PSYCHOLOGISTS’ PRACTICES IN OBTAINING INFORMED CONSENT

by

V. Lynn Bristow

An Abstract
of a thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science
in the Department of Psychology
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ABSTRACT

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The degree and extent of the use of informed consent by licensed and practicing psychologists was explored via random sampling of 150 psychologists licensed in the State of Missouri. Those sampled received a questionnaire about the type of informed consent they employed, with query about the number of journals or journal articles they read per month. Participants were asked whether written informed consent (WIC) or verbal informed consent (VIC) was used in their practice, and whether the consent information was discussed prior to beginning the therapeutic process. The results showed that the majority of practicing psychologists use a WIC form in conjunction with verbal discussion about the form prior to beginning the therapeutic process. While the majority of psychologists read one journal article or more per month, there was no significant relationship between the number of journal articles read, and how thorough the use of informed consent was.
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CHAPTER 1
NATURE AND SCOPE
OF THE STUDY

Purpose of the Study

The study explored the form and extent of the use of informed consent procedures by licensed and practicing psychologists. This research used a relational study to attempt to determine (a) what type of informed consent is predominately used by psychologists (i.e., written procedures, verbal procedures, or a combination of the two), (b) the level of involvement the professional has in the informed consent process, and (c) whether those who attempt to remain up to date on the scientific literature versus those who do not report using more thorough informed consent procedures.

Need for the Study

While a great deal has been written regarding the importance of obtaining informed consent to treatment, including recommendations for obtaining informed consent (Haslam & Harris, 2004), the actual procedures that practitioners employ have yet to be determined empirically. Practitioners appear to have considerable latitude in defining (a) what informed consent should entail, (b) what the most effective manner of ensuring truly informed consent is, (c) what constitutes an acceptable range of content and interaction (e.g., the extent to which clients should be encouraged to ask questions regarding information provided during this process), and (d) what process the professional should use to obtain informed-consent as a precursor to the therapeutic process. The question arises as to whether psychologists do in fact discuss informed
Informed Consent

consent issues with clients/patients in more than a cursory manner, or at all (Beahrs & Gutheil, 2001).

The American Psychological Association’s (APA) Ethical Principles of Psychologists and Code of Conduct (hereinafter referred to as the Ethics Code; 2002) indicate that “psychologists should seek to promote accuracy, avoid intentional misrepresentation of fact and inform their clients/patients without engaging in fraud or subterfuge” (p.1062). The informed consent process is an important part of upholding this principle, as the intent of the informed consent process is to ensure that clients have received sufficient information in order to make informed choices about their decision to seek or deny treatment (Beahrs & Gutheil, 2001).

Licensed and practicing psychologists who do not abide by the Ethics Code (APA, 2002) are susceptible to allegations of malpractice. When an allegation is made that a practitioner has committed malpractice, the legal system will typically judge the professional’s behavior by comparing the accused person’s actions according to the “standard of care” that a reasonable individual of the same profession would utilize in a similar situation (Brooks/Cole, 2004, p.12). That is, psychologists are expected to “possess and exercise the knowledge, skill and judgment common to other members of their profession” (APA, 2002, p. 181). There are six conditions required for an allegation of malpractice. These are that an individual has: (a) used methods that are not considered acceptable in the profession, (b) used a procedure that he/she was not properly trained to use, (c) not elected to use a technique that would have been more effective for
the client, (d) failed to notify others about potential threat from a hostile client, (e) failed to obtain or document having obtained informed consent, and/or (f) failed to adequately define treatment and possible consequences of treatment procedures. Thus, providing potential clients with sufficient information as part of the informed consent process is an important risk-management strategy in avoiding potential malpractice suits (Corey, Corey, & Callanan, 2003).

As noted by Barnett, Wise, Johnson-Greene and Bucky (2007), it is important for any practicing psychologist to be aware of the “Standard of Care” being employed by his or her professional peer group. With regard to the informed consent process, however, there appear to be no clear guidelines as to what constitutes an acceptable standard of care for obtaining informed consent prior to providing psychological services. This seems highly problematic, given the importance of informed consent as discussed in the clinical literature (e.g., Barnett et al., 2007). Thus, questions arise as to whether or not the majority of professional psychologists use a relatively thorough written consent form and/or provide such information verbally to clients. Additionally, it would be helpful to identify the specific content areas that psychologists typically address during the informed consent process. Another question to examine is whether those who attempt to stay updated on the professional literature (e.g., via continued perusal of professional journals) employ a more thorough informed consent process than those who do not try to stay abreast of the literature. The present study attempted to address these questions.
Description of Informed Consent

Informed consent refers to consent given by a client for services (e.g., testing/assessment, and psychotherapy) provided by a professional psychologist (Fisher & Oransky, 2008). Informed consent is best conceived as a process during which the professional shares information with a client in a manner that supports the client’s ability to make a rational choice about treatment options that are in his or her best interest (Beahrs & Gutheil, 2001). Changes in ethical thinking, as well as in ethics codes and legislation, have led to changing views of the informed consent process (Elkin, 2001). According to the American Psychological Association’s Committee on Professional Practice and Standards, the purpose of informed consent is to “gain the patient’s consent to treatment or release of records after the patient has been given necessary and appropriate information” (2003, p. 596).

