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Informed Consent and Psychotherapy:

An Interpretative Phenomenological Analysis of Therapists' Views

Abstract

Objectives: To examine the issue of informed consent and how this is translated into clinical psychotherapy practice.

Design: A qualitative approach was taken in which interviews were used to produce data.

Methods: Nine clinical psychologists with specialist psychodynamic training took part in the research. Participants were interviewed using a semi-structured interview schedule. The interviews were transcribed and the data were analysed using Interpretative Phenomenological Analysis.

Results: The tensions between balancing the requirements of informed consent with psychodynamic practice were explored and the notion of whether clients can truly be 'informed' prior to undertaking psychodynamic therapy was raised. Four major themes emerged from the data: 'Psychodynamic therapy as risky'; 'Balancing expectations between therapist and client'; 'Psychodynamic therapy as unique and experiential'; and 'Informed consent as complex: a linguistic conceit?'

Conclusions: This research has been valuable in identifying therapists' views and experiences of how the issue of informed consent is addressed in therapeutic practice. In light of the findings of this research, future investigation would benefit from more detailed examination of the process of providing informed consent, examining if, and

how often, consent issues are revisited by therapists. More research focusing on the views and need of clients are also warranted.

Introduction

The concept of informed consent is central in many academic and professional disciplines including medicine, law, psychology and philosophy (Appelbaum, Lidz & Meisel, 1987). The emergence of this concept as a key concern in the psychological sciences was prompted following the seminal, but controversial work of Stanley Milgram in the 1960's. Milgram's classic obedience studies (Milgram, 1963) involving deception drew attention to the importance of ethical issues in psychological research and, in particular, to the notion of informed consent. The main rationale for securing informed consent is to protect autonomous choice which, Beauchamp and Childress (2001) suggest, has been a '...loosely defined goal that is often buried in broad discussions of protecting the rights of patients ... historically, we can claim little beyond the fact that a general, inchoate societal demand has emerged for the protection of patients' and subjects' rights, particularly their autonomy rights' (2001: p. 77).

The increased focus on the rights of clients to make informed choices has been reflected within the provision of health services (Corrigan, 2003). The change in the professional and legal responsibilities of clinicians has been influenced and shaped by policies (prompted by various medical controversies) and legislation such as the Human Rights Act (1998) (Doyal, 2001). This has brought change in the relationship between the health professional and service user where consent to treatment now lies at the heart of the relationship (Department of Health, 2001a, 2001b, 2003). This conversion has been

portrayed as a move from a ‘paternalistic and autocratic’ culture, to an environment which promotes and advocates the role of ‘autocratic decision making’ on the part of the service user (Corrigan, 2003). Whilst this shift cannot be contested, the implementation of the principles of informed consent in clinical practice is challenging (Corrigan, 2003; Doyal, 2001; O’Neill, 2002), particularly within the field of psychotherapy (Beahrs & Gutheil, 2001), which will be the specific focus of this paper.

Informed consent in psychotherapy

Research on the translation of the principles of informed consent into the practice of psychotherapy is a growing concern. The majority of empirical studies in this area, however, are published in the USA. Whilst there are a few discussion papers in the UK which consider this issue (Gelsthorpe, 1995; Holmes, Adshead & Smith, 1994; Jenkins, 2004; Marzillier, 1993; Sutton, 2001) there is a lack of empirical data. This dearth of research in the UK may well be explained by the cultural and legal differences between the USA and UK. In the USA, informed consent is enshrined within law (Marzillier, 1993) and the legal standards of disclosure of informed consent in the UK have been described as relatively weak in comparison (Doyal, 2001). However, given the changing climate in the NHS concerning the emphasis on service user involvement and delivery of evidence based practice, the notion of informed consent is increasingly important (Doyal, 2001).

The developing interest in the publication of professional practice guidelines for many professions (including the profession of clinical psychology) has risen from the need to reduce professional vagueness about acceptable practice and, to specify moral responsibilities in the form of codes of conduct. Guidelines for clinical psychologists

were first published in 1974. These were subsequently revised in 1983, 1990 and, more recently, in 1995, following changes within the NHS through the introduction of various forms of legislation (British Psychological Society, 2003). In these guidelines, informed consent is defined as ‘...the client’s right to choose whether to receive psychological services and to make this choice on the basis of the best information available’ (British Psychological Society, 1995: p.16). These guidelines also outline in detail other issues for psychologists to consider which include: timing of consent; process of informed consent; information that should be provided to clients and factors to consider that may influence ability to obtain informed consent (British Psychological Society, 1995).

Review of the evidence

Whilst the evidence in relation to informed consent and psychotherapy is expanding, this body of research remains underdeveloped. Research in the USA has examined therapists’ practice and views on consent in general and how the principles of informed consent are communicated to clients (Croarkin, Berg & Spira, 2003; Dsubanko-Obermayr & Baumann, 1998; Noll & Haugan, 1985; Somberg, Stone & Clairborn, 1993). The methodologies typically employed in such studies have been the distribution of self-report questionnaires via surveys.

