Established in 1871

Swiss Medical Weekly

Formerly: Schweizerische Medizinische Wochenschrift

An open access, online journal • www.smw.ch

Viewpoint | Published 23 March 2019 | doi:10.4414/smw.2019.20028
Cite this as: Swiss Med Wkly. 2019;149:w20028

Setting as informed consent in psychotherapy

Novosel Dragutin

Basel, Switzerland

Introduction

In recent publications, Trachsel and colleagues [1] and Blease and colleagues [2] noted that informed consent – the gold standard in modern medicine – has yet to find its deserved role in psychotherapy. In this paper, I argue that informed consent has been a crucial element in psychotherapy since its beginnings, but under another name: the setting.

Definition of setting

The term setting is frequently used to specify the general situation in which therapy takes place, for example, an in-hospital setting, an outpatient setting, an online setting, or some other specified environment [3–5]. However, in the context of psychotherapeutic treatment, and for the purposes of the present discussion, I propose a more comprehensive definition, as described elsewhere [6]: setting defines the therapeutic frame and boundaries, including the place of therapy, duration and weekly frequency of consultation, payment for consultations or missed consultations, and termination, as well as the therapist's explanation of technique, definition and limits of confidentiality, and eventual reports. Finally, setting should also encompass the client's understanding of and commitment to the above elements.

Background

In recent decades, informed consent has increasingly gained a deserved role in both diagnostic and therapeutic medical procedures [1, 2]. We can say that the previous parental approach has found a valid replacement in informed consent, increasing the value ascribed to autonomy and the client's capacity to consent. The goal of psychotherapeutic treatment is not only to deliver the person from symptoms, but also to enable them to understand subconscious conflicts. The concept of psychoanalytical treatment is grounded in the presumption that conflicts will occur within the frame of treatment. As these conflict processes are interpersonal in nature, they inevitably include some form of dependency, which can be described as parental. The goal of psychotherapeutic treatment is to resolve these subconscious conflicts and so augment the client's autonomy. The psychoanalytic process seeks to move the client away from dependency and thereby reduce it to a minimum.

Correspondence:
Dragutin Novosel, MD,
Glaserbergstrasse 23,
CH-4056 Basel,
d.novosel[at]bluewin.ch

Defining setting for the client: an example

Below is an example of what a therapist typically discusses with the client at the outset of treatment:

1. It is important to emphasise that the therapy is initiated by and continues on your behalf, and that it is voluntary.
2. The method of psychotherapy I practice is called psychoanalytic psychotherapy. As discussed, we will have two appointments per week, on Monday and Thursday at 10 o'clock in the morning. The duration of each session is 50 minutes.
3. As defined by health legislation, one session costs 160 Swiss francs (for example). You will receive a bill following the last session of each month. You can cancel an appointment for serious reasons no less than 24 hours in advance. Otherwise, any missed appointment will be billed to you.
4. Our contact will be limited to the sessions at my practice, and we will have no contact elsewhere. In the event of an emergency, you can call me and leave a message, or contact the emergency service directly.
5. The duration of treatment cannot be known at the beginning of therapy and may be discussed at any time.
6. The method is simple: you should express in words any sensations you have, irrespective of relevance or relation to the subject we discuss. This may include wishes, dreams, memories, bodily sensations, or anything else that comes to mind. I will listen to you and react from time to time. Sometimes, feelings or wishes may find expression in therapy in the form of a question; sometimes I will answer, depending on whether I think my intervention will be of use to you. Difficult and/or unpleasant memories or situations can and do occur during therapy. It is important to express these and talk about them, in order to understand their meaning or to consider them in terms of your reaction to the therapy itself.
7. Everything we discuss is confidential, with three exceptions: if you are in danger or any other person is in danger because of you, or if the insurers request a report on the progress of therapy. However, you can tell me if you do not want me to write any such report on you.
8. I am obliged to make notes about the therapy.

How well did you understand my explanation? Do you agree to these rules?

Discussion

The definition of setting as described is known and discussed elsewhere [6]. Although I do not believe this is the right or only way to define setting, I have continued to use it unchanged for almost 20 years. It is usually necessary to adapt the definition to the client's educational level and their capacity for abstraction by offering some additional explanation. Unless the specifics of the setting change in some way (while remaining compatible with the law), I believe it is important that the agreed definition is used and remains unchanged. In psychotherapy, one benefit of explicitly defining the setting (or informed consent) is its diagnostic potential. Therapists who work a lot with countertransference use their own reactions to the client's reaction as a tool to scan for probable conflicts. This is grounded in the assumption that the therapist also reacts to clients and always tends to change the setting in a particular way for that particular client. This reflective process can be (and is) used in the diagnostic process.

