Informed Consent to Psychotherapy: Protecting the Dignity and Respecting the Autonomy of Patients

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Well-implemented informed consent procedures demonstrate psychotherapists' respect for clients' right to self-determination and can initiate meaningful contributions to treatment through enhancing mutual trust, building rapport, and facilitating a sense of ownership. This article details key components of informed consent to psychotherapy by placing them within real-world psychotherapy scenarios. We provide information on client–therapist discussions of the nature and course of therapy, fees and payment policies, the involvement of third parties, confidentiality policies, and new and untested treatments. In addition, this article addresses informed consent procedures for individuals with impaired cognitive capacities and under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. © 2008 Wiley Periodicals, Inc. J Clin Psychol:In Session 64: 576–588, 2008.

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Providing clients with the opportunity to make an informed decision about engaging in psychotherapy communicates respect for personhood and reflects the collaborative nature of psychotherapy. In this vein, informed consent to psychotherapy not only satisfies the ethics of professional conduct but is integral to the formation of a balanced and healthy therapeutic relationship. For example, by asking for voluntary participation, informed consent demonstrates respect for a client's autonomy and right to self-determination. Furthermore, informed consent procedures emphasize the patient's role in making treatment decisions, increasing a sense of ownership over the process. Indeed, therapies that emphasize and employ the agency and self-direction of the patient tend to have more successful outcomes than therapies that do not (Beahrs & Gutheil, 2001; Draper, 2000; Pope & Vasquez, 2007). Informed

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consent procedures also can establish the therapist and patient as partners working toward a common goal, decreasing the likelihood that patients will put the therapist on a pedestal and become overly or dangerously dependent (Beahrs & Gutheil, 2001). Finally, informed consent procedures can reduce a patient's anxiety by demystifying the therapeutic process.

The American Psychological Association's (APA; 2002) Ethical Principles of Psychologists and Code of Conduct (hereafter the Ethics Code) recognizes the importance of informed consent procedures as an aspirational principle (Principle E: Respect for People's Rights and Dignity) and as required behavior. The Ethics Code's enforceable standards relevant to informed consent to psychotherapy are embodied both under the broader Standard 3.10 Informed Consent and the more specific Standard 10.01 Informed Consent for Therapy. This article details the ethical rationale for the Ethics Code's standards on informed consent and places them within the context of real-world psychotherapy scenarios.

General Requirements of Informed Consent

Informed consent is often seen as the primary means of protecting the self-determination and self-governing rights of those with whom psychotherapists work. To this end, informed consent to therapy is invaluable as it ensures that a patient's decision to take part in psychotherapy is informed, voluntary, and rational. Whether in written or oral presentation, psychotherapists must make every effort to use consent language that is understandable to the patient. For different clients, this may require familiarity with literature on the communication needs of individuals varying in age, language, cultural background, and other individual characteristics.

Case 1: Cultural Expectations

A client who had recently immigrated to the United States from China told a psychotherapist that his general practitioner had referred him to her for treatment for his trouble falling and staying asleep. After she listened to the man's presenting problem, the therapist briefly explained that she applied a cognitive-behavioral treatment technique to working through insomnia with patients. The patient was rather quiet during the session, and when at the end of the session the clinician asked if he had any questions, the patient asked what kind of medication she would be prescribing. In response, the therapist carefully explained how her cognitive-behavioral treatment differed from standard pharmacological care.

Clinician red flag. Psychotherapists may assume that most patients seeking treatment are familiar with the basic goals of and practices involved in psychotherapy. For those living in large metropolitan areas, this may be even more true. However, familiarity based on pop-culture representations of psychotherapy (e.g., on television shows, TV commercials, movies, novels) often misrepresent, simplify, or exaggerate the therapeutic process. Thus, it is important that psychotherapists do not assume that new clients truly understand the nature of psychotherapy (Fisher, 2003a).