Findings from the research highlight variation in the practice and opinion of therapists in relation to informed consent according to their theoretical orientation. For example, Somberg et al. (1993) found that cognitive behavioural therapists were statistically more likely to inform clients about the length of treatment and discuss alternative treatment options than psychodynamic and eclectic therapists. Dsubanko-Obermayr and Baumann (1998) found that psychodynamic therapists rated disclosure of

financial arrangements as important, whereas behavioural therapists were more likely to discuss the methods and goals of treatment and use of written consent procedures as part of their informed consent process. In addition, Croarkin et al. (2003) found that psychodynamic therapists gave lower opinion ratings of the importance of the general value of informed consent in therapy, the perceived benefits of informed consent to clients, and the use of written consent procedures.

Of further interest are the reasons provided by therapists for not informing clients about consent issues. Somberg et al. (1993) found 37 % of therapists did not discuss the limits of confidentiality because they felt it irrelevant and unnecessary. Around 25% of therapists reported that they did not discuss the risks of therapy as they considered the risks to be minimal or none, or they deemed the issue irrelevant and unnecessary. Others (14%) expressed the belief that non-disclosure of risk information would have a negative impact on the client/therapeutic relationship and 52% of therapists reported that the length of treatment was not discussed as this was difficult to predict or define. In relation to procedures to be used, 26% stated that they were unable to identify/define their procedures. Finally, alternatives to therapy were considered irrelevant and unnecessary by 20% of therapists.

To account for the differences in opinion and practice, some writers have suggested that psychodynamic therapists may not advocate the application of the principles of informed consent, namely sharing detailed information with the client, based on the belief that it may injure the rapport between client and therapist (Croarkin et al. 2003). Jensen, McNamara and Gustafson (1991) further suggest that disclosure of such therapeutic methods in psychodynamic practice may undermine the therapeutic techniques which often rely on the spontaneous production of unconscious material.

The inferences that can be drawn from these studies are that the concept of informed consent is not solely an important ethical issue but also one which requires consideration from a clinical perspective. Consideration of the theoretical interest and how this may influence therapists' practice is needed. This view is supported by Jordan and Meara (1990) who contend that more reflection of the principles of virtuous ethics is needed taking into account the clinicians' characteristics, beliefs and experiences. Such considerations should occur alongside the examination of principle ethics, which concerns the professional obligations of the person outlined by their codes of conduct.

Whilst professional practice guidelines exist which define informed consent, how such guidelines are translated into practice is an issue of judgement for the clinician as suggested by the research findings (Croarkin et al. 2003; Somberg et al. 1993). Consequently, exploration of clinicians' decision making processes is elemental and requires further investigation.

Other empirical research in the area of informed consent and psychotherapy has surveyed clients' views concerning the information they require when accessing therapy (Braaten & Handelsman, 1997; Jensen et al., 1991). Interestingly, the outcomes of these studies suggest that therapists' reluctance to impart information to clients, based on their belief that it would be detrimental to the therapeutic relationship, have not been supported. On the contrary, in the Braaten and Handelsman (1997) study, current and former clients rated inappropriate techniques, confidentiality and the risks of treatment as the most important issues to be included in discussions with their therapist related to informed consent. Similarly, the Jensen et al. (1991) study (which surveyed the views of mothers), showed that parents rated discussion about the risks of therapy as an important issue. However, this was considered less important by clinicians, thus highlighting a

discrepancy between the information that therapists deem important to make available to clients with what clients consider important to know about therapy.

Aims of the research

Previous research has highlighted how clinicians' practices and decision making processes in relation to informed consent are influenced by several factors, including therapeutic orientation and clinical judgment (Croarkin et al. 2003; Dsubanko-Obermayr & Baumann, 1998; Somberg et al. 1993). Interest in this area within the UK is sparse and the research findings to date have been largely informed by quantitative methods of enquiry. The present study aimed to supplement this existing research by exploring the issue of informed consent in psychodynamic therapy practice using a qualitative methodology. Through adopting a qualitative approach, this study aimed to provide depth to the existing findings in this complex field (Smith, 1996). As Parker (1994: p.3) describes qualitative research is '...an attempt to capture the sense that lies within, and that structures what we say about what we do, an exploration, elaboration and systemisation of the significance of an identified phenomenon, the illuminative representation of the meaning of a delimited issue or problem'.