Legally, informed consent is comprised of three critical key elements which are necessary to ensure that informed consent has truly occurred. These are “Capacity, Comprehension of Information, and Voluntariness” (Corey et al., 2003, p.150). Capacity refers to the notion that the client who is receiving services must have the ability to make a sound decision regarding whether or not to participate in the treatment/procedures being offered. Comprehension of information refers to the fact that the professional must provide information about the services being offered, including risks and benefits, in a manner that the client can understand. Finally, voluntariness indicates that clients have
the capacity to make a decision about participation in the services being offered, after having understood the procedures involved, and they are making a decision to enter into the process voluntarily (i.e., of their own volition), with an awareness that they can decide to revoke their consent at any time during the treatment process (Corey et. al., 2003).

A basic principle of medical ethics dictates that those receiving services for therapeutic and/or research purposes should be fully informed about the procedure or services to be utilized prior to giving their voluntary, formal, and retractable consent to participate (Kottow, 2004). The obligation of the service provider is to present information that encourages clients to request more information if they have questions, based upon the provider’s ethical obligation to supply detailed information pertinent to the services being provided (Itlis, 2004). Informed consent ideally denotes a mutual understanding between the client and the service provider about the services provided, including procedures, privacy issues, and each party’s responsibility in the therapeutic process (Talbert & Pipes, 1988).

The Importance of Obtaining Informed Consent

Numerous authors and professional organizations have underscored the importance of obtaining clients’ informed consent prior to the provision of professional services. Daugherty (1999) emphasized the responsibility that practitioners have to actively work toward ensuring clients’ full understanding, so that clients can truly make an autonomous, voluntary decision to participate. Doyle (2001) observed that there is a professional and legal consensus that it is a clinical duty to obtain informed consent from
clients before treating them; however, the fulfillment of this duty could be hindered by
the fact that many clinicians are poor communicators. Doyle maintained that the client’s
potential for better understanding could be realized if clinicians received better training in
communication skills in relation to social and economic inequalities that clients may
experience. Doyle endorsed the ethical point of view that the process of ensuring
informed consent requires that a clinician aid the participant in understanding the
information reviewed in the consent process, to enhance the client’s autonomous and
voluntary decision to participate in treatment.

The APA’s (2002) Ethics Code, General Principal A: Beneficence and
Nonmaleficence, states, “Psychologists strive to benefit those with whom they work and
take care to do no harm” (p.1062). This principle encourages practicing psychologists to
make every effort to promote the well-being and rights of those they serve, and is
supported by Corey, Corey, and Callanan’s (2003) observations that mental health
professionals are required by their ethics codes to disclose to clients the risks, benefits,
and alternatives to proposed treatments. In addition, Corey et. al. have suggested that one
of the best steps to take in avoiding treatment problems that could harm a client and/or
lead to an ethics complaint is to employ professional honesty and openness with clients,
in conjunction with additional safeguards that begin with making use of informed consent
procedures.

According to General Principal C: Integrity, of the APA’s (2002) Ethics Code,
“psychologists seek to promote accuracy, honesty, do not engage in fraud, subterfuge, or
intentional misrepresentation of fact and strive to keep their promises to avoid unwise or
unclear commitments” (p. 1067). This principal suggests that psychologists are to inform clients of the anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality as soon as it is feasible, and are to present opportunities for clients to ask informed questions and receive intelligible answers.

Likewise, according to the APA’s (2002) Ethics Code, Standard 10.01, Informed Consent Section (b), informed consent is necessary when treatment deviates from the general recognized standard, into “procedures that have not been established” or “alternative treatments that may be available” (p. 1072). In such circumstances, clients are to be informed of the “developing nature” of the treatment processes and are to be informed of the potential risks that are involved and of the voluntary nature of their participation (p. 1072).

Informed consent directly influences the patient/provider relationship and is believed to be crucial to facilitating the “three key elements of ethical behavior: autonomy, nonmaleficence, and beneficence” (National Academy of Neuropsychology [NAN], 2003, p. 335). The principle of autonomy embraces the belief that clients should have relevant and complete information so that they can make informed choices in the determination of their treatment process (Kitchener, 1984). Informed consent allows patients to consider and explore treatment options and to take responsibility for their own welfare, which is an integral component of self-determination and personal investment in the treatment process (NAN, 2003).

