similar opinions regarding the ethical importance of addressing negative treatment effects during the process of informed consent. These congruent attitudes centered on the existence of potential risks of engaging in psychotherapy, and that there are some treatment procedures which have greater potential to produce negative treatment effects than others. Contrary to expectation, discussion of potential risk of negative treatment effects were generally not thought to adversely impact therapeutic alliance and subsequent treatment outcome. In the clinical setting, however, there is some variability among licensed psychologists' practices relative to addressing informed consent of potential risk. Licensed psychologists did not rate invoking therapeutic privilege (using clinical judgment), potential deterioration effects and ineffective psychotherapy, personality factors and overall functioning as potential variables that affect therapeutic decisions to include a discussion of risk as part of informed consent. These finding are supported by Pope,

Tabachnick, and Keith-Spiegel (1987) who discuss "self-reported behavioral norms are not the same as ethical standards" (as cited in Somberg, Stone, & Clairborn, 1993). The apparent variability may be attributed to the complexity of factors which impact the process of obtaining informed consent for a specific issue. The data does not support the notion that licensed psychologists practice in accordance with their attitudes toward addressing risk of negative treatment effects during informed consent. This conclusion is not reflected in the literature on informed consent practices and ethical issues.

A possible explanation for the discrepancy between attitudes toward informed consent procedures and implementation of informed consent practice might be related to vague guidelines outlined in the Ethics Code (2002). Although the code is intended to be used as a guideline for standards and professional conduct, personal attitudes about ethics and implementation of informed consent practice appear to vary widely. Because of ambiguous ethical guidelines, the addressing of potential risk during informed consent is susceptible to individual interpretation (Pomerantz, 1998). Walker et al. (2005) note that informed consent with psychotherapy appears less clear, due to the nature of the consent process, which tends to take place over a period of time. As a guiding principle, information that is material to the particular client's decision is needed in informed consent discussions (Beahrs & Gutheil, 2001). Although the level of detail varies depending on the costs, the risks of the proposed treatment, viable alternatives, professional acceptance and the fact that it is research-based, the question remains how to address "problematic or controversial psychotherapeutic trends that temporarily enjoy wide professional support" (Beahrs & Gutheil, 2001, p. 4). Lack of clear and distinct

outlines for informed consent procedures related to addressing risks of negative treatment effects, may account for licensed psychologists' contradicting views.

There is another possible reason that licensed psychologists report that they agree with engaging in psychotherapy that has the potential to produce negative treatment effects, but do not include a discussion of risk during informed consent; this reason involves the limitations of humans as information processors and may suggest cognitive biases (e.g. Dawes, Faust, & Meehl, 1989; Lutz et al., 2006). The potential biases may limit the degree to which clinicians can accurately assess whether or not client outcome will be a success or failure. Another possible explanation may be that clinicians might simply not trust their clients' decisions or abilities to make choices about psychotherapeutic treatment. Twenty-three percent of surveyed licensed psychologists reported that they use clinical judgment (evoking therapeutic privilege) when addressing risk toward negative treatment effects. There is, however, no known evidence to suggest that clients informed about risks of engaging in psychotherapy cannot make informed decisions about treatment (in the absence of clear incompetence) (Walker et al., 2005). In fact, Jensen and MacNamara (1991) suggest that disclosure about potential risks during informed consent appears to have no negative effect on client decision to engage in psychotherapy. Similarly, Handelsman (1990) reported that there is no empirical evidence to support adverse effects as a result of informing clients about risk that is related to psychotherapy during informed consent. In light of evidence-based practice, the Institute of Medicine (2001) states that the process of informed consent must include an "integration of best research evidence with clinical expertise and patient values" (p. 146). The process of informed consent is intended to combine clinical knowledge with

client participation, while assuming an ethical and moral obligation to provide a detailed explanation of potential risks of negative treatment effects. Another key expectation for informed consent includes respect for autonomy and the fact that informed consent is considered an on-going process throughout the psychotherapy experience. Walker et al. (2002) suggest that informed consent, at a minimum, must contain disclosure of potential risks and benefits and address particular recommended alternative treatment.

Contrary to expectation, no significant differences were found in regard to the extent that years of clinical experience, theoretical therapeutic orientation, and the age of those practitioners impact attitudes and practices related to addressing risk of negative treatment effects during informed consent. Although research indicates that some orientations may lend themselves more closely toward informed consent than others, because they consider issues "more important" (e.g., CBT treatment possesses a highly structured manualized approach) (Somberg et al., 1993, p. 153), results from this survey revealed orientation does not impact the decision about whether or not licensed psychologists inform clients of potential risks in treatment. This finding is supported by both Dsubanko-Obermayr and Baumann's (1998) and Tymchuk, Drapkin, Major-Kingsley, Ackerman, Coffman, and Baum's (1982) survey studies, both of which produced similar results. The finding that years of clinical experience does not correlate with attitudes or practices of addressing potential risk during informed consent is similarly supported by Boisvert and Faust's (2003) study (see section *Informed Consent and Risk*).

Implications for Informed Consent Practice

In the clinical setting, a conversation of risk that is related to potentially negative treatment effects as a result of engaging in psychotherapy has received limited attention, but is nonetheless important on ethical and moral grounds (see Ethics Code, 2002). On a practical level, these arguments for addressing risk have potential implications related to the conduct of clinical practice protocols. According to the Ethics Code's (2002) informed consent standards, licensed psychologist should be given clinical guidelines. The specifics of "viable alternatives" and "their relative grounding in scientific data and professional acceptance" during a proposed treatment remains unresolved (Beahrs & Gutheil, 2001). Risks and benefits are clearly discussed when psychotropic medications are prescribed, "due to pharmacological side effects"; however, Walker et al. (2005) noted that it is less the case with psychotherapy alone (p. 241). Although potential risk from verbal therapies might appear to have less visible impact, research reveals they are considered just as important to include during informed consent, as are the potential medical risks (Walker et al., 2005; Berg et al., 2001). As previously mentioned, Thyer and Myers (1998) assert that clients are entitled to information related to evidence-based psychological treatment. However, as research has noted, even the most effective and efficacious psychotherapeutic treatments do not work for everyone, which emphasizes the importance of including a discussion of potential risk that is related to negative treatment effects during the informed consent process.