As the process of informed consent as practised by clinical psychologists working within a psychodynamic therapeutic model was the focus of the study, a method of enquiry was needed that allowed the issues of relevance to participants to emerge. Therefore participants were recruited as 'experts' of their own experiences to talk in depth about their views and experiences of the management of informed consent in therapeutic practice. The main aims of this research study were to explore the opinions of clinical psychologists practising within a psychodynamic therapeutic model around the

issue of informed consent. In particular, a focus was developed on what clinical psychologists thought a client should know about treatment; if and how they communicated this information to clients; and their understanding and views of the concept of informed consent (with particular reference to the psychodynamic model of practice).

Method

Participants

Nine participants took part in the study. The participants were qualified clinical psychologists who had completed post doctoral training in psychodynamic therapy in addition to their qualification in clinical psychology. All participants worked across the North West of England in adult mental health services, working with clients with complex needs. The aim of these inclusion criteria was to attempt to obtain a sample similar in terms of training background and work setting. Homogeneity is in line with research practice using qualitative paradigms, given that the emphasis is focused on understanding the frames of reference for a small group of people, as opposed to testing hypotheses on a large sample of participants, which is characteristic of quantitative forms of research (Smith & Osborn, 2003).

Eight of the participants were female and one participant was male. The mean age of the participants was 47 (range 41 - 50) and the average length of time since obtaining their specialist qualification in psychodynamic therapy was 8 years (range 2 - 13). Eight of the participants identified themselves as White British, and one participant identified themselves as White Caucasian.

Interviews and procedure

Following ethical approval for the project, clinical psychologists who fulfilled the sampling criteria were approached and invited to participate in the research project. Individual interviews (average length 75 minutes) were conducted at a convenient time and location for the participants, which, for all, was at their place of work. The interviews were semi-structured in order to provide participants opportunity to express the views which they deemed important, thus allowing opportunity for unanticipated issues to be raised, not based on the researchers' pre-conceived ideas. Topics that were included in the interview schedule were: the participant's clinical practice, their thoughts about how change occurred within their model of work, what they thought a client should know about treatment, what their understanding of informed consent was and how this related to their clinical practice. All of the interviews were tape recorded and transcribed for data analysis.

Data Analysis

The interview transcripts were analysed using Interpretative Phenomenological Analysis (IPA) (Smith, Jarman, & Osborn, 1999). The development and interest in IPA methodology has grown over recent years. The theoretical and philosophical underpinnings of IPA include phenomenology, hermeneutics, and symbolic interactionism. However, IPA places particular emphasis on capturing and exploring the meanings that participants assign to experiences in order to gain an insider's perspective on the area of research interest. The approach also recognises the central, interpretative role of the researcher in analysing and making sense of these experiences.

The process of arriving at the main themes involved intensive reading of the participants' transcripts to familiarise the researcher with the data. An idiographic approach was taken (Smith et al., 1999) in that one transcript was examined in detail before considering other transcripts. Each transcript was therefore coded in detail before moving on to the next and clusters of themes that were related from each transcript were noted, marking the different aspects of the participants' experiences. Emergent themes were then extracted after detailed analysis of all the transcripts as a group, with consideration of both the shared experiences within the group, and issues on which participants voiced differing viewpoints. During the process of arriving at the final list of themes, the researcher was alert to consideration of differences and inconsistencies of views across the sample.

Results

Emergent themes

From the process of analysis four major themes emerged: Psychodynamic therapy as risky; Balancing expectations of therapist and client; Psychodynamic therapy as unique and experiential; Informed consent as complex: a linguistic conceit? For presentation purposes, quotes from participants have been corrected grammatically to enhance readability. All of the names used in the paper to quote participants are pseudonyms.

Psychodynamic psychotherapy as risky

The issue of ‘risk’ associated with psychodynamic therapy emerged as an important theme and was emphasised by all participants. Risk issues in various contexts were highlighted by participants which included those linked with the psychodynamic model and the powerful role of therapist. A discussion with clients about the risks of pursuing psychodynamic therapy and the complexity between balancing these potential risks with the benefits of working within this framework was a common experience that was elaborated by all participants. Participants discussed the methods they adopted to reach decisions about client suitability and how this was often informed by conversations with clients explicitly about risk. There was a strong sense from participants of the need to inform clients that ‘psychotherapy would make them feel worse before they felt better’. Often this idea was conveyed by therapists asking clients how they had behaved or felt at their lowest point with the therapist then trying to think with the client based on their previous behaviour/feelings what form their ‘disturbance’ may take. Crucially, whilst all adopted this approach, some questioned the meaning and value of sharing this information with the client. Doubts were raised about whether imparting and providing this information ‘informed’ the client and therapist for what may unfold over the course of therapy.

‘...I think even though people know it and you’ve said, I don’t know that they hear it and can anticipate that, because they feel pretty bad when they come anyway’ (Kate).

There was also an awareness of the role of the therapist providing information in the clients' best interests, particularly if the therapist deemed that a psychodynamic approach was suitable for the client.

'...if you feel that this really would be the best form of therapy then stressing the risks and the distress so much that you are putting them off is not in the best interests of the client either' (Gillian).

