PAPER

Disclosure of incidental constituents of psychotherapy as a moral obligation for psychiatrists and psychotherapists

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ABSTRACT

Informed consent to medical intervention reflects the moral principle of respect for autonomy and the patient's right to self-determination. In psychotherapy, this includes a requirement to inform the patient about those components of treatment purported to cause the therapeutic effect. This information must encompass positive expectancies of change and placebo-related or incidental constituent therapy effects, which are as important as specific intervention techniques for the efficacy of psychotherapy. There is a risk that informing the patient about possible incidental constituents of therapy may reduce or even completely impede these effects, with negative consequences for overall outcome. However, withholding information about incidental constituents of psychotherapy would effectively represent a paternalistic action at the expense of patient autonomy; whether such paternalism might in certain circumstances be justified forms part of the present discussion.

PSYCHOTHERAPY AND PLACEBO—UNWANTED PROXIMITY

Debate on the ethical implications of placebo elements and their effects has been turbulent and controversial. In recognition of their potency, the tacit approval of the era prior to randomized controlled trials (RCT) gave way to dismayed renunciation and regulation, leading on to their current contested conceptualisation as either powerless or powerful. While placebo effects in medical contexts are widely acknowledged and harnessed with varying success in clinical practice[1 2] or as open placebos in clinical populations,[3] their status in psychotherapy resists such elucidation. In the recent past, it has been proposed that because 'psychotherapy is less burdened by doubts about the placebo effect … it was able to come to its aid when it was orphaned by medicine'.[4]

It is important to emphasise that psychotherapy is evidence-based, and a wealth of scientific findings confirm that psychotherapy is an effective and efficacious intervention for psychological problems and disorders.[5] Crucially, however, the mechanisms underpinning these impressive effects are either unknown[6] or subject to debate.[7] Here, an exclusive focus on specific treatment components must be abandoned in pursuit of the as yet undefined principles of psychotherapeutic change.[8] Given the evidence of little or no difference between the various forms of psychotherapy[9] and following direct comparisons with control conditions such as pill placebos[10] or pseudo-placebo treatments, debate on the mechanisms of psychotherapy has gained renewed momentum.[11] It has therefore been proposed that psychotherapy can best be understood from a contextualist perspective, stressing the importance of the therapeutic alliance and the importance of plausibility (of both rationale and intervention), which need not necessarily be scientifically valid.[7]

While this contextual model—widely synonymous with the so-called 'common factors' model of psychotherapy[12]—offers a valid framework within which to examine effective processes in psychotherapy, it also bears some (presumably unwanted) proximity to explanatory models of the placebo effect. With regard to the contextual understanding of psychotherapy, Frank[13] argued that psychotherapy ameliorates the perceived menace of experienced symptoms through collaborative formulation of a plausible explanation, in conjunction with plausible therapeutic strategies. This centrality of meaning and its transformation has also been noted with regard to placebo effects. As Moerman put it, "the one thing of which we can be absolutely certain is that placebos *do not* cause placebo effects. Placebos are inert and don't cause anything".[14] On that basis, as he persuasively argued, the 'primary thing—the really interesting thing that makes this important—is 'meaning''.[15]

CHARACTERISTIC AND INCIDENTAL CONSTITUENTS OF PSYCHOTHERAPY

Both empirically and theoretically, then, it is more difficult to draw a clear distinction between placebo and psychotherapy than might be considered desirable. And the issue cannot be resolved either by equating placebo with psychotherapy or by denying their shared processes. Rather, it is best addressed by a theoretical definition of the placebo that can identify placebogenic processes in psychotherapy without discarding its active elements.

Grünbaum elegantly solved the problem by offering a definition of placebo that was based on theory rather than effect and did not conflate specific and active treatment components.[16] From this perspective, each treatment consists of both characteristic and incidental constituents, assigned to one or other category on the basis of an underlying theory of treatment. A *generic* placebo is then understood as an intervention containing no characteristic constituent for the ailment being treated;

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this becomes an *intended* placebo when knowingly administered by a practitioner to a patient, who remains otherwise ignorant of the true nature of the intervention. This theory-driven definition has two advantages: (1) it solves the 'placebo trap' in psychotherapy—that is, equating placebo and psychotherapy on the basis that both work through psychological processes[17] and result in near-identical effects when compared;[10 11] and (2) it includes a clear statement that the unintended use of incidental treatment constituents still 'constitutes a generalization of the genus placebo'.[18]

On this understanding, each treatment theory defines its own incidental and characteristic constituents; depending on the underlying treatment theory, the same treatment constituent could be viewed as characteristic or incidental. As to psychotherapy, the assumption that its effects are mediated by its proposed characteristic treatment constituents is not to date supported by the evidence. On the contrary, the early belief that implicit common factors underlie psychotherapy's effects still holds.[19] Theoretically, these problems could be overcome simply by revising theories of psychotherapeutic treatment, openly stating what is to be considered characteristic and what is incidental. For example, if belief in the treatment rationale is an important and proven characteristic of psychotherapy for both patients (vide supra) and therapists, then this issue should be actively addressed in therapy and with the patient.[20] In reality, however, matters may be more complicated.

DOES INFORMED CONSENT TO PSYCHOTHERAPY REQUIRE INFORMATION ABOUT CHARACTERISTIC AND INCIDENTAL CONSTITUENTS?

