# Open therapy and its enemies

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Consider a scenario where, at the start of an appointment with a therapist, she explains to you that 'the success of the therapy will depend on your own positive expectations, the respect and esteem that you have for me as a qualified health professional, the warm tone and empathic approach that I adopt towards you, and the trust that you place in me, during the course of treatment'. You might find this transparency about the therapeutic process to be refreshingly honest. You might, however, be surprised if this openness turned out to be an ethical obligation that she owed you. Yet, for some commentators, this 'open' approach to psychotherapy – where there is openness about the common factors that can explain the efficacy of the therapy –is required by ethical standards of informed consent and (more generally) respect for patient autonomy.

In this edition of the *Journal of Medical Ethics*, Garson Leder formulates two responses to this type of 'open therapy claim': that '….informed consent does not require the practitioners 'go open' about the therapeutic common factors in psychotherapy, and clarity about the mechanism of change shows us that…psychotherapy, as it is commonly practiced, is not deceptive…'.[1] This edition also contains a comment by Charlotte Blease on Leder's paper, and a response by Leder to Blease's comment. All of which makes for an engaging exchange between a proponent of, and an opponent to, open therapy.

The open therapy claim stems from 'common factors findings in psychotherapy', specifically, the consensus that there is a set of "common factors mediate some, and possibly most, of the ameliorative effects in psychotherapeutic interventions".[1] These factors include:

> client characteristics (eg, positive expectations and hope), therapist qualities (eg, the ability to cultivate positive client characteristics), change processes (eg, the acceptance of a theoretical rationale for the therapy on offer), treatment structure (eg, the delivery of concrete treatments and techniques) and therapeutic relationship (eg, the development of a working alliance between therapist and patient).[1]

There are, therefore, common factors that help explain the efficacy of therapy that are *incidental* to the theory that grounds or explains the specific psychotherapeutic intervention. Since these incidental common factors – client characteristics, therapist qualities, and the therapeutic relationship – are necessary components to a sufficient understanding of the efficacy of psychotherapy, we can appreciate why proponents of open therapy want patients to be informed of these 'incidental' common factors that explain why therapy works (when it does work).

Leder's response to open therapy, is to differentiate between mechanisms of change and mediators of change. The mechanisms of change amount to 'the reasons why change occurred or how change came about' whereas the mediators are the 'variables that are statistically correlated with this change'.[1] In Leder's example of cognitive therapy, he explains that where a therapist seeks to address maladaptive cognitions (ie, thoughts, beliefs, and assumptions), the therapist may adopt techniques of 'identifying and challenging maladaptive thoughts and beliefs and training patients to challenge maladaptive patterns of thought (eg, all-or-nothing thinking, catastrophising, and overgeneralisation)'.[1] In order to explain the therapy, the therapist may then make a 'theory-specific claim' about the intervention, that it 'works by modifying maladaptive core beliefs'.[1] Leder argues that, while it remains true that the incidental common factors also explain 'how it works', one is a mechanism for change (that needs to be explained to the patient), the others are mediators for the change.

For Blease, this will not do. Her concern is that, given the enormous difficulty in isolating and testing the 'efficacy of the so-called specific factors of any psychological modality', it entirely plausible that the important agents of change are the mediators themselves, and the mechanisms may even be immaterial to the efficacy of any given therapy.[2] Which is why 'ethicists have argued patients should know about them'.[2] According to Blease, until basic research can 'take up the baton' and provide 'a clear mechanistic explanation about how a treatment is effective',[2] psychotherapy should be open therapy.

Leder's response to the problem of isolating and testing the efficacy of therapeutic interventions is also call for openness. But it is an openness about the uncertainty that surrounds the therapeutic intervention (the mechanism) itself. Since 'there is currently no consensus about mechanisms of change in psychotherapy', Leder suggests that patients need to be informed that 'the therapy on…is based on disputed theoretical foundations' and that 'theory-specific techniques are not necessary for healing'.[3] At dispute, therefore, is how open should open therapy be. An openness about what we know about how the therapeutic intervention (the mechanism) works or an openness about what we know about how therapy (the mechanism and the mediators) works.

Both Leder and Blease seem to agree on one thing, at least. They agree on the question that needs to be answered. For them, it is the 'how does the therapy work' question. For Leder, the answer lies in the mechanisms of change (the specific psychotherapeutic intervention). For Blease, the answer must also include the mediators of change (the incidental common factors). Answering this question is then equated with providing informed consent. Now, if 'explaining efficacy' amounts to 'providing informed consent' then Blease might be on strong ground. But there may be a baton that needs to be taken up by ethicists: to clarify whether satisfying the ethical requirement of informed consent is the same as, or differs from, a scientific explanation of a treatment's efficacy.

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