In order to assess treatment that is not working, Lambert and his colleagues (2003) studied client feedback in psychotherapy, including its impact on outcomes. In order to detect improvement, prior to the beginning of each psychotherapy session,

feedback regarding therapy was elicited from the clients and subsequently compared with average progress made by similar norms (onset and symptom severity). Results demonstrated that providing clinicians with feedback had beneficial effects on psychotherapy outcomes. Lambert et al. (2003) reported sole reliance on pure clinical judgment to identify and make treatment decisions was insufficient. One of the main reasons that client feedback had such a dramatic effect on outcomes, Lambert et al. (2003) assert, is that, without this information, psychotherapists seldom expect their clients to become worse. Lambert et al. (2003) equated measuring client outcomes to having one's blood pressure taken in medicine. Obtaining tangible mental health vital signs can be used as a gauge for psychotherapy. Roth and Fonagy (2004) report the fact that therapists often ignore signs that clients are not benefiting from psychotherapy due to biases in thinking. Tracking progress would be beneficial in ensuring psychotherapists' awareness of outcomes. In order to assess psychotherapy treatment, an awareness of informed consent and negative treatment effects is essential. Teaching critical thinking and facts regarding psychological disorders is paramount (Lilienfeld, 2007). Lilienfeld (2007) asserted that a careful understanding of biases and heuristics can impact and influence one's judgment into thinking that certain techniques or treatments are working, when in fact they are not.

Results from this study could have potential implications, for example, in establishing better comprehensive, informed consent guidelines for practitioners. Half of the participants surveyed, for example, either remained neutral or did not rate the survey question: "Approximately 10 percent of clients get worse as a result of engaging in some aspect of psychotherapy" (See Table 2). Although the reasons about why this particular

question was ignored are unknown, it could be argued that practitioners are unfamiliar with knowledge from psychotherapy research on potential risk of negative treatment effects in psychotherapy. Thus, they may be relying on personal opinions rather than on evidence-based research. It seems essential that in order to apply science to psychotherapy, an understanding of findings about research on negative treatment effects would be considered paramount to practical application.

Method for obtaining progress in psychotherapy. The method most commonly used to inform clients of overall progress in psychotherapy was outcome measures and questionnaires. The other methods reported were asking the client directly, and giving and receiving feedback. The use of outcome measures and questionnaires have their advantages (documentation, standardization of treatment, fewer liability concerns); however, it is interesting that verbal communication was not in greater use. The available empirical data suggest a combination of both verbal and written methods are best practice in assessing overall progress.

Timing of informed consent procedures. Although approximately one-third of the participants reported starting a discussion of informed consent prior to the first session of psychotherapy, more than half reported starting the discussion during the first session, and significantly fewer reported a discussion of informed consent on an "as-needed" basis or not at all. Interestingly, female licensed psychologists are more likely to begin the discussion of informed consent before or during the first session, but male licensed psychologists begin the discussion between the first and second sessions of psychotherapy. Although early presentation of informed consent factors might be ideal, a conversation of risks related to negative treatment effects might argue for greater

flexibility. In one study, Pomerantz (2005) surveyed licensed psychologists regarding the "earliest feasible point at which they could provide information regarding specific aspects of therapy" (p. 351). Results found more substantial information, such as potential risks, could be presented only after some engagement in psychotherapy. Reasons for participants informing clients on an "as-needed basis" or "not at all" are unclear. If, however, a specific therapeutic treatment/procedure has not yet been identified, it seems premature to expect licensed psychologists to inform clients of potential risks of negative treatment effects as a result in engaging in psychotherapy. Appelbaum, Lidz, and Meisel's (1987) process model of informed consent (see Chapter 2) would provide greater flexibility if it viewed the informed consent process as continuous throughout the entire course of psychotherapy treatment rather than as a one-time event. Although this survey study did not inquire about the kind of model that licensed psychologists use, the answers themselves appear to be within the context of a one-time event model. Similarly, although most of the sample agreed that it is important to address risk of potential negative treatment effects, the survey did not inquire about a time when those potential risks are initially presented.

Post-Doctoral Ethics Training and Attitudes of Risk. Data from this study suggest licensed psychologists who report receiving post-doctoral ethics training are more likely both to agree that some therapeutic treatment techniques have greater probability of producing risk of negative effects than others, and to agree to the ethical importance of addressing potential risk of negative treatment effects during informed consent. Results, however, did not find that those who reported having had post-doctoral ethics training were more likely to inform clients of potentially negative treatment

effects. These findings are consistent with other research which suggests that there is little consistency between ethical decision-making and psychologists' attitudes toward training in ethics (Tymchuk et al., 1982). Licensed psychologists may have a limited understanding of the importance of post-doctoral training in ethics as it relates to informed consent practices that subsequently impact clients engaging in psychotherapy. Researchers strongly believe that it is important for clinical practice to be influenced by outcome research; Bohart (2000), however, notes that it is another thing for practice to be dictated by findings from clinical research.

Degree and attitudes. Research revealed that licensed psychologists who hold a Psy.D. degree rate informing clients about alternative treatments and/or procedures (including no treatment) during the process of informed consent, as more important, than those who hold a Ph.D. degree. The primary emphasis placed on a Psy.D. degree involves clinical practice and on training practitioners to be consumers of research. Research has substantiated the fact that, unlike the Ph.D. degree (Boulder-model) with an emphasis to produce research, the Vail-model Psy.D. programs provide slightly more clinical experience and clinical courses, but with less research experience (Tibbits-Kleber & Howell, 1987). Although there appears to be little difference in employment opportunities, graduates from research-oriented Ph.D. programs are more likely to be employed in academic positions and in medical schools (Gaddy, Charlot-Swilley, Nelson, & Reich, 1995). Thus it could be argued that psychologists with Psy.D. Degrees may be more likely to be practicing psychotherapists and have greater clinical exposure with informed consent procedures related to risks. Those psychologists who hold Psy.D. Degrees may also have more experience in the clinical application of informed consent

related to addressing alternative treatments and/or procedures (including no treatment) during the informed consent process.

Limitations and Implication for Future Research

Several limitations to the present study are apparent; this is evident with any research methodology. First, the sample of licensed psychologists pooled belongs to the National Directory of Psychologists, the Association of Black Psychologists, and graduate school psychology programs listed on the APA directory. Licensed psychologists with posted electronic mail addresses on these directories may possess unique characteristics which may affect their responses, in comparison with licensed psychologists who are not members of those websites and directories.

Another limitation involves the selection of subjects. Licensed psychologists with electronic mail addresses posted on websites may possess unique characteristics which can limit generalizability to the entire population of psychologists. Most of the participants were either in academic settings or in solo private practice (or both). Consequently, the selection of subjects may be a threat to external validity. Furthermore, nearly all the participants were Caucasian, which may also limit how well the results represent the overall population of psychologists across the United States. Another demographic characteristic that is considered a limitation is the type of degree, Ph.D. versus Psy.D. of the sample. The majority holds a Ph.D.; therefore, they may have responded differently from psychologists who hold a Psy.D. or an Ed.D. Degree.

