INFORMED CONSENT TO PSYCHOANALYSIS

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INFORMED CONSENT TO PSYCHOANALYSIS

The Law, the Theory, and the Data



Elyn R. Saks and Shahrokh Golshan

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Introduction

Psychoanalysts have been up in arms about certain legal intrusions into the analytic space. For instance, inroads on confidentiality have been a great concern (see, for example, Bollas and Sundelson, 1995); indeed, the American Psychoanalytic Association has devoted considerable resources to lobbying in Congress and intervening in lawsuits so that privacy may be better protected (see the American Psychoanalytic Association's "Essential Privacy Principles for Quality Health Care" and the American Psychoanalytic Association amicus brief in *Jaffee v. Redmond* [1996] and in *Maryland v. State Board of Physicians v. Eist* [2007]).

At the same time, legal actions have turned on the failure to disclose alternatives in the case of psychiatric and psychological treatments for certain conditions (see, for example, Klerman, 1990; and Packman, Cabot, and Bongar, 1994). The issue here is whether patients claiming injury from the treatment procedure would have refused the treatment had they been adequately informed, among other things, of the nature of, and iatrogenic problems associated with, the treatment.

The fundamental legal and ethical problem is whether informed consent (IC) is a good idea and what constitutes adequate informed consent. There are a small number of court cases that discuss informed consent to therapy. There are also a considerable number of state statutes and regulations that imply IC is required. In addition, the clinical organizations' ethical codes do require informed consent of some kind (American Psychoanalytic Association, American Psychiatric Association, American Psychological Association, National Association of Social Workers; see Appendix A), and in many states, Codes of Ethics are incorporated into state law. So it would appear that a full informed consent is a requirement for therapy in many states, and it is not unthinkable that it could come to be so in many other places as well.

Whether informed consent is required by law or professional ethical standard, it is important to consider whether it is a good idea: If it is not, we should repeal or not enact informed consent laws in this context. In other words, we would do well to ponder the desirability of an informed consent[1] requirement in this context so that we may better inform a public debate. Could a requirement for informed consent actually impair an analysis in destructive ways? Or is it rather the only proper course, given the need to respect patients and ally them with the goals of the treatment? Indeed, is adequately informed consent a condition as well as an effect of a therapeutic alliance?

We might think of the matter another way. Most psychoanalysts say something early in the treatment process about the psychoanalytic procedure. The question is not whether to inform patients about treatment but exactly what information to give a patient and how to present that information. Perhaps more important, why should clinical psychoanalysts disclose everything they do?

Note, in this connection, that we focus on "psychoanalysis" and "psychoanalytic procedure" but recognize that many of the same issues and concerns apply to psychoanalytic psychotherapy. We also don't make a distinction between psychoanalysis and psychoanalytic psychotherapy. This issue is controverted but beyond the scope of our work.

The central goal of this book is to examine the advantages and disadvantages of an informed consent requirement for psychoanalysis. The book is divided into several chapters. In Chapter 1, we review the law and literature on informed consent: What can we learn from the law about whether informed consent is necessary and what informed consent should look like? What do the legal and psychologic/psychiatric commentators say about the elements of informed consent and the pros and cons? The review of the law will help us determine if informed consent is now required as a matter of positive law in the various states. The review of the literature will reveal what others have identified as important issues in considering the informed consent doctrine in the context of therapy. For example, what do commentators identify as the main components of informed consent in the psychoanalytic context?

[1] By speaking of "an" informed consent, we do not mean to imply that this is something done only at the beginning of the process. In a "process view" of an informed consent, an informed consent unfolds over time in the course of the treatment.

Chapter 2 of this book, the theoretical part, will explore the psychoanalytic dimensions of informing patients, among other things, of the benefits and risks of psychoanalysis. For example, is informed consent even possible? If so, is it countertherapeutic?

Chapter 3 is empirical. It reports on a survey of a significant number of analysts throughout the country. A random sample of four hundred members and candidates was selected to learn about their informed consent practices and their views on an informed consent requirement. The response rate was fairly low. This is a pen-and-paper survey that asks quantifiable questions (for example, "Do you tell prospective patients about the risks of psychoanalysis?" "Do you disclose malignant regression as a risk?" "Do you disclose alternatives like short-term therapy?" "Do you think on balance the informed consent process has been more therapeutic or more countertherapeutic?").

The survey provides an estimate of the beliefs and practices of analysts and their perceptions of the likely and actual effects of these practices. We will also obtain a better sense of what motivates analysts in their practices regarding informed consent. We are particularly interested in whether psychoanalysts believe that an informed consent requirement serves or detracts from the therapeutic goals of psychoanalysis or might even be construed to do both at the same time. Similarly, we are interested in understanding how analysts might deal with potential conflicts between the values behind informed consent and the patient's treatment interests. University of Southern California's University Park Institutional Review Board granted approval for the human subjects portion of this study.

The fourth chapter of this book discusses our Results—both intuitive and counterintuitive—with some thoughts on how to understand our findings.

Then, after discussing in Chapter 5 limitations of our study and future research that would be useful, we briefly lay out the contours of our own ideas about the optimal informed consent policy in the psychoanalytic context in the Afterword. We follow this with a Conclusion, which summarizes our findings.

The ultimate goal of this book is to arrive at an understanding of the pros and cons of an informed consent requirement, as well as an account of the different practices, and beliefs about those practices, that analysts have. It is also important to explore what underlies the variability we find in our results. Is the hypothesis that ambivalence in analysts explains this variability borne out?

This book fills an important gap in the literature. First, this book reviews the law on informed consent. We look at the few legal cases on informed consent to try to develop a conception of the contours of the legal landscape. To the same end, we look at statutes and regulations in the fifty states. We also look at the disciplines' Ethics Codes. Then we examine legal and psychologic/psychiatric commentary on IC in this context. One purpose of the book, then, is to scrutinize the law and literature on this issue to help answer the question about whether some form of informed consent for psychoanalysis is indeed required as a matter of positive law.

A second goal of this book is to consider whether an informed consent requirement for psychoanalysis *should* be part of the law as a normative matter. This examination will involve looking at the extent to which informed consent is desirable or even possible from a psychoanalytic perspective. This part of the book could therefore represent a potential contribution to the law—and to the way in which psychoanalysis is practiced—by adumbrating the legal issues, as well as the psychoanalytic considerations, that informed consent to treatment implies.

Finally, a third purpose of this book is to collect and report data on what analysts do and how they think about what they are doing when they embark on psychoanalyzing a patient. There is very little professional literature currently in this vein. What psychoanalysts think about what they tell patients to expect from psychoanalysis could be of great use in formulating policy concerning informed consent. In this regard, this book could make an important contribution to our understanding of a central ethical principle governing the delivery of medical and psychological care.

A study combining psychoanalysis and the law of informed consent follows an important tradition. Psychoanalytic understandings of the doctor/patient relationship have, to date, influenced many discussions of informed consent, although in contexts other than psychoanalysis. Katz (2002), for example, speaks of transference in the informed consent process. To study in a rigorous and nuanced way what psychoanalysis can tell us about an informed consent requirement is likely to have much wider significance than merely helping us formulate sensible legal rules in this particular area. Psychoanalysis can contribute to an understanding of a practice—obtaining informed consent—that has, in the last forty years, radically changed the delivery of health care in America.

1. Law and Literature on Informed Consent

The Cases, Statutes, and Regulations

Is there a legal requirement to obtain informed consent? Reviewing relevant cases and statutes bearing on informed consent to psychotherapy should help us gauge that. Naturally, there is less urgency for mental health professionals sorting through what to disclose or not if there is no legal informed consent requirement. There are very few cases that imply such a duty on the part of mental health professionals in the context of psychotherapy. On the other hand, many state statutes and regulations seem to require informed consent to therapy. In addition, Ethics Codes of the professions raise their own expectations, and many states incorporate the disciplines' Ethics Codes into state law. (Of course, even if the statutes do not incorporate the Ethics Codes, the codes themselves impose an informed consent duty or the professional risks disciplinary sanctions.) Naturally, if the law is unclear and things are in flux, our study might enable us to better shape the direction of the law. Even if the law is clear, thinking about whether there *should* be an informed consent requirement may lead us to advocate for change.

We turn first to a discussion of informed consent cases.

Informed Consent Cases

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body.
>
> *Schloendorff v. Society of New York Hospital*, 1914

We showcase two general informed consent cases here, drawing out the important features of this doctrine. We then spend time on the most famous informed consent case in the therapy context, the Chestnut

Lodge case. While this case settled out of court, there is considerable literature about it and it seems to have affected practice. We then very briefly review some other relevant cases.

Canterbury v. Spence (1972), a seminal informed consent case, was also a very sad case. A teenaged boy with back pain had an operation without being informed of the risk of paralysis. A day after his operation, as he attempted to reach a bathroom when no staff was present, he fell from his hospital bed. A few hours later, the lower half of his body was paralyzed, and he had to undergo another operation. Now, years later, instead of back pain, "he hobbled about on crutches, a victim of paralysis of the bowels and urinary incontinence. In a very real sense this lawsuit is an understandable search for reasons" (*Canterbury v. Spence* at 776).

Canterbury v. Spence discusses a number of important informed consent issues that are rather technical—for example, the informed consent action is a matter of negligence rather than battery. It also covers the element of "cause" (did the failure to disclose cause the injury?) and how to understand the cause element, namely, as a matter of whether a reasonable person in the patient's situation would have declined treatment had he or she been informed of the risks.

In its decision, the court also discusses some exceptions to the doctrine—for example, so-called "therapeutic privilege" (when the doctor can elect not to inform the patient if he or she believes it will be too destructive to the patient psychologically); the right not to inform of very remote risks or things the patient knows already anyway; and the right not to disclose if the patient expresses the wish not to be informed.

We would like to focus on why disclosure is important and how to measure the doctor's disclosure obligation: What must he or she disclose in this context?

Why then is disclosure important? The epigraph at the beginning of this section is a good place to start: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." The court goes on to note that true consent is the informed exercise of choice, and that entails that one be able to evaluate the options available and the risks attendant upon each. Also the average patient has little or no medical knowledge and is dependent on the doctor to provide information. "From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible." As the court says later in the decision, "It is evident that it is normally

impossible to obtain a consent worthy of the name unless the physician first elucidates the options and the perils for the patient's edification" (*Canterbury v. Spence* at 783).

The court also later underscores how dependent the patient is on the doctor: "The patient's reliance on the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms-length transactions. His dependence on the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject" (*Canterbury v. Spence* at 783).

We turn now to the important question of the doctor's disclosure obligations. The court addresses this in two ways: by identifying the sorts of things that must be disclosed and by articulating a general standard for measuring disclosure.

Under the first, the court speaks several times of the usual elements of a disclosure: The physician must generally inform the patient "in nontechnical terms as to what is at stake: the therapy alternatives open to him, the goals expectably to be achieved, and the risks that may ensue from particular treatment and no treatment" (*Canterbury v. Spence* at 783). The court reiterates this later: "The topics importantly demanding a communication of information are the inherent and potential hazards of the proposed treatment, the alternative to that treatment, if any, and the results likely if the patient remains untreated" (787–88).

A most important question in the context of informed consent is the general standard for measuring the doctor's disclosure obligations. One possibility, which a number of states adopt, is the "professional standard": What would a reasonable doctor disclose in this kind of case? A more progressive standard is the "objective, patient standard": What would a reasonable patient in this patient's situation find material to her decision? And the third standard is "subjective": What would this patient deem material to his decision?

The jurisdictions are roughly split between the first and second. *Canterbury*, and all the more progressive states, adopts the patient-based standard. The courts provide a number of reasons for their choice. For example, *Canterbury* notes that there is no real professional standard and the questions aren't so technically complex as to require expert testimony. In addition, the court notes that what to disclose is "ofttimes a non-medical judgment and, if so, is a decision outside the ambit of the special standard" (785). But to adopt the professional standard is to "bind the disclosure obligation to medical usage"; and this in turn is "to arro-

gate the decision on revelation to the physician alone" (784). This surely doesn't make sense if the decision is largely nonmedical.

More generally, "any definition of scope (of duty to disclose) in terms purely of a professional standard is at odds with the patient's prerogative to decide on projected therapy himself" (786). Indeed, "respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves" (784).

The court therefore adopts the objective, patient-based standard: "The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision" (786). The court, quoting from a commentator, defines materiality in this way: "A risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forgo the proposed therapy" (787).

We discuss briefly another seminal case, *Cobbs v. Grant*, in which a man went into surgery for a duodenal ulcer and, over time, suffered a number of problems requiring a number of additional surgeries—for example, he had to have his spleen removed, which was a 5 percent risk of the first surgery. He later developed another ulcer, another risk of the earlier treatment. A third operation was then required, which removed 50 percent of the patient's stomach. Yet another hospitalization was necessitated when the patient began to bleed internally as a result of the premature absorption of a suture, another inherent risk of surgery.

We first want to discuss a number of areas of agreement between *Canterbury* and the Cobbs. *Cobbs* agrees that an informed consent action is a negligence issue, as well as the elements of required disclosure: "Therefore, we hold, as an integral part of the physician's overall obligation to the patient there is a duty of reasonable disclosure of the available choices with respect to the proposed therapy and of the dangers inherently and potentially involved in each."

The duty of the physician is more generally to provide "any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment" (8). The court also adds some important reasons for adopting an objective, patient-based standard: "Even if there can be said to be a medical community standard as to the disclosure requirement for any prescribed treatment, it appears so nebu-

lous that doctors become, in effect, vested with virtual absolute discretion. . . . Unlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision regarding the course of treatment to which he knowledgeably consents to be subjected" (9).

The court adds that the doctor's expert function is to supply the medical data on which the patient relies: "But once this information has been disclosed, that aspect of the doctor's expert function has been performed. The weighing of those risks against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation and decision is a nonmedical judgment reserved to the patient alone" (9).

The court, citing *Canterbury*, summarizes: "In sum, the patient's right of self-decision is the measure of the physician's duty to reveal. That right can be effectively exercised only if the patient possesses adequate information to enable an intelligent choice. The scope of the physician's communications, then, must be measured by the patient's need, and that need is whatever information is material to the decision. Thus the test for determining whether a potential peril must be divulged is its materiality to the patient's decision" (10).

We would like now to turn to the context of informed consent to therapy in particular. The most famous case is *Osheroff v. Chestnut Lodge*. This case did not reach the courts but settled. Still, there was a lot of press about it, as well as scholarly articles, and, anecdotally, it seems to have affected practice to a considerable degree.

Osheroff was a 41-year-old nephrologist. He was consulting a psychiatrist for depression. Antidepressants were not effective, and he was advised to check himself into Chestnut Lodge Hospital, a very famous psychoanalytically informed hospital. The Lodge diagnosed him as having a narcissistic personality disorder as well as depression (his own expert denied the former), and believed that intensive psychotherapy was the way to treat him. He was on no medications, although he asked for them quite frequently.

Over the course of seven months of in-patient treatment, he deteriorated terribly: "I was waking up at 4 every morning, pacing so much that my feet deteriorated. I lost 40 pounds, I deteriorated mentally and physically, I lost a whole life. I had a million-dollar medical practice, I lost that. I lost my status in the medical community, I lost the respect of my patients, I even lost contact with my children" (*New York Times*, October 1990).

Another account of his deterioration addressed the fact that, no matter how badly he wanted to, "Ray Osheroff couldn't stop pacing. For months he had spent nearly every waking moment—sometimes 16 hours—trudging an estimated 18 miles a day up and down the hall of a locked ward in a mental hospital. The soles of his feet blistered, ulcerated and turned black. He lost 40 pounds and stopped bathing and shaving. His uncut hair hung in limp hanks on his shoulders. He couldn't sit still long enough to eat with a knife and fork—instead, he would snatch food off a plastic tray as he paced" (*Washington Post*, 1989).

Eventually, Osheroff went to another hospital, which immediately put him on antidepressants, and within a couple of months he improved considerably and was discharged. Over time, he was able to rebuild his life and his practice, but all of this took some doing.

There were two main issues in the *Osheroff* case. First, was the treatment he was given substandard? Was it malpractice not to give medication? Second, was Osheroff provided adequate informed consent?

The first question is outside the scope of this book, but we will say that one view—as proposed by Gerald Klerman (1990) among others—is that whenever there is an evidence-based treatment and one not supported by the evidence, the doctor has to give the evidence-based treatment. The alternative—as suggested by Alan Stone (1979) among others—is that the "substantial minority" rule should apply: If a substantial minority supports and uses the treatment, it is within the standard of care. For a variety of reasons, we support the latter view: Some things may be hard to study but are still highly effective, or patients may have reasons for preferring a less supported therapy (for example, it doesn't have what, for them, is a terrible side effect). In any event, even if we take the first view, there was considerable controversy over a correct diagnosis for Osheroff and how he should be treated—for example, if he indeed had narcissistic personality disorder, we might think differently of the therapy option. And of course he had already failed on at least one medication.

More important for us, however, is the informed consent issue. One might say that Osheroff, who kept asking for medication, did not need to have that alternative disclosed to him. He was a doctor, after all. As we have seen, disclosure of what the patient already knows needn't be made. But a more careful view suggests that his knowing about this alternative is not enough. Osheroff needed to be informed of the pros and cons of therapy versus medication to be able to make a "knowing

choice." That is, he needed to know the costs and benefits of the different alternatives, as well as whatever was known about their efficacy.

For example, if Osheroff had been told at the beginning of his hospitalization that the hospital would treat him only with therapy, that medication was an alternative that would be much quicker but perhaps not as long-lasting, that there were such-and-such other costs and benefits of the two interventions, and that he could be referred elsewhere if he wanted medication, perhaps he would have been empowered earlier to seek this alternative.

The bottom line is that informed consent doctrine says that the nature of and risk/benefit profile of a therapy, as well as alternatives, needs to be provided to prospective patients. Indeed, one might think this is especially true if the clinician thinks in the particular case that a minority-supported treatment would be better for this patient.

The most famous legal case involving informed consent to therapy, then, has sent up a red flag that informed consent is important. There are a few additional cases that discuss informed consent in this context, although none so famous: One case discusses the issue generally; two possibly relevant cases concern children; and a few cases concern a particular disclosure—namely that the doctor might have to breach confidentiality.

Only one reported case explicitly deals with informed consent to psychotherapy in the case of an adult. *Daly v. Wisconsin Patients Compensation Fund* (Wis. 2005) concerns informed consent to psychotherapy in the context of a false memory / MPD case. A state statute required doctors to inform their patients about the availability of alternatives, and risks and benefits. The disclosure must allow a reasonable person in the patient's position to exercise the right to consent or refuse treatment, or to request an alternative. The court in this case held that this doctrine applied to psychologists as well through the common law.

This false memory / MPD case is noteworthy for three major reasons: 1) the court applied a general statute on informed consent to psychotherapy; 2) the court applied, through the common law, a requirement of informed consent to a psychologist as well as a psychiatrist or other doctor; and 3) the court judged specific items that appeared to be relevant to the conception of informed consent as unnecessary.

Two other cases indicated informed consent must be provided to the parents of juvenile patients. The first explicitly concerned therapy—see *Miller v. Board of Psychologist Examiners* (Or.App. 2004)—whereas the second addressed the hospital treatment the children would receive,

which would seemingly include therapy. See *Doe v. Public Health Trust of Dade County* (11 Cir. 1983).

A number of cases in the course of discussing therapist/patient privilege require, in the therapy context, that the patient must be informed of the limits of confidentiality.

In *Jaffee v. Redmond* (1996), the Supreme Court addressed the issue of a federal psychotherapist-patient privilege. In the case, the decedent had been killed by a police officer, and her estate sought the records of the respondent-police officer's therapy with a social worker. The Court concluded that there was such a privilege; that it extended to social workers; that it should not be subject to balancing on an individual basis; and that it would cover this case.

While *Jaffee v. Redmond* was a therapist/patient privilege case, it did make clear that a no-privilege rule wouldn't lead to more information being available in court because patients would have to be informed about the limits of confidentiality and then they wouldn't speak ("At the onset of their relationship, the ethical therapist must disclose to the patient 'the relevant limits on confidentiality'" (*Jaffee* court quoting several Ethics Codes in n.12). This statement is important in seeming to read into the law provisions stipulated in a discipline's Ethics Code and in suggesting that a therapist has the duty to disclose at least one thing—the limits of confidentiality and privilege.

See as well *Hicks v. Talbott Recovery System, Inc.* (11th Cir. 1999) where the court considered whether the defendants had breached the patient/psychiatrist/psychologist privilege by releasing records containing certain information that ultimately led to the doctor/plaintiff being unable to work again as a doctor.

This case is important for a number of reasons. First, it implicitly approved of the patient being given an informed consent about the limits of confidentiality. Second, it required that the waiver of the privilege (essentially an informed consent to release of the information) be itself informed. Third, it took a position on whether this waiver was informed. Finally, it was a case involving psychotherapy rather than pharmacological treatment or hospitalization.

United States v. Auster (5th Cir. 2008) is important for us in mentioning in dictum that the therapists "have an ethical duty to inform Auster of that legal duty" (to warn). The court cites *Jaffee* on this: "At the outset of their relationship, the ethical therapist must disclose to the patient the relevant limits on confidentiality" (*Jaffee*, 518; U.S. at 13 n.12).

In summary, aside from the most important case, *Osheroff v. Chestnut Lodge*, which settled, there are very few reported cases that deal with informed consent to psychotherapy in particular. Only one deals with an adult. Only one other clearly deals with a parent's consent for her child. A number of privilege cases seem to require disclosure of the limits of confidentiality in informing patients in therapy. Informed consent to psychotherapy has clearly been litigated very infrequently. Whether disciplinary actions against non-informing therapists occur more frequently is an important topic for future research.

The Statutes

In this section, we review statutes on informed consent for psychotherapy in general, and psychoanalysis in particular. The statutes are of considerable help in trying to determine if there is an informed consent requirement in the various states. Statutes and regulations in this context are especially important because of the doctrine of "negligence per se": If there is a statute requiring specific action, and the person doesn't take it (with this causing injury), then the person is "negligent per se." There is no need to prove anything beyond the existence of the statute to establish the duty (see Jones, 1996).