Competency to Give Consent Capacity

The rights of minors and adults who are legally incompetent to give consent are protected by Ethics Code Standard 3.10b. Issues related to the treatment of minors are examined in detail in Koocher's (2008) contribution to this issue. Here, we focus on adults with persistent, transient, or increasing cognitive impairments, including those with mental retardation, schizophrenia, or Alzheimer's disease. Although a legally appointed guardian may be officially responsible for medical and mental health care decisions, psychotherapists must nevertheless provide patients with an appropriate explanation of services, consider the patient's preferences and best interests, and seek the patient's assent.

Psychotherapists are well advised to view consent capacity not as an all-or-none ability but as a continuum (Bennett et al., 2006). Indeed, a goodness-of-fit model of the informed consent process (Fisher, 2003b; Fisher, Cea, Davidson, & Fried, 2006) recommends that psychotherapists design informed consent processes to fit each patient's cognitive strengths, vulnerabilities, and decision-making capacities and styles. For example, adults with mild levels of developmental disabilities may have the cognitive abilities to understand the reasons for and nature of therapy, but may be at a disadvantage because they lack experience making healthcare decisions on their own (Fisher, 1999, 2002a, 2002b). Approaching the consent conference in an educational manner and encouraging patients to discuss treatment decisions with family members or other trusted care providers may enable them to make more informed decisions.

Therapists should not assume consent impairment simply based on a diagnosis. Indeed, studies of consent capacity consistently demonstrate marked within-diagnosis heterogeneity, with level of cognitive confusion or distortion—particularly verbal and executive functioning skills—a more reliable predictor of consent capacity than diagnostic criteria (Howe et al., 2005; Jeste & Saks, 2006). Psychologists also may draw upon assessment instruments such as the MacArthur Competence Assessment Tool for Treatment (MacCAT-T; Grisso et al., 2001; Palmer et al., 2005) to evaluate consent capacity (for adaptation of the MacCAT-T for adults with mental retardation, see Cea & Fisher, 2003).

Clinician red flag. Questions of consent capacity most likely arise when a patient refuses treatment that the psychotherapist, family members, or other healthcare providers believe to be the best course of action. It is important that clinicians not assume that a client lacks the reasoning skills necessary for consent capacity just because he or she disagrees with the expert opinion about the necessary course of treatment. Likewise, it would be dangerous for clinicians to assume that a client possesses the capacity to consent merely because he or she agrees with the suggested course of treatment (Fisher, 1999). Adults with a history of mental disorders may lack confidence in expressing their own opinions and may agree to a course of treatment simply because it is suggested by an authority figure.

Informed Consent Timing

As written in Standard 10.01 of the Ethics Code, psychologists should strive to present each client with the information necessary for informed consent "as early as is feasible" in the therapeutic relationship. While informed consent ideally would be obtained in the first session, this is not always possible or clinically appropriate. For example, informed consent during the first meeting may be contraindicated if the patient is in a crisis that requires urgent therapeutic care (Fisher, 2003a). In such cases, consent should be obtained at the first possible opportunity once the crisis has subsided. Additionally, because insurance policies often dictate the duration of therapy, psychotherapists may be unable to accurately inform clients about the course of their therapy until they receive the necessary information from the client's managed care organization (Fisher, 2003a).

Informed consent to psychotherapy is best conceptualized as an ongoing process, designed around a patient's evolving treatment needs and the subsequent treatment plans to which he or she must consent (Fisher, 2003a). Survey research among 130 practicing psychotherapists has confirmed the usefulness of a "process" model of informed consent (Pomerantz, 2005). Indeed, while some parts of the informed consent process can reliably occur at the outset of therapy (e.g., confidentiality and disclosure procedures, fees and payment options, cancellation policies), more substantive parts of the informed consent process may continue into the second, third, or even fourth session. Many therapists have reported that information such as the specific goals of the therapy, the techniques used, and the estimated duration of the therapy may not be clearly formed during the initial meeting; in such cases, it is neither in the best interest of the client nor the therapist to establish such matters in haste (Pomerantz, 2005).