As noted in a position paper issued by NAN (2003), APA’s (2002) Ethical Standard 10.01, does not explicitly state whether the client’s consent must be written or
oral. APA’s Ethical Standard 3.10 (d) does state that “Psychologists are to appropriately document written or oral consent, permission and assent” (p. 338). While obtaining written informed consent is not mandatory, failing to obtain informed consent or failing to document the fact that informed consent has occurred can lead to the view that the psychologist has been negligent. According to Corey et al. (2003), failing to implement APA’s Standard 3.10 (d), with written documentation can result in difficulty in “ascertaining whether counselors communicated clearly and effectively to clients about the therapeutic process and whether clients understood the information” (p. 183).

In summary, numerous authors, as well as major professional organizations (e.g., the APA and NAN), have emphasized the many reasons why it is critical to obtain clients’ informed consent prior to the provision of psychological services. Obtaining clients’ informed consent not only serves to protect clients, but can also be one of the most important steps practicing psychologists can take to avoid having an ethics complaint or malpractice suit filed against them. Given the importance of informed consent, it is not surprising that several authors have provided recommendations on how to approach the informed consent process. The following section discusses some of the literature in this area.

**Recommendations for Obtaining Informed Consent**

In 1988, Handelsman and Galvin cautioned practicing psychologists, “If psychologists do not take the lead in developing adequate, inclusive informed consent procedures, court and legislatures will do so for us” (p. 224). Thus, in an effort to facilitate the ethical goal of obtaining informed consent to treatment, they proposed that
psychologists provide clients with a list of questions that could be asked about the therapy process. Thus, rather than limiting the informed consent procedure to merely asking the client to sign an informed consent document, these authors urged practitioners to encourage clients to actively ask questions about the services they were about to receive. The proposed informed consent procedure consisted of providing clients with a list of questions they were entitled to ask the professional. Handelsman and Galvin’s written informed consent format centered on questions relating to the topics of: Therapy, Alternatives to therapy, Appointments, Confidentiality, Money, and General information.

Handelsman and Galvin’s (1988) approach was intended to be an inclusive model that required conversation and encouraged “a complete and effective informed consent process” (p. 224). The authors also hoped that use of this format would contribute to “increasing a professional’s self-scrutiny, respecting the autonomy of clients, and allowing clients to enhance their welfare by becoming partners with the therapist in their mental health care” and that it would “require a conversation between the therapist and the client to take place” (p. 223-224).

Noting the many changes in professional practice (e.g., the advent of managed care, increasing awareness of empirically supported treatments) that had taken place since Handelsman and Galvin (1988) published their original suggested procedure for ensuring informed consent, Pomerantz and Handelsman (2004) later recommended specific additions to Handelsman and Galvin’s procedure. Pomerantz and Handelsman suggested that the newly modified format should not be used as a “cookbook” approach, but rather should be used to meet the needs of individual clients in providing the opportunity to be
fully informed about the therapy process. Their goal in providing the updated format was to help clinicians to “facilitate the open and honest discussion about important issues in psychotherapy, including common contemporary issues like third-party payment, manualization, and psychopharmacology, which reasonable people seeking contemporary psychotherapy would find relevant” (p. 203).

Pomerantz and Handelsman (2004) designed their informed consent procedure to encourage further open discussion of informed consent processes, which, in turn, cultivates autonomy and empowerment through ensuring clients to seek relevant information, rather than creating an atmosphere of distrust or ambiguity about the treatment process. The updated written question format included questions pertaining to (a) therapy, (b) alternatives to therapy, (c) confidentiality and its limitations, (d) fee arrangements, (e) insurance/managed care issues, and (f) general information in reference to the training, experience, and licensure of the psychologist. The authors’ intent in developing the revised consent form was to provide potential clients with a comprehensive list of questions that would facilitate the discussion and understanding of important therapy issues that every client has a right to know.

Empirical data supports the positive impact of utilizing Pomerantz and Handelsman's (2004) written informed consent documents, especially when they are “presented in a personalized way” (p. 203). This further supports Pomerantz and Handelsman’s suggestion that the informed consent document’s purpose is to provide information while encouraging discussion or conversation about issues listed in the
informed consent document. Such discussion, in turn, might “enable the growth of a strong therapeutic relationship between the therapist and the client” (Pomerantz & Handelsman, 2004, p. 203).