Also, the present study relied solely on self-report measures which are associated with a few major problems (Kazdin, 2003). Respondents may distort their answers in a biased fashion because of the tendency toward giving socially desirable answers. The

current study attempted to offset this limitation by including reassuring statements that the survey is completely anonymous and voluntary. It is noteworthy that estimates of licensed psychologists' attitudes, not their actual practices were assessed. The attitudes obtained may represent upper estimates of the reality of addressing potential risk of negative treatment effects associated with psychotherapy. Feedback from participants in the survey revealed they had difficulty rating only one modality of therapy (Question 24). It is also important to note that the sample consisted of licensed doctoral level psychologists and did not include those from other specialties. Results were based on participants' attitudes and practices at the time of the measurement and because attitudes are dynamic, actual practices may vary considerably from self-reports or opinions (Croarkin et al. 2003). The other problem that characterizes self-report measures is the lack of evidence that the questionnaire measures the construct of interest (Kazdin, 2003). This newly formed questionnaire is the only survey of its kind found in the literature. Therefore, comparisons could not be made with other research surveys regarding the constructs of interest.

More research is needed to gain insight into how licensed psychologists understand and practice addressing potential risk related to negative treatment effects associated with psychotherapy. For example, it is unclear whether or not addressing negative treatment effects during informed consent affects how clients view treatment and subsequent outcome. Further, there is extremely limited research that describes the practice of informed consent related to addressing risk of negative treatment effects. Addressing risk of negative treatment effects in the clinical context and its influence on psychotherapy outcome remains unknown. Future research might investigate the impact

of addressing, early in the process of informed consent, potential risk of negative treatment effects and the implications on treatment outcome. In addition, future research might investigate psychologists' attitudes toward informing clients of potentially negative effects with psychological assessment. Although controversial, some projective tests (Rorschach inkblot test and Thematic Apperception Test) lack empirical support. Research has found that these tests are not invalid; however, the norms and decision rules tend to pathologize healthy individuals (Wood, Garb, Lilienfeld, & Nezworski, 2002). In fact, Wood et al. (2002) reveal that 70 percent of pathology- free individuals will demonstrate serious disturbance on these measures. Future research might investigate informed consent practices in the forensic setting, specifically, those regarding psychological evaluations and their potential to produce negative outcomes and life-altering consequences.

Conclusion

The apparent variability among licensed psychologists' self-reported attitudes and practices, suggest that sole reliance on standards outlined in the Ethics Code (2002) might not be enough for clinical implementation regarding risk related to negative treatment effects associated with psychotherapy. The informed consent process related to addressing potential risk of negative treatment effects must be tailored to the unique context of a particular psychotherapeutic treatment. This study underscores the inherent complexity of applying ethical standards and principles to informed consent procedures related to risks of negative treatment effects as a result of engaging in psychotherapy. Although the phenomenon of risk, related to negative treatment effects appears convoluted, this survey study intended to both acknowledge the significance of the

problem and add to the limited body of research on practical applications of informed consent practice.

References

Adler, C. M., Craske, M. G., & Barlow, D. H. (1987). Relaxation induced panic (RIP): When resting isn't peaceful. *Integrative Psychiatry*, *5,* 94-100.

American Medical Association's (AMA) Code of Medical Ethics (2006 - 2007) Retrieved from http://www.ama-assn.org.

American Psychiatric Association (1973). Principals of medical ethics. Retrieved April 4, 2008, from http://www.psych.org/MainMenu/PsychiatricPractice/Ethics/ResourcesStandards/PrinciplesofMedicalEthics.aspx

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57(12), 1060-1073.

American Psychological Association Presidential Task Force on Evidence-Based Practice (2006). Evidence-based practice in psychology. *American Psychologist*, *61*, 271-285.

Appelbaum, P. S., Grisso, T., Frank, E., O'Donnell, S., & Kupfer, D. J. (1999). Competence of depressed patients for consent to research. *American Journal of Psychiatry, 156*, 1380-1384.

Appelbaum, P. S., Lidz, C8. W. & Meisel, A. (1987). *Informed consent: Legal theory and clinical practice*. New York: Oxford University Press.

Arboleda-Florez, J. (1987). Reibl v. Hughes: The consent issue. *Canadian Journal of Psychiatry*, *32*, 66-70.

Aronson, E., Akert, R. D., & Wilson, T. D. (2005). *Social psychology* (5th Ed.). Upper Saddle River, NJ: Pearson Prentice Hall

Barden, R. C. (2001). Commentary: Informed consent in psychotherapy - a multidisciplinary perspective. *Journal of the American Academy of Psychiatry and the*

Law, 29, 160-166.

Beahrs, J. O., Gutheil, T. G. (2001). Informed Consent in Psychotherapy. *American Journal of Psychiatry*, *158*, 4-10.

Beck, J. S. (1995). C*ognitive therapy: Basics and beyond*. The Guilford Press, New York: London.

Berg, J. W., Appelbaum, P. S., Lidz, C. W., & Parker, L. S. (2001). *Informed consent: Legal theory and clinical practice.* Oxford University Press.

Bergin, A. E. (1963). The empirical emphasis in psychotherapy: A symposium. The effects of psychotherapy: Negative results revisited. *Journal of Counseling Psychology*, *10*, 244-250.

Bloom, B. L. (1992). Planned short-term psychotherapy: Current status and future challenges. *Applied and Preventive Psychology*, *1*, 157-164.

Bohart, A. C. (2000). Paradigm clash: Empirically supported treatments versus empirically supported psychotherapy practice. *Psychotherapy Research, 10*, 488-493.

Boisvert, C. M. (1999). *Practitioners' familiarity with psychotherapy research and their relative weighting of research and experience in formulating beliefs*. Unpublished doctoral dissertation.

Boisvert, C. M., & Faust, D. M. (2002). Iatrogenic symptoms in psychotherapy. *American Journal of Psychotherapy, 56*(2), 244-259.

Boisvert, C. M., & Faust, D. M. (2003). Leading researchers' consensus on psychotherapy research findings: Implications for the teaching and conduct of psychotherapy. *Professional Psychology: Research and Practice*, *34*, 508-513.

Boisvert, C. M. & Faust, D. M. (2007). Practicing psychologists' knowledge of general

psychotherapy research findings. *Professional Psychology: Research and Practice*, *37*, 708-716.

Borys, D. S, & Pope, K. S. (1989). Dual relationships between therapy and client: A national study of psychologists, psychiatrists, and social workers. *Professional Psychology: Research and Practice*, 20, 283-293.