Case 2: Responding to the Immediate Needs of Clients

During an initial therapy session, the client appeared quite excited. Speaking rapidly, he told the psychotherapist he was planning a gambling trip that he was sure would win him millions of dollars. After some probing, the therapist learned that the patient had recently stopped taking his medication prescribed for bipolar disorder because he had been feeling so happy. The therapist decided to postpone discussions of some elements of informed consent and focus the initial session on helping the client deal with his manic episode and the immediate crisis. After assessing the patient and deciding that he was not in immediate danger, at the end of the session the therapist and patient made a follow-up appointment for the next day, and the therapist gave him a referral for an appointment with a psychiatrist with whom she often consulted. During the second appointment, the practitioner felt the situation was stable enough to present the patient with informed consent information, including the anticipated nature and course of therapy as well as a discussion of fees and confidentiality policies.

Clinician red flag. Some treatment facilities and practitioners require clients to sign informed consent documentation before entering the therapy room. In many of these instances, the forms are handled by administrative staff and may not be written in plain language or adequately explained (Pope & Vasquez, 2007). The purpose of such forms is often to release the institution from legal liability. If clinicians are unable to change these informed consent procedures, they still should openly and comprehensively discuss with their clients issues such as payment, confidentiality, involvement of third parties, and treatment goals, protocols, and duration.

The Nature of the Psychotherapy

The movement to formalize informed consent procedures for psychotherapy grew in large part out of the fear that clinicians were negligent in advising their patients about treatment options other than their own (Beahrs & Gutheil, 2001). The Osheroff v. Chestnut Lodge (1980) court case was instrumental in popularizing the notion of psychotherapist negligence. After undergoing a year of extensive, but unsuccessful, inpatient psychoanalysis for major depression, Osheroff discontinued therapy and began a course of antidepressant medications to which he reportedly responded well. In this case, the plaintiff asserted that had he been told of this option in advance, he could have been spared a year of severe psychological distress and a large financial burden. Although the case was settled out of court—thus leaving no legal doctrine or precedent—it shifted public attention to the role of informed consent in psychotherapy, specifically the therapist's duty to present clear information regarding the nature of treatment and goals of therapy, and when appropriate, viable treatment alternatives (Beahrs & Gutheil, 2001). This emphasis on full disclosure is representative of a societal shift from the traditional paternalistic medical model of healthcare to one that respects the autonomy, agency, and self-determination of patients (Fisher, 2003a).

Standard 10.01 of the Ethics Code requires therapists to inform patients of the nature and aspects of therapy that would reasonably be expected to affect their decisions to enter into therapy with the psychologist. This information typically includes, but is not limited to, appointment schedule, the duration of each session, and the general treatment objectives and therapeutic techniques. Depending upon the clinician's treatment approach, the consent process might inform patients that treatment entails exposure therapy, dream analysis, detailed developmental history, conjoint family sessions, behavior contracts, homework assignments, or any other information relevant to making an informed decision to engage in treatment (Fisher, 2003a).

Case 3: Describing Potentially Anxiety Producing Components of Therapy

During her first therapy session, a client tells the psychologist that despite having landed her dream job, she is feeling anxious and stressed. She has developed a crippling fear of elevators in the last several years, and her new job is on the 30th floor of a high-rise building. After listening to his new client's presenting problem and establishing good rapport, the therapist explains that a cognitive behavioral treatment—involving relaxation techniques coupled with gradual exposure to elevators—has shown to be very effective in overcoming specific phobias and would be his treatment of choice. He explains that to accomplish the goals of therapy, he and the patient will need to meet on a weekly basis and that the patient will be expected to complete regular homework assignments, usually entailing practicing the relaxation technique. After explaining that this type of treatment usually takes about 3 to 4 months, the therapist assures his patient that the treatment pace will be matched to her comfort level. In addition, the therapist makes sure to encourage the patient to ask questions about any concerns she may have.

In the aforementioned example, knowing that patients suffering from phobias may become anxious when told about exposure therapy, the psychologist fully discloses the key elements of his therapeutic techniques only after he has established a trusting rapport. To provide the patient with sufficient information to make a choice about continuing therapy, he then makes sure to inform her about activities that may make her uncomfortable (e.g., getting in an elevator) and parts of the process which she will be required to do on her own (e.g., homework assignments). He encourages her to ask questions, which in turn helps to fortify a trusting and collaborative therapeutic alliance. Case 4 illustrates how well-intentioned, but ethically and therapeutically naïve, decisions to withhold information about the nature of therapy may create iatrogenic results.