In addition to the specific procedures recommended by Handelsman and colleagues (Handelsman & Galvin, 1988; Pomerantz & Hansdelsman, 2004), more general recommendations have been offered regarding how to best approach the informed consent process. For instance, Beahrs and Gutheil (2001) have pointed out that informed consent is best conceived of as a clinician’s process of sharing information in a manner that supports the client in making a rational choice about treatment options that are in his/her best interest. These authors also noted that the practicing professional can best support the client’s ability to make informed choices by considering the developmental, educational and cultural diversity of the client, and the potential bearing these factors could have on making a sound decision about treatment participation. In conjunction with considering the effects of diversity upon the informed consent process, it is suggested that the informed consent process should be thought of as an ongoing and ever evolving component of the counseling process itself, as opposed to a single “one time document signing” (Barnet, Wise, Johnson, Greene, & Bucky, 2007, p. 184).

Haslam and Harris (2004) have noted that the use of informed consent documents is central to facilitating a client’s ability to make an informed choice, and have noted that informed consent documents “facilitate greater patient involvement” (p. 359). These authors also noted, however, that “there does not appear to be a consensus as to what
constitutes an adequate informed consent and how it should be applied in a clinical practice” (p. 360). In particular, they observed that, despite the ethical and legal importance of informed consent documents, there continues to be a limited amount of empirical research on what an informed consent document should contain. The following section will discuss the research that has been conducted on the use of informed consent procedures.

**Research on Informed Consent Procedures**

Despite the uncontested importance of the informed consent process, the available research does not provide clear evidence as to which type of informed consent process is predominantly used by professionals, nor does it tell us how often practitioners actually discuss various aspects of the informed consent process with clients. The extant research also does not indicate whether more experienced psychologists, as well as those who attempt to stay updated on the current standards of practice by reading relevant journals, tend to be more thorough in their approach to the informed consent process as compared to those who are less experienced and/or who do not remain updated on the current professional literature.

In 1986, Handelsman and colleagues conducted a survey in which 196 licensed members of a state psychological association were asked to disclose whether they used a written informed consent statement or contracts in their practice. Participants were also asked to submit any consent forms that they used in practice. Of the 104 respondents, only 30 reported using written forms, and only 19 returned copies of the forms that they used. One respondent indicated that he went over his policy statement verbally, item by
item, at the conclusion of his first session with a client. Of the 18 who commented that they did not use forms, 12 expressed a preference for oral procedures. Five indicated that the form “got in the way” (p. 7025) of the therapeutic process and 3 viewed the use of a form as counter-therapeutic. One respondent observed, “Verbal contracts are preferable because they require the client to take complete responsibility for remembering the terms of the contract” (p. 7025). Nine respondents expressed consideration of making a change in their policy by employing a formal contract or consent form, or becoming more organized to facilitate the creation of an appropriate form. Of the 19 consent forms that participants submitted, 17 addressed the matter of method of payment and 16 addressed policies about fees for missed sessions. Confidentiality was addressed in 12 forms, while 6 mentioned the nature of the treatment and 5 indicated the purpose of treatment. Three of the forms were too short for evaluation of readability; however, the 16 remaining forms were written at the 12.5 grade level. Handelsman et al. (1986) concluded that the respondents appeared to be attempting to “avoid malpractice suits with written forms” (p. 7026), but were lacking in terms of satisfying the ethical requirements of the informed consent process. Furthermore, they advised that “Therapists need to evaluate their practices regarding informed consent in terms of ethical principles such as autonomy, the ability of their clients to understand the forms used, and the range of information that the clients need to know in order to be properly informed” (p. 7027).

According to Jensen, McNamara, and Gustafson (1991) the use of informed consent procedures are mandated as an “ethical responsibility for psychotherapists” (p. 161); however, the content that should be addressed as part of the informed consent
process remains ambiguous. The Ethics Code (APA, 2002) specifically states that clients must be informed about the limits of confidentiality, and are to be given full disclosure about the purpose of evaluations, treatment and educational or training procedures that may be implemented by the therapist. Jensen et al. (1991) noted that the informed consent process should give rise to discussion of therapeutic risks and benefits with the client, while imparting clinicians with the liberty to make a decision about which information to include in the informed consent discussion.