Braaten, E., & Handelsman, M. (1997). Client preferences for informed consent information. *Ethics and Behavior,* 7, 311-318.

Braaten, E. B., Otto, S., & Handelsman, M. M. (1993). What do people what to know about psychotherapy? *Psychotherapy: Theory, Research, Practice, Training, 30,* 565-570.

Buckley, P., Karasu, T. B., & Charles, E. (1981). Psychotherapists view their personal therapy. *Psychotherapy: Theory, Research, and Practice*, *18*, 229-305.

Canter, M. B., Bennett, B. E., Jones, S. E., & Nagy, T. F. (1994). *Ethics for psychologists: A commentary on the APA ethics code*. Washington, DC: American Psychological Association.

Canterbury v. Spence. (1972). 464 F 2d 772, U.S. Downloaded from: Court of Appeals, District of Columbia Circuit. Retrieved June 1, 2008, from http://www.stanford.edu/group/psylawseminar/Canterbury.htm

Centers for Disease Control and Prevention, Department of Health and Human Services. (2008). Retrieved June 1, 2008, from http://www.cdc.gov/tuskegee/timeline.htm

Chadwick, J., & Mann, W. N. (1978). *Hippocratic writings* (pp. 67– 68). London: Penguin Books.

Chambliss, C. H. (2002). Psychotherapy and managed care: Reconciling research and

reality. Boston: Allyn and Bacon.

Childress, J., & Fletcher, J. (1994). Respect for autonomy. *Hastings Center Report*, *24*(3), 34-35.

Code of Federal Regulations, Title 45, Public Department of Health and Human Services Part 46 Protection of Human Subjects (2004), Revised June 23, 2005, Protection of human subjects. Washington, DC: U.S. Government Printing Office. Retrieved May 1, 2008, from http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.htm

Coyne, J. C., & Wildiger, T. A. (1978). Toward a participatory model of psychotherapy. *Professional Psychology, 9*, 700-710.

Croarkin, P., Berg, J., & Spira, J. (2003). Informed consent for psychotherapy: A look at therapists' understanding, opinions, and practices. *American Journal of Psychotherapy, 57*(3), 384-400.

Dawes, R. M., Faust, D., & Meehl, P. (1989). Clinical versus actuarial judgment. *Science*, *243*, 1668-1674.

Denney, M. K., Williamson, D., & Penn, R. (1976). Informed consent: Emotional responses of patients. *Postgraduate Medicine*, *60*, 205-209.

Dies, R., & Teleska, P. (1985). Negative outcome in group psychotherapy. In D. T. Mays, & C. M. Franks, C. (Eds.), *Negative outcome in psychotherapy and what to do about it*. New York: Springer Publishing Company.

Dishion, T., McCrod, J., & Poulin, F. (1999). When interventions harm: Peer groups and problem behavior. *American Psychology*, *54*, 755-764.

Dommeyer, C. J. (1988). How form of the monetary incentive affects mail survey response. *Journal of the Market Research Society, 30*, 379-385.

Dsubanko-Obermayr, K., & Baumann, U. (1998*).* Informed consent in therapy: Demands and reality. *Psychotherapy Research, 8*(3), 231-247.

Dyer, A. R., & Bloch, S. (1987). Informed consent and the psychiatric patient. *Journal of Medical Ethics, 13*, 12-16.

Elliott, C. (1997). "Caring about risks: Are severely depressed patients competent to consent to research?" *Archives of General Psychiatry*, *54*, 113-116.

Emanuel, E. J., Crouch, R. A., Arras, J. D., Moreno, J. D., & Grady, C. (Eds.) (2003). *Ethical and regulatory aspects of research: Readings and commentary*. Baltimore: The Johns Hopkins University Press.

Everstine, L., Everstine, D. S., Heymann, G. M., True, R. H., Frey, D. H., Johnson, H. G., & Seiden, R. H. (1980). Privacy and confidentiality in psychotherapy. *American Psychologist, 35*, 828-840.

Faden, R. R., & Beauchamp, T. L. (1980). Decision making and informed consent: A study of the impact of disclosed information. *Social Indicators Research*, *7*, 313-336.

Faden, R. R., & Beauchamp, T. L. (1986). *History and theory of informed consent*. New York: Oxford University Press.

Fisher, C. B. (2003). *Decoding the ethics code: A practical guide for psychologists*. Thousand Oaks, CA: Sage.

Flory, J., & Emanuel, E. (2004). Interventions to improve research participants' understanding in informed consent for research. *Journal of the American Medical Association*, *292*, 1593-1601.

Foa, E. B., Zoellner, L. A., Feeny, N.C. Hembree, E. A., & Alvarez-Conrad, J. (2002). Does imaginal exposure exacerbate PTSD symptoms? *Journal of Consulting and*

Clinical Psychology, 70, 1022-1028.

Freud, S. (1964). Analysis terminable and interminable. In J. Stratchy (Ed. And Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 23, pp. 216-253). London: Hogarth Press. (Original work published 1937).

Gabbard, G. O., Lazar, S. G., Hornberger, J, & Spiegel, D. (1997). The economic impact of psychotherapy: A review. *American Journal of Psychiatry, 154*, 147-155.

Gaddy, C. D., Charlot-Swilley, D., Nelson, P. D., & Reich, J. N. (1995). Selected outcomes of accredited programs. *Professional Psychology: Research and Practice, 26*, 507-513.

Galietta, M., & Stanley, D. (2007). Ethical issues. In Evidence-based outcome research: A practical guide to conducting randomized controlled trials for psychosocial interventions. Nezu, A. M., & Nezu, C. M. (Eds.), Oxford University Press: NY.

Garfield, S. L. (1986). Research on client variables in psychotherapy. In S. L. Garfield & E. Bergin (Eds.), *Handbook of psychotherapy and behavioral change* (pp.213-256). New York: Wiley.

Gomes-Schwartz, B. (1978). Effective ingredients in psychotherapy: Prediction of outcome from process variables. *Journal of Consulting and Clinical Psychology, 46*, 1108-1132.

Gorkin, M. (1987). *The uses of transference*. New York: Jason Aronson.

Greenburg, S., & Jesuitus, L. (2002). The study of the practice of licensed psychologists in the United States and Canada. The Association of State and Provincial Psychology Boards. Retrieved July 10, 2008, from http://www.asppb.net/files/public/Practice_Analysis_2003.pdf

Grisso, T., & Appelbaum, P. S. (1998). Assessing competence to consent to treatment: A guide for physicians and other health professionals. New York: Oxford University Press.