Case 4: Avoiding Discussion of Potentially Anxiety Producing Methods

A young man seeks therapy due to a dog phobia that has significantly limited his functioning. During the informed consent procedure, the therapist explains that she will begin the treatment by teaching the young man some relaxation techniques that he will then be required to practice at home. Once this has been accomplished, she will begin the next step of the treatment by showing him a slide show of different dogs. The day he is able to look at a picture of dogs without hesitation, he feels accomplished and relieved, and believes that his therapy is coming to a close. At the beginning of the next session, the therapist meets him at the door to her office, gently warning him that she has a live (but small) dog in the room. She tells him that over the course of the next three sessions, she wants him to be able to pet the dog. When the patient balks at the suggestion, she informs him it is the only way to truly conquer his fear and end his suffering. The patient feels as though he has been misled in his informed consent. He looks back at the consent process as being full of "half-truths" and finds it difficult to trust or feel safe with his therapist again.

The psychotherapist in this scenario may have been well intentioned. Perhaps she thought that the idea of live contact with a dog would be so anxiety producing that the patient would outright refuse to join treatment. Perhaps she did not want her client to spend weeks worrying about his eventual contact with a live dog. No matter what the therapist's intention, professional ethics and collaborative practice require practitioners to fully inform patients as early as feasible about treatment goals and techniques during informed consent. If the practitioner thought that informing her client about contact with a live dog would be too anxiety producing during the initial informed consent process, she could have waited until his symptoms had decreased rather than introducing the animal in an earlier session. This decision would reflect the evolving nature of consent to new stages of the treatment.

Anticipated Course of Treatment

Patients will be able to make the most informed decision about participating in treatment if they have information about the amount of time treatment will take. The anticipated course of therapy typically refers to the number of sessions the psychologists thinks will be necessary to treat the presenting problem based on the information presented by the patient and professional expertise regarding a typical course of treatment (Fisher, 2003a). Therapy, like informed consent, is an evolving process, and unanticipated patient needs may require modifications in the course and nature of therapy. As illustrated in Case 5, consent discussions also should strive to make clients aware of the possibility that the length of treatment may be reassessed and discussed again as the psychologist learns more about treatment needs or unique personality characteristics.

Case 5: Providing a Balanced Perspective on the Anticipated Length of Therapy

A psychologist saw a new client who complained of depressive symptoms and relationship difficulties. As part of the informed consent process, the therapist explains her interpersonal therapy, highlighting the fact that it is a manualized treatment with demonstrated effectiveness in research studies for the client's symptoms. She also describes the average number of sessions after which clients often feel some relief from their symptoms while making sure to emphasize that each person responds differently and that they will together reassess her progress after a specific number of sessions.

Clinician red flag. It may be frustrating for both patient and psychotherapist when treatment plans do not move according to a proposed schedule. Treatment schedules can be disrupted by patient resistance, unforeseen treatment side effects or needs, trauma or stressful events, or simple individual differences. In reaction to such uncertainty, therapists may avoid making predictions regarding the length of treatment. The Ethics Code Principle C: Integrity encourages psychologists to promote accuracy, honesty, and truthfulness in their practices and to avoid unwise or unclear commitments. For many disorders, psychologists can draw upon a substantial body of scientific knowledge and their own clinical expertise to anticipate the average number of sessions as well as to expect that such estimates will probably evolve. Therapists familiar with a client's insurance plan also may be able to estimate the degree of progress that can be made within and beyond the number of sessions covered. Honestly sharing this information gives them the opportunity to make an informed choice about continuing in treatment and helps to maintain the therapeutic alliance.