Handelsman and Martin (1992) noted that written informed consent documents might not always serve to protect therapists and that use of such forms could even discourage conversations between therapists and clients. However, they also noted that use of a written informed consent document, in some cases, might lead to attitudes of greater likeability and higher levels of trust in the therapist by the client, which, in turn, could lead to an increased willingness to engage in therapy. In 1990, Handelsman conducted research that supported the notion that there could be “positive effects” (p. 500) associated with the use of informed consent documents. In Handelsman’s research, 24 men and 105 women were presented with three different written consent forms: (a) Handelsman and Galvin’s original 1988 informed consent question form, (b) a form designed to comply with Colorado State Law or (c) a generalized informational brochure about psychologists. The participants then read transcripts of hypothetical psychologists who used alternate forms. Handelsman observed that in “no case” (p. 500), did the actual presence of an informed consent form lead to less favorable ratings of therapists.
In an effort to more effectively understand how practitioners view the informed consent process, Somberg, Stone, and Claiborn (1993) surveyed the beliefs and practices of 324 randomly selected doctoral-level APA members who were involved in health and mental health practices. Somberg and colleagues focused on the content areas of informed consent, methods used to obtain consent, timing of the consent process, and therapists’ reported beliefs in the importance of addressing five specific issues: “a) limits of confidentiality, b) alternatives to therapy, c) potential risks of therapy, d) expected length of therapy, and e) possible procedures to be used in therapy” (p. 154). Participants were asked to provide the following demographic information: gender, psychological specialty, theoretical orientation, age, and years in practice since having received a doctoral degree.

Somberg and colleagues (1993) reported finding a great deal of variability in the percentage of practitioners who provided clients with information regarding the five consent issues addressed by the study. Providing information about the limits of confidentiality was considered very important to the majority of participants, as was the general practice of addressing informed consent during the initial session with clients. There was a varying degree of importance attached to providing information regarding alternatives to therapy, the potential risks of therapy, expected length of therapy and possible procedures to be used in therapy. Participants also indicated a strong preference for verbal consent discussions, followed by a preference for verbal discussion and use of a written form. Verbal discussion was believed to be beneficial to “assessing a client’s comprehension, addressing questions and concerns, and collaborative decision making”
Informed Consent (p. 158). The authors noted that, unexpectedly, documentation requirements and liability concerns did not appear to lead to a greater utilization of written methods or combined written and verbal consent methods.

The premise that the clear understanding of information leads to a more positive perception of the counseling professional has been supported by the results of an empirical investigation on the practical benefits of providing informed consent (Sullivan, Martin, & Handelsman, 1993). That is, Sullivan and colleagues found that higher ratings of expertness and trustworthiness were given to professional therapists who used informed consent documents (ICDs) and to those who employed informed consent procedures, as opposed to those who did not. Participants in their study read transcripts that described two hypothetical therapists. The first hypothetical therapist set time aside at the end of the first session to discuss the process of therapy and to discuss the written consent form that the patient had received. The second hypothetical therapist did not discuss informed consent with the client. The therapist who had presented the client with a written ICD, and who then discussed it, was rated as more “expert” and “trustworthy” than the therapist who did not discuss informed consent.

As noted previously, Handelsman’s (1990) research, which assessed the impact of written informed consent forms on potential clients’ first impressions of therapists, generally indicated that the use of such forms could have a beneficial impact on the rapport between therapists and their clients. Additional research by Handelsman and Martin (1992) has further confirmed the positive impact of using written informed consent forms, and revealed that, in some cases, the use of such forms led to higher
ratings of “trustworthiness, likeability, experience, and willingness to go to the therapist” (p. 500). Handelsman and Martin also noted that none of the hypothetical therapists in their research received less favorable ratings from participants because of the presentation of a written ICD.

Although several authors have discussed what should be included in informed consent documents (e.g., Pomerantz & Handelsman, 2004, Barnett, et. al, 2007, & Fisher & Oransky, 2008), little is known about the informed consent procedures that clinicians actually use, perhaps due to professionals’ own lack of consensus on this very issue (Haslam & Harris, 2004). Therapists vary in reference to what they believe might be in the best interest of the client (Croarkin, Berg & Spira, 2003), their preferred mode of therapy, what they perceive to be the risks of the chosen therapy, and their discussion of informed consent in relation to the chosen treatment strategy (Jensen, et al, 1991). This variability has likely contributed to the present lack of clear guidelines as to how to most effectively carry out the informed consent process.

According to Haslam and Harris (2004), a great deal has been written about informed consent in general; however, there is a much smaller body of literature published in regard to empirical research on informed consent procedures used by psychologists. In particular, there is scant information available regarding the general areas of content covered, practices employed, and clients’ comprehension of the information addressed via informed consent procedures. To the best of this author’s knowledge, no empirical research has investigated the informed consent procedures that professional psychologists use since the latest version of the APA’s (2002) Ethics Code
Informed Consent appeared. Further, the majority of the existing research on informed consent is specifically directed toward examining consumer comprehension and finding ways to enhance client involvement in the informed consent process. In contrast, little is known regarding the procedures most psychologists use in attempting to obtain informed consent and whether the use of particular informed consent procedures varies as a function of the practitioner’s experience and/or tendency to remain updated on the clinical literature. Such information could potentially be useful in attempting to establish a reasonable standard of care regarding how most professionals carry out this important component of professional practice.