Gustafson, K. E. (1988). Parents as consumers: The decision to seek psychological treatment for children. Unpublished doctoral dissertation, Ohio University.

Gustafson, K. E., McNamara, J. R., & Jensen, J. A. (1988). *Informed consent practices of child clinicians: Risk and benefit of disclosure*. Paper presented at the meeting of the Southeast American Psychological Association, New Orleans, LA.

Haas, L. (1991). Hide-and-seek or show-and-tell? Emerging issues of informed consent. *Ethics and Behavior*, *1*, 175-189.

Hansen, N. B., Lambert, M. I., & Forman, E. M. (2002). The psychotherapy dose-response effect and its implication for treatment delivery systems. *Clinical Psychology: Science and Practice*, *9*, 329-343.

Handelsman, M. M. (1990). Do written consent forms influence clients' first impressions of therapists? *Professional Psychology: Research and Practice, 21*, 451-454.

Handelsman, M. M., & Gavin, M. D. (1988). Facilitating informed consent for outpatient psychotherapy: A suggested written format. *Professional Psychology: Research and Practice, 19*(2), 223-225.

Handelsman, M. M., Kemper, M. B., Kesson-Craig, P., McLain, J., & Johnsrud, C. (1986). Use, content, and readability of written informed consent forms for treatment. *Professional Psychology: Research and Practice, 17*, *51*4-518.

Handelsman, M. M., & Martin, W. L. (1992). Effects of readability on the impact and recall of written informed consent material. *Professional Psychology: Research and*

Practice, 23, 500-503.

Hare-Mustin, R. T., Maracek, J., Kaplan, A. G., & List-Levinson, N. (1979). Rights of clients, responsibilities of therapists. *American Psychologist, 34*, 3-16.

Haslam, D. R., & Harris, S. M. (2004). Informed consent documents of marriage and family therapists in private practice: A qualitative analysis. *American Journal of Family Therapy, 32*, 359-374.

Havik, O. E. & Vanden Bos, G. R. (2006). Limitations of manualized psychotherapy for everyday clinical practice. *Clinical Psychology: Science and Practice, 3*, *264-267.*

Horowitz, S. (1984). The doctrine of informed consent applied to psychotherapy. *Georgetown Law Journal, 72*, 1637-1663.

Institute of Medicine. (2001). Crossing the chasm: A new health system for the 21st century. Washington, DC: National Academies Press. Retrieved July 16, 2009, from http//www.nap.edu/books/0309072808/html

Jensen, J. A., McNamara, J. R., Gustafson, K. E. (1991). Parents' and clinicians' attitudes toward the risks and benefits of child psychotherapy: A study of informed-consent content. P*rofessional Psychology: Research and Practice, 22*(2), 161-170.

Kadden, R. M., Cooney, N. L., Getter, H., & Litt M. D. (1989). Matching alcoholics to coping skills or international therapies: Posttreatment results. *Journal of Consulting and Clinical Psychology*, *57*(6), 698-704.

Katz, J. (1999). Physicians and patients: A history of silence. In T. L. Beauchamp, & L. Walters (Eds.), *Contemporary issues in bioethics* (5th ed., pp. 135–138). Belmont, CA: Wadsworth Publishing Company.

Kazdin, A. E. (2003). *Research design in clinical psychology* (4th Ed.). Boston: Allyn and

Bacon.

Kent, G. (1996). Shared understandings for informed consent: The relevance of psychological research on the provision of information. *Social Science and Medicine, 10*, 1517-1523.

Kitchener, K. S. (1984). Intuition, critical evaluation and ethical principles: The foundation for ethical decisions in counseling psychology. *Counseling Psychologist, 12*(3), 43-55.

Klerman, G. L. (1990). The psychiatric patient's right to effective treatment: Implications of the Osheroff v. Chestnut Lodge. *American Journal of Psychiatry*, *147*, 419-427.

Knapp, S. J., & VandeCreek, L. (2006). *Practical ethics for psychologists: A positive approach*. American Psychological Association. Washington: DC.

Lambert, M. (2007). What we have learned from a decade of research aimed at improving psychotherapy outcome in routine care. *Psychotherapy Research*, *17*, 1-14.

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavioral change* (5th ed., pp.139-193). New York: Wiley.

Levine, R. J. (1995). Consent issues in human research. In Emanuel, E. J., Crouch, R. A., Arras, J. D., Moreno, J. D., & Grady, C. (Eds.), *Ethical and regulatory aspects of research* (pp. 197-201). Baltimore, London. The Johns Hopkins University Press.

Lieberman, M. (1994). Growth groups in the 1980's, in *Handbook of Group Psychotherapy: An Empirical and Clinical Synthesis*, edited by Fuhriman, A., Burlingame, G. New York, Wiley, 1994, pp. 527-558.

Lieberman, M., Yalom, I., & Miles, M. (1973). *Encounter groups: First facts*. New York:

Basic Books.

Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Association for Psychological Science, 2*(1), 53-70.

Litz, C. W., Appelbaum, P. S., & Meisel, A. (1988). Two models of implementing informed consent. *Archives of Internal Medicine, 148*, 1385-1389.

Luborsky, L., Mintz, J., Auerbach, A., Christoff, P., Bachrach, H., Todd, T, Johnson, M., Cohen, M., & O'Brien, C. (1980). Predicting the outcome of psychotherapy: Findings of the Penn Psychotherapy Project. *Archives of General Psychiatry*, *37*, 471-481.

Lutz, W., Lambert, M. J., Harmon, S. C., Tachitzaz, A., Schurch, E., & Stulz, N. (2006). The probability of treatment success, failure and duration-hat can be learned from empirical data to support decision making in clinical practice? *Clinical Psychology and Psychotherapy*, *13*, 223-232.

MacDevitt, J. W., & Acker, T. L. (1990). Using an information sheet for clients at a university counseling center. *Journal of College Student Development*, *31*, 568-569.

Manning, S. S., & Gaul, C. E. (1997). The ethics of informed consent: A critical variable in the self-determination of health and mental health clients. *Social Work Health Care, 25*(3), 103-117.

Mays, D. T., & Franks, C. M. (1985). *Negative outcome in psychotherapy and what to do about it*. Springer Publishing Company: New York.

Meade, C. D., & Howser, D. M. (1992). Consent forms: How to determine and improve their readability. *Oncology Nursing Forum, 19*(10), 1523-1528.

Meisel, A., Roth, L., & Lidz, C. (1977). Toward a model of the legal doctrine of informed consent. *American Journal of Psychiatry, 134*, 285-289.

Mercer, J., Sarner, L., & Rosa, L. (2003). *Attachment therapy on trial: The torture and death of Candace Newmaker*. Westport, CT: Praeger Publishers.