Fees and Financial Arrangements

As embodied in Ethics Code Standard 6.04a Fees and Financial Arrangements, psychologists are responsible to discuss with clients as early as feasible information about fees, payment options, and plans. Whenever possible, therapists also should inform a client of the fee for the initial session when the patient calls for an appointment. Barring an acute mental health emergency, a full discussion of fees and payment options usually takes place during the initial meeting. Discussion of fees most often includes the cost of the therapy, types of reimbursement accepted (e.g., checks, credit card payments, direct payment from insurance companies), the payment schedule (e.g., weekly, monthly), when fees may be re-negotiated (e.g., annual fee raises), and practitioner policies regarding missed appointments and late payments (Fisher, 2003a). In instances in which therapists are unfamiliar with a patient's insurance plan, they can inform the patient that (with the patient's written authorization) they will communicate with the insurer and discuss coverage and payment options at or before the next session. As soon as they gather the appropriate information, therapists should inform their patients of the percentage of therapy costs covered by their health insurance and any limitations their health plan may put on the number of sessions it will cover (Acuff et al., 1999).

Case 6: Treatment Limits Imposed by Health Plans

Before coming in for her initial meeting, a patient made sure that her psychologist took her insurance plan. On the telephone, the psychologist explained that the insurance company would cover 50% of each session and that the client would have to pay the rest out-of-pocket. Once the therapy sessions began, the patient received a bill for her half of the therapy costs at the end of each month. One month, the client was surprised to receive a bill that was much higher than usual. Certain it was a mistake, she called her insurance company to inquire about the error. A staff member at the insurance company explained that based on her therapist's report of the progress of her symptoms, her weekly therapy was no longer deemed "medically necessary" and that her psychotherapy benefits were discontinued. The patient was shocked that this was the first she was hearing about any such limit.

Clinician red flag. Practitioners directly contracting with HMOs may have agreements that provide financial incentives to limit the number of treatment sessions. Ethical practitioners will ensure that such arrangements do not affect their objectivity or influence their treatment plans in ways that jeopardize patient welfare (Standard 3.06 Conflict of Interest). When legally permissible, psychologists should inform patients about such agreements (Acuff et al., 1999; Fisher, 2003a).

Involvement of Third Parties

In some cases, a third party may be involved in paying for the client's treatment. A third party can refer to legal guardians, employers, organizations, insurance carriers, medical companies, or other legal or governing authorities. Standard 10.01 Informed Consent to Therapy requires psychologists to inform patients of the involvement of third parties. Clients should be informed if a third party has requested the therapy, is paying for the therapy, or if they are legally or contractually entitled to receive diagnostic evaluations or other information regarding the therapy, and to whom this information will go, providing written release or authorization from the client (Fisher, 2003a).

Case 7: Involvement of Third Parties in Financial Arrangements

A psychotherapist working as an outside consultant for an assisted-living residence is approached by the son of a resident requesting that she provide psychotherapy for his mother. He tells the psychologist that his mother was diagnosed with moderate depression and that her health insurance has approved payment for only an antidepressant medication; however, the patient's son would like her to receive psychotherapy. He also tells the psychologist that his mother does not have the funds to pay for therapy and would refuse treatment if she knows that her son would have to pay for it. The man asks the psychologist if she would tell his mother that psychotherapy is included in the cost of the assisted-living home. The psychologist conducted a recent assessment of the resident as part of her consulting duties and concurred with the depression diagnosis, but found no evidence that the woman lacked the cognitive capacity to consent to her own treatment. She informs the son that while her professional code of ethics does not permit her to hide such third-party involvement from a patient, she would discuss the issue with his mother during an initial meeting and also explore with the mother whether it might be beneficial to have a family session.

Describing the Limits of Confidentiality

Maintaining patient confidentiality promotes the therapeutic alliance and reflects the profession's respect for the privacy and dignity of persons. The Ethics Code devotes an entire section to standards on confidentiality protections; however, the obligation to respect patient autonomy sometimes conflicts with the therapist's obligation to safeguard the welfare of patients and protect others from harm. Recognizing this dual obligation, the Ethics Code also permits disclosure of confidential information to protect the welfare of patients and others (Standard 4.05b Disclosures). Confidentiality and its exceptions in psychotherapy are detailed in this issue in an article by Jeff Younggren (2008). In this section, we focus on informing clients about the extent and limits of confidentiality.