Many jurisdictions have statutes requiring that informed consent be given by physicians to their patients in general. These statutes tend not to spell out when such consent must be acquired and when not. Although it is required for hospitalization, surgery, and probably medication, the question we want to investigate is whether informed consent is similarly required for psychotherapy, or other modalities (for example, case management) that do not involve an intrusion into the physical person. (We limit our discussion to nonsomatic psychotherapies. While some psychotherapies include physical contact with the patient—for example, Reichian and neo-Reichian—the informed consent issues raised by these are distinctive and do not affect our general discussion of informed consent to therapy.)

Our search led us to two types of statutes that extend an informed consent to therapy requirement. First, twenty-one states require consent for clinicians in addition to doctors. Second, sixteen of these same states explicitly mention therapy in this context (see Appendix B for two charts identifying these state statutes and regulations). Both of these routes are of import—those explicitly mentioning therapy and those

extending the doctor's duty to psychologists and other mental health professionals who provide non-physical treatments. It would seem, then, that the law in many places contemplates informed consent for psychosocial interventions, including therapy.

A final source of instruction on informed consent comes from all of the national mental health professional organizations that require informed consent in their Ethics Codes (see Appendix A). This ethical requirement is sometimes directly read into the state's law. For example, according to the American Psychological Association's Director of Ethics, twenty-eight states "adopt or follow" the APA Ethics Code.

A clear case could be made that the Ethics Code should be read into state law everywhere because it represents a judgment about the standard of care that mental health professionals themselves hold. On the other hand, Ethics Codes may be thought to set a higher standard for mental health practice, holding more robust aspirations than the law requires. In any event, the therapist may be exposed to liability under his or her Ethics Code in a disciplinary hearing, so Code requirements make it important to explore the issue of informed consent whether or not there is a legal requirement.

All told, then, at least twenty-one statutes suggest there is an informed consent to therapy requirement. The twenty-eight states that read the discipline's ethics code into their statutes may include some of the twenty-one and/or may add to the twenty-one. Even in those states that do not read the disciplinary code into law, clinicians risk discipline by their professional organization if they fail to get proper informed consent.

It appears, then, that an informed consent obligation would likely be imposed on therapists as a matter of positive law. One critical issue for us is what disclosure standard should be adopted. We believe the courts' adoption of the patient-based standard is correct as a matter of legal theory and policy—the arguments in its favor are strong. As the courts note, the professional standard arrogates the decision to the doctor and the standard there is so nebulous as to allow any doctor judgment to hold—the standard invests doctors with virtual absolute discretion. This is especially problematic since what to disclose is not essentially a medical judgment; the doctor supplies the medical data but it is for the patient to decide what decision best serves his values. Neither is the information so esoteric as to require expert testimony to establish its

contours. Perhaps most important, the professional standard is at odds with the patient's right to decide. A right to decide is only meaningful if the patient understands the issues at stake; this means she needs to know those items that are material to her decision.

A critic might, however, disagree that the reasonable patient standard is better and might urge that the professional standard, as the majority view, is the standard we should adopt. By not doing so, we are proposing a change in current law. We must make clear that our normative commitments are not reflected in current law.

To say the professional standard is more common and we needn't/shouldn't use the reasonable patient standard—that that is a minority view, and not current law—ignores that the standards are almost equally employed: twenty-three states use a reasonable patient standard and twenty-six use the professional standard. So what "the law" is here is hard to say—both views can claim to be at least one version of "the law." And so the argument that only a small number of states will be governed by the standard we use, and our analysis will have little potential impact, is clearly wrong.

Several other important points should be made. First, even if we prefer the professional standard, that standard itself has clear limits because courts say both that the disclosure is measured by what doctors do and that they should disclose risks, benefits, and alternatives. (The disciplines' Ethics Codes all also require disclosure, say, of risks.) The latter places a limit on doctor discretion. Imagine that it is the practice in medicine not to disclose any risks of a risky procedure. Indeed, imagine that doctors never disclose risks of any procedure, ever. Courts would almost certainly say that this is impermissible. (Recall the Caroline towing case, which went beyond the professional standard of care because it didn't make cost-benefit sense.)

Given this, we would need at least to do some kind of analysis of the nature of the limits on professional disclosure standards. Again, if most analysts were to disclose only when and where their sessions will occur, and what the sessions will cost, a court would likely find that substandard.

Second, our study would be important even if the professional standard were by far most common and accepted by us. In essence, in examining what doctors say they do, we see that there is wide variability. This essentially says that almost everything goes (keeping in mind the point

above). In other words, our empirical study investigates what reasonable professionals disclose. Our study, as such, will help arm the analyst with evidence that she has met the professional standard of disclosure.

Third, the argument that the professional standard renders our study moot may underestimate that the point of this book is not to prescribe risk/management imperatives, but to ask, as a theoretical matter, whether the best account of informed consent conflicts with our general understandings of psychoanalysis. It may be that some deep-lying conceptions of psychoanalysis make it resistant to the intrusion of such legal thinking. In essence, our discussion becomes an opportunity to interrogate the nature of psychoanalytic experience from the point of view of how disclosure and consent operate within it.[1]

Fourth, even if the doctrine on our understanding would have little impact (assume our findings applied only in a small number of states), this does not mean that the doctrine of informed consent is unimportant. In the same way, the insanity defense occurs only in a minuscule portion of criminal cases but it tests our understandings of responsibility and is important in that way.

In short, the main audience for this analysis is the clinician who wishes to think more deeply about the process and ethics of psychoanalytic therapy. As a colleague has put it, it emerges here that "'consent' describes a tension that has existed since early Freud in psychoanalytic theory itself, viz. the extent to which analysis should proceed by forming a powerful and influential alliance with the patient vs. its eschewing 'influence' in favor of the patient's autonomous ego-functioning."[2]

This is not to say that the legal practitioner will find nothing of use in this book; far from it. The legal practitioner may be able to point to a widespread norm to reveal x or y, thus suggesting that analysts think an item important.

That said, we want to reiterate that the point is not to give risk/management prescriptions and/or arguments for use in a lawsuit. Whatever the standard for disclosure, very few informed consent lawsuits occur in the context of psychotherapy, which suggests that such cases are not likely to be profitable and therefore not likely to be brought. And so therapists face very little exposure for failing to get informed consent. Indeed, psychiatric malpractice cases in general are not often brought, both because the privacy issues are strong and because the cases are hard

[1] We are grateful to Martin Stone for these points.

[2] We are grateful to Martin Stone for this observation.

to win; in essence, the doctor will argue that it is not what he did that caused the bad outcome, but the very course of the patient's illness. If these cases are rarely brought, the risk of liability is low.

A final argument that our project is ill conceived is that informed consent is really very unimportant. It is substandard treatment that we should care about. And in fact, most informed consent cases piggy-back on the much more powerful malpractice cases alleging substandard care.

The Chestnut Lodge case itself illustrates the weakness of the informed consent norm. As one commentator has put it, "the plaintiff's lawyers tossed into their complaint an allegation that the patient was not adequately informed of medication alternatives to psychoanalytic treatment; but the real gravamen of the complaint was the patient's visible, gross deterioration over a substantial period of time without any exploration by the analytic therapists of the possible benefits of psychotropic drugs, even as an adjunct therapy. The lawsuit was arguably a malpractice action with a separate claim of inadequate informed consent thrown in for reasons of litigation tactics. On the face of the informed consent doctrine, one might say that this was independent grounds for liability. But that's not the way the doctrine actually works.

"There is a larger point of principle at stake here. The analyst's failure to warn the patient of the possibility of decompensating into psychosis is trivial compared to his obligation to protect the patient against this possibility. The analyst is obliged to scrutinize day by day into the course of the analysis whether the risk of excessive regression comes to the fore. But it makes much less sense to say that the analyst should monitor this possibility in order to identify the moment that he should solicit the patient's consent to continue than to say that the analyst is obliged to monitor regression in order to shift therapeutic modalities when harm to the patient becomes evident. In other words, observing professional standards of negligence are more important in protecting this patient than protecting the norm of patient choice."[3]

We have a number of things to say. First, it seems to us that the fact that substandard treatment is a wrong does not mean that substandard consent is not. In addition, the criticism of informed consent here applies to informed consent law generally, in all medical contexts. Generally, one is injured by substandard treatment and only peripherally by being prevented from giving informed consent. If this is enough

[3] We are grateful to Robert Burt for this argument.

to show that informed consent is generally unimportant, we will have squandered many resources trying to understand and improve the informed consent doctrine.

Perhaps more important, there could be cases where the treatment does not deviate from the standard of care yet injury happens and the patient wouldn't have chosen the treatment if properly informed. Thus, we want to challenge the idea that informed consent is unimportant in its own right here and that the real issue is substandard care.

Consider, for example, someone who is accepted into psychoanalysis and appears to be an ordinary neurotic person—there are no indications that he has a vulnerability to psychosis. Two months into the treatment, he declines precipitously and without warning into frank psychosis. The doctor immediately changes the nature of the treatment and again has done nothing below the standard of care in offering this treatment. It was a completely competent choice. But in the meantime, the patient has incurred great costs in becoming psychotic. Suppose, for example, he has spent vast amounts of money he could not afford to spend. And of course there is the pain and suffering. Most important, imagine he now faces the possibility of a decline into chronic psychosis.

Now imagine that, if told that some people in analysis become psychotic, he would have declined psychoanalysis and chosen another treatment. Imagine there is no question about this—he would have declined psychoanalysis. He had a good friend who became psychotic and is motivated to avoid psychosis at all costs, and has stated so numerous times to a wide group of friends and family. A reasonable person in his situation would have declined the treatment. An informed consent cause of action would allow him recovery even though there is no violation of the standard of care in the treatment offered.

Granted, these cases will be rare. But their existence shows why informed consent is an important doctrine that may supplement or supplant a charge of negligent provision of treatment. The cause of action requires injury but not negligent treatment. An informed consent action may then be a stand-alone lawsuit in its own right. Also, of course, the doctrine protects patients' interest in autonomous decision-making. Patients are harmed not only by substandard treatment but also by substandard elicitation of their consent.

For our purposes in this book, then, we adopt the patient-based standard—the doctor's duty is measured by the patient's informational needs, not by what other doctors do. We believe this standard is both

normatively correct and likely to be a limit on therapist discretion. Is a particular risk, for example, important enough for a patient to know even if knowing this might harm the patient in some (identified) ways?

In conclusion, informed consent in the context of therapy is almost invisible in the courts, although many statutes require it. We turn now to a review of the legal and psychiatric literature on informed consent, followed by a discussion of the theoretical issues that informed consent raises—e.g. what should we do if the patient's informational needs conflict with his therapeutic interests?

Review of the Legal and Psychological/Psychiatric Literature

In this section, we review the legal and psychiatric literature on informed consent to psychotherapy. We conducted searches in both legal databases, such as LEXIS and WESTLAW, and psychiatric and psychological databases, such as Medline and Psych Info. Our searches identified a number of articles and one book that discuss informed consent to psychotherapy.[4] (We should mention here that only a small number of these looked at psychoanalytic therapies in particular, but all at least mentioned psychotherapy.) Instead of reviewing the articles individually, we will summarize their findings in two areas. First, we will look at what the authors consider to be the elements of informed consent—for example, risks and benefits, and what these are in the context of psychotherapy. Second, we will discuss what the authors think are the benefits/justifications of an informed consent requirement, as well as the costs. Third, we will briefly mention the three existing empirical studies. Finally, we will present the questions that we will study in more detail in the theoretical and empirical chapters of this book.

The first issue we will discuss is what our selected authors think the elements of informed consent should be. That is, assuming that informed consent is justified—that, in part, the benefits outweigh the risks—what must clinicians disclose? Note that many of these items will be common to all forms of psychotherapy, and not just analysis. For example,

[4] See Appelbaum, 1997; Beahrs and Gutheil, 2001; Beeman and Scott, 1991; Biesterveld, 2002; Braaten et al., 1993; Dyer and Bloch, 1987; Epstein, 1978; Green, 1993; Gutheil, 1993; Hampton, 1985; Hjelt, 2002; Horowitz, 1984; Macklin, 1982; Marczyk and Wertheimer, 2001; Mason et al., 1978; Noll and Seagull, 1982; Note, 1970; O'Neill, 1998; Pomerantz and Handelsman, 2004; Raybin, 1979; Robitscher, 1978; Stone, 1979; and Wenning, 1993 and 1993a.

all therapists have a reporting obligation in the case of suspected child abuse, and hence an obligation to disclose this risk of a breach of confidentiality.

The elements of informed consent are obviously of utmost importance. Virtually everyone in the literature we consulted mentioned the nature of the treatment, its benefits, its risks, its alternatives, and risks and benefits of alternatives (see, for example, Note, 1970; Epstein, 1978; Macklin, 1982; Mason et al., 1978). Several included the patient's diagnosis (Mason et al., Note, 1970), and some included the therapist's qualifications (Robitscher, 1978). A number noted that relative efficacy of different therapies should be sought out and discussed with the patient (see, for example, Robitscher, 1978; Macklin, 1982; and Mason et al., 1978). Confidentiality was frequently mentioned (Mason et al., 1978; Horowitz, 1984). Among the more specialized and less standard items, the authors mention disclosing when there is uncertainty about, say, risks and benefits; expectations conveyed about the importance of attendance (Mason et al., 1978); disclosure of supervision when the therapist is under supervision; discussion of the aims and risks of "reconstructive therapy," as well as the possibility of false memories in certain kinds of therapy (Horowitz, 1984); and the importance of personal compatibility between therapist and patient (Macklin, 1982).

Perhaps the most important items mentioned were the specific benefits and risks that the authors believed should be discussed. As for risks, items noted included the following: one's condition might worsen—one's existing symptoms could be exacerbated or new symptoms could appear (Mason et al., 1978); the treatment might arouse painful and intense feelings generally (Mason et al., 1978), and a decision to stop could worsen things (Horowitz, 1984); and a transference neurosis or psychosis could happen, and the latter might be incapable of resolution (Horowitz, 1984). The patient could also experience a pervasive deterioration of personality functioning or develop a sustained dependency that interferes with his autonomy. One might, in addition, feel shame at the need to be in therapy. Social problems with peers and family might be exacerbated or those relationships might change in negative ways (Wenning, 1993 and 1993a). For example, the therapy might stimulate the devaluation of others toward the patient, producing unwanted damage to extra-therapeutic relations (Wenning, 1993 and 1993a). In the context of reconstructive therapy, one might undergo a violent reaction against treatment (Horowitz, 1984). In the context of repressed memory therapy,

in particular, if the alleged abuser brings suit, the patient should know that patient/therapist privilege will be waived (Biesterveld, 2002). Limits of insurance coverage are also a cost that should be mentioned. Finally, the therapy may simply result in no change in the patient's presenting symptoms, so that he will incur opportunity costs to no good end.

Benefits mentioned include symptom relief, personality change or modification, improved interpersonal functioning, heightened self-esteem, improved ability to take responsibility for one's problems, and a greater sense of options in life (Wenning, 1993 and 1993a).

The second issue of importance is the values behind an informed consent requirement—for example, the promotion of autonomy—and how these disparate values are served by an informed consent requirement. Many of the authors weighed in. In terms of benefits, the authors mentioned most frequently that informed consent serves autonomy, sometimes described as such and sometimes as patients having "equal bargaining power," "rights to knowledge," and so on (Stone, 1979 and Macklin, 1982). Many authors also noted that informed consent may at times serve the patient's therapeutic interests—for example, by fostering mutual participation and enabling decisions in the patient's best interests (Beahrs and Gutheil, 2001). An informed consent requirement may enable the protection of patients against risk by giving them the information necessary for a decision. Indeed, the fact that doctors today do not know their patients as they once used to argues for a collaborative decision-making process (Note, 1970; Epstein, 1978). We have moved from indoctrination to information sharing (Robitscher, 1978). A collateral benefit is that clinicians may be moved to investigate their biases more and this may lead to attention to, and improvement in, the scientific validity of different treatments (Epstein, 1978). Informed consent doctrine also provides a legal theory for recovery and provides therapists with some protection from lawsuits (Horowitz, 1984). Finally, many of the authors pointed out that, while informed consent may serve both autonomy and paternalism, as noted previously, there is also a potential conflict in this sphere between the two (Macklin, 1982).

In terms of possible costs of an informed consent process, a number were mentioned. A possible distortion of the transference was brought up (Epstein, 1978). Another concern was that the informed consent process could be time-consuming, confusing, and anxiety-producing. Clinicians could impose their own value judgments in the process (Macklin, 1982). The process could cause therapeutic complications, such as stifling

an initial rapport and decreasing a possible placebo effect (Horowitz, 1984), along with complications caused by patients' dependence. In addition, the doctor could give incomplete information, face difficulties in providing the information, or could not be in a good position to predict the likelihook of risks eventuating. Finally, a focus on informed consent could distract attention from other causes of action, such as those having to do with the standard of care (Hampton, 1985).

The literature also includes three empirical studies. Two of them looked mostly at what patients want to know about therapy. The third covered a long, qualitative look at the informed consent process conceived as a negotiation that changes over time. This study also mentioned some possible costs of the process. (For another empirical study of the informed consent process in a psychiatric hospital, see Lidz et al., 1984.)

Our review of the literature puts us in a good position to think about and explore the concept of informed consent to psychoanalysis. The following chapters include a theoretical discussion of informed consent to psychoanalysis, as well as an empirical discussion of the same. At least two central issues are discussed in the literature and will help guide our analysis. The first issue is what elements are and should be included in an informed consent to psychoanalysis. We take as our starting point the literature on this question, although we think through more clearly and exhaustively what those items should include. For example, the literature mentions threats to confidentiality, but no article clearly itemizes what all those items should be, as well as what level of detail to go into. We do so. In addition, we explore empirically what our analyst-subjects do and think they should do concerning these elements. And we explore what they do and think they should do regarding risks and benefits. Similarly, we look both theoretically and empirically at the ways an informed consent requirement may be therapeutic and countertherapeutic. Once again, our discussion is more exhaustive than the literature. And we look at what analysts find and expect to find regarding therapeutic benefits and risks of an informed consent process. In addition, our study asks questions not explored in the extant literature, such as whether informed consent is really possible at the beginning—whether one can understand then—and whether, once one understands, it is too late to withdraw; whether informed consent is much ado about nothing; and what motivates analysts to obtain informed consent. In addition, we study whether analyst attitudes are consistent across items. Our empirical study is the first to discuss in detail analysts' perceptions

of the informed consent process. There are other empirical studies that look at different things—for example, two other empirical studies look at the issue of informed consent largely from the point of view of the patient and patient's family, while the third is entirely qualitative.

In short, the existing literature is a good first step to thinking about informed consent to psychoanalysis. We hope our theoretical discussion and empirical study fill an important gap in the literature and help us understand whether informed consent in the context of psychoanalysis makes sense.

We turn now to our discussion of the theory behind informed consent to psychoanalysis.

2. Analysis of the Concept of Informed Consent: The Theory

This chapter, in essence, is an exploration of the concept of informed consent. What are the values behind it? Is it possible? Is it desirable? The first section presents background material on an informed consent requirement: the values behind an informed consent requirement and whether psychoanalysis shares those values. The second section discusses what the standard elements of informed consent are in the psychoanalytic context. The third section considers whether informed consent to psychoanalysis is even possible. The fourth section discusses the likely (or possible) effects of an IC requirement, while keeping in mind alterations in certain technical precepts, such as anonymity, that an IC requirement entails. Is the IC largely therapeutic or largely countertherapeutic, and how so? The fifth section explores the process view of IC. The last section responds to the claim that an informed consent requirement will have little effect on patients generally, and so is unimportant to study.

We should declare at the outset that we approach this issue from the point of view of the largely classical analyst. Thus, we rely on concepts such as abstinence that other schools of psychoanalysis do not make use of. We recognize that the psychoanalytic community today is quite pluralistic and various members of the community may have different views on our topic.

In what follows, we briefly sketch out some likely differences in different schools of psychoanalysis in the IC context, recognizing that some of what we say will be caricature-like. For instance, Kleinians are freer and faster with interpretations than classical analysts, and tend to focus on deep, archaic fantasies more than pedestrian concerns involved in living in the world. So an informed consent may involve thinking about things in a more superficial way than a Kleinian would like. On the other

hand, the informed consent itself might lead to deeper issues, and some of this might be good and some bad. The patient listening to the informed consent, for example, may be in a paranoid-schizoid space—she is being warned of harm and may be quite agitated about it. By contrast, a patient squarely in the depressive position may be better able to tolerate that analysis is a mixed bag—it potentially has good aspects and bad aspects—and may recognize that the person telling her all the negative things (whom she may hate) is also the person telling her the positive (whom she may love). Also, in our context, it is important to note that Kleinians, like classical analysts, are equally committed to not engaging in self-disclosure. The analyst shouldn't tell about herself, for example, because this will detract from the patient's ability to imagine the analyst in her own way, including archaic ways that are found in the unconscious.

By contrast, self-psychology may be more open to informed consent and its value. One focus in self-psychology is on healthy and unhealthy narcissism. One could imagine informed consent conducing to both: The patient, for example, may feel respected but also offended (wounded) by the idea that he doesn't already know about all the issues and needs help to learn them. In general, the self-psychological focus on empathy may be quite compatible with a full informed consent. For example, engaging the patient in understanding the process may again make her feel respected and understood. To look at this from the other side, disclosures may feel like an empathic failure if the patient feels overloaded with information and angry that the therapist does not care enough to make choices for him.

Self-psychologists also focus on the patient's effort to maintain the cohesiveness of the self, and informed consent may have a significant impact on the self-selfobject relationship. The kind and informing analyst, that is, may become a valued selfobject: The patient may feel his anxieties about the treatment are being addressed—in a kind of mirror transference. Alternatively, he may feel a collegiality about working with the therapist—in a kind of twinship transference. Two other differences from a classical approach are the lesser emphasis this school places on the "blank screen" concept (self psychologists are more open to self-disclosure), and a greater focus on equality in the patient-analyst relationship (the analyst is less authoritarian). (Self psychologists share these features—with, for example, relational psychoanalysts.)[1]

[1] These comments are obviously very brief and preliminary, and the question of the different schools' reactions to IC is clearly worthy of further exploration.

This part of the book, then, should have a major payoff in shedding light on the possibility and desirability of an informed consent requirement in the context of psychoanalysis.