Milgram, S. (1974). *Obedience to Authority: An Experimental View*. New York: Harper and Row.

Mohr, D. (1995). Negative outcome in psychotherapy: A critical review. *Clinical Psychology*, *2*, 1-27.

Mohr, D. H., Beutler, L. E., Engle, D., Shoham-Salomon, V., Bergan, J., Kaszniak, A.W., and Yost, E. B. (1990). Identification of patients at risk for nonresponse and negative outcome in psychotherapy. *Journal of Consulting and Psychology*, *58*(5), 622-628.

Morse, H. (1967). Psychiatric responsibility and tort responsibility. *Journal of Forensic Sciences*, *12*, 305-358.

Morrison, J. K. (1979). A consumer-oriented approach to psychotherapy. *Psychotherapy, Research and Practice, 16*, 381-384.

Muehleman, T., Pickens, B. K., & Robinson, R. (1985). Informing clients about the limits of confidentiality, risks, and their rights: Is self-disclosure inhibited. *Professional Psychology: Research and Practice, 16*, 385-397.

National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research. (1979). The Belmont report: Ethical principles and guidelines for the protection of human subjects of research. Washington, DC. U.S. Government Printing Office. Retrieved May 27, 2008, from http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.htm

National Institutes of Health. Retrieved June 1, 2008, from http://www.nih.gov.

National Institutes of Mental Health. Retrieved June 1, 2008, from

http://www.nimh.nih.gov.

Nishith, P., Resick, P. A., & Griffin, M. G. (2002). Pattern of change in prolonged exposure and cognitive-processing therapy for female rape victims with posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, *70*, 880-886.

Nolan, S. A., Strassle, C. G., Roback, H. B., & Binder, J. L. (2004). Negative treatment effects in dyadic psychotherapy: A focus on prevention and intervention strategies. *Journal of Contemporary Psychotherapy, 34*(4), 311-330.

Noll, J. O. (1981). Material risks and informed consent to psychotherapy. *American Psychologist, 36*(8), 915-916.

Noll, J. O., & Haugan, M. L. (1985). Informed consent to psychotherapy: Current practices at university-affiliated psychology training clinics. *Law and Psychology Review, 9*, 57-66.

Nunnally, J. C., & Bernstein, I. H. (1994). *Psychometric theory (3rd Ed.)*. New York: McGraw-Hill.

Olfson, M., Marcus, S. C., Druss, B., & Pincus, H. A. (2002). National trends in the use of outpatient psychotherapy. *The American Journal of Psychiatry, 159*, 1914-1920.

O'Neill, P. (1998). *Negotiating consent in psychotherapy*. New York: New York University Press.

Pellegrino, E. D., & Thomasma, D. C. (1993). *The virtues in medical practice*. New York: Oxford University Press.

Permissible Medical Experiments. Trials of War Criminals before the Nuremberg President's Council on Bioethics. (2008). Retrieved June 1, 2008, from http://www.bioethics.gov.

Military Tribunals under Control Council Law No. 10. Nuremberg October 1946 – April 1949, Washington. U.S. Government Printing Office (n.d.), *2*, 181-182.

Plaut, E. A. (1989). The ethics of informed consent: an overview. *Psychiatric Journal of the University of Ottawa, 14*(3), 435-438.

Pomerantz, A. M. (2005). Increasingly informed consent: Discussing distinct aspects of psychotherapy at different points in time. *Ethics and Behavior*, *15*(4), 351-360.

Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1987). Ethics of practice: The beliefs and behaviors of psychologists as therapists. *American Psychologist, 42*, 993-1006.

Reamer, F. (1987). Informed consent in social work. *Social Work, 32*(5), 425-429.

Roback, H. B. (2000). Adverse outcomes in group psychotherapy: Risk factors, prevention and research direction. *Journal of Psychotherapy Research and Practice, 9*, 113-122.

Roberts, L. W., Geppert, C., & Bailey, R. (2002). Ethics in psychiatric practice: Informed consent, the therapeutic relationship, and confidentiality. *Journal of Psychiatric Practice*, *8*, 290-305.

Rogers, C. R. (1954). The case of Mr. Bebb: The analysis of a failure case. In C. R. Rogers & R. F. Dymond (Eds.), *Psychotherapy and personality change: Coordinated research studies in the client-centered approach* (pp. 349-409). Chicago: University of Chicago Press.

Roth, A. & Fonagy, P. (2004). What works for whom? New York: Guilford Press.

Rothman, D. J. (1982). Were Tuskegee & Willowbrook "Studies in nature"? *The Hastings Center Report*, *12*(2), 5-7.

Sachs, J. S. (1983). Negative factors in brief psychotherapy: An empirical assessment. *Journal of Consulting and Clinical Psychology, 51*(4), 557-564.

Schloendorff v. Society of New York Hospital (1914). 211 N.Y. 125, 105 N.E. 92.

Schulte, D., Kunzel, R., Pepping, G., & Shulte-Bahrenberg, T. (1992). Tailor-made versus standardized therapy of phobic patients. *Advances in Behavior Research and Therapy*, *14*, 67-92.

Schwitzgebel, R. K. (1976). Treatment contracts and ethical self-determination. *The Clinical Psychologist, 29*, 5-7.

Shapiro, D. A., & Shapiro, D. (1982). Meta-analyses of comparative therapy outcome studies: A replication and refinement. *Psychological Bulletin, 92*, 581-604.

Siminoff, L. A. (2003). Toward improving the informed consent process in research with humans. *Internal Review Board: Ethics and Human Research Supplement, 25*(5), 1-3.

Simon, R. I. (1992). Informed consent: maintaining a perspective. *Psychiatry and the Law*, (2nd ed.), Washington, DC, American Psychiatric Press, 21–153. Retrieved March 30, 2008, from http://www.apahelpcenter.org/articles/article.php?id=51

Somberg, D. R., Stone, G. L., & Claiborn, C. D. (1993). Informed consent: Therapists' beliefs and practices. *Professional Psychology: Research and Practice, 24*(2), 153-159.

Smith, R. (2001). Informed consent: One standard for research, another for practice. In L. Doyal, & J. S. Tobias (Eds.), *Informed consent in medical research.* London: Books.

Smith, M. L., Glass, G. V., & Miller, T. I. (1980). *The benefits of psychotherapy.* Baltimore: Johns Hopkins University Press.

Smyth, J. D., Dillman, D. A., Christian, L. M., & Stern, M. J. (2007). Comparing check all and forced - choice question formats in web surveys. *Public Opinion Quarterly*, *70*(1), 66-77.