Several standards within the Ethics Code mandate that clients are told about the extent and limits of confidentiality during informed consent. Important information to convey includes limits to confidentiality, such as disclosure of child abuse, elder abuse, or other state laws governing mandatory reporting, and the therapist's policies for disclosing confidential information for professional services, consultation, or to protect the patient or others from harm. In cases involving minors or adults with impaired consent capacities, psychotherapists inform patients about guardian access to records (Fisher, 2003a). Furthermore, when working with patients whose treatment will be covered by health plans, psychotherapists typically discuss what information will be made available to case managers working at their health company (Acuff et al., 1999). Due to the sensitive information disclosed during therapy, psychotherapists may want to remind clients from time to time about confidentiality policies.

Case 7: Confidentiality and Disclosure Related to Domestic Violence

A man decided to enter therapy after separating from his wife of many years. During the initial session, he told the clinical social worker that he was having difficulty concentrating at work and controlling his sense of loss and anger. During the session, the clinician explained that while what the patient said during the sessions would be kept confidential, there could be exceptions if the clinician believed that there was an imminent risk that the client might harm himself or someone else. During the third session, the client was very agitated and admitted to the social worker that he had devised a plan to assault his wife and could not stop thinking about retaliation. After assessing the level of risk presented by her patient's violent feelings, the clinician reminded the client of the disclosure policies. They spent the rest of the session discussing strategies for reducing the husband's agitation and other risk factors known to be associated with domestic violence. At the end of the session, the client agreed to permit the social worker to arrange short-term hospitalization.

Implications of the Health Insurance Portability and Accountability Act

Psychologists providing healthcare services must include in their informed consent procedure requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA regulations cover any clinical practice or healthcare provider that electronically creates or receives protected health information (PHI) from insurance companies. HIPAA is not triggered with each individual patient; rather, if a psychotherapy practice has electronically transmitted any PHI, the psychologists are considered a covered entity in regards to each client thereafter (Fisher, 2003a). HIPAA mandates that each client receives a Notice of Privacy Practices, which includes a document detailing patients' rights to access and amend their PHI, restrict uses and disclosures, and to receive an accounting of disclosures made by the provider to others during the past 6 years. Additionally, psychologists who are considered covered entities must demonstrate that patients have received the privacy notice and the information it entails. Psychologists typically do this by obtaining the patient's signature in a format that demonstrates that the privacy notice has been read and understood. If a patient refuses to sign the Privacy Notice, psychologists should probably note this in their official records (Bennett et al., 2006). In cases in which a patient is unable to make his or her own health-related decisions, a personal representative must be appointed to receive and sign the privacy notice.

Exceptions to this rule can be made if the psychologist suspects that the personal representative is abusing the patient (Fisher, 2003a).

Psychologists have traditionally sought permission from patients to disclose private health information to other professionals and managed care organizations. HIPAA has formalized the requirements for such permission. For each request to send information to a third party, a written document authorizing the release of such information must include a description of the information to be disclosed, identification of the specific person(s) to whom the psychologist is authorized to disclose information, a description of the purpose of the disclosure, a statement explaining the patient's right to revoke the disclosure, exceptions to the right to revoke, an expiration date, and the patient's signature (Fisher, 2003a). In most cases, the patient receives a copy of the written authorization as well. Importantly, psychologists making such disclosures should disclose no more than what is sufficiently required for the third party to carry out its responsibilities.

Clinician red flag. When making referrals to other treating professionals, it is often helpful to share PHI information with them so that they can best treat the patient. When working with a long-term, trusting client such as the one described in the next scenario, it may seem natural to both psychologist and client to simply contact the colleague and jointly discuss the case information. Indeed, in circumstances such as these, psychologists infer that the particular client would not object to such a discussion between his psychologist and psychiatrist. However, legal and ethical guidelines inform us that it is more prudent to make sure that the client has authorized, in a written document, the release of the specific information before it is shared.

Case 8: Authorizing Release of Information

A middle-aged man suffering from moderate anxiety has been in psychotherapy for over a year when he and his therapist decide it is time for him to have a medication consultation. They agree that the psychologist should send a written report to a psychiatrist who is on the patient's health-coverage plan. The patient trusts his psychologist and thinks it is unnecessary to sign a form authorizing her to transmit the information. After discussing the protections that an authorization provides, the patient agrees to review and sign the authorization form.