The Values Behind Informed Consent

This section will address two preliminary matters: the values behind informed consent and whether psychoanalysis shares them. An informed consent requirement treats the patient with dignity and respect. It may also confer some sense of control on the patient. The requirement lodges decision-making authority in the person who has the most at stake—and who knows himself best and cares about himself most. It serves deontological interests—moral and ethical dignitary interests—inasmuch as it values autonomy. It also serves consequentialist interests—interests in optimizing good consequences—inasmuch as it supposes that lodging decision-making authority in patients will result in the best outcomes. After all, medical decisions involve knowing information about the medical facts, but also evaluating these facts in light of one's values. Is a drug that makes one's hands shake not a good fit for you because you are a concert pianist and you value that part of your life? You, of course, are the best judge of your own values and how the proposed treatment impacts them. If so, informed consent may serve, in the long run, both autonomy and well-being. (Note also that promoting sound therapeutic outcomes may promote the formal value of autonomy by enhancing functionality.)

Before we look at whether psychoanalysis shares these values, it should be noted that there are many complexities behind the concepts of autonomy and well-being.[2] IC may promote autonomy as an abstract, deontological value, autonomy as functionality (as well as self-directed functionality), autonomy as increasing the opportunity set, or autonomy as promoting the rational constraints limiting what can be autonomous. Autonomy can be at war with itself in these different senses, and also others—for example, short-run vs. long-run, autonomy as self-direction vs. autonomy as the ability to pursue one's preferences, including preferences to delegate choice or become more dependent. And, of course, autonomy as self-direction may conflict with autonomy as functionality: A person may become more functional if she assigns some decisions out.

When we talk about beneficial effects of IC there are also complications. In what dimension are the effects? Overall patient well-being? Personal satisfaction? The very autonomy interests we have already dis-

[2] We thank Michael Shapiro for pointing out these complexities.

cussed? And so, when we look at efficacy, are we assessing what the patient learns and retains, or therapeutic benefit, or simply improvement along certain dimensions (for example, mood)? Similarly, when we speak of something being "countertherapeutic," we must ask, in what respect? A lessened sense of well-being? Less functionality in terms of ability to pursue one's interests?

It is also worth noting that autonomy and best interests may pull apart and come together in different ways. For example, becoming more autonomous may sometimes make one worse off in both therapeutic and non-therapeutic senses. Someone may become more functional and autonomous but feel worse. On the other hand, good therapeutic outcome generally reflects a more autonomous state, so that autonomy, purely as a deontological value, is promoted. Likewise, one aspect of well-being is being more autonomous. In short, being better off in a treatment sense may entail being more autonomous in all dimensions—self-direction, functionality, and rationality.

Keeping in mind the multiple meanings of these terms, we should recognize that psychoanalysis shares many of the same values behind an informed consent. For instance, psychoanalytic theory envisions people as being both dependent and independent (see Bowlby, 1969–80; Mahler, 1972; and Eagle, 2006). The informed consent process fosters both.[3] It fosters dependence by encouraging the patient to depend on the analyst as the informative and helpful professional. It also fosters dependence by increasing trust: It strives to be completely above board about what will happen, and therefore permits the patient to develop a workable transference. Finally, the patient is ultimately consenting to putting himself in the hands of the analyst—to being an object of care in the treatment. (This last differs from the first in that the patient consents to dependence in the treatment versus being dependent in the informing process.)[4] At the same time, the informed consent process

[3] Note that if the comparison is with no informed consent, then some of our points are less potent. For example, IC may foster dependence, but lack of IC, with an authoritarian doctor making all the decisions, is obviously much more likely to foster dependence. We are not comparing IC with no IC, but just detailing what IC entails or involves.

[4] There are, of course, different senses of "dependence." To say otherwise is to suggest too strongly that all forms of division of labor involve "dependence." For example, an architect who designs every aspect of a structure, the materials, and modes of construction and the assembly, but who doesn't build the whole thing with his or her own hands, has delegated but has not become "dependent" in some global sense. This dependence in the attenuated sense yields greater long-term independence.

also fosters independence because it ultimately places decisional authority in the patient, and gives her the tools—the "informed" part of the informed consent—to make a choice. It also underscores that she has agency throughout the psychoanalytic process, as she must continually renew her choice to participate. Treating people with dignity and respect is a goal of both psychoanalysis and informed consent.

There are, of course, counterweights. Informed consent may not in fact serve the patient's autonomy interests. One may be skeptical, for example, about whether, at the beginning of the process, the patient can really absorb the information about risks and benefits in any meaningful way. It might also be argued that the concept of autonomy itself is chimerical; certainly psychoanalysis teaches us that we are often, unawares, buffeted about by forces beyond our conscious control, and it could be argued that unconscious motivation pulls against the idea that we have truly autonomous choice. If autonomy is chimerical, so is the idea that informed consent fosters autonomy—there is no such thing.

In addition, even if informed consent does serve patients' autonomy interests, there is reason to think it does not serve their best treatment interests. Indeed, it may even be countertherapeutic. For instance, the values behind informed consent may require disclosures that are not in the patient's best treatment interests to know: Learning too much about the analyst might actually impede the patient's willingness to say whatever comes to mind. For example, knowledge of the analyst's personal data—say that he was trained as a doctor abroad—might alter free association, actually interfering with the process.

Imagine many patients want to believe that their therapist is highly trained. This kind of patient cares a lot about credentials—he and his kids all went to Ivy League schools. If he didn't know about his doctor's training, his transference reaction would be to idolize him as a top-notch clinician with only the best training. Knowing that the doctor not only didn't go to an Ivy League school, but indeed wasn't even trained in this country, would interrupt the idealizing transference. Knowing too much prevents his fantasy life, in this regard, from emerging. If so, it could be said to be antithetical to the goals of self-knowledge, which psychoanalysis purports to promote through the psychoanalytic method. In short, it could be countertherapeutic.

Finally, there is one additional paradox with informed consent: To say that it is required may lead to an infinite regress, especially in the case of analysis, because the IC is so complex and poses risks (even if rare), so that you need an informed consent for the informed consent.

Exploring the possibility that an informed consent requirement is countertherapeutic, and how we should adjudicate the conflict between the patient's autonomy and treatment interests, will form the heart of this book.

The Elements of Informed Consent to Psychoanalysis

The informed consent elements to any medical intervention generally focus on what the "reasonable patient" would find material to his decision about whether to consent to having the treatment. Typically, as noted, these elements include the nature of the intervention; its risks and potential benefits; alternatives to the proposed intervention (including no treatment); and the risks and potential benefits of these alternatives. Other elements are also important, such as the clinician's qualifications and potential incursions of legal requirements into the treatment space (for example, mandated breaches of confidentiality when a doctor suspects child abuse). (As mentioned before, many of these elements would be critical for informed consent to any kind of psychotherapy. For example, all therapists arguably have a reporting obligation in the case of child abuse and hence an obligation to disclose this to patients.)

If IC for psychoanalytic treatment is to follow the procedures already established for medical interventions, the list of required elements in the procedure could be fairly extensive. But in any case, based on the review of the IC literature, a fully informed or "robust" consent procedure would have to include the following items: First, certain descriptive elements from the analyst's background and training should be included. Is she a licensed M.D., Ph.D., or M.S.W.? Is he a graduate of a psychoanalytic institute or is he a psychoanalytic candidate? Is he under supervision?

Supervision status, while arguably very important, could have significant counter-therapeutic effects on the treatment. Imagine a patient with paranoid features. He might have fantasies that his therapist is very unskilled and the supervisor is malevolent. When the therapist makes an interpretation, the patient immediately wonders if the intervention came from the therapist or his supervisor. He might denigrate the therapist and fear the supervisor. Of course, many different reactions are possible. The point is that there is a third person in the room, so to speak, and while we may think the patient has a right to know this, this knowledge might be countertherapeutic.

Second, some fairly full description of the nature of the process must be given.[5] We note that there are different accounts in the literature of what psychoanalytic process consists of. For instance, Merton Gill (1984) makes a distinction between "extrinsic" criteria (for example, use of the couch, frequency of sessions) and "intrinsic" criteria (transference, interpretations, and so on). We don't believe an analyst needs to have a full and considered theory of what psychoanalysis is, and how it is distinguished from other therapies, when informing the patient of the nature of the procedure. Rather, he or she should reference many of the criteria Gill lists. For example, the patient is to free associate and the analyst is to listen carefully and offer interpretations or make other interventions (such as clarifications or empathic observations) that are likely to facilitate treatment progress. Integral parts of the process, such as the development of transference and the possibility of regression in the service of the ego (see Hartmann, 1958), should also arguably be discussed.[6] In addition to these "intrinsic" criteria, "extrinsic" criteria should also be mentioned, such as use of the couch. Also, the likely duration of the treatment should arguably be discussed. Finally, what are called "frame issues"—the frame surrounding the treatment—must also be discussed, including the frequency of sessions, the fees, the analyst's vacations, and the policy on missed sessions.[7] Of course, how one tells is equally as important as what one tells, and research is needed on the best way to do this.

One of the unique dimensions of informed consent in this context is that it is impossible to have a "framing" conversation concerning the nature of the treatment, which stands apart (as it would in other medical cases) from the treatment itself and does not affect it. We will return to this point later.

[5] At least one analyst we have spoken with recommends books about psychoanalysis for certain of his patients so that they might learn about the process. This is an interesting idea, which probably presents certain complications of its own—and deserves extended study.

[6] We include these as part of the process because they are costs only if they are uncontrolled and they are benefits only if they are managed well.

[7] Some of these—for example, when you will meet and how much it will cost—could be construed as IC issues around the frame. But they could also be construed as conditions of the very possibility of a treatment relationship, which, once started, is subject to informed consent requirements. There is no "right answer" to this question of how to construe this—it is just a choice.

Third, one must understand the goals—and therefore potential benefits—of the treatment. These goals include an understanding of why one is seeking treatment—involving, perhaps, some negotiation over what the problem is. Does the patient have a bona fide illness? Does she understand what is wrong in the same way as the analyst? Clearly the patient's perception of his or her difficulties may change over time—as indeed may the analyst's understanding of the patient's illness. In addition, it is important to note that, unlike, say, behavioral therapy, analysis is not primarily symptom-oriented, but is interested in deeper issues such as the structure of the personality and what psychoanalysts believe are the underlying causes of the psychiatric symptoms.

The potential benefits of treatment, of course, include remedying what is wrong. In the first instance, removal of symptoms is important. The patient may also have life goals such as obtaining good work and being married. Indeed, both the patient and the analyst may also have more ambitious goals: achieving insight, working through the transference neurosis, effecting structural change (for a definition of this, see Moore and Fine, 1990, pp. 185–186). Consider, for example, Balint's (1948) conception of the goals of treatment: the development of "a strong critical ego, capable of bearing considerable strains, free from any unnecessary identification, and from any automatic transference or thinking patterns" (Balint, 1948, p. 166). Understanding these possibilities, and what they mean, would seem an important part of an informed consent.

Once again, what one says, both about how to understand what is wrong and how analysis might help, is very important. In terms of what is wrong, the patient is coming to the analyst because he is in pain and psychoanalysis is a form of treatment that purports to help the patient understand how what he or she is doing (or not) could contribute to that pain. For instance, the analyst might say in a preliminary way something like "I think you are feeling depressed because of some losses in your life whose effects you may not completely understand. If you are willing to say whatever comes to your mind here, I will help you to identify the barriers to your understanding of whatever contribution to your unhappiness you may inadvertently be making. Some of the barriers are simply not conscious and my job is to help you see them, and learn how and why they operate. Most often, these unconscious problems and conflicts affect the ways in which you experience the type of discomfort you've begun to tell me about." In this illustration, by

informing the patient about how the treatment works to gain consent to continue, the IC procedure becomes part of the therapeutic process.[8]

Fourth, the patient must also understand the potential risks of the procedure. Primary among these is a malignant regression,[9] worsening of symptoms of any kind, or developing new symptoms. In rare cases one may become psychotic. More commonly, symptoms of anxiety or depression may intensify. One may become needy and unhappy that one's needs are not being met (the analyst aims to not gratify neurotic wishes, and this can be painful to patients). A related risk is an intense transference. Combined with the regression, this can become quite problematic in certain people, who may become preoccupied with the person of the analyst in an unfortunate way.

For instance, a patient may feel upset that he is deeply involved with someone (i.e., the analyst) who doesn't really care about him in the way he would like to be cared about. The patient may become completely preoccupied with the analyst—eat, drink, and sleep him, so to speak. He might become unable to recognize this as a transference. At an extreme, he might start stalking the analyst. All of this could eventuate in what has been called a stalemated psychoanalysis[10] and could lead the patient or the analyst to have to end the treatment. So, arguably, such a patient

[8] We assume here that it is legitimate for the analyst to state the treatment goals and identify the treatment benefits for the patient in her own way. Ultimately, of course, it is the patient whose desires and expectations regarding goals and benefits are paramount. We do believe, however, that therapists often have goals for patients that the patients come to share only over time. That they must ultimately share them does not mean that analysts shouldn't have their own provisional goals and views of benefits. It should be clear, however, that what the analyst does is to explore with the patient how the analyst understands the symptoms, the illness, and the patient's suffering. Must he explain also how analysis helps? But how do we conceptualize what analysis does? Some may say to their patients that making the unconscious conscious changes symptoms. Others may say that providing more in the way of empathy is what helps. It is of interest that, at some level, what the psychoanalyst says is theory-driven (this has very interesting implications, which we cannot explore here). It is not obvious to us that some explanation of what the mechanism is should be part of the informed consent. If it should be, therapists will need to signal that this is a matter of controversy. Of course, the therapist may also say things that describe the "what" as much as the "how," as we noted previously: for example, "Analysis won't make you into a different person, but will change some of your characteristic responses to things and hopefully improve the quality of your life."

[9] For a definition of "regression," see Moore and Fine (1990).

[10] For discussions of stalemate see, for example, Kantrowitz 1992, 1993; Kern, 1995; and Maguire, 1990.

needs to be informed that he might develop such a transference so as to make a knowing decision whether to risk it.

Another important risk is that one's current life may come to seem unacceptable and one may make changes one would not want now but will then (Coyne, 1976); for example, divorce can be a complication of psychotherapy (Chapman, 1964). One may also suffer a derailment of one's interests. A rather different risk is that one will put off life, so to speak. An additional very serious risk is that the procedure will not help, or will only partially help, and one will have spent all the time and money that analysis requires to no good end. One will have incurred important opportunity costs. And even if the analysis works, of course, the fee one must pay must be counted as a serious cost of the procedure. Thus, one must mention not only really bad outcomes, such as a malignant regression, but also the more mundane limitations of the process, such as only partial effectiveness.

One important question for psychoanalysts to consider is whether it is necessary to mention extremely low probability events. For example, some of the legal cases say that extremely remote risks needn't be disclosed (see, for example, Meisel and Kabnick, 1980; and Miller, 2006). So that could be a rationale, for example, of not mentioning the risk of a regression into psychosis, except for those patients for whom this is a significant risk.

Consider also the risk that the analyst will act out sexually. One could say that this is such a low probability event, it seems unlikely to be necessary to disclose. Also, ethical analysts are really not at risk for this kind of behavior, and unethical ones are not likely to warn anyway. Nor do we require doctors in the context of physical medicine to disclose that they may engage in wrongdoing, whether this be through negligence, such as leaving a sponge in your body, or whether it is intentional, such as sexually acting out with an anesthetized patient. There are limits on the things to be disclosed.

Arguably, alternatives to psychoanalysis, along with some of their risks and benefits, must also be disclosed. One must mention shorter-term therapies, particularly when these have proven efficacy for the particular symptoms the patient presents. If the patient is a good candidate for medication, one must discuss this as an alternative or adjunct to psychoanalysis. One must also mention that no treatment is a viable alternative when it is so.

In connection with alternatives to psychoanalysis, must one also disclose the literature on the efficacy of psychoanalysis? Early studies

argued there was no proof that psychoanalysis is better or worse than other alternatives. More recent studies have found efficacy (see Portuges, 2001; Fonagy et al., 2001; and Shedler, 2010; see also Luborsky, 1994). Must one lay out all this evidence for the patient? Might it unduly temper whatever optimism and hope the patient brings to the process? And is it necessary even if, as a clinician, one believes that analysis would be better for this kind of patient—a conviction that may turn out to be true but is just not (yet) proven. (Of course it follows that it might also turn out to be false.) It is also worth noting here that there are other medical treatments that haven't been proven effective either because of difficulties in getting proof (think of studying medicines in pregnant women), or simply because of failure yet to conduct the studies (think of off-label uses of medicines); but we know of no requirement that this be disclosed. Still, the patient arguably has a right to know the relative efficacy of the analysis and alternatives. Because complications from such a disclosure could mean the patient elects not to continue, the psychoanalyst has to resolve the professional and ethical conflicts that attend such disclosures before making them. Not to disclose such information could be construed as an ethical violation, whereas disclosure could result in harm to the patient. That it may also harm the analyst by way of a loss of income may unconsciously affect how analysts think about this and what they do, although of course it does not and cannot justify non-disclosure.

There is, however, a perhaps deeper concern about disclosure of alternatives in the context of psychoanalysis. Doesn't the very notion of "alternatives" to psychoanalytic treatment involve a controversial stance within psychoanalysis? As a colleague puts it, "to think of psychoanalysis as one among several treatment options is of course to represent it as a sub-field of medicine or psychology rather than—as some analysts maintain—something *sui generis*."[11]

This is an intriguing notion. Compare a doctor who says one needs physical activity and then lists different sports; listing other activities that might improve one's life, such as being in a book club, does not contribute to our notion of alternative sports. On the other hand, if the goal is reframed as "making your life better," book groups fit as well as different sports activities. The problem is that if your goals are so broad, the list of alternatives could be endless. So the notion of alternatives in

[11] We are grateful to Martin Stone for this point.

the context of informed consent perhaps requires an understanding that it is one among many therapies. And we should keep in mind that this is a controversial position to some.

Finally, one must inform the patient of potential intrusions into her life that are imposed by the law: for example, breaches of confidentiality over which the analyst may have no choice, such as warning potential victims of his patient's threats, and incursions on her liberty if she needs to be hospitalized. In addition, the patient should be aware of other potential breaches of confidentiality.

Does this include publication of an article that gives details of the patient's case, or presentation of his case at a professional meeting? There is considerable controversy about this. Note that disclosures can be more or less extensive. One possibility is to simply disclose that one may produce disguised case studies at some point in the future. Another is to get informed consent at the point at which one actually plans to do this. Finally, one might invite the patient to read what one plans to present or publish and give approval then.

Judith Kantrowitz has done an extended study of this question, both empirical and theoretical (Kantrowitz, 2006; and book review and comment by Rudnytsky, 2007). For example, she interviewed analysts publishing in American and international psychoanalytic journals, as well as in a relational journal. She also interviewed patients experiencing being written about, both candidates and non-candidates. She looked at the effects of timing on this question—of when the paper is written and consent sought. Different complications may present if the consent is sought in the middle of treatment, say, or after termination.

The central question is whether disguising the patient is enough or whether one also needs to get informed consent. Kantrowitz's findings were that analysts were basically split on this question.

As long as the patient is disguised, so the argument goes, there is no need to involve the patient and get his consent. Indeed, involving the patient is likely to produce complications in his treatment and will certainly not help him. Patients can be traumatized to learn what their analysts think when they read their reports; they can feel used or betrayed; they can have their grandiosity stimulated. At the least, informing patients may introduce complications into the treatment. The issue is further complicated because advancing science is also advancing the analyst's career, and so the analyst may have countertransference reactions in this context, too.

Yet advancement of the science does depend on such presentations. In the context of general research—where we are also using patients to benefit science—we finesse the privacy aspects by getting the subjects to give informed consent. Eliciting informed consent from the patient to be used for science in the psychoanalytic context should arguably happen, too, even though the process will introduce costs.

This is especially important because although the analyst will present the case in disguised form, there is always a risk that the patient will be identified. Others may recognize him. Worse yet, he may stumble upon the case report and recognize himself—and feel betrayed or have other negative reactions. Indeed, the risk of identification by others, even if he never learns about this identification, may wrong him, much as someone who posts a nude photo of someone else on the web has wronged that person, even if the subject of the photo doesn't find out. Is the risk of being identified not a risk he should know about? The question, then, is complicated, but it is beyond the scope of this book to provide a full treatment here.

Informed consent is important for a variety of reasons, one of which is to avoid inducing false hopes and expectations in the patient.[12] The question is what analysts can legitimately tell their patients about what to expect from psychoanalysis. Can they provide a treatment and explain the process that provides the cure? The informed consent process is, in part, an attempt by analysts to provide their patients with answers to these questions.

This, then, is a brief rendition of the kinds of things that the analyst could disclose, if informed consent for psychoanalysis follows the same path as in other professional service contexts. It is of interest, as noted, that all analysts probably disclose some things: at a minimum, issues such as how often the patient and analyst will meet and at what cost, and more important, some description of the nature of the psychoanalytic procedure. So the question, again, is not whether we should inform but what should be included in what we inform. Because, as we shall see, a fairly full disclosure such as the one we just discussed could have clear negative effects—and may involve the analyst in a breach of certain technical principles such as anonymity—it is worth trying to tease out whether such an informed consent requirement is likely to be countertherapeutic and what should be done if it is.

[12] It should also be added that psychoanalysts do not want to falsely suppress them either (reciting a long list of risks, say, might do so).

Before elaborating on the effects, therapeutic or countertherapeutic, of an informed consent to analysis, we want to consider the possibility that informed consent to psychoanalysis may not be a viable possibility: that it is too hard to understand the relevant information at the beginning of the process, and once one understands, it is too late to withdraw.

Is Informed Consent Even Possible?

Is IC for psychoanalysis even possible? If it is not really possible in the way it was intended, and if it is additionally countertherapeutic, perhaps it does not make sense to impose it as a requirement. The argument that informed consent is not really possible here is as follows. No one can understand something like transference or regression until it happens. And once it happens, one is not free to truly consent or decline: One is already too caught in the transference or regression to be able to escape.

But is this situation any different from any other major informed consent situation? Let's say there is a risk of paralysis with a particular procedure. Can you really understand what it's like to be paralyzed? Can you really appreciate yourself as being at risk of that—perhaps at serious risk? Or do you minimize the possibility that it will happen to you?

One difference between these two situations is that people do not have models of transference or regression the way they do of paralysis. The concepts may simply have no meaning to the person. But is this right? Can people not understand the concept of an intense relationship fraught with emotion? Can they not understand acting in a less mature way? Still, the actuality of these phenomena may really catch one by surprise. And the regression is likely more intense than any the patient will have experienced in his life to this point. There may truly be a sense in which the patient cannot understand these phenomena until it is too late.