Sperry, L., Brill, P. L., Howard, K. I., & Grissom, G. R. (1996). *Treatment outcomes in psychotherapy and psychiatric interventions*. New York, Brunner/Mazel.

Stevenson, J., & Meares, R. (1992). An outcome study of psychotherapy for patients with borderline personality disorder. *American Journal of Psychiatry*, *149*, 358-362.

Stewart, R. E., & Chambless, D. L. Treatment failures in private practice: How do psychologists proceed? *Professional Psychology: Research and Practice*, *39*(2), 176-181.

Stone, A. A. (1990). Law, science, and psychiatric malpractice: A response to Klerman's indictment of psychoanalytic psychiatry. *American Journal of Psychiatry, 147*, 419-427.

Stoudemire, A. (1998). *Clinical* p*sychiatry for medical students* (3rd ed), Philadelphia, J.B. Lippincott Company.

Stricker, G. (1995). Failures in psychotherapy. *Journal of Psychotherapy Integration, 5*, 91-93.

Strupp, H. H., & Hadley, S. W. (1976). Contemporary views of negative effects in psychotherapy. *Archives of General Psychiatry, 33(*11*)*, 1291-1302.

Strupp, H. H., & Hadley, S. W. (1976). Negative effects and their determinants. In D. T. Mays, & C. M. Franks, C. (Eds.), *Negative outcome in psychotherapy and what to do about it*. Springer Publishing Company: New York.

Strupp, H. H., Hadley, S. W, & Gomes-Schwartz, B. (1977). Psychotherapy for better or

worse: An analysis of the problem of negative effects. New York: Aronson.

Stewart, R. E., & Chambless, D. L. (2007). Does psychotherapy research inform treatment decisions in private practice? *Journal of Clinical Psychology*, *63*, 267-281.

Stewart, R. E., & Chambless, D. L. (2008). Treatment failures in private practice: How do psychologists proceed? *Professional Psychology: Research and Practice*, *39*(2), 176-181.

Sugarman, J., McCroy, D. C., Powell, D., et al. (1992). Empirical research on informed consent: An annotated bibliography. *Hastings Center Report, 29*, 1-42.

Sullivan, T., Martin, W. L., & Handelsman, M. M. (1993). Practical benefits of an informed-consent procedure: An empirical investigation. *Professional Psychology: Research and Practice, 24*, 160-163.

Talbert, F. S., & Pipes, R. B. (1988). Informed consent in psychotherapy: Content analysis of selected forms. *Professional Psychology: Research and Practice, 19*, 131-132.

Talmon, M. (1990). Single-session therapy: Maximizing the effect of the first (and often only) therapeutic encounter. San Francisco: Jossey-Bass.

Thieren, M., & Mauron, A. (2007). Nuremberg code turns 60. Bulletin of the World Health Organization, 85(8). Retrieved May 3, 2008, from http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0042-96862007000800004&lng=&nrm=iso

Tibbits-Kleber, A. L., & Howell, R. J. (1987). Doctoral training in clinical psychology: A students' perspective. *Professional Psychology: Research and Practice, 18*, 634-639.

Thyer, B. A., & Myers, L., L. (1998). Supporting the client's right to effective treatment:

Touching a raw nerve? *Social Work*, *43*, 87-91.

Trials of War Criminals before the Nuremberg Military Tribunals Under Control Council Law (1949). *Nuremberg code: Directives for human experimentation*, *2*(10), 181-182. Washington, DC: U.S. Government Printing Office. Retrieved May 1, 2008, from http://ohsr.od.nih.gov/guidelines/nuremberg.html

Tuckett, D., & Williams, A. (1984). Approaches to the measurement of explanation and information-giving in medical consultations. *Social Science and Medicine, 18*, 571-580.

Tymchuk, A. J. (1997). Informing for consent: Concepts and methods. *Canadian Psychology*, *38*(2), 55-75.

Tymchuk, A. J., Drapkin, R. Major-Kingsley, S., Ackerman, A. B., Coffman, E. W., & Baum, M. S. (1982). Ethical decision-making and psychologists' attitudes toward training in ethics. *Professional Psychology*, *13*, 412-421.

U.S. Presidential Commission for the Study of Ethical Problems in Medicine and Biomedical Research (2008). Retrieved May 1, 2008, from http://www.bioethics.gov.

Walker, R., Logan, T. K., Clark, J. J., & Leukefeld, C. (2005). Informed consent to undergo treatment for substance abuse: A recommended approach. *Journal of Substance Abuse Treatment, 29*, 241-251.

Warwick, D. P. (1973). Tearoom trade: Means & ends in social research. *The Hastings Center Studies*, *1*(1), 27-38.

Whittington, C. J., Kendall, T., Fonagy, P., Cottrell, D., Cotgrove, A., & Boddington, E. (2004). Selective serotonin reuptake inhibitors in childhood depression: Systematic review of published versus unpublished data. *Lancet*, *363*, 1341-1345.

Widiger, T. A., & Rorer, L. G. (1984). The responsible psychotherapist. *American Psychologist*, *39*(5), 503-515.

Wirshing, D. A., Wirshing, W. C., Marder, S. R., Liberman, R. P., & Mintz, J. (1998). Informed consent: Assessment of comprehension. *American Journal of Psychiatry, 155*, 1508-1511.

Wood, J. M., Garb, H. N., Lilienfeld, S. O., & Nezworski, M. T. (2002). Clinical assessment. *Annual Review of Psychology*, *53*, 519-543.

World Medical Association. (2008). Retrieved June 1, 2008, from http://www.wma.net.

Wu, W. C., & Perlman, R. A. (1988). Consent in medical decision-making. *Journal of General Internal Medicine, 3*, 9-14.

Zimmerman, J. F. (1997). The Belmont Report: An ethical framework for protecting research subjects. *The Monitor*, 1-4.

APPENDIX A

(Electronic mail message sent for participant solicitation and recruitment purposes)

Dear Volunteer/Doctor:

My name is Neshe Sarkozy; I am a Doctoral Candidate in the APA accredited Clinical Psychology program at the Philadelphia College of Osteopathic Medicine (PCOM). I am doing a survey research study on attitudes and practices of licensed psychologists related to the informed consent process. By participating you may feel some personal satisfaction having taken part in research that may improve the ethical practice of informed consent implementation. I would be grateful if you would complete the questionnaire at the following URL address:

http://www.surveymonkey.com/s.aspx?sm=dSDV2FSbARlZFjKu6_2bB4lA_3d_3d

Completion of the questionnaire is expected to take about 10 minutes. Participation in this project is voluntary and you are not asked any identifying information. If you would like to take part in this survey study, please click NEXT at the beginning of the survey and it will automatically prompt you through to the questionnaire. Should you have any comments or concerns resulting from your participation in this survey study, you can also contact PCOM's Research Compliance Specialist at 215-871-6782. Thank you for your time and interest in this research project.