In the above passages Gillian and Kate reflect on sharing information with the client and the therapists' need to consider the implications of doing this. The powerful and potentially 'risky' influence of therapists' words is elucidated by Mary, reflecting on a dilemma she experienced when observing another therapist with a client.

'...I have sat in on him interviewing patients and he works in a way that basically opens up someone's pathology immediately...by not playing the game if you like of being friendly and sociable and particularly very and going along with their defences if you like...it's very, very powerful in terms of discovering something about this person's pathology and what's likely to happen in the therapy when they become disturbed...it also raised for me...I found it very uncomfortable witnessing something like that ...to give somebody that kind of an experience you need to know that they can leave the room afterwards...but in essence I think that's what all therapists would try and do to some degree as part of the assessment...is to get some sense of what's lurking underneath how people present themselves' (Mary).

In the above passage, Mary describes the tension between balancing ‘assessment’ of the client for suitability with the ethics of imposing ‘risk’ to the client. Lindsay goes on to describe the power linked with the psychodynamic approach and the potentially powerful effect of the relationship between therapist and client.

‘...I think it’s (psychodynamic therapy) a lot more, psychological invasive, CBT is a much more, much less dependent upon the therapist and it’s much more about a set of tools...psychodynamic therapy is much more intrusive emotionally, drawing on the relationship and the person is much more readily manipulated’ (Lindsay).

Whilst therapists described the explicit discussions they had with clients about risk, they also described how they attended to clients’ ‘unconscious’ communication of distress or risk through their use of language.

‘...if people use a lot of metaphors like ‘I’m falling apart’, you know, ‘something’s going to crack in me’, often people you know, although they’re not conscious of it, they’re actually very acute, struggling with what’s going on for them, so they talk about metaphors like ‘drowning’, ‘falling’, you can get a sense of them that may trigger alarm bells really’ (Lindsay).

Although discussions of risk were, in the main, linked with powerful negative responses, some therapists shared experiences where issues of risk were contained through adopting a psychodynamic approach.

‘...psychodynamic therapy can have quite a containing function and that minimises risk ... quite honestly what happens I think generally in psychotherapy more than less directive forms, people start talking about the self harm that they’ve done ... I think if you say no, you’re never really going to find out what’s going on’ (Brian).

The decision making and balancing of expectations of client and therapist is explored in more depth within the next theme.

Balancing expectations of therapist and client

Participants discussed their expectations of the client and their need as therapists to balance this with the clients’ expectations of therapy. There was a sense expressed by therapists that often clients referred for psychodynamic work were not ‘ideal’ candidates. Participants also described the tension between balancing the system ‘NHS’ with the psychodynamic model of practice.

Participants felt that clients often entered therapy with ‘magical and erroneous’ ideas and conveyed a sense that they were passive recipients in the process. They emphasized clients’ active involvement in the therapeutic process, and the need to clarify in detail with the client their goals for therapy before embarking on the process. This included informing clients that the process of psychodynamic therapy was difficult and that the outcome of treatment was not always about ‘feeling better’.

‘...it isn’t about coming here, and you know, and feeling better just from the process of talking, it’s much more complicated than that’ (Katherine).

Participants stressed the ‘unknowingness’ of the process and outcome of therapy. Words such as ‘balance of probabilities’, ‘leap of faith’ and ‘uncertainty’ were used by participants.

‘...So quite a lot of patients who are referred for psychotherapy you can either look at an assessment in two ways. Is this approach appropriate for someone? ...is there any reason this person shouldn’t be using this approach? Often, erm, there’s this huge grey area in between’ (Mary).

Despite the level of uncertainty and complexity expressed by participants in relation to decision making regarding clients’ suitability for psychodynamic therapy, certain client characteristics were considered as necessary attributes that helped inform therapists’ decisions. These included: clients’ ability to reflect and think about their difficulties and the ability to consider the relationship with the therapist as important. Clients who were not curious about themselves or did not want to think about their role in their problems/relationships were considered unsuitable. A need for stability and an ability to contain difficult feelings between sessions were also considered as important characteristics for the client. Therapists talked about how they assessed for these attributes during the assessment process, particularly by discussing with the client their use of coping strategies such as alcohol use or self harm to self medicate. In the passage below Mary describes being honest with the client.

‘...self medication isn’t a legitimate thing, I mean I take paracetamol if I get a headache you know, but if you’re wanting to do this then you have to be willing to bear and try and understand the pain rather than avoid it’ (Mary).

Therapists discussed the importance of the need for social support and a need for a lack of ‘chaoticness’ in their social relationships. Regarding suitability, therapists talked about the need for clients to have experienced at least one good relationship in their life for them to have experienced a sense of ‘basic trust’. However, one therapist challenged this idea and did not think that a lack of a significant relationship would preclude a person from psychodynamic psychotherapy.