In addition, with paralysis, one knows that the condition will be irreversible, while with effects of analysis one may imagine not. The risk, one may think, is less because one can simply return to the status quo ante. But this is precisely what may not be the case in this context.

Consider the analogy of a religious conversion. One simply cannot imagine what one will be like after the conversion. And one may imagine that if one doesn't care for it, one can just return to how one was. But arguably, after the conversion, one doesn't want to be any different. It is too late to go back. In the same way, one may fail to recognize that, once in a transference state, one won't want to detach from the person

of the analyst. On the other hand, we do let people submit to experiences that may lead to this outcome—such as religious conversion—and people can choose such experiences, realizing that they cannot know in advance what their new state will be like and that they will not want to change once they are in it. At a minimum, then, patients must be warned about the phenomenon of not wanting to go back.

Another possibility is that a process view of informed consent makes more sense, and, in light of this view, a more hopeful response to the conundrum posed previously is possible. The idea would be that as the analysis progresses one both understands better and is *more* free to make choices. As the analysis progresses and the transference neurosis develops, one also has a strengthened observing ego, and may be both more understanding of what is happening and more autonomously able to embrace or reject it. With the process view, once one understands it may not be too late to decide.[13]

Whether a process view makes sense and whether, indeed, patients on average are better able to make choices as an analysis progresses are important questions that deserve extended study. Later, we will consider advantages of the process view. For now, let us assume that informed consent is possible and see if we think it likely to be therapeutic or countertherapeutic.

Is Informed Consent Therapeutic and/or Countertherapeutic?

Informed consent may be both therapeutic and countertherapeutic in different ways. It may be therapeutic in bolstering the therapeutic alliance.[14] Most important, the patient is likely to feel respected and treated

[13] To take this to an extreme, as one analyst, Dr. Gerald Aronson, put it, informed consent may be possible only at the very end of treatment—not at the beginning, when one cannot understand, and not in the middle of a stormy transference, when one's understanding is clouded, but at the end of a successful analysis. This idea deserves further consideration. In essence, it takes the process view to its logical conclusion: The process of therapy must end for the process of informed consent to itself properly end.

[14] The therapeutic alliance is characterized as the "realistic cooperation and collaboration in the therapeutic process." See Moore and Fine (1990) at 195–196. See also Hanly, 1994. Consider that such a collaborative relationship involves informing and negotiating consent. It would not do to have someone unilaterally imposing the law—in an authoritarian as opposed to authoritative way. Negotiation, which is essential to IC, is a form of collaboration and an example par excellence of working together to reach agreement. In many ways, the IC and the therapeutic alliance are coextensive with each other.

like an adult. A significant meaning of the disclosure is likely to be that the analyst sees the patient as a collaborator. She wants the patient to understand, to appreciate the risks no less than the benefits. And she wants the patient to make an informed decision. The analyst, that is, is speaking to the healthy part of the patient, and that must mean that she sees her as having a healthy part. The patient, in short, may feel honored and respected both consciously and unconsciously.

Another positive meaning of the informed consent process to the patient may be that the analyst is hopeful. He is recommending a course of treatment that, despite the risks, he thinks best in this case. The patient may feel hopeful, too, and more committed to the process. Indeed, to be deemed suitable for this particular course of treatment—analysis—is something of an achievement, and the patient may feel gratified that she is believed to be up to the challenge.

Imagine a patient who has strong dependency needs. Being approached as the central decision-maker, who must be informed and consulted, may bolster the patient's independence and make him feel an authority over himself. Conversely, a very independent person might benefit from ceding authority to the doctor, on whom he depends for information. Informed consent may in these ways serve the patient's therapeutic interests.

Also on the positive side, the patient may feel drawn to aspects of analysis that have been described, as well as pleased by the thought of the potential benefits. Lying on the couch, say, may appeal to her as a way to remove distractions, relax, and let the thoughts come without the interference of social cues. She may be able to appreciate the potential benefits of transference.

Despite these potential benefits of an informed consent process bolstering the therapeutic alliance, there are also potential pitfalls—possible negative effects on the transference. A full disclosure process may be thought to violate several important technical precepts of analysis, including anonymity, abstinence, and neutrality (see, for example, Greenson, 1978). In this sense, it is not that IC is potentially countertherapeutic, but that it may be formally inconsistent with the rules and specifications of what constitutes a sound analysis (within a given school).[15] It may also simply cause the patient important dysphoric affects that will have to be resolved through the treatment process.

[15] Of course, if violating these rules and specifications is not countertherapeutic—or, more, if it is therapeutic—then perhaps the rules and specifications do not make sense. In any case, perhaps we should not care.

In what follows, then, we will discuss how knowing too much about the psychoanalyst or about the psychoanalytic procedure might be harmful. We want to consider ways in which IC could affect important features of the psychoanalytic process. We will argue that it could impair anonymity and so compromise the associative process. Then we will discuss the potential neurotic gratification effect IC may produce as we consider ways in which IC procedures might conflict with the psychoanalytic neutrality thesis. Warning of possible breaches of confidentiality, as we will also discuss, may inhibit patient honesty because of the risk that what they say will be disclosed to others. Indeed, it may be that "not knowing in advance"—say, what a transference is—is important for the effectiveness of the initial transference interpretations. For example, the interpretation may have less impact than it would have if it has been discussed abstractly in advance. In this way, it may be that keeping the patient in the dark is important for the therapy to work.[16]

Let us consider, first, anonymity.[17] In some technical discussions of the role of the psychoanalyst, he or she is meant to be anonymous: a blank screen, a mirror (of course it is understood today that these are, at best, relative achievements—no one can be a completely blank screen or mirror[18]). The analyst may speak very little, waiting for the patient's associations. She will engage in very little self-disclosure: The therapy is about revealing the patient's mind, not the analyst's. By not revealing much of herself, she gives the patient space to give free rein to his fantasies about her. This allows the transference to develop: The patient is seeing and experiencing certain things about the analyst that come from

[16] Compare deception in research that would not be possible without it—for example, you, as a subject of a research study, think you are tracking certain information to determine your tracking ability, while the task is actually designed to uncover unconscious racism. In other words, the keeping-in-the-dark is essential to the functioning of a process. Of course we are not saying analysts should use deception, but it may be that they should keep the patient innocent of certain information to make the process work better.

[17] The "rule of abstinence" is typically given as the name of the rule that encompasses anonymity. But it also encompasses nongratification (which is obviously related). We separately name these two for ease of exposition. The differences among neutrality, abstinence, and anonymity have been discussed recently in an article by Adler and Bachant, 1996. On anonymity and neutrality, see also Renik, 1975, 1976.

[18] For commentators who strenuously call into question the idea of anonymity, see, for example, Renik 1975, 1976; and Natterson and Friedman, 1995.

him, not her. Because she is so anonymous, the patient will come to realize how much he is bringing to his perceptions of her.

A robust informed consent requirement, on the other hand, somewhat breaches the precept of anonymity. Consider, for instance, that the analyst may tell the patient certain important things about herself. She is an M.D. and has been in analytic practice for ten years. He is a second-year candidate and the analysis will be supervised. He has been in practice for fifteen years but never became a training analyst. The analyst may even reveal (if asked) where she went to school and where she was trained analytically, and perhaps what her theoretical orientation is.

Some of these elements are not, perhaps, important enough to be required disclosures. Even those that are are bound to have an effect on the patient. One can no longer imagine that the candidate analyst is widely experienced. Or recall the previous example of a disclosure that the therapist got his M.D. in a foreign country. The bottom line is that one may, simply put, know too much for the process to be optimally effective. One's fantasies could have less scope in which freely to range. This could have a serious effect on the unfolding of the transference. It could also interfere with analyst and patient coming to understand how the patient's mind works.

In short, knowing too much about the analyst may contaminate the "blank screen" and make it more difficult for the patient to project his own issues onto the analyst. Again, this idea has been questioned, but even admitting that it is a relative matter, we may think the informed consent detracts from the aspiration to have the patient know as little about the analyst as possible. With this disclosure, then, the patient knows too much for the process to be optimally effective.

Telling too much may then have a stifling effect on one's fantasy life. It may also be countertherapeutic in setting up expectations that will inevitably be frustrated. For example, the disclosing analyst may set up expectations about how he is likely to act that will be thwarted in the analysis proper. The disclosing analyst is quite forthcoming and participatory. The patient may come to expect someone who talks freely and explains. She may come to expect someone who tells things about himself. Frustrated expectations could lead to complications in the relation between analyst and patient and to a lessened tolerance of the patient to the deprivations of analysis.

Telling too much could be countertherapeutic not only in curbing fantasy and setting up false expectations, but also in acting as a sugges-

tion: One ought to develop such and such psychological phenomena, one ought to achieve such and such benefits—and so, as a form of compliance, one does. This is not analysis, but suggestion. Indeed, it may work in a negative direction, too, as when a patient actuates risks he has been warned of. This is one way, as we have noted, that the consent and both the disease and treatment are not independent. Being warned about a malignant regression may lead to one.

In addition to full disclosure involving violation of principles of anonymity, it may also violate principles of non-gratification: A full disclosure may simply be overly gratifying to the patient. It could be gratifying because, even in the beginning, the patient invests the analyst with a lot of power, and so he could find provision of information a form of provision in general: The analyst is giving a lot. In addition, to the extent the analyst tells about himself, the patient may feel she is a confidante, and special in that way. An informed consent process may be gratifying as well in leading to exaggerated responses of hopefulness and specialness.

A full disclosure in an informed consent process may also be perceived to involve the analyst in violating precepts of neutrality. Neutrality requires the analyst, as it is commonly put, to be equidistant from ego, id, and superego (cf. Freud, A., 1966). (For another definition, see, for example, Moore and Fine 1990, p. 127. On some perils of disclosure see Renik, 1976.) He should not endorse certain courses of action, and should take care not to impose his own values on the patient, whose values are for her alone to decide. Giving an informed consent, however, may involve the analyst in endorsing certain health values, at least, and in giving a positive valuation of what he is recommending. The analyst may also be perceived as pursuing certain goals quite apart from health (for example, the patient's getting a better job), and so imposing his own values upon the patient. This may happen even apart from the informed consent, but is a greater risk in this context because the analyst is laying everything out in some detail.

Perhaps more important, the patient may understand the analyst to be making a recommendation that he is not, in fact, making. For instance, a patient in the grip of a strong transference may focus intently on all the analyst says, wanting to be the best and most compliant patient she can be. When the doctor brings up medication as an adjunct to the therapy, the patient may believe the analyst is making a recommendation. This could actually be the farthest from the analyst's mind; he believes analysis is the way to go for this patient and he could make more progress without med-

ication. But he also knows that medication can be helpful in such situations and it is entirely the patient's choice. So he must inform the patient.

Telling the patient about the alternative of medication, then, may be taken as an endorsement of that option, even though that may be far from the analyst's intent. That patients second-guess what they think their analysts want them to do—another reason for relative abstinence—makes a disclosure about options and risks and benefits somewhat hazardous. At the least, the analyst must carefully analyze compliance resistances and thereby give the patient a chance to recognize that he appears to be all too willing to treat IC as something to be enacted. In short, the IC may involve, or more likely give the appearance of involving, recommendations that it should not be the business of the analyst to make.

The content of the IC may also curb one's expression of one's fantasy life because of fears of negative consequences if disclosure of what one has said is required by law. It has been widely stated that inroads on confidentiality—not only required warnings of danger but even consented-to disclosures to insurance companies—will make patients much more reluctant to talk: to give rein to their fantasies, or at least to verbalize them (see Bollas and Sundelson, 1995).

Take a patient who is angry at his spouse. He even has fantasies about how he can teach her a lesson: He could brandish a knife and tell her that next time he will act on it. The patient, however, has been informed that the analyst might have an obligation to warn his wife if he thinks there is a danger to her. So the patient does not articulate the fantasy. It might actually be even more dangerous if he doesn't talk, so that the law, counterintuitively, leads to more harm.

There are other ways that an informed consent disclosure may tell too much and therefore not give adequate scope to the unfolding of the patient's fantasy life. For instance, the disclosure will say much about the process of analysis itself—for instance, that the analyst will talk little and that transference will likely develop. But it may be better, therapeutically, to wait and see how the patient reacts when the analyst is silent, for example, rather than forewarning (and forearming) the patient. And it may be better for the transference to slowly develop on its own rather than being hurried along, or retarded, by too much knowledge.

Indeed, we should perhaps think of the practice of analysis as on par with deception research. They may both be endeavors where a certain amount of deception (or unforthcomingness, to be less stark) is necessary for the activity to work optimally. Giving away the plot of the

story, so to speak—or the punch line of the joke—may, in the case of analysis, dull its effect when it would in the ordinary course emerge. It may just pack a much greater punch to hear about transference when the first major transference interpretation is given. We ordinarily do not think that deception/hiding is a good thing. But if it is necessary for an optimal process to emerge—a process that is therapeutically efficacious or that yields important experimental information in the case of a deception study—then we may want to countenance it.[19]

To think of this in yet another way, certain medical interventions will not work if too much is disclosed. Consider the therapeutic use of placebos. The patient must be kept in the dark about the intervention being inert therapeutically for it to produce any placebo effect. We are in no way suggesting, of course, that analysis is a placebo. We are only pointing to an example where not knowing is essential to therapeutic efficacy, and may be something we countenance for the good effects it works. It should be noted, of course, that this kind of use of placebos is controversial, so psychoanalysts ought to be conflicted about keeping people in the dark even if they believe it might be therapeutic to do so.

Finally, a fully informed consent may produce all manner of dysphoric affects in the patient. The nature of the process, for instance, may scare him. What will lying on the couch be like? A patient might have fantasies of being dominated, hurt, and upset by the strangeness of the procedure and the lack of stimulation. Indeed, these fears and fantasies may even lead the patient to refuse the couch.

He may also have fantasies about other aspects of the process. What will transference be like? Will the patient become so preoccupied by the analyst that he can think of nothing else? What will regression be like? Will he become like a young child?

Similarly, the patient may feel fear and pain at the recitation of risks. Will he undergo a malignant regression? Will the process turn out to be a huge waste of time and money? Is it possible he will be seriously hurt by psychoanalysis?

Indeed, the patient may also hear a sense of hopelessness in the psychoanalyst, given his recitation of the risks. If the psychoanalyst does not

[19] Deception research is, of course, not without controversy. But with proper safeguards, it is indeed today permitted by Institutional Review Boards. One must simply justify why it is needed and generally have a debriefing period afterwards. Also, as implied, deception is different from just not telling.

have faith in the beneficence of the process, why should the patient? Perhaps he is recommending psychoanalysis but fears the patient is a hopeless case. The patient may then lose hope himself.

In addition to the fear and pain the patient may feel, she may also find the informed consent process a meaningless ritual, and feel that the analyst is just trying to cover herself. The message received is that the analyst cares more about herself than about what is good for the patient. This may be a somewhat paranoid response, but some analytic patients may feel it nevertheless.

Indeed, even if the patient doesn't think the analyst is simply looking out for her own interests, the informed consent process may, for the patient, be meaningless or worse: He may feel, consciously or unconsciously, that his autonomy is being appealed to at the expense of his well-being. How should the patient know what is good for him? Can't the analyst decide that? The patient may feel the analyst is putting undue pressure on him to make a decision that he is not in a good position to make. The analyst should have enough strength in her own convictions to do what is best without burdening the patient with unhelpful information.

These, then, are some of the ways that an informed consent process may be countertherapeutic. And at the beginning of this section we also saw some of the possible therapeutic effects. Of course, these claims are based on speculation and not empirical study. Later, we look at a survey of sixty-two analysts about their experience with informed consent, both as analysts and patients, and whether they were concerned about any countertherapeutic effects and whether any resulted. Even here we are not directly studying the effects, therapeutic or countertherapeutic, of this process, but rather what analysts think. Still, the study gives us more data on how the IC is likely to affect treatment.

Before we look at our data, we turn to the process view of informed consent, followed by a discussion about whether informed consent is much ado about nothing.

The Process View of Informed Consent

Some have suggested that we adopt a process view of informed consent or they describe working with such a view (Beahrs and Gutheil, 2001; O'Neill, 1998). In brief, the process view is that one obtains informed consent over time.

We must consider first a contrasting view, which says that we need informed consent *to start the process*. According to some analysts, IC is supposed to be a precursor so what we are talking about here is not properly named "a process view of informed consent" but not a view about IC at all. It is, rather, a view of just bungling along with no real agreement or understanding.

This claim, however, is conclusory; it does not amount to an argument. Why should we require informed consent at the beginning, all at once? If this claim is definitional, it is not very interesting. If it is not, it is an open question whether a process view accomplishes best what we want out of an informed consent. We discuss this view briefly here and return to it in the Afterword to this book, where we lay out our own thoughts about informed consent to psychoanalysis.

Let's return to our discussion of the process view. At its most extreme—and implausible—just showing up for the therapy is taken as sufficient informed consent for the therapy to continue. (Compare, for example, Robitscher 1978, who says this is enough, with Horowitz 1984, who says it is not.) Little reflection is required to see that this is problematic at best, at least for many treatments. Consider another, very risky therapy that unfolds over time and that a patient continues to come back for. Now assume that the patient totally lacks capacity to understand what is happening—what he is being treated for, what the treatment consists of, what its risks and benefits are. Simply showing up may evince consent, but hardly a form of it that could legitimately be called informed and capable consent.

In the same way, even if the patient has complete capacity, simply showing up for treatment is not enough. It certainly does not mean one is making an informed choice to continue. Without a discussion of risks and benefits, the patient would not know what was in store for him. To give an extreme illustration of the problem here, let's say the first ten therapy sessions of a treatment involve talking, and in session eleven the patient is to be subjected to electroshock. Showing up for the eleventh session does not constitute informed consent for the ECT in particular—indeed for the treatment that encompasses the ECT as a whole. The point here is that simple attendance does not assure informed consent. If the patient lacks information about what is going to happen, he has not provided informed consent just by showing up.

Of course, the typical analytic patient is not going to lack capacity to consent. And the treatment doesn't change radically from session to

session–or even phase of treatment to phase of treatment. In such a circumstance, is simply showing up consent enough?

One consideration is that, even though the treatment doesn't change radically, its impact on one may. In the beginning, one is relatively unattached to the therapist, for example. Over time, however, the attachment intensifies. By the time, again, one is able to recognize the intense transference—to understand it—one may be relatively unable to resist it.

Even this, however, may be something of a distortion. For one thing, the development of the relationship happens gradually over time and is not something that, at some particular moment, changes radically. So the first transference interpretation may involve a mild relational distortion, which one can understand and process. The relationship intensifies over time, but incrementally. Informing the patient about the nature and meaning of a transference distortion at the point it happens may put the patient in a much better position to understand the meaning of transference, and the idea that it might intensify over time; and yet the transference is not yet so intense that one can't resist. So one will have greater understanding and not so impaired volition that one cannot act on the understanding.

Informing over time in this way, then, has advantages. It may put patients in a better position to understand and freely choose, as noted. In addition, it avoids the problem of "giving away the punch line." One hears the punch line at the moment of its correct delivery. It may thus have a much greater impact or "punch"—may be much more therapeutic.

Another thing to note is that elements to be disclosed in a robust informed consent may change over time anyway. A person's issues may change, as well as the best way to treat them, and the benefits and costs of a (somewhat) modified treatment (the changes may be subtle but still important). And a change in "issues" may reflect a change in symptoms, even illness—and therefore of the benefits to be strived for. All of this may suggest that, even if we don't adopt completely a process view of informed consent, gaining consent may necessarily happen over time anyway, given that circumstances may change—those of the patient, those of the analyst, and that of the treatment itself—and that the patient should arguably understand this when it happens.

Some analysts have laid out the "developmental history" of the therapeutic alliance between analyst and patient (Meissner, 1992 and 1996; Novick, 1980; and Novick and Novick, 1998). It may be that allying the patient to the treatment—which requires knowing about it—may

look different at different phases of the treatment. So the informed consent process may have a developmental history of its own. For instance, one must understand different things in the opening phase, the middle phase, and the termination phase of an analysis. This is something to consider in future explorations of the topic.

In short, a process view of informed consent suggests that when one tells the patient, and how one tells him, is likely to have a significant effect. For example, to learn about regression in advance may just scare a patient; while it is happening, it is likely to be experienced in profound ways, but one is unlikely to be as apprehensive about it. In addition, telling the patient about many things all at once may have its own effects: for example, overloading him with information. Finally, there are some things some people would require in an informed consent that the analyst would ordinarily not tell the patient in the course of treatment—that the patient wouldn't hear just by showing up—for example, things about the analyst and her training.

Whether we should adopt a wholly process view of informed consent is, then, something quite worthy of continued and thoughtful consideration. Later in this book, we suggest that we find the process view very attractive, why we do, and what we need to study to come fully to endorse that view.

We now turn to the issue of whether IC is much ado about nothing.

Is the Informed Consent Debate All Much Ado About Nothing?

The argument that this is all much ado about nothing is based on the belief that a few minutes of informing patients is likely to have little effect at all. Thus, the argument goes, examining the different meanings it might have to patients is unnecessary. And thinking about how it might be therapeutic or countertherapeutic makes little sense. This is a very benign, very innocuous process, according to this argument; it doesn't deserve the attention we have given it.

There are several avenues of response to this claim. First, one may, we think, underestimate the impact of even a brief conversation. Analysis teaches us that, in a way, people are set in their conscious and unconscious mental configurations so one need not worry overly much about the effects of an informed consent process. Yet analysis also teaches us that one event can have many unconscious reverberations that last for a long time. We also can't predict what event is going to seem meaningful to people. This event, for some people, is likely to be quite charged.

The stated risks might be scary, for example. The event may have considerable potential both to strengthen and to undermine an alliance between analyst and patient.

Second, not everyone agrees that an IC process is a benign or trivial event. Particularly in the case of fuller consents, some analysts feel quite strongly that it is contraindicated to do them. Third, even if in many analyses the impact of an IC process is likely to be minimal, thinking about what the impact might be could be of use in cases where it does have a significant effect. Fourth, exploring the various value dimensions involved in deciding on an IC process of a certain kind is of use. Fifth, exploring what the elements of a proper IC should be is important, even if the process is not likely to have much effect on the therapeutic efficacy of the treatment. But sixth, it may be that the conclusion that the IC process has little effect on patients means that it is not even worth the time. If patients don't really understand, or don't really care, or don't really remember, maybe we should dispense with the whole thing. Finally, whether IC has a significant effect on patients is, of course, an empirical question, and all we can do is speculate now. Our own view is that it probably affects some people quite a bit, and if a detailed disclosure were required, could do so even more often. In short, it is not obvious that informed consent has little effect, and it is worth thinking about it even if it does.