Rationale for Examining Clinicians’ Current Informed Consent Procedures

In summary, the existing literature suggests that the informed consent process is central to facilitating a client’s ability to make informed choices about the therapy process, and is a key element of practicing ethically as well as an important risk-management strategy. Despite the widely acknowledged ethical and legal importance of the informed consent process, there continues to be a limited amount of empirical research on how professional psychologists typically manage the informed consent process (Haslam & Harris, 2004). The present study attempted to determine the content areas that are most often addressed as part of the initial informed consent procedure and the process, (i.e., written, verbal, or a combination of the two) professionals most often use to ensure informed consent. The study also examined whether practicing psychologists with more experience as well as those who attempt to stay updated on the professional literature (e.g., via continued perusal of professional
journals) employ a more thorough informed consent process as compared to their less experienced counterparts and/or those who do not attempt to keep themselves updated on the professional literature.
CHAPTER 3
METHODOLOGY

Participants

The study sample consisted of 41 psychologists (25 women, 16 men) with a mean age of 49.5 years (range: 28 – 73 years), who were members of the Missouri Division of Professional Registration, and who returned a Psychologists’ Practices in Obtaining Informed Consent (PPOIC) self-report survey. The PPOIC recipients were advised that they had received the request to participate in the study on the sole basis of being registered as licensed practicing psychologists in the State of Missouri.

The survey was sent to of 150 randomly chosen individuals meeting the eligibility criteria, and of these, 41 individuals (28.2%) responded to the invitation to participate in the study. One additional survey was returned incomplete as the respondent was no longer in practice, and four surveys were returned with incorrect addresses.

Materials

The PPOIC self-report survey was developed specifically for the purpose of this study (See Appendix A) and was forwarded to each participant with a cover letter, explaining the research (See Appendix B). A self-addressed envelope with first class postage attached was included in the mailing for the return of the survey. The purpose of the PPOIC was to collect data to determine how much informed consent information is provided to clients/patients entering into a therapy situation, whether the informed consent is written (WIC) or verbal (VIC), and who in the therapeutic process is providing the information to the client/patient. The PPOIC survey instrument requested that each participant check a “yes/no” response in reference to 9 questions about the
Psychologist’s use of informed consent process in his/her practice. Each question was followed by additional space for a “comments” response. The single variable responses of “yes/no” were specifically chosen with the awareness that counseling professionals are required to provide their patients with informed consent of a written or verbal form. The “yes/no” questions included query of whether a member of the professional’s staff reviewed the informed consent information with the client/patient, whether the counseling professional personally discussed informed consent with the client/patient, whether there was discussion of the advantages/limitations of the professional’s credentials, the influence of the client/patients’ insurance, the amount of information given to the insurance provider, and if the professional uses a therapy manual with predetermined steps. The survey instrument included a request that the responder provide additional demographic information in reference to gender, age, years in practice, how many journal articles he/she reads regularly, and concluded with a request that the responder list, by name, the journal(s) or articles that were read on a regular basis.

Procedures

After 150 recipients were randomly chosen from the Missouri Division of Professional Registration, mailings were distributed. All recipients received a mailing which included a cover letter introducing the research with the PPOIC survey, which indicated that the completion and return of the survey was considered the professionals’ consent to be part of the study. Anonymity was provided to participants as they were not asked to give their name on the returned survey. Participants were asked to return the
completed survey in the self-addressed, stamped envelope provided in the mailing. An offer was made in the cover letter to send a brief summary of the research results, if the respondent made the decision to waive his/her anonymity by emailing the researcher with “Informed Consent Research” in the subject line (Dillman, 2002).
CHAPTER 4
RESULTS

Analysis

The obtained survey responses ($N = 41$) were collected independently of each other and were compiled from the Psychologists’ Practices in Obtaining Informed Consent (PPOIC) surveys that were returned. The “yes/no” responses to the 9 PPOIC questions were coded as nominal variables using 1 for “yes,” and 2 for “no.” The PPOIC requested a “yes/no” response to questions relating to whether the following occurred: was written informed consent used in the practice, was verbal informed consent used in practice, was the informed consent information reviewed verbally by the psychologist, did a member of the psychologist’s staff review the informed consent information with the client/patient, was there was discussion of the advantages/limitations of the psychologist’s credentials, was there discussion about the influence of client/patients’ insurance, was the amount of information given to the insurance provider discussed, and did the psychologist discuss a therapy manual or predetermined steps if used in the practice. Question #4, asking whether another member of the staff reviewed the informed consent, was not included in the total PPOIC response. The responses to the eight remaining questions were summed to create the PPOIC total response. The PPOIC scores ranged from 8 to 16, with 8 indicating the most thorough use of informed consent by the psychologist, and 16 being the least amount of informed consent being offered in the treatment process. Of the survey participants ($N = 41$), 12.1% ($n = 5$) scored an 8, indicating they were thorough in informed consent practices by using WIC and VIC in conjunction with personally reviewing the informed consent information with the
Informed Consent

client/patients. Additionally, of the 12.1% who were thorough, none had another staff member (as reflected in Question #4) review the informed consent information in their practice.