Consent for New and Untested Treatments

For therapies to evolve and to be introduced into practice, psychotherapists need the freedom to employ experimental and alternative treatments when preliminary knowledge suggests that they may be helpful. At the same time, when compared to more traditional methods, the effectiveness and risks of such treatments have not been established. Since patients may assume that they will be receiving treatments supported by scientific research and widely accepted by practitioners, it is especially important to describe the nature of new treatments during informed consent. Ethics Code Standard 10.01b requires that psychologists who are considering using a new or experimental treatment inform their clients of this fact, the potential risks of the new treatment, describe alternative treatments that may be available, and emphasize that participation in the experimental treatment is voluntary (Fisher, 2003a).

Case 9: Influencing Rather Than Informing Consent to New Treatments

Frustrated with how his patients were responding to evidence-based treatments for generalized anxiety and dysthymia, a psychologist seeks out workshops on alternative treatments. Intrigued by a new yogic breathing method, he decides to implement the yogic teachings with his patients who are suffering from anxiety and depression. Rather than emphasizing the experimental nature of the treatment to his patients, the psychologist emphasizes the profound effect it has had in his own life. He encourages his clients to consent to such treatment without discussing the alternative established treatments that are available.

Clinician red flag. When an experimental treatment has worked well with a number of consecutive clients, it may be natural for the clinician to no longer conceive of it as an "experimental" treatment; however, until a treatment is backed by an acceptable body of scientific or clinical knowledge, it should be presented to each client as experimental.

When the Therapist Is a Trainee

Many organizations providing mental health services also provide practicum and internship experiences for trainees. When a trainee provides psychotherapy, the trainee's supervisor is legally responsible for the trainee's decisions and actions. Standard 10.01c requires that patients be informed that their therapist is a trainee, that the supervisor is responsible for the trainee's therapy, and that the trainee meets regularly with the supervisor for guidance and advice. Additionally, the trainee will typically give the supervisor's name and contact information to his or her clients. Importantly, this Ethics Code Standard does not apply to licensed practitioners receiving postdoctoral training (Fisher, 2003a).

Case 10: Advising Clients That the Therapist Is a Trainee

A trainee feels insecure about telling clients that she is not a licensed practitioner. She fears that they will reject her services or that they will carefully monitor any mistakes that she makes. She tells her supervisor that she has held off mentioning her trainee status during the initial session with two new clients so that a trusting therapeutic alliance can be formed. Although her supervisor empathizes with her discomfort, he explains that by not disclosing her trainee status she may have in fact undermined the future of the therapeutic alliance since they may now question her integrity and motives for not disclosing sooner. The supervisor works with the supervisee on ways in which she can introduce discussion of her status at the next session with these clients.

Clinical red flag. Predoctoral clinical trainees may find that new clients begin a session calling the trainee "Doctor." Even when trainees inform clients that they are under supervision, some clients may feel it is respectful or feel more comfortable using the "Doctor" designation. When such circumstances arise, the trainee should work with the client to use a designation that is appropriate to the trainee's status. Trainees should be aware that failure to take additional steps to encourage the client to use a correct designation is contrary to the intent of the Ethics Code's Standard prohibiting false or deceptive statements about academic degrees.

Conclusions

Informed consent procedures reflect the profession's commitment to respecting clients' self-determination and autonomy. Demystifying the therapeutic process and giving clients a sense of ownership—both of which can be initiated through informed consent procedures—can enhance rapport building, patient enthusiasm, and clinical outcome. The goodness-of-fit ethics approach to informed consent highlights the role that informed consent plays in the ethical provision of psychotherapy, especially when provided to those with impaired or limited cognitive capacity. Fitting the language, timing, and content of informed consent to the client's unique needs and cognitive-emotional skills as well as to the nature of the psychotherapy demonstrates commitment to advancing human welfare, respecting client autonomy, and establishing relationships of trust.

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