Conclusion

Does an informed consent requirement to psychoanalysis make sense? This chapter has looked at this question from a number of different points of view. Most important is the idea that informed consent to psychoanalysis generates an important set of paradoxes. It is not just that it is of little or no effect, or even that it is countertherapeutic, but that it is conceptually or factually impossible. While their arguments have largely been proven unsound, some have made the following arguments that IC is impossible:

> Not enough facts can be provided and even if they are, they wouldn't be understood, so that IC is impossible, not just counterproductive or useless.
>
> To say IC is required leads to an infinite regress, at least in the case of analysis, because IC is so complex and poses such risks (even if rare) that you need IC for IC.

Informed consent in this context does not stand apart from the treatment itself and may actually affect the treatment.

One way this may happen is through suggestion—stating the risks makes them likelier to happen in a way that is untrue for many other medical treatments; and finally.

IC is self-defeating by fatally impairing the therapeutic process, thus making IC to therapy impossible because it makes the therapy itself impossible.

Again, these arguments ultimately are not persuasive but they are certainly challenging. In addition, certain conceptual and normative questions remain. For instance, should we indeed conceptualize informed consent as a developmental process whose history could then be mapped? Should the IC take place in writing? (We suspect not, although this needs to be discussed.) Should the IC be renewed at different intervals in the treatment process? In the same way, it is an empirical question how informed consent affects, or is even thought by analysts to affect, the treatment, in particular the therapeutic alliance and the transference. Such questions as these would need more definitive answers before we could endorse or reject an IC requirement to psychoanalysis. Our goal in this chapter was to explore the nature and desirability of informed consent.

We turn now to the empirical part of this book, which will discuss analysts' actual thoughts about and experiences with informed consent. Our theoretical discussion (as well as the legal cases and commentary) guides the empirical study—for example, we directly ask analysts what kinds of risks they disclose to patients, whether they think IC is possible, and if so, whether they think it is countertherapeutic in any of the ways we identified in this theory chapter. As noted, we also extend to therapy the empirical work that has been done to date on informed consent, which has been either heavily qualitative or mostly focused on the patient's experience.

3. Empirical Study: Methods and Results

The empirical part of this project surveys a significant number of analysts throughout the country. We discuss first the development of our survey instrument. We then discuss our most general hypotheses and explain how our subjects were randomly selected. Then we describe demographic characteristics of the sample respondents.

We then lay out the data, both descriptive and inferential, in the Results section. We describe our data analytic methods here. We report descriptively the findings on the survey questions. For example, what percentage of survey participants gives an informed consent and what percentage includes malignant regression as a risk? In an inferential portion of the Results section, we look to test whether ambivalence in analysts is behind the variability in our findings by exploring possible conflict revealed in analysts' answers. In reviewing these things, we produce tables as well as descriptive presentations of the data, and comment on both intuitive and counterintuitive findings.

Survey Instrument

Our survey instrument (see Appendix C) was developed in response to our theoretical consideration of informed consent to psychoanalysis in the previous chapter, as well as the law and literature on the topic. It is a pen-and-paper survey with forty items in question form, most of which have quantifiable components—involving either a Likert scale or a yes-no format. (The Likert scale's range includes Always, Frequently, Sometimes, Rarely, and Never.) The questions cover what analysts actually do in general (for example, do you give an informed consent?) to specific aspects of what has been typically included in IC procedures for

psychotherapy (for example, do you mention regression as a risk? Do you disclose CBT as an alternative?). The questions also ask why analysts do what they do (for example, do you think the law requires IC?), and what, to their mind, its effects have been (for example, do you think the IC is countertherapeutic and in what ways?).

Main Hypotheses

The fundamental hypothesis that guides this research is that the results will show considerable variability. Unlike, say, informed consent to surgery, where we would expect close to 100% to provide an informed consent, our results will vary considerably—a substantial percentage of analysts will give an informed consent and a substantial won't. Note also that this variability will extend from what analysts actually do by way of giving an informed consent to what they include in the IC process to their overall posture about whether or not letting patients know about the risks and benefits of psychoanalysis is good practice (we directly ask about these issues). More specific hypotheses regarding these issues are mentioned in the material that follows.

To explain this predicted variability, we suggest a conflict-based hypothesis (the "ambivalence hypothesis") in which we argue that analysts feel pressure from the law and their ethics codes to obtain informed consent, but feel pressure also from their desire to act therapeutically. Thus they may resist getting an IC out of worry that the informed consent process might be countertherapeutic. That is, we propose and try to test an "ambivalence in individual analysts" hypothesis to explain the variability.

Reviewing our results in both the "Results: Descriptive Data" and "Results: Inferential Statistical Data" sections of this chapter will also produce further hypotheses, which can be studied later—that is, will be "hypothesis generating."

Subjects

Our subjects were all American analysts. The American Psychoanalytic Association and the American branches of the International Psychoanalytic have approximately 3,500 members in the United States. We selected a random sample of 400 members and candidates to learn about their informed consent practices and their views of an informed consent requirement. To do so, we computer-generated a list of random num-

bers that were assigned to analysts based on the order in which they appeared in a roster of analysts. Of the 400 surveys sent out, approximately 40 were returned because the recipient was no longer at that address. Of the remaining 360 potential respondents, 62, or 17%, participated in the survey. This is a below average response rate, but the demographics of this group and the length and complexity of the survey make this not surprising. There is evidence that response rate is not as important as once thought. (See Wikipedia on response rate; and Hamilton, 2003.)

In terms of demographics of our survey respondents, most of the subjects were male (62%). The age of our subjects was, relatively speaking, older; our greatest percentage was over 70: 32%. Only 4.0% were under 50. The vast majority of our subjects were physicians (78%), with 16% being Ph.D.s in Psychology and 6.0% having a Master's degree. The vast majority were graduate analysts (94%), with only 6% being candidates / clinical associates. In terms of the year of license, the age of the population was consistent with the fact that they had been licensed for a significant number of years. For instance, only 20% were licensed since 1981. Similarly, only 7% had been in practice under twenty years. The percentage of the subjects' work being private practice was high: only 13% were in less than fifty-percent private practice. The percentage of the person's practice being psychoanalytic was also rather high: Only 41% had under 25% of their practice being psychoanalytic, with 9% having 76–100% of their practice being psychoanalytic. Theoretical orientation was bimodally distributed, with both classical and eclectic orientations comprising 26% of the sample. No Kleinians returned the survey in the study sample. Finally, only 32% of the sample of analysts indicated that they had any instruction in administering informed consent during their clinical training. This may be higher than expected given how long ago most had received their education—informed consent was not on people's radar back then.

Results: Descriptive Data

For the Descriptive Data section, we divided the 40 items into different categories. First were what we called "Rates" questions—for example, how often the analyst gives an informed consent. Second, we looked at why analysts do so. Third, we looked at whether our subjects think the psychoanalytic context is special or different in some way. Then we looked at what analysts believe to be the conditions and effects of an

informed consent. Finally, we looked at their normative positions on this issue—should we give an informed consent and what should it look like?

In reviewing the different survey questions in this chapter, we note some important findings. We note items within each question that were endorsed "At Least Frequently" on the Likert scale (that is, "Always" or "Frequently"); "At Least Frequently" will be a term of art throughout this text. We pay attention to those so endorsed greater than and less than 50% of the time. We also note the response rate to yes/no items in percentages of the study sample. If there are several items in a question, we rank them by the percentage of the votes they got. And we then point out gross differences in percentages between questions, querying whether participants have significantly distinct attitudes toward different items. (Occasionally in the discussion, we bring up other numbers—for example, rate at which something is Never disclosed.)

We used a number of different data analytic techniques. The data was examined initially for missing values. Descriptive statistics were obtained for all variables, including: distributions, means, medians, variances, standard deviations, skewness, kurtosis, ranges, and quartiles. Tests of normality of continuous measures were made using the Shapiro-Wilk W and the Kolomogorov D statistics in conjunction with plots of the distribution of data and descriptive measurements. The data were also examined for homogeneity of variance. The statistical method was employed to correct for any abnormalities. All statistical tests were two-tailed. Differences or association were considered statistically significant provided a p-value of 0.05 or less was obtained. Analyses of variance (ANOVAs) were used for continuous variables and chi-squared analyses for dichotomous variables.

Rates Questions

The first Rates question concerned whether our subjects give patients an informed consent At Least Frequently.

Q1	Do you give an informed consent?	57.6%

The second asked how many survey respondents had been given an informed consent when they were patients.

Q2	Were you given an informed consent when you were a patient?	4.9%

The third question looked at whether the subjects would have wanted an informed consent to be given.

Q3	Would you have liked an informed consent to be given?	30.9%

Q4 had nine items on disclosure rates of different elements. We looked at Rates that were endorsed At Least Frequently.

Q4I	Frame issues	98.4%
Q4B	Nature of process	88.8%
Q4C	Nature of patient's problem	81.11%
Q4D	Benefits	81.7%
Q4F	Alternatives	71.7%
Q4G	Risks and benefits of alternatives	69.0%
Q4H	Risks to confidentiality	67.3%
Q4A	Qualifications	58.6%
Q4E	Risks of the process	51.7%

We will keep these in mind as we look more closely at what is disclosed under each of the elements listed—for example, risks and alternatives.

For the qualifications listed in Q5, only one of the items was endorsed At Least Frequently over 50% of the time, with the others endorsed under that amount in the following order.

Q5A	Degree	82.1%
Q5B	One's license	44.6%
Q5C	Where one trained	38.2%
Q5E	Whether one is a analytic candidate	34.0%
Q5F	Whether one is being supervised	33.3%
Q5D	How long one has been an analyst	26.8%

For questions regarding the nature of the process in Q6, three items were endorsed At Least Frequently over 50% of the time, with three others endorsed at under that amount.

Q6A	The fundamental rule	91.5%
Q6B	The analyst's role to listen and interpret	86.2%
Q6F	The use of the couch	80.0%
Q6C	The analyst's general passivity	43.6%

Q6D	The likelihood of transference occurring and what that means	38.6%
Q6E	The likelihood of regression occurring and what that means	35.1%

The next group of questions, Q7, referred to disclosures about the nature of the patient's problems. All of these except the diagnosis were endorsed over 50% of the time At Least Frequently.

Q7D	Life issues	70.7%
Q7B	The nature of the patient's symptoms	69.0%
Q7C	Character traits	60.3%
Q7A	Diagnosis	31.7%

For the goals/benefits of treatment, Q8, three items were above the 50% mark for At Least Frequently, the fourth being close.

Q8A	Help with life issues	80.7%
Q8B	Removal of symptoms	71.2%
Q8D	Character change	50.9%
Q8C	Structural change	47.4%

The risks of treatment in Q9 were endorsed at a decidedly lower rate than the other items. There was only one item that was endorsed 50% or higher of the time at an At Least Frequently rate, namely, the financial costs of treatment. Others were endorsed less often, noted from higher to lower.

Q9J	Financial costs	88.5%
Q9K	Opportunity costs	42.0%
Q9C	General worsening of symptoms	34.0%
Q9D	Increased anxiety	26.4%
Q9E	Intense transference	23.1%
Q9I	The treatment won't work	21.2%
Q9G	Changes one wouldn't now approve of	12.2%
Q9H	Divorce as example of changes one wouldn't now approve of	12.2%
Q9F	Acting out	7.5%
Q9A	Malignant regression	7.5%
Q9B	Regression to the point of actual psychosis	0%

Alternatives, Q10, were also endorsed infrequently. Only one item reached the 50% mark of At Least Frequently, with the others endorsed less often.

Q10A	Psychoanalytic psychotherapy	81.5%
Q10F	Medication as an adjunct	40.4%
Q10D	Other psychotherapy of other schools	25.0%
Q10B	Brief dynamic psychotherapy	24.1%
Q10E	Medication as an alternative	23.2%
Q10C	Cognitive behavioral therapy	22.6%
Q10G	No therapy	20.0%

In terms of the risks and benefits of alternatives (in this case, medication), Q11, only one item was endorsed At Least Frequently at a rate of 50% or greater, with the others endorsed less often.

Q11A	Physical risks	62.1%
Q11D	Lesser cost	33.9%
Q11B	Short-circuiting of the therapeutic process	27.8%
Q11C	Shorter time to work	23.6%

Threats to confidentiality, Q12, were endorsed at a much lower rate than expected given concerns about this in the analytic community. Only one item was endorsed At Least Frequently at a rate greater than 50%, with the other items endorsed less often at that rate.

Q12E	Disclosure to insurance company	57.1%
Q12A	Disclosure if need to be hospitalized	42.6%
Q12B	Warning potential victims of credible threats	37.5%
Q12C	Reporting of child or elder abuse	33.9%
Q12I	Disclosing that the analyst is being supervised	28.3%
Q12D	Disclosing that the analyst might have to testify in lawsuit if mental state at issue	26.9%
Q12G	Presenting material at conference	19.3%
Q12H	Presenting material at institute	19.3%
Q12F	Publishing material	17.5%
Q12J	Doing case write-ups for Progression Committee	13.1%

Other frame issues, Q13, were endorsed at a very high rate—from 62.9% to 100%.

Q13A	Time and frequency of sessions	100%
Q13B	Cost of sessions	100%
Q13E	Policy on missed sessions	89.8%
Q13D	Analyst vacation times	70.9%
Q13C	Likely duration of treatment	62.9%

As we look at these Rates issues, certain trends are evident. We want to consider three issues now—percentage of items endorsed At Least Frequently at a rate 50% or over, the high percentage under each item, and the low percentage under each item. It is clear that frame issues were most often endorsed. Five of five items were at the 50% mark or higher. Two of the items were endorsed at a rate of 100%, and the low percentage was the highest of all the questions—62.9%. By contrast, risks and threats to confidentiality had the lowest percentage of items at or above the 50% mark—one out of eleven items each. The high for risks was higher than the high for threats to confidentiality (although the "risk" item at that level was the financial cost of treatment, something very benign). And the low item was lowest for risks—0% disclosing the threat of regression into psychosis—with the low item for confidentiality at 13.1% for doing case write-ups for a Progression Committee. We will try to shed more light on this in Chapter 4, the discussion chapter, but note for now that the low rate of disclosure for risks is problematic given that risks are arguably most important in assessing whether to undergo a course of treatment.

Why Analysts Disclose

For questions surrounding why analysts disclose (Q15), all items except one were disclosed at a Rate of At Least Frequently 50% of the time or more.

Q15E	The patient's therapeutic interests	79.6%
Q15C	Ethical considerations generally	75.0%
Q15D	Technical considerations	58.5%
Q15B	Professional ethics codes	51.9%
Q15A	Legal requirements	30.2%

It is interesting to compare Q15A with Q36, which asks analysts if they think the law now requires them to give an informed consent.

Q36	Do you think the law now requires you to give an informed consent to your patients?	Yes: 43.9% No: 56.1%

It's of note that analysts have cited legal requirements as the basis for the informed consent they give at a low rate of 30.2% in Q15, yet a greater number than this believe the law requires it, as shown in Q36.

Whether the Psychoanalytic Process Is in Any Way Different or Special

Two questions tapped into this issue, Q19 and Q39.

Q19	Does the informed consent process in the psychoanalytic process differ in any way from other informed consent contexts?	Yes: 73.2% No: 26.8%
Q39	Is there a distinctively psychoanalytic way to procure informed consent?	Yes: 63.0% No: 38.2%

These questions are obviously related, although different: The context may differ but the way of obtaining consent might be the same.

Questions Regarding Whether Informed Consent to Psychoanalysis Is Possible and What Its Effects Are and/or Are Likely to Be

Two questions, Q16 and Q17, looked at whether informed consent is even possible and were endorsed at a rate of At Least Frequently.

Q16	Can patients really understand at the beginning?	38.2%
Q17	Do you think that once the patient understands, it is too late?	17.0%

If we combine these questions, analysts think that only around 10% of patients cannot give meaningful consent (i.e., 17% of 61.8%).

A number of questions looked at whether analysts think informed consent is therapeutic or countertherapeutic, and in what ways. An initial question of this kind, Q21, looked at whether there is a conflict between informed consent and good analytic technique.

Q21	Does an informed consent requirement conflict with analytic principles of good technique?	Yes: 22.2% No: 77.8%

Another question, Q22, asked specifically whether IC is likely to be countertherapeutic.

Q22	Is an informed consent requirement likely to be countertherapeutic?	Yes: 26.0% No: 74.0%

Q23 asked specifically how informed consent might be countertherapeutic.

Q23J	The patient may feel the analyst is just covering his or her back.	Yes: 55.6% No: 44.4%
Q23I	Informed consent may feel like meaningless ritual to the patient.	Yes: 50.9% No: 49.1%
Q23E	Informed consent may act as a suggestion.	Yes: 50.0% No: 50.0%
Q23C	Fears of breaches of confidentiality may lead the patient to censor what is on her mind.	Yes: 48.1% No: 51.0%
Q23G	Informed consent may be perceived as the analyst making a recommendation.	Yes: 36.0% No: 64.0%
Q23D	Informed consent may set up expectations (for example, of an active analyst) that will inevitably be frustrated.	Yes: 29.6% No: 70.4%
Q23H	Informed consent may lead to all manner of dysphoric affects.	Yes: 29.4% No: 70.6%
Q23B	It may have a stifling effect on one's fantasy life.	Yes: 23.6% No: 76.4%
Q23A	It may reveal too much, conflicting with the "blank screen" desideratum.	Yes: 22.2% No: 77.8%
Q23F	Informed consent may be overly gratifying to patient.	Yes: 20.4% No: 79.6%

Q25 asked about whether an informed consent is likely to be therapeutic.

Q25	Do you think an informed consent requirement is likely to be therapeutic?	Yes: 55.6% No: 44.4%

Q26 looked at the ways analysts think informed consent could be therapeutic.

Q26A	The patient may feel respected and treated as an adult.	Yes: 86.3% No: 13.7%
Q26B	The patient may feel treated as a collaborator.	Yes: 84.0% No: 16.0%
Q26D	The Patient may feel drawn to aspects of analysis that have been described.	Yes: 79.6% No: 20.4%
Q26C	The patient may perceive the analyst as being hopeful.	Yes: 68.0% No: 32.0%

Q33 asked about the actual effects of the informed consent process in terms of its effect on the therapy.

Q33	Has the informed consent process been more therapeutic or more countertherapeutic?	More therapeutic: 88.1% More counter-therapeutic: 11.9%

Q29 and Q31 also asked about the conditions and effects of informed consent.

Q29	Do your patients given an informed consent ever talk about it or associate to it?	Yes: 54.5% No: 45.5%
Q31	Have you had any experience of effects of informed consent on the therapeutic alliance, or the therapeutic alliance on the informed consent?	Yes: 47.5% No: 52.5%

The final question in the section on conditions and effects, Q34, addressed whether informed consent even matters.

Q34	Do you think it probably doesn't matter much at all whether the analyst obtains informed consent from the patient?	Yes: 46.7% No: 53.3%

Normative Questions

The last set of items (Q18, Q20, Q35, Q37, and Q38) concerns the normative questions in this domain: what analysts think ought to be the case in terms of informed consent.

Q18	Do you think it is better to obtain informed consent at the very beginning or to do it over time as the process unfolds?	At the beginning: 60.4% Over time: 39.6%
Q20	Is the fact that the patient experiences the process and comes back as much informed consent as needed?	Yes: 22.2% No: 77.8%
Q35	If there is a conflict between respect for patients' rights to understand and their therapeutic needs, which should prevail?	Patients' rights: 30.0% Patients' therapeutic needs: 42.0%
Q37	Should informed consent to psychoanalysis be required?	Yes: 47.4% No: 52.6%
Q38	Should the informed consent to psychoanalysis be minimal or robust, including many of the items discussed in other questions as elements?	Minimalist: 57.1% Robust: 14.3% It depends: 28.6%

Results. Inferential Statistical Data: Is the Variability of the Answers a Result of Analyst Ambivalence?

The final question we explored was whether the variability in our findings was due to ambivalence in analysts or not. In the material that follows, we discuss the ambivalence hypothesis and alternatives, as well as how conflicts in certain items can support the ambivalence hypothesis. We looked at items suggesting conflict in analysts—in particular, the following five items and their relation to Q1 (rate at which IC is given) and Q37 (rate at which you think it should be given):

Q3 (Would like to be given an informed consent) contrasted to Q1 and Q37: Why do you do it and why would it be a good thing to do if you don't want it yourself?

Q21 (Conflicts with analytic principles of good technique) contrasted to Q1 and Q37: If it conflicts with important principles, one would expect a lower endorsement of giving IC and thinking it should be given.

Q25 (Likely therapeutic) contrasted to Q1 and Q37: If you think it likely therapeutic, one would expect a higher endorsement of giving an IC and thinking it should be given.

Q33 (Is IC, on balance, in the analyst's experience, more therapeutic or countertherapeutic) contrasted to Q1 and Q37: If you think

it more therapeutic, you would be more likely to give an IC and think it should be given.

Q35 (Which would you choose if there were a conflict between the patient's rights and his or her therapeutic needs) contrasted to Q1 and Q37: One would expect an effect of the conflict question on the Rates questions. If you think, say, that rights should trump, you should be more willing to give an informed consent and should think it is a good thing.

We ran statistical tests to see if there were significant associations of these pairs of items: One would, again, expect significant associations—for example, if you want informed consent for yourself, you would be likelier to think you should give it to others. If the significant associations were to go in the wrong direction, so to speak, that would be some evidence consistent with the ambivalence hypothesis. For instance, if the rate of giving and rate you think should be given were significantly associated with *not* wanting an informed consent oneself, this is important data concerning whether analysts are conflicted.

Looking at these items, we found much evidence consistent with a conflict in analysts.

Looking at Q3, the rate at which the respondent would like to be given IC, and Q1, the rate at which the respondent actually gives IC, we saw 17.6% who would like to be given an informed consent only Sometimes or Never giving an informed consent themselves (chi-square = 6.76, p = .009).