*Hypothesis #1: The majority of practicing psychologists use a written informed consent (WIC) form.*

Of the survey participants (*N* = 41) 92.7% (*n* = 38) reported using WIC in their practice, as opposed to 7.3% (*n* = 3) who did not. These findings support hypothesis #1.

*Hypothesis #2: The majority of psychologists who use a written informed consent do not discuss the form with the client.*

Of the survey participants (*N* = 41) who reported using a WIC, 82.9% (*n* = 32) reported discussing the form, as opposed to 15.8% (*n* = 6), who did not. These findings do not support hypothesis #2, as the majority of practicing psychologists who reported using a WIC form did discuss informed consent verbally in their practice.

*Hypothesis #3: The majority of psychologists who read professional journal articles more than once per month will use a written form of consent with discussion of the form.* The chi-square test of independence was performed to determine whether the majority of psychologists who read professional journal articles more than once per month would use WIC in conjunction with verbal discussion of informed consent. The test failed to indicate a significant relationship of the variables of written and verbal informed consent and having read more than one professional journal article per month, $\chi^2 (1, N = 41) = .092, p = .762$. Therefore, the hypothesis was not supported.
Table 1 shows the frequencies of the use of written and verbal consent for participants’ use of informed consent when more than one journal article is read per month.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Less than One Article Read per Month</th>
<th>More than One Article Read per Month</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both Written &amp; Verbal Informed Consent Used</td>
<td>Count 9</td>
<td>23</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Expected 9.4</td>
<td>22.6</td>
<td>32.0</td>
</tr>
<tr>
<td>Both Written &amp; Verbal Informed Consent Not Used</td>
<td>Count 3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Expected 2.6</td>
<td>6.4</td>
<td>9.0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>41</td>
</tr>
</tbody>
</table>

Based on the fact that one cell in the chi-square had an expected frequency of less than 5, this assumption was violated. Therefore, the results of the chi-square test may not be valid.

*Hypothesis #4: The majority of psychologists read 4 or more journal articles per month.* Of the survey participants ($N = 41$), 36.5% ($n = 15$) reported reading 4 or more journal articles per month as opposed to 63.4% ($n = 26$) who did not. These findings do not support hypothesis #4, as the majority of practicing psychologists do not read 4 or more journal articles per month.
Hypothesis #5: The majority of psychologists who do read 4 journal articles or more per month will use a more thorough informed consent process, i.e.: written and verbal informed consent. The chi-square test of independence was performed to determine whether the majority of psychologists who read professional journal articles 4 or more times per month would use a WIC in conjunction with verbal discussion of informed consent. The results of the test were not significant as the variables of written and verbal informed consent in conjunction with having read 4 or more professional journal articles per month were not significantly related, $\chi^2 (1, N = 41) = 1.025, p = .311$. Therefore the hypothesis was not supported. In total, $(n = 23)$ 56.1% of psychologists who read four or more journal articles per month, reported using both written and verbal informed consent. Table 2 shows the frequencies of the use of written and verbal consent for participants’ use of informed consent when four or more journal articles were read per month.
Table 2

*Frequencies of Use of Written and Verbal Informed Consent When Four or More Articles Are Read per Month.*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Less than Four Articles Read per Month</th>
<th>Four or More Articles Read per Month</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both Written &amp; Verbal Informed Consent Used</td>
<td>Count: 19</td>
<td>13</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Expected: 20.3</td>
<td>11.7</td>
<td>32.0</td>
</tr>
<tr>
<td>Both Written &amp; Verbal Informed Consent Not Used</td>
<td>Count: 7</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Expected: 5.7</td>
<td>3.3</td>
<td>9.0</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>15</td>
<td>41</td>
</tr>
</tbody>
</table>

Based on the fact that one cell in the chi-square had an expected frequency of less than 5, this assumption was violated. Therefore, the results of the chi-square test may not be valid.
CHAPTER 5
DISCUSSION