Respectfully,

Neshe Sarkozy, M.A., M.S. Responsible Investigator

Ginny Burks Salzer, Ph.D. Principal Investigator, Associate Professor

Director of Clinical Psychology Research

APPENDIX B

SURVEY QUESTIONNAIRE

Dear Participant,

All your responses will be kept confidential and you will not be identified in any way.

You will be able to opt out of the survey at any time by simply exiting the survey.

1) Are you licensed for independent practice as a psychologist?

- Yes
- No

If you have answered YES, please complete the following survey. Thank you in advance.

Instructions: For purposes of this study, client harm (negative effects) caused by some aspect of psychotherapy include; no change or benefit, excessive concern over worsening or new symptoms, excessive dependency on therapist, reluctance to seek future treatment, client abuse or misuse of psychotherapy, or physical harm.

2) There are potential risks (negative effects) to clients engaging in psychotherapy.

- Strongly Agree
- Moderately Agree
- Slightly Agree
- Neutral
- Slightly Disagree
- Moderately Disagree
- Strongly Disagree

3) How important is it to you to address potential negative effects of psychotherapy during the informed consent process?

- o Very Unimportant
- o Moderately Unimportant
- o Slightly Unimportant
- o Neutral
- o Slightly Important
- o Moderately Important
- o Very Important

4) How important is it to you to inform clients of alternative treatment/procedures (including no treatment) during the informed consent process?

- o Very Unimportant
- o Moderately Unimportant
- o Slightly Unimportant
- o Neutral
- o Slightly Important
- o Moderately Important
- o Very Important

5) At what point during the therapeutic process do you usually begin a discussion of informed consent?

- Before the first session
- During the first session
- During the second session
- During the third session
- After the third session
- On a “as needed” basis
- Never

6) What methods do you most commonly use to assess your patient/client's overall progress in therapy?

- Questionnaires
- Outcome measures/assessment
- Asking the client
- Giving and receiving feedback
- None
- Others: _____

7) Some psychotherapeutic treatment techniques produce a greater probability of potential negative effects than others.

- Strongly Agree
- Moderately Agree
- Slightly Agree
- Neutral
- Slightly Disagree
- Moderately Disagree
- Strongly Disagree

8) There are times when my judgment about a client prevents me from addressing negative effects of psychotherapy during the informed consent process.

- Strongly Agree
- Moderately Agree
- Slightly Agree
- Neutral
- Slightly Disagree
- Moderately Disagree
- Strongly Disagree

9) My clients have reacted negatively during the informed consent process.

- Strongly Agree
- Moderately Agree
- Slightly Agree
- Neutral
- Slightly Disagree
- Moderately Disagree
- Strongly Disagree

10) Addressing potentially negative effects of psychotherapy during the informed consent process does not negatively impact the therapeutic alliance and subsequent treatment outcome.

- Strongly Agree
- Moderately Agree
- Slightly Agree
- Neutral
- Slightly Disagree
- Moderately Disagree
- Strongly Disagree

11) During the informed consent process, a client's current symptomology, personality, and overall functioning, impacts whether or not to address potential negative effects of engaging in psychotherapy.

- Strongly Agree
- Moderately Agree
- Slightly Agree
- Neutral
- Slightly Disagree
- Moderately Disagree
- Strongly Disagree

12) It is unethical to include a discussion of risk of potential negative effects of psychotherapy during the informed consent process:

- Strongly Agree
- Moderately Agree
- Slightly Agree
- Neutral
- Slightly Disagree
- Moderately Disagree
- Strongly Disagree

13) At the onset of therapy, I always tell my clients not only that therapy might not work for them but they could become worse as a result of engaging in psychotherapy.

- Strongly Agree
- Moderately Agree
- Slightly Agree
- Neutral
- Slightly Disagree
- Moderately Disagree
- Strongly Disagree

14) Approximately 10 percent of clients get worse as a result of engaging in some aspect of psychotherapy?

- Strongly Agree
- Moderately Agree
- Slightly Agree
- Neutral
- Slightly Disagree
- Moderately Disagree
- Strongly Disagree

Demographic Information:

15) Gender:

- Male
- Female

16) Year of Birth: (Scroll down option for ages 1935 - 1985)

17) Ethnicity:

- Caucasian
- Black or African-American
- Hispanic-American/Latino/a
- Native-American/American Indian
- Asian or Pacific Islander
- Multiracial/Mixed
- Other (please specify)

18) Highest terminal degree completed:

- Ph.D.
- Psy.D.
- Ed.D.
- Other (please specify)

19) What is your Doctorate in? (Scroll down options)

- Clinical
- Counseling
- Developmental
- Experimental
- Educational
- Social
- School
- Industrial/organizational
- Physiological
- Environmental
- Health
- Family
- Rehabilitation
- Psychometrics and Quantitative
- Forensic
- Other (please specify)

20) Are you American Board of Professional Psychology (ABPP) Certified?

- Yes
- No

21) What is your ABPP Certification Area(s)?

- Behavioral
- Clinical
- Neuropsychology
- Counseling
- Family
- Forensic
- Group
- Health
- Psychoanalysis
- Rehabilitation
- School
- Not certified by ABPP
- Other (please specify)

22) Number of years working as a psychologist of in a closely related field.

- Less than 5 years
- 5-10 years
- 11-15 years
- 16-20 years
- 21-25 years
- 26-30 years
- More than 30 years

23) Population treated. (check all that apply)

- Child
- Adolescent
- Adult
- Older Adult

24) Therapy modalities. (check all that apply)

- Individual
- Couple
- Family
- Group

25) Primary work setting/location. (check all that apply)

- o Hospital (public or private)
- o Partial hospitalization
- o Treatment facility (Drug and Alcohol, Residential Treatment, Rehabilitation)
- o Community Mental Health Center
- o Solo Independent Practice
- o Group Practice
- o Academia (College/University)
- o Research
- o Administration
- o School (public or private)
- o Managed care company
- o Correctional Facility
- o Retired
- o Other (please specify)

26) Primary theoretical therapeutic orientation.

- Behavioral
- Cognitive-Behavioral
- Existential/Humanistic
- Psychodynamic
- Social learning
- Systems
- Other (please specify)

27) Have you ever attended a post-doctoral training on ethics that included information on the informed consent process?

- Yes
- No

The End. Thank you for your participation.