Another important issue is client dependency. At the beginning of therapy, the client is in a subordinate position because they feel bad and are seeking help. This is one reason why only the highest ethical standards should be acceptable in psychotherapy – as a protection against misuse, including tertiary disease profit. In understanding and dealing with dependency, it is typical to acknowledge that the client is paying for the treatment, and in this sense at least, one is leveraging their dependency. (Conversely, this means that therapists depend on client payments.)

In essence, informed consent means that the client understands what is going on during treatment. The problem in psychiatry and psychotherapy is precisely that individuals have limitations in terms of cognition and emotion and, frequently, problems with boundaries. In general, an important part of informed consent is an explanation of the side effects of the therapy and alternative treatments. To the best of my knowledge, this element is sometimes neglected in psychotherapy. Certainly, therapists have a clear understanding of phenomena that may occur during psychotherapies, and they are informed about alternative treatments. The argument against providing explicit information of this kind is that it is difficult in the first place for patients to accept or acknowledge that they need help; any such information may increase their anxiety or may cause them to feel rejected by the therapist, so diminishing the value of containment as a therapeutic mechanism of action. For that reason, this part of the informed consent may always be assigned lower priority in psychotherapeutic treatment.

As noted above, there are many ways of defining setting. Some therapists offer phone consultations whereas others do not. For example, a part of behavioural psychotherapy is the exposure of clients, outside of the therapist's office, to situations that trigger panic attacks, but therapists with a psychoanalytical background would only handle this situation in their office. As far as is compatible with the law and the current state of the art, there are good reasons to adapt the definition of setting to encompass the therapist's personal attitude and work style. A personal definition of setting grounded in one's own understanding reflects each therapist's deep commitment and is therefore authentic.

Some therapists explain that they are (anonymously) discussing the therapy with colleagues and some avoid this part of the explanation. There are good reasons for both approaches: discussions with colleagues can be understood as an integral path of the therapeutic method and must not be declared separately as a violation of confidentiality, but can be declared in an explicit way as a detailed explanation of one's own understanding of the setting.

It is important that the setting should be both rigorously defined and sufficiently flexible to be adapted. Without going into the details, the predefined setting can be understood as Kant's categorical imperative. The need for rigor can be understood in terms of a global concept of justice as well, which should not, however, overlook the local level of justice when applied in a concrete, singular case [7]. Informed consent of a general kind (e.g., for surgical procedures) cannot be exacted in psychotherapy, but this does not mean that these minimum requirements should be ignored. Note that some legal systems accept an oral contract and some require a written contract, and that there is legal obligation of duty of disclosure.

The definition of setting may change because it must be defined within the law. The issue of confidentiality in Swiss law provides an illustrative example: previously, a short psychotherapy report was sent to a third party (health insurer) only on request, but today therapists are required to send such a report if the course of psychotherapy exceeds 40 sessions, even in the absence of any request from the insurances.

Conclusion

To my best knowledge, all psychotherapists define the setting in explicit ways when beginning sessions with patients, and some of them obtain informed consent in extended written form. As discussed above, the psychotherapeutic treatment includes at least some – but important – parts of informed consent as used in other branches of medicine and therefore it cannot be stated that informed consent does not have the role it deserves. As work in a private practice is lonely work away from institutions, I truly believe that the lack of systematic research about informed consent in psychotherapy, rather than its absence, creates opinions about its underestimated role. Therefore it is important to investigate the current situation and variety of informed consent in psychotherapy.

Disclosure statement

No financial support and no other potential conflict of interest relevant to this article was reported.

References

1 Trachsel M, Holtforth MG, Biller-Andorno N, Appelbaum PS. Informed consent for psychotherapy: still not routine. Lancet Psychiatry. 2015;2(9):775–7. doi: http://dx.doi.org/10.1016/S2215-0366(15)00318-1. PubMed.

2 Blease C, Trachsel M, Grosse Holtforth M. Paternalism, Placebos, and Informed Consent in Psychotherapy: The Challenge of Ethical Disclosure. Verhaltenstherapie. 2016;26(1):22–30.

3 Hundert EM, Appelbaum PS. Boundaries in psychotherapy: model guidelines. Psychiatry. 1995;58(4):345–56. doi: http://dx.doi.org/10.1080/00332747.1995.11024739. PubMed.

4 Zur O. To Cross or Not to Cross: Do boundaries in therapy protect or harm. Psychotherapy Bulletin. 2004;39(3):27–32.

5 Johnston SH, Farber BA. The maintenance of boundaries in psychotherapeutic practice. Psychotherapy. 1996;33(3):391–402. doi: http://dx.doi.org/10.1037/0033-3204.33.3.391.

6 Smith D, Fitzpatrick M. Patient-therapist boundary issues: an integrative review of theory and research. Prof Psychol Res Pr. 1995;26(5):499–506. doi: http://dx.doi.org/10.1037/0735-7028.26.5.499. PubMed.

7 Rawls J. A theory of justice. Cambridge, MA: Harvard University Press; 1971.