Looking at whether informed consent conflicts with analytic principles of good technique (Q21) and rate of giving (Q1), we saw 16.7% saying it conflicts who nevertheless Always/Frequently give an informed consent (chi-square = 10.767, p = .001).

Looking at whether informed consent conflicts with analytic principles of good technique (Q21) and the rate at which the analyst thinks IC should be given (Q37), we saw 9.1% who think IC conflicts and yet think it should be given (chi-square = 9.85, p = .002).

Looking at whether informed consent is likely therapeutic (Q25) and the rate of giving IC (Q1), we saw 24.2% who think it therapeutic only Sometimes or Never give an IC (chi-square = 9.57, p = .002).

In terms of whether informed consent is likely therapeutic (Q25) and whether informed consent should be given (Q37), 30.3% said that it is likely therapeutic but still don't think it should be given (chi-square = 16.664, p = .000).

Looking at whether the IC is, on balance, in analysts' experiences more therapeutic or countertherapeutic (Q33) and their rate of giving IC (Q1), we saw 27% who think it more therapeutic only Sometimes or Never giving an IC (chi-square = 3.84, p = .050).

Looking at whether the IC is, on balance, in analysts' experiences more therapeutic or countertherapeutic (Q33), and the rate at which analysts think IC should be given (Q37), we saw 29.7% who think it is more therapeutic and yet still don't think an IC should be given (chi-square = 4.85, p = .028).

In terms of which should prevail (Q35) in a conflict between rights and therapeutic interests, and the rate at which respondents think IC should be given (Q37), we saw 53.3% who said rights should prevail and yet don't think IC should be given (chi-square = 8.43, p = .051).

Our study arguably faces the problem of multiple statistical tests. With multiple statistical tests on a data set, the likelihood increases of some passing the statistical test of $p < .05$ even if the null hypothesis is true. Correction may also be needed if one doesn't have definite hypotheses to test. In the face of these, many people do some kind of correction, usually Bonferroni. To do a Bonferroni correction on our eight out of ten significant associations involves dividing a p-level of .05 by the number of tests one runs—in this case, .05 divided by 10, or .005. Using this figure, four out of the ten items reach the new p-level (and one, the first at .009, is close). So even with a Bonferroni correction, four out of our ten associations reached the heightened significance level.

We discuss the import of all this for the ambivalence hypothesis in Chapter 4.

4. Empirical Study: Discussion

In this chapter, we discuss some of the more interesting and important aspects of our findings in both the descriptive and inferential data sections. Our most basic hypothesis was that the results would show considerable variability. We so hypothesized because there are pressures on both sides in the context of informed consent—pressures pulling toward and pulling against giving informed consent. This hypothesis was amply confirmed. Our further hypothesis was that these pressures would result in ambivalence in individual analysts. That is, each analyst may have felt both pressures. (The alternative is that roughly half felt unambivalently in favor of one side of the dilemma and half in favor of the other.) The ambivalence hypothesis seems to be borne out when we look at analyst endorsement of conflicting items.

We turn to a discussion of individual findings now.

Discussion of Descriptive Data Results

Rates Issues

In terms of Q1, the rate of giving an informed consent, we saw considerable variability: 39% Always do, 23.7% Never do, and 57.6% do so At Least Frequently. It may be that this variability reflects conflicting pressures—concerns about law and ethics on the one side, and therapeutic effect on the other. On the other hand, the variability could also be attributed to some respondents being very rights-focused, and others very therapy-focused. We have more to say about this later.

In terms of Q2, the rate at which subjects were given an informed consent, we saw a very low rate—4.9%. The fact that our subjects were older and the relative newness of informed consent may explain this result.

In terms of Q3, most analysts said they would not want an informed consent themselves—69.1%. This is loosely consistent with the 47.4% who say an informed consent requirement is a good idea, although fewer want it than think it is a good idea.

In terms of Q4, how often analysts disclose identified elements of informed consent, if we look at percentages at which the elements are At Least Frequently disclosed, we see all items receiving scores over 50%, with risks of psychoanalysis at the lowest level—51.7%. The analyst's qualifications were next. And risks to confidentiality, which have gotten much press in the psychoanalytic literature, were also disclosed at a lower rate—67.3%. These results should raise some concern, in that risks of psychoanalysis are arguably the most important items in considering whether to consent to analysis but were rated the lowest in terms of disclosure rates. Still, all of these scores are consistent with the overall rate of giving an informed consent (see Q1), and again demonstrate the considerable variability we mentioned above.

The next nine items spell out what things analysts disclose under each category (for example, the nature of the process, the risks of the process). For questions regarding qualifications, all but one item were below 44.6% for At Least Frequently. The exception was the analyst's degree (82.1%). This is certainly expected as most patients will know the letters after their analyst's name. The relatively low disclosure of supervision status (33.3% At Least Frequently) is of some concern as the American Psychoanalytic Association and some Institutes, as well as the American Psychological Association, either require or recommend that this be disclosed, and it is arguably ethically necessary as well.

For questions regarding the nature of the process, some items were endorsed at a high rate and some at a low rate. Three of the items were above 80% At Least Frequently disclosing, with the remainder under 43%. The "fundamental rule" that patients should say whatever comes to mind was most often At Least Frequently disclosed at 91.5%, with regression the lowest, at 35.1% At Least Frequently disclosing. Next was the nature of transference (38.6%). If we look at Never Disclosed, regression came first and transference second. All of this is consistent with risks being the items least often disclosed, and is potentially problematic, as we certainly want patients to understand risks if at all possible. Analysts may also have a concern about suggesting complications, which can trigger the complication itself, and about revealing the plot of the story, so to speak (for both of these see Chapter 2, which covers theory).

In terms of the nature of the patient's problem, the items enumerated had a high level of disclosure of over 60% At Least Frequently disclosing, except for diagnosis, which was only 31.7% At Least Frequently disclosing. Again, diagnosis may trouble some patients and may be thought by some therapists to be a red herring. What is important is understanding the patient's underlying dynamics, not putting the patient in some category, especially when the diagnostic categories don't really further the therapy, as some may think. On the other hand, some patients may want to know this, and withholding this information may be ethically unjustified when we think of the values behind the informed consent doctrine.

For the questions regarding the goals / potential benefits of the process, the lowest disclosure rate at the At Least Frequently level was 47.4% (structural change). The highest disclosure rate was for help with life issues (80.7%). Patients likely come to treatment focused on the latter, so there is little cost to disclosing this. The possible ambivalence about items such as structural change (represented by the roughly 50% response rate) may result from a desire not to overload the patient with information that will likely not help him or her, and not to give away the plot, so to speak.

The risks of the process are obviously very important. The level of disclosure here was generally very disappointing. Financial costs (88.5%), opportunity costs (42%), and risk of increased anxiety or depression (34%) were At Least Frequently disclosed at a nontrivial rate (although again evincing possible ambivalence). All of the other items were below 26.4%, with two items being at 7.5% (malignant regression and acting out). 0% mentioned the possibility of regression to the point of actual psychosis (oddly, some say they use the word "psychosis" and some not, which is inconsistent with saying they don't give this disclosure). (Note that the regression and transference items are those that are destructive and harmful; compare the "nature of the process" items, which just refer to regression and transference, not malignant forms of these.)

Clearly it was the most obvious and the most benign items that were most often mentioned, with the most troubling the least often disclosed. This finding is of concern, although it is understandable that analysts would want to not scare their patients. Indeed, there is a doctrine in informed consent law called "therapeutic privilege," which says that clinicians can not disclose risks if doing so would be very detrimental to the patient (see *Canterbury v. Spence*, 1972; *Barcai v. Betwee*, 2002, Berg

et al., 2001; Meisel, 1977; and Miller, 2006). Our guess is that this case would be hard to make in the analytic context. In addition, informed consent doctrine allows doctors not to disclose very remote risks. So, decompensation into psychosis might be rare enough that it need not be disclosed under ordinary informed consent principles. One might think of this in another way, however: that only when the risk of psychosis is significant—based on the patient's evident pathology—would the analyst have a duty to disclose. If so, the 0% disclosure rate may be problematic.

This discussion of remoteness of risks underscores an important point: Remoteness may vary based on patient characteristics and, thus, any requirement to disclose risks may vary, too. Decisions about what to disclose occur in the context of an evaluation of the patient—of her reality testing, ego strength, tolerance of anxiety, capacity for introspection, and so on. Many analysts would screen out patients who appear unanalyzable and for whom a risk of psychosis is significant. In other words, the risk of decompensation to the point of psychosis may be a contraindication for analysis. Thus, the process of evaluation may lead to different assessments of level of risk and thus the need for disclosure. It is also true that some analysts, perhaps older ones, may disclose a risk, say, of regression less than others because they do not believe in the "widening scope of analysis": Analysis is only appropriate for certain kinds of neurotic patients. In Chapter 5, "Limitations of Our Study and Directions for Future Research," we explore some of the implications of the points made here.

For questions concerning disclosure of alternatives, most of the items ranged around 25% At Least Frequently disclosing. The exceptions were medication as an adjunct (40.4%) and psychoanalytic psychotherapy (81.5%).

These findings are interesting. Failure to disclose medication as an alternative for depression is the most famous case involving informed consent to psychoanalysis. (See the previous description of the "Chestnut Lodge" case. See also, for example, Malcolm 1986.) Interestingly, the item most often disclosed after psychoanalytic psychotherapy—a treatment analysts are best trained and best suited to deliver—was medication as an adjunct. It is also interesting that CBT was the most often Never-Disclosed item. CBT is a competitor treatment that has garnered considerable research support and so one would expect it to be mentioned. On the other hand, Brief Dynamic Treatment has psychoanalytic roots, yet it was given as an alternative even less often than medication instead of psychoanalysis. Perhaps analysts believe it is a less viable alternative

than psychoanalysis in people for whom dynamic work could be useful but that there are people for whom medication is really the treatment of choice. In addition, the very brevity of the treatment might make it seem not ideal to those committed in general to long-term treatment, at least long-term dynamic treatment.

A few comments about CBT as an alternative are warranted. (The same argument and answer apply to medication for minor depression, where effect sizes are poor.) Some may argue that the research literature suggests CBT has not been found to have an enduring effect in patients with chronic/personality problems. Perhaps one could argue that analysts don't and shouldn't disclose CBT as an alternative in this context because it might be a weaker approach. This is a reasonable suggestion, but we think one is obliged to disclose plausible alternatives even if they aren't the best options because choice of treatment depends on more things than pure efficacy—for example, financial costs, opportunity costs, preferences for certain styles of working—even such things as stance toward spirituality. That is, this choice is a personal decision that implicates important value questions and isn't determined by efficacy alone. Also, of course, general efficacy studies may say something about the modal patient but a particular patient may do better with what is generally less optimal treatment.

To put this another way, why wouldn't an argument that there is no reason to disclose CBT as a treatment because it is not as effective apply equally to those who think medication is more effective than psychotherapy for, say, moderate depression? Even if people on medication get better faster, there are other considerations that might counsel a doctor to recommend psychotherapy to his depressed patient. For example, he may think the changes brought about by psychotherapy might be longer lasting or more profound. Or he may know his patient doesn't tolerate certain side effects well.

The point is that many issues figure into treatment choice, and the patient needs maximal information to decide what is best for her. Therapists may not know all the considerations that do or might move their patients—for example, that the patient wants a brief focal intervention. So giving maximal information on plausible choices makes sense. The requirement to disclose alternatives is not a requirement only to disclose what you think are the best alternatives, but any plausible alternatives.

In terms of risks and benefits of alternatives, the physical side-effects and risks were most often At Least Frequently disclosed (62.1%) fol-

lowed by lesser cost (33.9%). The other items were in the 20% range. The first pushes against medication while the second pulls toward it. The generally low level of disclosure is disturbing as it does not put patients in a good position to decide.

For the question of threats to confidentiality, the only item over 50% At Least Frequently disclosing was disclosure to insurance companies if patient so desires (57.1%). This is obviously quite benign, given that the disclosure is with the consent of the patient. Danger to self or others for hospitalization purposes was disclosed At Least Frequently 42.6% of the time. The possibility that Tarasoff warnings might be necessary was disclosed only at a rate of 37.5%. This is surprisingly low given widespread knowledge of the need for such warnings in many places—psychoanalysts have been up in arms about intrusions into the psychoanalytic space made by legal requirements to breach confidentiality in cases such as *Tarasoff*. Similarly, the level of disclosure of the possible need to report child and elder abuse (33.9%) was also especially low given widespread knowledge that the law requires such reports. That these items were disclosed at such a low rate—indeed, they have, by far, the highest rates of Never Disclosing as well—suggests analysts feel a real conflict between their known legal duties and their views about patients' therapeutic needs.

Also of note, the lowest disclosed items concerned use of patient material for professional purposes—for example, at meetings or in papers. Most of these items were below 20%. Also noteworthy is that even disclosure of material to a supervisor was disclosed at a rate of only 28.3%, which is surprisingly low given the posture of the American Psychological Association, as well as the American's Psychoanalytic Association, that such a disclosure is required or recommended; many analytic institutes also take this position. One could view withholding information about use of material in a professional context as justified in advancing knowledge, or rather, as serving primarily the analyst's professional self-interests.

For questions regarding other frame issues, we saw the highest level of disclosure among all items we have reviewed: 100% At Least Frequently disclosed frequency and times of sessions as well as cost of sessions. These items are obviously essential to know. The other items ranged from 62.7% to 89.8%.

The pattern of items here is interesting. Some of the items are essential—costs and frequency/times of the sessions. It is impossible to conduct an analysis without appointment times scheduled. The cost item is also important: Money is what the patient gives up and the analyst

expects/needs. The actual amount is critical to the informed choice of the patient and her informed consent to pay it is essential to the well-being of the analyst. The length and number of vacations may not be that important. On the other hand, the likely duration of the treatment would seem especially important. But that cannot perhaps realistically be gauged at the outset. (In addition, patients themselves may frequently not "complete" analyses.) On the other hand, group information about duration of analysis perhaps can and should be asked for and given.

Why Analysts Disclose

In terms of why analysts disclose, legal requirements were given as the reason At Least Frequently the least often (32.2%) (with the next lowest being 51.9%, the Ethics Code). The patient's therapeutic interests (79.6%), followed closely by ethical considerations in general (75%), were the reasons given most often At Least Frequently.

For the question of whether analysts think the law requires an informed consent, the endorsement rate was 43.9%. The fact that respondents cited legal requirements at such a low rate is of note given that many say the law requires it. Either analysts recognize that the law requires it but that is not their reason for acting, or they somehow forget about their legal obligations when they are accounting for their behavior.

Indeed, the fact that legal requirements were cited at such a low level is counterintuitive for other reasons, too. Many analysts, and analytic authors, seem to complain about legal requirements intruding into the analytic space, in particular, rules regarding permissible and required breaches of confidentiality. Many profess to dislike informed consent but feel the law imposes it on them. This question, however, belies those anecdotal findings: It is not the law, nor even the professions' Ethics Codes, that moves analysts to give informed consents. It is rather patients' therapeutic interests, and their own ethics generally, that move them. At least this is what analysts say moves them.

So, while anecdotally therapists profess hostility to legal requirements to disclose at least certain things—such as the obligation to report child abuse or threats of violence—when they describe why they disclose, therapists point to patient interests and general ethics, not legal requirements or even ethical requirements from their professional disciplines' Codes. Either analysts by and large consider informed consent to be therapeutic or ethically necessary, and are concerned only about cer-

tain items (but see the earlier discussion on how they don't cite these, for example, in the discussion in Chapter 3 and in this chapter about threats to confidentiality), or they have internalized the ethical norms even in these cases and see them as part of good clinical/ethical practice. Another possibility is that they are conflictedthey are conflicted and complain about legal requirements but feel they are nevertheless doing the right thing and for the right reasons.

Whether the Psychoanalytic Context Is in Any Way Different or Special

A high percentage of analysts think the informed consent differs in the analytic context (73.2%). Similarly, a high percentage of analysts think that there is a distinctively psychoanalytic way to procure informed consent (63.0%). These findings are not surprising given that analysts, understandably, think analysis is "special."

There are a number of ways one might think analysis special—for example, that people going into talk therapy obviously expect talk to be involved. Another difference is that analysis is far more subject to self-defeating (Arrow?) paradoxes than other health care procedures. The statement "You may regress" might stimulate regression, but the statement "You might get an infection after surgery" is unlikely to (seriously) increase the likelihood of infection. On the other hand, a statement that you may experience a particular side effect from a medication—for example, hand tremors—might increase the risk of this. Indeed, even some risks from surgery—such as tremors, again—can be caused by suggestion. Still, the risk of this is perhaps greater with therapy. In addition, analysts, at least over time, are likelier to know their patients better than other doctors, so perhaps we should have a more subjective standard—what *this* patient would want to know. Finally, we have seen how disclosure differentially affects the analysis in constitutive ways. Still, we need to study further what analysts think that distinctively psychoanalytic way might be, particularly in light of the finding that most analysts don't, for example, endorse the "process" view of informed consent to psychoanalysis.

Questions Regarding Whether Informed Consent to Psychoanalysis Is Possible and What Its Effects Are and/or Are Likely to Be

On the responses regarding whether patients can understand at the beginning of the informed consent process (40%), and whether, once they

understand, they are free to make a choice (only 18.9% were said to be unable), around 88% of patients were thought to be capable of an informed consent. In one sense, this seems high, given how difficult some of the concepts are, but in another sense, it seems low, given that most analytic patients have significant intellectual and psychological resources.

The next twelve questions explored whether informed consent is therapeutic or countertherapeutic and in what ways. Only 22.6% said it conflicted with analytic principles of good technique, and 26% said it was Likely to be countertherapeutic. These are lower numbers than expected.

The options for ways that IC might be countertherapeutic were generally not endorsed at a high level. Roughly half of the items were below 30%. The items of most concern involved disclosure of the possibility of breaches of confidentiality, the disclosure acting as a suggestion, the disclosure seeming like a meaningless ritual, and feeling the analyst is just covering his or her back. Respondents listed these as possibilities at a rate of 50% or higher. So while there is concern about the countertherapeutic potential of an informed consent, it is not overwhelming. In addition, a number of the items of concern are of fairly limited concern—for example, that the process is not so meaningful.

As to whether the IC process is likely to be therapeutic, fully 60% said yes. This is not trivial, yet it is also not high. So again there is some possible ambivalence about the process.

As for ways it might be therapeutic, the endorsement levels were high—68% to 86.3%. The highest concerned the patient feeling respected and treated as an adult (with feeling treated like a collaborator the next highest at 84.0%). This finding suggests that the speculation in Chapter 2, the theory chapter, concerning how informed consent might be therapeutic, is actually endorsed by analysts familiar with the process.

Over half of analysts (54.5%) said their patients sometimes talk about or associate to the informed consent. This suggests, as mentioned previously, that IC means something to most patients—it is not something they just ignore.

Similarly, over half of the analysts (52.5%) said they have had experiences of the effects of the IC on the therapeutic alliance and vice versa. Again, the process doesn't seem to be just trivial.

Our subjects felt, on balance, that the informed consent was more therapeutic (88.1%). As noted previously, this figure is higher than what analysts said they would expect (60% likely therapeutic).

Almost half of the analysts (46.7%) thought the informed consent process has little effect on the therapy. This is anomalous, as noted, as earlier questions suggest they think the process can be beneficial, and other responses suggest that analysts feel it might be harmful. Perhaps they feel that the benefits and risks, though real, are small.

Normative Questions

As to whether it is better to obtain informed consent at the beginning of the process or over time, 60.4% said at the beginning, whereas 39.6% said over time. The 60.4% seems counterintuitive, given that many profess dislike of informed consent and doing it over time is less of a threat to analytic values that come into conflict with informed consent, such as analytic abstinence. We speculated earlier about why analysts might take this position—they might be responding to what they think the rules are.

One might, however, think the 60.4% figure makes perfect sense. If one believes that informed consent is inconsistent with good technique or injects notions that the analyst is simply covering her back, then why wouldn't one want to dispense with it at the beginning and not over time? The latter might produce a greater chance that the informed consent would interfere with good technique. We believe there are factors, however, that cut the other way: Offering informed consent over time allows one to titrate the information so it doesn't overwhelm the patient, it gives the disclosure in a context where it can make more sense, and it will depart from ordinary analytic technique in a less stark way than disclosing all at once. In the Afterword, we explore the idea that, in some ways, it is hard even to distinguish the process of informed consent from the process of analysis itself.

Q20, which asked whether coming back was informed consent enough, was endorsed by 22.2%, which is fairly substantial, but not as high as one might expect based on anecdotal evidence.

Interestingly, 30% of respondents felt respect for patients' rights should prevail in case of a conflict, whereas 42% felt the patients' therapeutic needs should prevail (28% said it depends). The fact that the respondents were so evenly divided is of interest, as one would expect analysts to care more about therapeutic interests of their patients. On the other hand, this figure is consistent with the rate at which analysts always give an informed consent—the same roughly 30%. It is also con-

sistent with the rate at which analysts disclose some limits on confidentiality—for example, the possibility of Tarasoff warnings (37.5%) and disclosure of child or elder abuse (33.9%): Legal rights sometimes trump therapeutic needs.

47.4% of respondents said that obtaining informed consent should be required versus 52.6% saying not. This figure is of interest in light of how many say they give an informed consent (about 50%). It also, of course, demonstrates the possible ambivalence we have already mentioned: There is no clear trend.

As to whether an informed consent requirement should be minimalist or robust, 57.1% said minimalist, 9.7% said robust, and 28.6% said that it depends. (32.3% didn't answer, presumably because they didn't think an informed consent was required.)

It is important to note here that the latter percentages are a bit unclear. The term "robust" is used in the questionnaire to include all or most of the elements enumerated in Q5–Q13 (for example, under Risks, the variety of risks mentioned). But that leaves a big range in what analysts might have meant by "minimalist." Perhaps the most natural interpretation, if "Robust" is the more detailed disclosure, is the remainder of the field, so to speak—that disclosure which is just south of a full disclosure. Alternatively, "minimalist" may mean what is described in Q1—a brief recitation of problem, risks, and benefits. Or perhaps a given analyst will mean *really* minimalist—a one-sentence disclosure with little information—for example, we'll meet four times a week at such and such a price, and the fundamental rule is X? In addition, some minimalists may mean by this that they specifically address patients' concerns as they come up (like answering a child's questions regarding sex). Other interpretations of this language also exist. A note that tempers this criticism, however: This item does identify those who endorse a full disclosure. Further studies will need to be designed and conducted to tease this distinction out. (We return to the same kind of question in Chapter 5, where we discuss the limitations of our study.)