Following the classical principles of biomedical ethics,[21] informed consent reflects the principle of *respect for autonomy* and the right to *self-determination*.[22] Informed consent to psychotherapy requires that therapists explain diagnostic findings, characteristics of the proposed treatment, alternative therapy options and potential risks, side effects and benefits, among other matters.[23] It follows that an integral part of properly informed consent is to explain which treatment components are purported to cause the therapeutic effect—that is, known characteristic constituents should be disclosed. This disclosure of both effect and assumed mechanism is especially important in the case of psychotherapy, in light of its scope and actions. With regard to scope, psychotherapy has been likened to an inner *Bildungsreise*, offering 'the opportunity (…) to change oneself, but also to answer the question of who one wants to be',[24] so that '(p)sychotherapy, to a much greater extent than psychopharmacological interventions, involves the whole profile of the self in its attempts to effect a change, not only in the temperament, but also in the character of the person in question, and this is decisive from an ethical point of view'.[24]

With regard to psychotherapy's effects, as these are achieved through 'laborious 'self-work'',[24] underlying mechanisms must be understood and applied to secure those effects. This differs from other (medical) interventions, in which therapeutic actions are caused mainly[i] by characteristic treatment constituents. For example, after taking pain medication, its effects are influenced by response expectancies, but the pharmacological agents then take effect without further subjective input. But in the present context, it would clearly be a case of the fallacy of post hoc ergo propter hoc to infer the validity of a treatment theory (and its associated characteristic and incidental treatment constituents) from its effects, either because there is little valid knowledge about mediating factors or because the effects are caused by processes beyond the stated treatment theory. It follows that the disclosure of truly characteristic psychotherapy constituents (rather than assumptions or beliefs) is severely hampered. For that reason, informed consent to psychotherapy should encompass disclosure of uncertainty about its characteristic constituents, as well as disclosure of the role of so-called 'incidental' constituents.

While this may seem antithetical to the widespread belief in so-called 'specific' effects of the various methods and techniques of psychotherapy, there is a risk that providing information about the efficacy of constituents assumed incidental may lower or even completely impede these effects. Consider the case of a therapist who first explains the scientific background of a chosen therapeutic technique before asserting that the patient must really believe in this technique if they are to fully benefit. This information may negatively affect the overall treatment outcome, reducing the benefit to the patient and conflicting with the moral principle of beneficence.[21]

The psychotherapist must therefore choose between two options: (1) disclosure of any incidental constituents of psychotherapy (according to the treatment theory), so respecting the patient's autonomy and right of informed consent at the possible expense of therapeutic benefit; or (2) withholding of information about the potential incidental constituents of psychotherapy, so achieving therapeutic benefits at the expense of the patient's autonomy and their right to properly informed consent. This constitutes a moral conflict between the two classical principles of biomedical ethics: 'respect for autonomy' and 'beneficence'.[21] Whatever the final decision, the structure of such conflicts means that one of these two moral principles will be overridden.

ARGUMENTS FOR 'JUSTIFIED PATERNALISM'

The withholding of information about incidental constituents of psychotherapy for reasons of therapeutic benefit represents a paternalistic action. Paternalism can be defined as "the interference of a state or an individual with another person, against their will, and defended or motivated by a claim that the person interfered with will be better off or protected from harm".[25] On this definition, for a number of reasons, paternalism always involves some degree of constraint of autonomy.

Paternalistic behaviour may be characterised as *weak* (soft) or *strong*. According to weak paternalism, "a man can rightly be prevented from harming himself (when other interests are not directly involved) only if his intended action is substantially non-voluntary or can be presumed to be so in the absence of evidence to the contrary".[26] Strong paternalism, on the other hand, means that a person is protected 'against his will, from the harmful consequences even of his fully voluntary choices and undertakings'.[26] Whether weakly or strongly paternalistic, the motive is usually to avoid harm (non-maleficence) and/or to benefit the person whose autonomy is overridden.

Clearly, withholding information about possible incidental constituents of psychotherapy corresponds to weak paternalism. Nevertheless, because paternalistic actions always involve a violation of autonomy, strong reasons must be advanced if it is to be justified. Fost identified the following situations in which paternalism is justified: (1) if immediate harm to the patient is

[i]Of course, the effects of medical interventions are also influenced by behavioural and psychological processes, such as expectancies, compliance and distress.[2]

likely; (2) if paternalistic behaviour seems likely to protect the person from future harm; (3) if the patient is likely to be thankful for the treatment at a later time; or (4) if the paternalistic behaviour is generalisable, in the sense that those supporting it would wish the same for themselves.[27]

CONCLUSION: GO OPEN!

The above discussion illustrates how the lack of a treatment theory that is generally accepted and valid makes it difficult for the psychotherapist to abide by the classical principles of biomedical ethics. On the one hand, a paternalistic stance may seem warranted, as open disclosure of incidental constituents of treatment would be seen as at best overstated and unduly cautious and at worst detrimental to treatment. The treating psychotherapist needs to assess which information may jeopardise the therapeutic outcome, bearing in mind that to withhold crucial information (eg, about incidental constituents) represents a *paternalistic action* and must be ethically well founded. However, given (1) the wealth of empirical support for the importance of so-called 'implicit common factors',[12] (2) the seminal importance of goal consensus and collaboration in psychotherapy[28] and (3) the fact that even open administration of a placebo does not severely impede its effects,[29] it seems possible and empirically justifiable (as well as non-maleficent, at least) for the psychotherapist to inform patients openly and comprehensively about both characteristic and incidental treatment constituents. Clearly, these practical issues are best resolved by substantial revision of underlying treatment theories and by thoroughly informed psychotherapists who are at least cognisant of existing debates in psychotherapy research.[12] While our proposal to 'go open' seems at least ethically justified, future empirical studies should address the impact of such measures on therapeutic outcomes in pursuit of a better balance between disclosure and the classical principles of biomedical ethics.

We conclude that an ethical point of view requires open disclosure of all relevant constituents of psychotherapy, and that open disclosure is both theoretically possible and potentially non-detrimental.

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