‘...And there’s the thing that people say that if there’s been one good relationship in somebody’s life then there’s usually hope, and if there’s been none, then it’s very hard to find hope, because everything is damaged and destroyed, but I’m not too sure about that one’ (Lucy).

Whilst therapists were able to describe some characteristics that were necessary attributes, most therapists reflected on the value of providing the client with a trial experience of therapy during the assessment stage as a way of informing them about the process of therapy. This was also considered as an opportunity for the therapist and client to reflect on the process and consider whether the approach was suitable. Many therapists discussed the value of meeting with the client over more than one assessment session as an opportunity to help inform their experience of the process in order to make a decision. However, Brian described his doubts about this process.

‘...I don’t trust the assessment process because people don’t tell you what their story is very often in the first few sessions. We’ve all seen people who after two years have disclosed that they’ve been raped’ (Brian).

Although the purpose of assessment and a trial therapy experience were easily described, therapists expressed difficulties in describing how they reached a decision as explored in the following passage.

‘...it’s hard to say actually crystallise what category of people when I would back off from psychodynamic work and what category within that I would say, okay’ (Lindsay).

Finally, Gillian described how she reconciled the uncertainty of balancing unsuitable characteristics with potential benefits of therapy for the client.

‘...and [what] you’ve got at the end of an assessment is a balance of probabilities and I think in terms of the, the contraindications if you like is people who do show any, then I think it gives you an indication of what you are likely to be up against if you take them on. And you’ve got to make a judgement as to whether, on in terms of the balance of probabilities, whether those are going to outweigh the positive indications for taking someone on or not’ (Gillian).

Psychotherapy as unique and experiential

When trying to explain how they described the therapeutic process, participants described this as extremely complex and difficult to explain. They questioned whether this could actually be explained in words and whether it was meaningful to the client. Gillian expressed her doubts regarding the limits and purpose of providing information to clients based on her belief that the important aspects of the psychodynamic approach, namely its' uniqueness and the importance of the developing relationship, cannot be conveyed into words.

‘...And the whole mode of the therapy is about experiencing something and its about experiencing it in a relationship and actually conveying something that can really only be experienced as it unfolds, conveying that into words at the very beginning is really hard’ (Gillian).

The experiential and practical experience of a trial therapy was considered more relevant and congruent with the psychodynamic model in providing the necessary means to ‘inform’ the client.

‘..but I’m not sure how you can do it, without already starting it, and getting an experience of doing it’ (Kate).

In the above passage, Kate describes the limits of the types of information that can be imparted to the client without undergoing an experience of the psychodynamic approach. This raises interesting questions about the manner in which a client can be informed prior

to psychodynamic therapy and the questionable limits and benefits of providing information to the client prior to undertaking an experience of the therapy.

Participants described information that they were able to impart, which included conversations about the timing, frequency, length of contract, confidentiality and boundaries of the work. Most therapists compared these conversations about the practicalities of therapy with the more complex discussions about the process of therapy. Some participants described how they compared the process of psychodynamic therapy with other life events, to provide a concrete description to clients. For example, they contrasted the process of therapy with 'learning to swim' or 'giving birth'. Leanne reflected on her own experiences of personal therapy to convey the difficulties in describing the approach.

'...it is extremely difficult to pinpoint just from my own experience of personal therapy. I found it incredibly helpful but if you asked me how did it help, you know, what was a,b,c,d,e from it, I wouldn't be able to tell you' (Leanne).

Interview extracts such as the above also indicate the difficulties that therapists had in articulating their decision making process.

Informed consent as complex: a linguistic conceit?

Most participants described how the notion of informed consent in psychotherapy practice was complex. Some participants considered that consent was limited in general psychotherapy practice, whilst others considered that consent was more limited in psychodynamic practice. In the passage below Brian challenges the notion of consent in

psychotherapy practice, highlighting the complexities and ‘mythical’ thinking behind providing information to a client on the assumption that this accurately informs a person about psychotherapy.

‘...Informed consent is a linguistic kind of conceit really, it’s a bit of a language based idea that you can tell somebody about something and that means they’re informed and I think that’s fairly mythical, especially in the consulting room’ (Brian).

Therapists often supplemented verbal information with written sources such as information leaflets. Some valued sending clients pre-therapy questionnaires and reflected that this often served a dual purpose being of benefit to the therapist in finding out more information about the client but also, as an informational component for the client, providing them with a sense of what the therapist may be interested in exploring with them. However, participants raised an experienced conflict between providing information as a result of organisational pressures and the ethos of psychodynamic practice. This was described by Mary.

‘...these sorts of, all this bureaucracy often throws up big tensions with psychodynamic practice...if you look at all of the information that we’re supposed to do, there is a tension between meeting these types of ‘shoulds’ and not interfering with the process of engaging with the patient. If people ask then we will tell them but we might be more interested in looking at why they ask the question and what’s behind that’ (Mary).