Inferential Data Discussion: The Ambivalence Hypothesis

Our final issue concerns the ambivalence hypothesis. We have noted that there is considerable variability in answering our survey. For example, if you consider the rate of giving informed consent (Q1), 39% Always do, 23.7% Never do, and 57.6% do so At Least Frequently—

i.e., either Always or Frequently. In other healthcare contexts, there would likely be less variability. For example, doctors doing surgery, as noted, likely obtain informed consent from their patients close to 100% of the time. In the psychoanalytic context, only 57.6% do so At Least Frequently. This could be explained in at least two ways: Individual analysts are ambivalent—torn. On the one side are pressures pushing toward informed consent and on the other side are pressures pushing away from informed consent. The analysts both want to respect the patient's autonomous interest in making an informed choice and to protect his treatment interests by not impairing the analysis for the sake of the law. So they compromise at around 50%.

Another possibility, however, is that around 50% strongly favor informed consent, while the remaining analysts feel a strong pull toward treatment interests. That is, the analysts are not ambivalent individually but, so to speak, as a group: Each half is unambivalently committed to one or the other.

Compare the death penalty. Suppose 50% are in favor and 50% against. These may be completely unambivalent about the death penalty —50% are really in favor and 50% are really against.

But, as in the informed consent context, it may also be possible that 100% are ambivalent, and so endorse the death penalty only 50% of the time—they are pulled in different directions depending on the particular case or how they are feeling about the relevant issues at a particular time.

The same is true in the informed consent process. The variability may be because 50% are unambivalently for and 50% unambivalently against; but it may also be that 100% are ambivalent and split the difference and sometimes endorse an informed consent requirement and sometimes don't—indeed, they do and don't 50% of the time.

Consider the low percentage of therapists disclosing limits on confidentiality posed by abuse reporting requirements. One could say that only 33.9% disclosing in the context of a law for 100% therapists suggests (but does not prove) that psychoanalytic ambivalence does, in fact, exist on this issue. On the other hand, it may be that the 66.1% who do not disclose are not torn by other considerations—for example, patients' therapy needs—but simply don't care about law and feel it unlikely to come back and haunt them. They are unambivalently against disclosure here.

On the other hand, one might suggest that comparing disclosure in analysis and surgery is not a good comparison. Surgery could lead to death. Also, it is a unique event. Analysis, on the other hand, happens

over a long period of time and may be something the patient has engaged in with another analyst. That is, the patient may be presumed already to have the relevant information.

These arguments are interesting but ultimately do not carry the day. People do die as a result of suboptimal psychotherapy. Also, other physical therapies unfold over time—for example, chemotherapy—yet we cannot dispense with informed consent. The point that the patient may already know is plausible, but it is often hard to know what he knows. For example, if a patient goes to a second surgeon for a second knee surgery, that surgeon ought to inform him again and not just presume he knows.

Yet another possibility is that analysts are focused on the uniqueness of individual patients. The patient's psychological equilibrium is far more complicated and idiosyncratic than say the patient in a gall bladder surgery. So the analysts vary what they say based on their assessment of what the patient can hear.

One might respond that informed consent doctrine requires us to think of the modal patient, so to speak. We give him basic information unless it would so upset him that he would become irrational—that is the purpose of the doctrine of "therapeutic privilege." So small differences in "better or worse for this and not that patient" are not part of the doctrine. Whether they should be, of course, is part of our inquiry.

On the other hand, it may be that certain elements of informed consent do not apply to particular classes of patients. So, for example, the doctrine of informed consent does not require us to disclose remote risks, so arguably disclosing the risk of decompensation into psychosis needn't be disclosed unless the patient is really vulnerable to that risk. And only a small percentage of possible analytic patients are in that category.

We think this point is well taken, but is a problem in this context only in very isolated cases—for example, malignant regression into psychosis, as mentioned previously. Even certain things unlikely to affect a particular patient should arguably be disclosed as possibilities in typical circumstances. For example, medication may not be indicated for many patients, yet it is a plausible modality in many and should arguably be revealed.

It is important also to point out that this same state of affairs exists in an ordinary medical context. If a risk of paralysis with a procedure only exists in the case of people with high blood pressure, only they must be told about this risk, arguably.

To return to teasing out the different explanations for our variability—i.e. is it ambivalence in individual analysts or not?—we would need to design a study that tests the hypotheses directly. But we wondered whether our current data could shed light on the ambivalence question. We endeavored, again, to look at items that might be in conflict, thus helping to substantiate the hypothesis of ambivalence. That is, do analysts endorse items in ways that conflict with each other, thus suggesting that they are pulled in different directions—i.e. are ambivalent?

We have reported on some findings in the Results section (see Chapter 3) that suggest this. We looked at five possible pairs to associate with two items (rate of giving and rate should give). We ran statistical tests to see if there were significant associations of these pairs of item. If there was an association but in the opposite direction from what one would expect—for example, wanting to be given an informed consent oneself but not giving it At Least Frequently to others or thinking one should be given—this would be consistent with the ambivalence hypothesis.

When we looked at associations that challenge what is expected, there were a number of significant associations. For example, 17.6% of respondents who would like to be given an informed consent themselves only Sometimes or Never give one to others. 16.7% who say IC conflicts with analytic principles of good technique nevertheless Always/Frequently give an informed consent. A relatively small percentage, 9.1%, say IC conflicts with analytic principles of good technique and yet should be given. 24.2% who think IC is Likely therapeutic only Sometimes or Never give one. 30.3% who think IC is Likely therapeutic still think it should not be given. 27% who think IC is on balance more therapeutic only Sometimes or Never give an IC. 29.7% who think IC is on balance more therapeutic nevertheless don't think an IC should be given. And 53.3% who think rights should prevail nevertheless don't think IC should be given. All of these associations are significant and all are unexpected. For instance, if you think giving an IC is in conflict with analytic principles of good technique, you shouldn't Always or Frequently give one. Or if you think it on balance more therapeutic than countertherapeutic, you should not think it should not be given.

When we apply a Bonferroni correction to these associations, four of the eight significant findings remain significant.

Additionally, there are explanations for these findings that are consistent with non-ambivalence. One might wish to have been given an informed consent but not want to give one at a high rate because one

thinks one's patients are different from oneself—that they will be more vulnerable to complications caused by knowing too much. In other words, there is no real conflict.

So, what shall we say about the ambivalence hypothesis? There is some evidence of this hypothesis explaining the variability in our results, but not overwhelming evidence. Many of the pairwise items were significantly associated in counterintuitive ways, thus suggesting ambivalence. Clearly, we need to design other studies to further confirm the ambivalence hypothesis.

Finally, certain findings are at least noteworthy even without doing studies to test an ambivalence hypothesis—we have mentioned, for example, that only around 34% disclose that reporting child abuse might be legally required, even though most therapists know of this legal requirement in 100% of the cases. One might assume that these results demonstrate that some analysts don't care about the law, but more likely is that there are countervailing interests—in particular, in the patient's therapeutic needs—that lead to this result when we would have expected all analysts to disclose. That only around 34% do suggests that, as a group at least, there is considerable ambivalence about this item, even though individual analysts may not be conflicted about it.

Clearly our study has raised some issues that deserve further study. We look at possible future studies in the next chapter.

5. Limitations of Our Study and Directions for Future Research

In this chapter, we address some important limitations of our study, suggest future studies that might address those limitations, and offer other suggestions for future research.

First, and perhaps most important, analysts may have different conceptions of informed consent when they answer questions such as whether they provide an informed consent to their patients. The first question of our survey asks, "Do you give an informed consent to your patients?" noting that "By 'informed consent' we mean a disclosure, roughly, of the nature of analysis, its risks and benefits, and alternatives." So, although the essential elements of informed consent are given—that is, nature of the process, risks and benefits, alternatives, and risks and benefits of alternatives—analysts may include a greater or fewer number of items under each element when they answer questions such as the Rates questions (such as how often one gives an informed consent, and how often one thinks it should be given). For example, one analyst may say he doesn't give an informed consent because he doesn't list all possible relevant risks, and another may say he does even if he discloses only, say, the most benign items listed as risks. Also, while no mention is made about whether the informed consent should be in writing, some analysts may say they don't give an informed consent, even if they provide a large quantity of the relevant information, because they don't use a form. That is, they have a fantasy that "if it is not in writing, it is not informed consent." Other analysts identify what we call the "process view" of informed consent as just the process of analysis itself, and therefore they answer "no" to the question of whether they give an informed consent, even though a particular communication could be both analysis and IC. (For instance, an analyst who explains transference at the moment it will

be most effective may think he is doing analysis, not informed consent, while really he is doing both.) That is, analysts may think that only what happens at the front end is informed consent, and that revealing relevant things over the course of the analysis is just the process of analysis, when it is actually both.

A number of features of the survey, however, temper this potential problem. The survey asks specific questions about particular items under the different elements of informed consent—for example, about a whole host of different risks. So we have a much more detailed and precise picture of what analysts actually do, even if they have different ideas of what IC means. In addition, the options are limited in terms of what IC can refer togiven that the first question, on rates of giving informed consent, lists the relevant elements. Also, the "process view" specifies how "doing process informed consent" may also be part of "doing psychoanalysis." Still, some responders may have made certain assumptions that we hadn't intended—for example, that informed consent needs to be in writing. Future studies should clarify this.

The bottom line is this misinterpretation does not affect the Rates issues in any important way. We have indeed collected the data on what analysts do, in regards, say, to disclosing the risk of regression, even if the question regarding the general rate of disclosure may be complicated by the fact that analysts interpret this differently.

This problem, however, affects not just the general Rates questions but some others as well. For example, an analyst may think of IC as providing a minimal amount of information, and therefore may not be worried about the possible countertherapeutic effects of IC. We think that the detailed Rates questions will cue most analysts to the fact that we are thinking of a robust informed consent, but we can't be sure of this.

One final note: This type of problem affects much research. As an example, a study of what therapists think about requirements of reporting child abuse may be affected by different assumptions they have about when a report is required. Or a study of how mock jurors respond to different evidence in deciding whether a defendant is guilty "beyond a reasonable doubt" may be complicated by the jurors' different understandings of what "beyond a reasonable doubt" means. Consider a study that asks doctors whether they adequately wash their hands before touching a patient and whether this affects rates of infection: Different doctors may interpret "adequately washing their hands" in different

ways: One may take several minutes to wash her hands and another may do it in a few seconds.

The point is that some unexpected results in research of many kinds may indicate confusion and inconsistency in understanding the relevant terms. And so in our case, too, analysts may be confused rather than exhibiting an "understanding" ambivalence. A future study might specify further what is meant by "informed consent" and "minimalist vs. robust informed consent." For example, it would clarify what is needed and what not (e.g., that this IC needn't be in writing). That way, everyone will be talking about the same thing.

There is one other, more technical, limitation to our study: Our sample size was small. Most people want a 30% return to have a valid estimation of the population being studied, whereas we had only a 17% response rate. However, our rate is deemed reasonable by our statistician given the population of interest, the length of the questionnaire, and the lack of any compensation for returning it. Still, the reader must keep in mind that our findings may not be generalizable given this response rate.

Let us turn now to future research. It is important to note that our research has been, in part, exploratory in nature. Our multiple analyses may have heuristic value and they do generate questions for future research.

For example, as we suggested, future research should use a more precise definition of "informed consent," and what is meant by "robust" and "minimalist" versions of informed consent.

Second, an extremely important future line of research is to explore further the question raised in this study—namely, is the ambivalence hypothesis borne out? The goal would be to differentiate between cases of ambivalence in explaining variability versus other explanations. Such an exploration would need to further tease out conflicting views in analysts versus strong views about different matters that don't involve conflict. Such a study could, for example, manipulate scenarios to see the effect on analyst responses. For example, survey participants could be asked, "Assume there is no law or ethical command to give informed consent. Would you still give an informed consent? How often? What if it might harm the patient therapeutically?" Or, "Assume that informed consent is always in patients' therapeutic interests. Would you always give informed consent in that event?"

In addition, one could directly ask whether and why analysts (sometimes) feel torn: "Do you embrace informed consent, reject it, or feel

ambivalent about it? If ambivalent, explain which aspects of IC you embrace and which you reject."

A number of other studies follow from our current research. For example, a qualitative study exploring whether there would be a "distinctively psychoanalytic way" to get IC would be quite useful. Is there something particular to the analytic process and the interactive aspects of intake (history, analyzability) that have a bearing on IC in important ways—and to a degree not found in other approaches to psychological or medical treatment? This makes sense and argues for a variability in what is disclosed that's dependent on the patient.

We would also have great interest in studying one possibly distinctive psychoanalytic way to get informed consent, that is to say, the process view of informed consent and what is and should be the developmental history of an informed consent so understood. Should we do IC at the outset of treatment, over time, or both? What are the hazards and opportunities of doing it over time?

Also interesting would be to study analysts who, so to speak, lived through the informed consent "changeover." Future research could study analysts' attitudes before and after a change in the approach to informed consent.

There are other extensions of our current project that could also be useful for our understanding. For example, we have asked analysts about the possible outcomes of an IC requirement, and we asked them as once-analytic patients themselves. But the typical analytic patient may feel differently from an analytic candidate, so it would be useful to administer our survey, in modified form, to ordinary analytic patients. What was done vis-à-vis IC in their case, what do they think the effects were, and what do they wish would be done?

Another potentially interesting research issue would be to tease out the effects of differences in patients in the context of informed consent. Is informed consent more important for some rather than others? Will it affect different kinds of patients in different ways? Should it therefore be done differently for different kinds of patients? Of course, we should ask these questions keeping in mind that different versions of IC are more or less robust. (And note that the question applies not just in the context of mental health but physical health as well: When must risks that affect people variably be disclosed? What is the threshold for when disclosure must be provided given that people vary in important ways?)

One fruitful approach might be to lay out the shape of an ideal informed consent exchange and then think about this question in terms of three different ideal types or modal cases: someone for whom object loss or loss of someone's love is a primary issue; someone for whom castration anxiety is a primary issue; and someone for whom self-punitive actions are a primary issue. The plan would be to study informed consent using these ideal case types, which are derived from Freud's account of the catastrophes of childhood (cf. "Inhibitions, Symptoms and Anxiety," 1926; or Brenner, 1982). Of course this is just one example of a relevant diagnostic typology and one would need to justify which typology to use. (And it is also clear that more accurate diagnostic understanding might emerge in the analysis over time—hence again we see the utility of a process view.)

The informed consent issue could then be studied using these ideal case types. The study could be theoretical (along the lines of what we have done for the general case); it could involve surveying analysts (again along the lines of what we have done for the general case); or it could involve actually studying the patients themselves (see the possible study described in the text that follows). What we are looking for here is a more nuanced understanding of the meaning and effects of an informed consent requirement on different types of patients that would be generalizable to other patients who share significant similarities with our ideal types.

Another way to think about IC and patient dimensions is to explore in a broader way the effect of patient dynamics on IC and vice versa. For example, it may be that patients with paranoid characteristics especially value IC—or, by contrast, get especially anxious or paranoid about it. Dependent patients might find the provision of information uncomfortable since the IC procedure calls on the patient to see himself as an independent agent who must make his own assessment and decide.

Perhaps we would do well to study IC in the context of actual practice. Analysts may vary their approaches with different patients in ways that could be identified and studied. As noted, the doctrine of informed consent typically looks at the "average reasonable" patient, and not this or that particular patient. But perhaps we should look at "the average reasonable patient with such-and-such psychopathology" in the context of an informed consent to analysis. It would seem that doctors to some extent tailor what they say to a medically ill patient depending on his characteristics, values, and interests. The standard is not fully subjective but does take subjective things into account.

Given these observations about patient-type and informed consent, we should note that some of the variability of our subjects' responses can be explained by the variability in patients themselves. So analysts saying that *x* percent of patients will experience countertherapeutic effects may reflect not ambivalence but differences in patients.

We should note that this is true in the ordinary medical context as well. Some surgery candidates will find an IC painful and unhelpful, too. Also, even if different types of people can be expected to react differently, we should still expect informed consent of some form to be given, as in surgery, 100 percent of the time. Everyone is entitled to some/most of the ordinary informed consent. So something is going on that explains the variability of our results beyond what can be explained by patient differences.

Finally, we have speculated about the elements and effects of informed consent. For example, we have reported what analysts themselves think the elements are or should be and what they think the effects of an IC requirement are. The next step is to study whether those effects actually occur. For example, an analyst could say she thinks an informed consent requirement is countertherapeutic in causing her patients severe anxiety. But actually studying the anxiety levels of patients might not bear out that this is the case or that it was a result of the informed consent disclosure.

So the logical progression for future studies is clear: what do we speculate; what do analysts think happens; and what actually happens? This last consideration would be an extensive project. But it could initially take place by investigating the effects of a relatively small number of items. One important item might be how "free" or "unfree" patients feel able to leave the treatment.

In short, there are a number of studies that could be conducted in the future. Some are based on outstanding questions from the current project; some are collateral questions raised by it; and some seek to study what really happens (versus what analysts think happens). Such studies would help us further understand and evaluate an informed consent requirement for psychoanalysis.

Afterword: Our Own View

While our aim in this book is to explore informed consent in the psychoanalytic context and not to advocate for a particular view, it would perhaps make sense for us to lay out, in a preliminary way, our current thinking on the topic. We also briefly discuss the dilemma of the analyst who disagrees with what may be required by informed consent laws.

As a normative matter, we believe that informed consent is necessary and important, but we would like to see a "process view" of informed consent implemented.

Why is informed consent necessary for patients undergoing psychotherapy? Simply put, it shows the patient dignity and respect. It arms her with the information to make an informed choice. And we must presume patients know themselves best and care about themselves most—so they are likely to make the best decision for themselves. It also allies the patient to the treatment from the start and can thus be therapeutic. Indeed, in our survey we found that analysts thought there were many benefits to having an informed consent requirement, even as they were concerned about some risks.

We are also hopeful that a process view will minimize the costs to the therapy—the countertherapeutic effects of an informed consent. We also endorse a process view because, given that analysis is a long-term treatment, benefits, risks, goals, and viable alternatives are likely to change, at which point a new informed consent may be necessary. So, for example, medication may not be an appropriate alternative in the beginning, but if, over time, the patient has depression that has deepened, at that point a disclosure might become imperative.

How would the process view work? More research is needed into the benefits and risks, and into the specific mode of implementation.

But what we would envision is something like the following: At the beginning of the treatment, the analyst would minimally disclose. Of course he would talk about frame issues (the when, where, and how much). He would talk about free association. He might mention one or two risks (confidentiality might need to be breached at times, one might get worse for a time in analysis, and so on); one or two benefits (feeling less anxious); and one or two alternatives (short-term dynamic therapy).

He would then tell the patient that it would benefit the therapy for the therapist himself not to disclose too much —that the therapy would work better if the patient made his own discoveries through the therapeutic process. He could ask if the patient was all right with that.

So, for example, in the context of a first transference interpretation, the analyst could say something more about how transference works—for example, "I have suggested to you that some of what you are saying about us is rooted in your childhood relationships. I think we will probably see that in the future, too. And given that I have told you little about myself, what you are thinking probably has more to do with you than with me. This understanding may help you in your life with your friends and families, too, as you are likely to be doing some of the same things with them, too."

This is put somewhat intellectually, and each analyst will have her own way of saying it, but the main point to convey to the patient is that the past is relevant to the extent it is unhelpfully shaping the present. So, in the context of an observable transference distortion, the patient can be encouraged to consider if there is a familiar pattern here.

Similarly, when the patient begins to regress, the analyst could explain that that is part of the process, and while it could be painful, it could also help over time. The analyst might also mention the risk that it could, on rare occasions, lead to overdependence and a bad outcome.

Or, on a more pedestrian level, the analyst might mention medication as an adjunct or alternative only at the point at which it is clear that the patient needs medication. If it is the patient himself who is asking for medication, the analyst might at that point inform the patient whether medication is a viable alternative or adjunct. Alternatively, in certain contexts, the analyst might discuss the meaning of medications for the patient and advise him to consider an initial brief period of talk therapy before starting on medication.

Another example—and something we believe is often done now—is to explain the analyst's general silence, and tendency not to answer

questions, only at the point in the treatment when the patient brings it up, or it is clear the patient is concerned about what is happening. One might explain this approach by telling the patient at the moment of silence that it will help the process for the analyst to talk sparingly and to not answer questions—for example, it will give the patient a better opportunity to reveal what her issues are.

In short, we think the process view has great merit. It gives the patient the opportunity to make his choices maximally armed with information, yet it does so in a way that minimizes the potential countertherapeutic effects of saying everything all at once. Most obviously, the analyst does not have to reveal the plot of the story before it is important to know it (and the patient is in a better position to understand it). In addition, he will avoid saying things at the beginning that could scare patients away—for example, that regression can turn malignant—or cause pain or anxiety. Waiting to inform the patient might make more dependent patients feel helpless if they are concerned about risks but feel too attached to leave. For the most part, however, we believe that patients will be more, rather than less, able to take action, should they want it, once they understand that the therapy strengthens patients' autonomy.

Note also that the process view can be responsive to some of these concerns. When the patient is frightened about risks, for example, this should be talked about, as should the fear that he won't be able to leave. The process view of informed consent says in part that IC issues will repeatedly present themselves throughout the treatment, and when they arise they should be addressed. In addition, a meaningful understanding of, say, transference may arise only after the transference has been deepened—intensified—and been successfully worked with.

Note finally that some might argue that what we call the process view of informed consent is actually just part of the process of analysis itself. IC may change as the process changes over time. But the very process of analysis may include weaving in such adjustments commonly, and analysts may simply call this "analysis" and not identify it as IC.

Indeed, some analysts might not endorse the process view because, for them, the process of analysis itself includes an ongoing assessment, which would allow for adjustments and "parameters" (for example, a referral for a medication evaluation, sitting up if regression anxiety is not well-enough tolerated), and it is possible that discussion of these parameters might be relabeled by others as a "process view of informed consent" and be seen by them as just "analysis."

Consider the earlier example of the first transference interpretation. This is both "doing analysis" and "doing informed consent." The IC part would be to indicate how transference interpretations are an important part of the analytic process ("nature of the process") and to indicate the value to the patient of these patterns being played out between the analyst and the patient in the here and now, giving the opportunity for understanding and working through of these old patterns to allow for something new to develop ("benefit of the process").