In the above, Mary describes the difficult balance between informing the client based on a sense of duty with the need to question the clients' requests for information from a therapeutic position. Joanne expanded upon this, considering the timing of the question and its significance.

‘...sometimes I struggle with it, sometimes you say things because you feel you should... practical bits about who you are and what your qualifications are, that sort of thing, ...I’m rarely asked about it these days, hardly ever, but if somebody did then I would, that’s the sort of thing I think they have a right to know, having said that if I was asked that in the middle of a long therapy, I’m not saying I wouldn’t answer it but I’m sure I wouldn’t answer it straight away I think I’d want to know why it was an issue at that point really’ (Joanne).

Interestingly, some therapists believed that clients considered consent to the therapist as more important than to a theoretical approach, which was in comparison, considered as irrelevant to the client.

‘...I think for most people they come in and they take a look at you and they think, can I talk to this person or not, ...and if they felt they can work with you and they get a sense of that being useful, they don’t care what the evidence base is I think people know if it seems okay for them’ (Joanne).

Discussion and conclusion

This study has elaborated the complex issues faced by clinicians in applying the principles of informed consent in psychodynamic practice. From this research, four main themes emerged. Firstly, issues relating risk and the powerful experience of psychodynamic work were evident. Issues of risk were discussed in relation to the psychodynamic model, and this was linked by participants to the powerful role of the therapist, and the use of the therapeutic techniques of psychodynamic therapy.

A second theme related to the need for therapists to balance their expectations of therapy, the demands of the NHS, and the expectations of the client was also raised as an important risk issue. Therapists considered that clients often had erroneous and magical ideas about psychodynamic therapy that did not necessarily correspond with their view of psychodynamic therapy. Whilst some characteristics and issues raised by clients were deemed as factors that may preclude them from psychodynamic therapy, therapists' often expressed difficulties articulating their decision making process. In particular participants struggled to express how they reconciled the need for informed consent with their experiences, intuition, emotional responses, and context of the therapeutic process.

The experiential and unique nature of psychodynamic therapy emerged as a third theme. Whilst therapists felt they were able to provide information about some issues, (for example, service related information confidentiality, appointments, boundaries), other types of information, such as description of the psychodynamic model, were viewed as more complex and problematic. Other models of practice, such as CBT were compared with psychodynamic practice and considered as more tangible, and easier to explain, as compared with the 'mysterious' and experiential psychodynamic approach.

A fourth theme elaborated therapists' experiences and beliefs about the notion of informed consent and the application of this concept in psychodynamic practice, and

highlighted therapists' belief providing verbal information to 'inform' clients was limiting, and in some respects superfluous. This was largely based on the therapists' experiences and emphasis on the unique and experiential nature of the approach. Many therapists considered that a more 'informative' and fitting approach to provide 'information' to clients was through experience.

Previous studies have often relied on quantitative methods of enquiry to explore therapists' opinions about informed consent, and have therefore not provided a full understanding of how therapists view and negotiate the importance of this principle in their therapeutic practice. The findings of the present study go some way in clarifying these important issues. Given that the present study is the only exploratory study to be conducted on this topic, and that previous studies have utilised quantitative methods of enquiry, comparisons of these findings with previous research are limited. However there are some similarities that can be identified. Some of the results from the Croarkin et al. (2003) study are consistent with themes raised in this research. For example, in this study the limits of informed consent in psychodynamic therapy were emphasised by participants. Croarkin et al. (2003) also found that psychodynamic therapists expressed the lowest opinion ratings on the importance of obtaining informed consent, and the potential benefits of this for the client.

In a discussion paper of the ethical dilemmas in psychotherapy, Holmes, Adshead and Smith (1994) challenge the concept of whether a client can be truly autonomous in psychodynamic psychotherapy. They posit that the therapists' unconscious processes may impact on their judgment and decision making, thus challenging whether therapists are able to offer 'real choices' to clients. The present findings lend some support to the view of Holmes et al. (1994), in that the conflict between the psychodynamic model of practice

with its emphasis on unconscious motivation conflicts with the rational decision making approach of ethical guidelines.

Unlike previous research (Jensen et al. 1991; Somberg et al. 1993), this study found therapists to report discussing with clients the risks of psychodynamic therapy. However, the results also highlight difficulties for clinicians in balancing prescriptive directives to provide information to the client with their own views that the information they were able to impart might not always be beneficial, meaningful and complete. Therefore, the content of therapists' discussions concerning the risks of therapy was influenced by their judgment of what they considered to be in the best interests of the client.

The present study helps in understanding the process of informed consent by therapists who largely identified themselves as practising within an object relations framework. Unlike previous research in this field, comparison with therapists of different theoretical orientations was not possible in this study due to the selection of a homogenous group of participants in accordance with the principles of IPA (Smith, 1996). Consequently, the generalisability of the findings of this research to all therapists practising within a psychodynamic framework or therapists in general is limited. More research is needed with other therapist groups.

In terms of the validity and reliability of the data, it was apparent that during the interview process some participants appeared anxious and concerned about their responses. This was apparent in the manner that pauses appeared to reflect participants' attempts to construct crafted replies, rather than 'top of the head' responses to some questions, or by the 'reworking' or rephrasing of replies already offered during the interview. There are two issues to highlight in relation to this. The first is that, as

highlighted in the analysis, participants sometimes found it difficult to fully convey how they reconciled the need for informed consent with their own experiences, intuition, and emotional responses within the context of the therapeutic process. Of particular relevance here is an influential phenomenological study on ‘feeling understood’ by Van Kaam (1959) which identified the importance for the person of perceiving signs of understanding from their conversational partner, their feeling safe in a relationship with the communicating person, and resulting feelings of relief, as key constituents of the experience of feeling understood. Although the researcher who conducted the interviews strove to enable these experiences, it is recognised that these are not always possible to invariably achieve with every interviewee and throughout an entire interview.

A second issue is that the interactional process of the research interviews may have unduly shaped the responses given by participants. The manner by which a person’s utterances can be shaped by the design of another person’s preceding utterance has been a particular focus of another qualitative approach, Conversation Analysis (Hutchby and Wooffitt, 1998). Indeed, in a general critique of qualitative analysis Wooffitt and Widdicombe (2006) highlight IPA as a particular approach which does not fully consider the manner in which the utterances of the interviewer give rise to particular responses from participants. They contrast this with a conversation analytic approach which shows that turns at talk are invariably connected in significant ways to prior turns, with turns in interaction being designed with respect to the activities performed by prior turns. Similarly, in accordance with the theoretical interest of IPA, the research presented here has focused on the interactional turns of the interviewee.

Given the existence of ethical guidelines for psychologists, aspects of either of the preceding highlighted issues could conceivably have given rise to cautiousness by

participants about the disclosure of information that was incongruent with these guidelines and may, therefore, have produced socially desirable answers. The practice of psychodynamic therapy is diverse and underpinned by many theorists. Consequently, this study helped understand the process of informed consent by therapists who largely identified themselves as practising within an object relations framework.

Whilst this project did not aim to explore clinicians' views of the British Psychological Society (BPS) guidelines per se, in view of the issues raised by participants, some consideration is warranted. This research highlighted that therapists were aware of, and, considered issues relating to informed consent in their practice, even though some suggested that their views did not concur with those of the BPS. Some participants expressed feelings of dissatisfaction with the current guidelines considering them to be difficult to apply in clinical practice. Upon closer inspection of the guidelines, there do appear to be similarities between the experiences and views elucidated from participants in this study with the guidance for practice as outlined by the BPS (2003).

With respect to outcome of therapeutic interventions, the views expressed by clinicians were similar to those in the guidelines in that, uncertainty and difficulty predicting outcomes of therapy were shared concerns. The guidelines state that '...it is not possible to predict psychological outcome with certainty, and clinical psychologists should base their prediction on best clinical judgements' (BPS, 2003: p.18). The utility and perceived unsuitability of providing verbal information to 'inform' clients expressed by participants in this study is further recognised in the BPS guidelines, where it is outlined that '...for many, therapeutic approaches...follows an evolving path...which cannot be precisely predicted in advance...clients should be made aware of this uncertainty...often unrealistic and undesirable to provide detailed information on all

aspects of psychological intervention, and consent should be obtained to a general strategy rather than specific procedures' (BPS, 2003: p. 18).

Summary of findings and implications for future research

This research has explored in detail a significant, yet somewhat neglected principal of psychological therapy, namely informed consent. Through in-depth exploration of the views and experiences of clinicians' a more detailed understanding of how the complex issues of consent and ethics are negotiated and considered in psychodynamic therapy have been elucidated. The findings of this research suggest that such issues are often fluid and unanticipated, therefore making it difficult to negotiate these issues in practice. Clinicians often found it impossible and inappropriate to 'inform' a client with information prior to undertaking psychodynamic therapy, believing that clients could only be 'truly' informed through undertaking an experience of therapy, thus emphasizing the experiential component of therapy as more 'informative' than other methods of information sharing.

The experiences of clinicians in this study provide depth to the guidelines for professional practice which highlight the complex and limited remit of information, and acknowledge the need to consent to the unknowingness of therapeutic approaches, as opposed to specific strategies. The guidelines also draw attention to the 'process of informed consent' and advocate that '...consent involves a process which may take place over several sessions... consent should be reviewed, formalised and recorded' (BPS, 2003: p.16). Given that this research suggests that informing a client occurs through experience, future research focusing specifically on this process, namely how often during the initial sessions of therapy issues of informed consent are revisited and how this

is achieved and monitored by the therapist would be a valued contribution to our existing knowledge and help inform clinicians' practice.