How shall we determine whether what analysts are doing in this regard is IC or simply analysis? We think the question is not well-taken. What is happening is *both* the process of analysis and the process of informed consent. In the same way, in another related context, an interpretation might both further the patient's understanding of the transference and solidify a therapeutic alliance. So it is not a question of one or the other, but of both. Of course, our analyst-subjects need to understand this when they are answering our questions.

Throughout this book, we have laid out the ethical issues surrounding informed consent. Should analysts change their behavior in light of this analysis? What if the analyst's best belief is that disclosure would harm the patient? We have the sense that this is the dilemma of therapists who think their patients might be dangerous—i.e., it is not a good idea, therapeutically, to make warnings, but it may be required by law. The same is true of reporting child abuse; some therapists take the risk of not reporting because they know that reporting will lead to bad results for the child—for example, the child being pulled from therapy.

We are not advocating that violating the law is a good idea in the context of informed consent (or indeed any of these other contexts). We are saying that these are all cases in which the therapist faces a difficult choice. If she informs, she may possibly hurt the therapy, but if she does not inform, she may possibly anger the patient and subject herself to a lawsuit.

A lawsuit is a real risk. The analyst may think some information—for example, that a much shorter and more evidence-based therapy is an alternative—shouldn't be disclosed; perhaps he thinks it would confuse the patient. Perhaps the analyst refuses to disclose a serious risk, even if he has good therapeutic reasons for doing so, and the risk eventuates; a lawsuit might easily ensue. No one can force the analyst to disclose, but he should know that his failure to do so is at his own risk.

Of course, it is possible to be sued by anyone for anything. The point is that the patient might prevail in such a lawsuit.

That said, as we have discussed, cases related to informed consent to therapy are very rare. So the importance of our analysis is not so much to protect therapists from litigation risks as to help them reason through the various issues and practice in an ethical way.

Our bottom line is that the process view of informed consent makes a good deal of sense. It is already in use to the extent that the analysis changes over time and new and different disclosures might be required. And many analysts already practice it to some degree. It ought, then, to be studied to see if it is indeed a good idea and, if so, how best to implement it.

Conclusion

In this book, we reviewed the law and literature on informed consent to psychotherapy. In terms of case law, there is actually only one reported case that speaks of an adult's informed consent to therapy in general. There are a few child cases, as well as cases where a specific item—the limits on confidentiality—is said to be a necessary item of disclosure for therapy patients. One case that settled, *Osheroff v. Chestnut Lodge*, strongly suggests that informed consent is necessary for therapy. There are also at least twenty-one statutes or regulations that say or imply that there is an informed consent requirement to psychotherapy. Also, twenty-eight states (which may overlap with the twenty-two statutes or regulations) read the Professions' Ethics Codes into state law. (And, of course, these codes subject professionals to sanctions if they are not followed.) As we have noted, the existence of statutes or regulations means a breach of the standard of care is negligence per se in this context.

In Chapter 2, we examined an informed consent requirement as a matter of theory. We asked what the elements would be of a robust informed consent, as is required in other medical specialties, and we explored the possible conditions and effects of an informed consent requirement in a psychoanalytic context. Is it even possible to obtain it? Is it therapeutic or countertherapeutic? In what ways? Is it all much ado about nothing? Should we adopt a "process" view of informed consent, and what would that mean?

Chapter 3, the data chapter, then asks analysts what they think about this issue. We looked at issues raised in Chapter 2, such as whether analysts provide an informed consent, what the elements are if they do, why they give an informed consent (for example, do they think the law requires it?), whether informed consent is even possible, whether

informed consent is therapeutic or countertherapeutic, whether it is much ado about nothing, whether analysts think informed consent should be given over time, whether they think it should be required, and, if so, whether it should be minimal or robust.

We reported on the descriptive data concerning these questions, finding some counterintuitive results—for example, that CBT as an alternative is often not mentioned, and neither are some important risks, such as a malignant regression and the limits of confidentiality.

Our main hypothesis—that there would be considerable variability in responses—was amply borne out. Our speculation was that this would be the result of pressures on analysts from both sides, which make them internally conflicted—ambivalent—about informed consent. The findings were consistent with this speculation, although other interpretations might be possible. Further study would be required to substantiate the ambivalence hypothesis.

We also discussed the limitations of our research in Chapter 5—for example, subjects may have had in mind different concepts of informed consent (IC) when answering our questions—and directions for future research. And we sketched out our own preferred view—the "process view of informed consent"—and what that would mean and how it would work.

In conclusion, we have undertaken an extensive study of informed consent to psychoanalysis, which included legal research and a review of literature, an examination of the theory behind informed consent, and a review of data collected. Our hope is that this study will shed light on informed consent to psychoanalysis and that this will be of use in other psychotherapeutic contexts—and indeed, medical contexts in general. Psychoanalysis has much to offer in terms of insight about a practice like informed consent. This study may return psychoanalysis to its rightful place as a premier tool for studying the psychological dimensions of law.

Appendixes

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A. Ethics Codes: Informed Consent Provisions

American Psychoanalytic Association Ethics Code

General Guiding Principles

III. Mutuality and Informed Consent. The treatment relationship between the patient and the psychoanalyst is founded upon trust and informed mutual agreement or consent. At the outset of treatment, the patient should be made aware of the nature of psychoanalysis and relevant alternative therapies. The psychoanalyst should make agreements pertaining to scheduling, fees, and other rules and obligations of treatment tactfully and humanely, with adequate regard for the realistic and therapeutic aspects of the relationship. Promises made should be honored.

National Association of Social Workers Code of Ethics

1.03 Informed Consent

(a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.

(b) In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients' comprehension. This

may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible.

(c) In instances when clients lack the capacity to provide informed consent, social workers should protect clients' interests by seeking permission from an appropriate third party, informing clients consistent with the clients' level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent.

(d) In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse service.

(e) Social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services.

(f) Social workers should obtain clients' informed consent before audiotaping or videotaping clients or permitting observation of services to clients by a third party.

American Psychiatric Association Principles of Medical Ethics Especially Applicable to Psychiatry

Section 2.5

Psychiatric services, like all medical services, are dispensed in the context of a contractual arrangement between the patient and the physician. The provisions of the contractual arrangement, which are binding on the physician as well as on the patient, should be explicitly established.

American Psychological Association Ethics Code

3.10 Informed Consent

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

10.01 Informed Consent to Therapy

(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask APA Ethics Code questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)

(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation. (See also Standards 2.01e, Boundaries of Competence, and 3.10, Informed Consent.)

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

B. Statutes and Regulations on Informed Consent to Psychotherapy

Informed Consent Laws Apply to People Other Than Physicians

Statute/Regulation	**State**	**Does It Apply to People Other Than Physicians? If So, to Whom?**
Ala. Code 1975 § 22-56-4	Alabama	Inpatient, residential, or outpatient settings (not specific about healthcare providers)
Ala. Admin. Code r. 420-5-6-.12	Alabama	Health maintenance organization
Alaska § 47.30.825	Alaska	Mental health care professionals
Alaska § 47.30.837	Alaska	Evaluation facility or designated treatment facility
Ariz. Admin. Code R9-21-206.01	Arizona	1) Mental health agency 2) Medical practitioner 3) Registered nurse
Ariz. Admin. Code R9-21-207	Arizona	Mental health agency, licensed nurse practitioner, or certified physician assistant
A.R.S. § 36-513	Arizona	Staff members of mental health agency
West's Ann.Cal.Health & Safety Code § 24173	California	Investigator or research institution

C.R.S.A. § 27-65-116	Colorado	Agency or facility providing the evaluation, care, or treatment
C.R.S.A. § 27-10.5-114	Colorado	Interdisciplinary team and a developmental disabilities professional
C.R.S.A. § 27-10.5-129	Colorado	Developmental disabilities professional, psychiatrist, or psychologist (refers to sterilization)
16 Del.C. § 5161	Delaware	Hospital or residential center
16 Del.C. § 5175	Delaware	Health care professional
16 Del.C. § 2220	Delaware	Attending or resident physician or staff of the facility
West's F.S.A. § 394.459	Florida	Receiving or treatment facility
65 FL ADC 65E-5.170	Florida	Receiving facilities, treatment facilities, or service provider
HRS § 334E-1	Hawaii	Health care provider
201 Ky. Admin. Regs. 23:080	Kentucky	Social worker
KRS § 319.140	Kentucky	Treating psychologist or psychological associate who provides or facilitates the use of telehealth
La. Admin Code. tit. 46, pt. LX, § 2111	Louisiana	Licensed professional counselor
La. Admin Code. tit. 46, pt. LX, § 4101.	Louisiana	Licensed marriage and family therapist
La. Admin Code. tit. 46, pt. LX, § 4705	Louisiana	Licensed marriage and family therapist
Code Me. R. 14-193 Ch. 1, § V	Maine	Employee of the facility or program in inpatient and residential settings
Code Md. R., Health & Men. 10.36.05.05	Maryland	Psychologist
258 CMR 20.02	Massachusetts	Social worker
Minnesota Rules, part 2150.7525	Minnesota	Provider

Minnesota Rules, part 8740.0320	Minnesota	Social worker
M.S.A. § 148E.230	Minnesota	Social worker
20 Mo. Code of State Regulations 2095-3.015	Missouri	Licensed professional counselor
20 Mo. Code of State Regulations 2233-3.020	Missouri	Marital and family therapist
Mont.Admin.R. 24.189.817	Montana	Psychologist
Neb. Admin. R. & Regs. Tit. 172, Ch. 156, § 003	Nebraska	Psychologist
Nev. Admin. Code ch. 641, s. 207	Nevada	Psychologist
Nev. Admin. Code ch. 641C, s. 415	Nevada	Person who is providing a clinical service for treatment for alcohol and drug abuse or treatment for problem gambling
N.H. Code Admin. R. Mhp 502.02	New Hampshire	Mental health practitioner, mental health provider, therapist
N.M. Admin. Code 16.22.2.10	New Mexico	Psychologist, psychologist associate, or both licensee and applicant
N.M. Admin. Code 16.63.16.8	New Mexico	Social worker
NDAC 75.5-02-06.1-01	North Dakota	Social worker

Informed Consent Laws for Therapy

Statute/Regulation	**State**	**Informed Consent for What?**
Alaska § 47.30.825	Alaska	Consent to medication and treatment in all situations that do not involve a crisis or impending crisis

Ariz. Admin. Code R9-21-206.01	Arizona	Telemedicine
Ariz. Admin. Code R9-21-207	Arizona	Therapy
C.R.S.A. § 27-65-116	Colorado	Consent for specific therapies and major medical treatment in the nature of surgery
16 Del.C. § 5161	Delaware	Mode or course of treatment
201 Ky. Admin. Regs. 23:080	Kentucky	"To provide a social work service"
KRS § 319.140	Kentucky	Telehealth (Treatment over phone)
La. Admin Code. tit. 46, pt. LX, § 2111	Louisiana	Formal appraisal
La. Admin Code. tit. 46, pt. LX, § 4101.	Louisiana	Therapy or related procedures, or treatment
La. Admin Code. tit. 46, pt. LX, § 4705	Louisiana	Therapy or related procedures
Code Me. R. 14-193 Ch. 1, § V	Maine	For all treatment
MD Health & Men. 10.36.05.05	Maryland	Assessment, psychotherapy, counseling, or consulting with an individual or organization in person or by electronic transmission or other forms of communication
258 CMR 20.02	Massachusetts	Social work
Minnesota Rules, part 2150.7525	Minnesota	The provider shall obtain informed consent for services to a client.
Minnesota Rules, part 8740.0320	Minnesota	Social work
M.S.A. § 148E.230	Minnesota	Social
20 Mo. Code of State Regulations 2095-3.015	Missouri	Counseling

20 Mo. Code of State Regulations 2233-3.010	Missouri	Marital and family therapy
Neb. Admin. R. & Regs. Tit. 172, Ch. 156, § 003	Nebraska	A psychologist shall obtain from a client or his or her legal representative informed and voluntary consent before providing or assisting *in the care or treatment of the client*. Failure to do so shall constitute unprofessional conduct.
Nev. Admin. Code ch. 641C, s. 415	Nevada	Treatment
N.H. Code Admin. R. Mhp 502.02	New Hampshire	Treatment and mental health services
N.M. Admin. Code 16.22.2.10	New Mexico	Therapy or related procedures or evaluation
N.M. Admin. Code 16.63.16.8	New Mexico	Services
NDAC 75.5-02-06.1-01	North Dakota	Services

C. The Survey Instrument: Informed Consent to Psychoanalysis

1) Do you give an informed consent to your patients? (By "informed consent," we mean a disclosure, roughly, of the nature of analysis, its risks and benefits, and alternatives.)

   Always: ____ Frequently: ____ Sometimes: ____ Rarely: ____
   No: ___ Never: ____

2) Were you given an informed consent when you were an analytic patient?

   Yes: ____ No: ____

3) Would you have liked one to be given?

   Yes: ____ No: ____
   Why?_____
   _____
   _____
   _____
   _____

4) Please indicate which of the following you disclose to your patients:

   4A) Your qualifications

   Always: ____ Frequently: ____ Sometimes: ____
   Rarely: ____ Never: ____

   4B) The nature of the psychoanalytic process

   Always: ____ Frequently: ____ Sometimes: ____
   Rarely: ____ Never: ____

4C) The nature of the patient's problem

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

4D) The benefits of the process of psychoanalysis

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

4E) The risks of the process of psychoanalysis

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

4F) Alternatives to the psychoanalytic process

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

4G) Risks and benefits of alternatives

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

4H) Risks to confidentiality

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

4I) Frame issues, such as frequency and cost of sessions

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

4J) Please indicate anything Other you disclose to your analysands:

_____
_____
_____

5) If you disclose your qualifications, what sorts of things do you disclose?

5A) Your degree (MD, Ph.D., MSW, etc.)

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

5B) Your license

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

5C) Where you trained

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

5D) How long you've been an analyst

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

5E) Whether you are a candidate

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____NA___

5F) Whether this patient's case will be supervised

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

5G) Other _____
_____

6) If you disclose the nature of the process, what sorts of things do you disclose (note Other frame issues are discussed below)?

6A) The fundamental rule, i.e. the patient should try to free associate and say whatever comes to mind

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

6B) The analyst's role to listen, attempt to understand, and interpret

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

6C) The analyst's general passivity, e.g. not answering questions

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

6D) The likelihood of a transference developing and what that means

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

6E) The likelihood of regression taking place and what that means

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

6F) The use and rationale of the couch

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

6G) Other _____
_____

7) If you disclose the nature of the patient's problem, what sorts of things do you disclose?

7A) His or her diagnosis

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

7B) The nature of his or her symptoms

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

7C) Character traits that might become subject to analysis

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

7D) His or her life issues (e.g., relationship problems)

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

7E) Other _____
_____

8) If you disclose the goals / potential benefits of the process, what sorts of things do you disclose?

8A) Help with life issues, such as relationships and job

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

8B) Removal of symptoms

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

8C) Structural change, such as softening of the superego

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

8D) Character change

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

8E) Other _____
_____
_____

9) If you disclose the risks of the process, what sorts of things do you disclose?

9A) A malignant regression

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

9B) Regression to the point of actual psychosis

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

9B) If B, do you use the word "psychosis" or just explain the concept?

Word: ___ Concept: ___

9C) Increased anxiety or depression

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

9D) Worsening of symptoms generally

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

9E) An intense transference

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

9F) Acting out

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

9G) A desire to make changes in one's life of which one would now not approve

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

9H) As an example (of 9G), a desire to divorce

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

9I) Analysis won't work

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

9J) Financial cost of the treatment

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

9K) Opportunity costs generally, i.e., Other opportunities forgone because of time/money commitment of analysis

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

9L) Other _____
_____
_____

10) If you disclose alternatives to analysis, what sorts of things do you disclose?

10A) Psychoanalytic psychotherapy

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

10B) Brief dynamic therapy

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

10C) Cognitive-behavioral therapy

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

10D) Other schools of psychotherapy

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____
What schools?_____)

10E) Medication instead of psychoanalysis

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

10F) Medication as an adjunct to psychoanalysis

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

10G) No treatment

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

10H) Other _____
_____
_____

11) If you disclose risks and benefits of alternatives (such as those in Q10), what sorts of things would or do you disclose? For example, with medication as an alternative, what sorts of things would or do you disclose?

11A) Physical side-effects and risks

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

11B) Short-circuiting of a therapeutic process that could lead to structural change

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

11C) Benefit of shorter time to work

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

11D) Lesser cost

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

11E) Other _____
_____
_____
_____
_____

12) If you disclose threats to confidentiality, what sorts of things do you disclose?

12A) Disclosure of danger to self or Others if need to be hospitalized

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

12B) Warning to potential victims in the event of a credible threat of harm

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

12C) Reporting of child or elder abuse

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

12D) Testimony in lawsuit if mental state is in issue

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

12E) Disclosures to insurance companies if patient so desires

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

12F) Potential use of material in disguised form in publications of analyst

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

12G) Case-presentations of material in disguised form at conferences

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

12H) Case-presentation of material, without identifying information, in classes and meetings at Psychoanalytic Institute

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

12I) Disclosure of material to supervisor

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

12J) Write-up of case at various intervals for review by Progression Committee

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

12K) Other _____
_____
_____

13) If you disclose Other "frame" issues, what sorts of things do you disclose?

13A) The frequency and times of the sessions

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

13B) The cost of the sessions

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

13C) The likely duration of the treatment

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

13D) The likely length and number of the analyst's vacations

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

13E) The policy on missed sessions

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

13F) Other _____
_____
_____

14) What would you inform patients of if it were totally up to you? That is, what do you think it is optimal to disclose? (Give the number and letter of the items above, if you wish.)

_____
_____
_____

15) Why do you disclose what you disclose?

15A) Legal requirements

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

15B) Professional Ethics Codes

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

15C) Ethical considerations generally

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

15D) Technical considerations

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

15E) The patient's therapeutic interests

Always: ____ Frequently: ____ Sometimes: ____
Rarely: ____ Never: ____

15F) Other _____
_____
_____

16) Do you think patients are capable of giving informed consent at the beginning of treatment? Can they really understand?

Always: ____ Frequently: ____ Sometimes: ____ Rarely: ____
Never: ____

17) Do you think that once patients can understand, it is too late? That is, they cannot make a voluntary choice at that point?

Always: ____ Frequently: ____ Sometimes: ____ Rarely: ____
Never: ____

18) Do you think it's better to obtain informed consent at the very beginning or to do it over time as the process unfolds?

Better at the beginning:____ Better as the process unfolds:____
How?_____

19) Do you think that informed consent in the psychoanalytic context differs in any way from Other informed consent contexts?

Yes:____ No:____

20) Do you think the patient's experiencing the process and continuing to come back is as much informed consent as is needed?

Yes:____ No:____

21) Do you think an informed consent requirement conflicts with analytic principles of good technique, like anonymity and abstinence?

Yes:____ No:____

22) Do you believe an informed consent requirement is likely to be countertherapeutic?

Yes:____ No:____

23) How may an informed consent requirement be countertherapeutic?

23A) It may reveal too much, conflicting with the "blank screen" desideratum, and therefore getting in the way of a natural unfolding of the transference.

Yes:____ No:____

23B) It may have a stifling effect on one's fantasy life.

Yes:____ No:____

23C) Fears of breaches of confidentiality may lead the patient not to say what is on his or her mind.

Yes:____ No:____

23D) The informed consent process may set up expectations (e.g., of an active analyst) that will inevitably be frustrated.

Yes:____ No:____

23E) It may act as a suggestion, e.g. one ought to develop such and such psychological phenomena.

Yes:____ No:____

23F) It may be overly gratifying to the patient.

Yes:____ No:____

23G) It may be perceived as the analyst making a recommendation (e.g., about alternatives).

Yes:____ No:____

23H) It may lead to all manner of dysphoric affects, such as anxiety, fear, hopelessness, anger, etc.

Yes:____ No:____

23I) It may feel like a meaningless ritual to the patient.

Yes:____ No:____

23J) The patient may feel the analyst is just covering her back, and be angry about that.

Yes:____ No:____

23K) Other _____

_____

_____

24) Which of the items in Q23 do you think likely to happen?_____

_____

25) Do you think an informed consent requirement is likely to be therapeutic?

Yes:____ No:____

26) In what ways do you think an informed consent requirement could be therapeutic?

26A) The patient may feel respected and treated as an adult.

Yes:____ No:____

26B) The patient may feel treated as a collaborator.

Yes:____ No:____

26C) The patient may perceive the analyst as being hopeful.

Yes:____ No:____

26D) The patient may feel drawn to aspects of analysis that have been described.

Yes:____ No:____

26E) Other _____

_____

_____

27) Which of the items in Q26 do you think are likely to happen?_____

28) Have any of your patients ever experienced any of the effects in Q23 and Q26 described above as a result of an informed consent being given? Which ones (give letter and number, if you wish)?

_____
_____
_____

29) Do your patients given an informed consent ever talk about it or associate to it?

Yes:____ No:____

30) What do they say about it?_____
_____
_____

31) Have you had any experience with the effects of informed consent on the therapeutic alliance, or the therapeutic alliance on the informed consent?

Yes:____ No:____

32) If yes, name the effects: _____
_____
_____

33) On balance, in your experience has the informed consent process been more therapeutic or more countertherapeutic?

More therapeutic:____ More countertherapeutic:____

34) Do you think it probably doesn't matter much at all whether the analyst obtains informed consent from the patient, that it probably has very little effect on the process? i.e. nobody pays much attention anyway?

Yes:____ No:____

35) If you perceive there's a conflict between respect for patients' rights to understand and their therapeutic needs, which should prevail?

Patients' rights:____ Patients' therapeutic needs:____
It depends____

On what?_____
_____
_____

36) Do you think the law now requires you to give an informed consent to your patients?

Yes:____ No:____

37) Overall, do you think obtaining informed consent to psychoanalysis should be required?

Yes:____ No:____

38) If you do think there should be a requirement for informed consent, should it be minimalist or robust, including many or all of the items discussed above as elements?

Minimalist:____ Robust:____
It depends____
On what?_____
_____
_____

39) Do you think if informed consent comes to be clearly required legally that there is a distinctively psychoanalytic way to procure it?

Yes:____ No:____

40) Describe in a few words what that distinctively psychoanalytic way would be:_____
_____
_____
_____
_____
_____

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