References

- Appelbaum, P.S., Lidz, C.W., & Meisel, A. (1987). *Informed consent: legal theory and clinical practice*. New York: Oxford University Press.
- Beahrs, J.O., & Gutheil, M.D. (2001). Informed consent in psychotherapy. *American Journal of Psychiatry*, 158, 4-10.
- Beauchamp, T.L., & Childress, J.F. (2001). *Principles of biomedical ethics* (5th ed). Oxford University Press.
- Braaten, E.B., & Handelsman, M.M. (1997). Client preferences for informed consent information. *Ethics and Behavior*, 7, 311-328.
- British Psychological Society (2003). *Professional Practice Guidelines: Division of Clinical Psychology*. BPS: Leicester.
- Corrigan, O. (2003). Empty ethics: the problem with informed consent. *Sociology of Health & Illness*, 25, 768-792.
- Croarkin, P., Berg, J., & Spira, J. (2003). Informed consent for psychotherapy: A look at therapists' understanding, opinions and practices. *American Journal of Psychotherapy*, 57, 384- 401.
- Department of Health (2001a) Good practice in consent implementation guide: Consent to examination or treatment. Department of Health, London.
- Department of Health (2001b) Reference guide to consent for examination or treatment. Department of Health, London.
- Department of Health (2003) Model Policy for consent to examination or treatment. www.doh.gov.uk/consent.
- Doyal, L. (2001). Informed consent: moral necessity or illusion? *Quality in Health Care*, 10, 29-33.

- Dsubanko-Obermayr, K. & Baumann, U. (1998). Informed consent in psychotherapy: Demands and reality. *Psychotherapy Research*, 8, 231-247.
- Gelsthorpe, S. (1995). Consent, compliance and coercion. *Clinical Psychology Forum*, 84, 36-38.
- Holmes, J., Adshead, G., & Smith, J. (2004 – check year: 1994 in text). An ethical dilemma in psychotherapy: can one give informed consent to transference? *Psychiatric Bulletin*, 18, 466-468.
- Hutchby, I. and Wooffitt, R. (1998). *Conversation Analysis: Principles, Practices and Applications*. Oxford: Polity Press.
- Jenkins, P. (2004). Informed consent to counselling and psychotherapy in the NHS: what next? *Healthcare Counselling and Psychotherapy Journal*, 4, 38-40.
- Jensen, J.A., McNamara, R., & Gustafson, K.E. (1991). Parents' and clinicians' attitudes toward the risks and benefits of child psychotherapy: a study of informed-consent content. *Professional Psychology: Research and Practice*, 22, 161-170.
- Jordan, A.E., & Meara, N. M. (1990). Ethics and the professional practice of psychologists: The role of virtues and principles. *Professional Psychology: Research and Practice*, 21, 107-114.
- Marzillier, J. (1993). Ethical issues in psychotherapy: the importance of informed consent. *Clinical Psychology Forum*, 54, 33-37.
- Milgram, S. (1963). Behavioural study of obedience. *Journal of Abnormal and Social Psychology*, 67, 371-378.
- Noll, J.O., & Haugan, M.L. (1985). Informed consent to psychotherapy: Current practices at university affiliated psychology training clinics. *Law and Psychological Review*, 9, 57-66.

- O'Neill, O. (2002). Some limits of informed consent. *Journal of Medical Ethics*, 29, 4-7.
- Parker, I. (1994). Qualitative research. In P. Banister, E. Burman, I. Parker, M. Taylor, C. Tindall (Eds.) *Qualitative methods in psychology: a research guide* (pp. 1-16). Open University Press.
- 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.
- Smith, J.A. (1996). Qualitative Methodology: analysing participants' perspectives. *Current Opinion in Psychiatry*, 9, 417-421.
- Smith, J.A., Jarman, M., & Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray & K. Chamberlain (Eds.) *Qualitative Health Psychology: Theories and Methods* (pp. 218-240). Sage Publications: London.
- Smith, J.A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.) *Qualitative Psychology: A Practical Guide to Research Methods* (pp. 51-80). Sage Publications: London.
- Somberg, D.R., Stone, G.L., & Claiborn, C.D. (1993). Informed consent: Therapists' beliefs and practices. *Professional Psychology: Research and Practice*, 24, 153-159.
- Sutton, A. (2001). Consent, latency and psychotherapy or 'what am I letting myself in for?' *Journal of Child Psychotherapy*, 27, 319-333.
- Wooffitt, R., and Widdicombe, S. (2006). Interaction in interviews. In P. Drew, G. Raymond and D. Weinberg (eds.) *Talking Research*. London and Thousand Oaks, CA.: Sage.