This study examined psychologists’ use or nonuse of WIC and VIC consent procedures. The results supported the hypothesis that the majority (92.7%) of practicing psychologists use a WIC form. However, they did not support the hypothesis that the majority of practicing psychologists who use a WIC do not discuss the WIC form with their clients/patients prior to beginning the therapeutic process, as 82.9% of psychologists reported discussing the WIC form. The hypothesis that the majority of psychologists who read professional journal articles more than once per month would use a WIC with discussion of the form was not supported, as no significant relationship was found between the variables of WIC and VIC in conjunction with having read more than one professional article per month. Nor was the hypothesis supported that the majority of psychologists who read four or more journal articles per month would use a WIC with discussion of the form, as no significant relationship was found between the variables of WIC and VIC in conjunction with having read more than four journal articles per month. Finally, the hypothesis that the majority of psychologists read four or more journal articles per month was not supported as only 36.5% of study participants reported reading four or more articles per month. A larger percentage of psychologists who read professional journal articles more than once per month (82.9%) used WIC and VIC in their practice, as compared to the number of psychologists who read four or more journals or journal articles per month (36.5%), indicating that the thoroughness of informed consent procedures did not appear to be connected to the number of journal or journal articles read per month.
Most participants read less than four articles per month, and participants predominantly read journals that appeared to be specific to their field of practice. This finding is disconcerting, given the importance of maintaining one’s competence through staying abreast of the professional literature (Barnett et al., 2007). Journals listed once, denoting an individual interest, included: *Family Therapy, Play Therapy, Clinical Sleep, Applied Behavioral Analysis, Analysis, Psychotherapy Networker,* and the *Family Therapy* online network. While these journals likely offer more support in remaining current in the psychologist’s field of specialization they likely offer little information in regard to the importance of informed consent procedures. Other journals listed by more than one participant and more often by those who read more than four journal articles per month were: *Journal of Professional Psychology Research and Practice* (4 readers), *Journal of Clinical Child and Adolescent Psychology* (2 readers), *Journal of Counseling and Clinical Psychology* (7 readers), *Psychological Assessment* (4 readers) and the *APA Monitor* (5 readers).

Based upon the standard of care being the major determining factor for establishing negligence in a court of law and according to the Ethics Code (APA, 2002) licensed and practicing psychologists who do not abide by the Ethics Code might leave themselves open to allegations of malpractice. This can occur particularly if the professional’s use of informed consent does not “…seek to promote accuracy, avoid intentional misrepresentation of fact and inform their client/patients without engaging in fraud or subterfuge” (APA, p. 1062). On this basis, these study findings suggest that licensed
psychologists, in the majority are, in fact, providing WIC in conjunction with verbal discussion about the form, prior to beginning the therapeutic process, which cultivates autonomy and empowerment through ensuring that clients receive relevant information prior to entering a treatment process. (Pomerantz & Handelsman, 2004). Additionally, this study suggests that among those who chose to respond to the invitation to participate in this study, the majority of psychologists do carry out informed consent procedures in both the written and verbal forms, and 90% of psychologists are personally reviewing the informed consent information with their clients.

Limitations

One of the most significant limitations to this study is the limited response by the targeted sample of 150 randomly chosen psychologists who were registered in the State of Missouri (four were returned with incorrect addresses and one respondent advised that he was retired). The 41 survey participants represent a response rate of 28.2%, which is an indication that the results should be interpreted with caution. Additionally, the self-report nature of this study may have contributed to possible self-selection and/or reporting bias which likely would reflect a desire to respond in a socially desirable manner. The self-report method may also have contributed to a limited return survey response by individuals who did not wish to disclose a limited use of WIC and VIC in their practice. In particular, 38 of 41 participants responded by indicating that they used WIC in practice, and only 3 of the participants indicated that they did not. The overwhelming majority of affirmative responses could be an indication that the
individuals who do not use WIC chose not respond to the study request as they might have been uncomfortable disclosing a lack of use of WIC in their practice.

The PPOIC could have been improved by limiting the number of journal articles read per month to a single number range or providing a check list of numbers to choose from, as 14 survey participants (34%) reported a range of numbers (i.e., 25-30, 10-20, 6-10) which required averaging the difference between the first and second reported range numbers, which may have convoluted the results. Additionally, had the response sample been larger, the use of chi-square tests of independence, as in regard to hypothesis 3 and 5, may have been more productive as the small sample resulted in expected cell frequencies of less than 5, which violated the test’s assumptions and, in turn, could have invalidated the results. A larger sample would be useful in preventing this type of assumption violation.

Further Investigation

Further investigation on the use of informed consent should include a larger sample of the registered psychologists in the State of Missouri, possibly through a computer survey if a database were available to reach the specific population of practicing psychologists. Additionally, further research that incorporated psychologists who practice in other states would allow exploration in regard to how psychologists differ from state to state in delivery of written and verbal consent. Further investigation of informed consent using Pomerantz and Handelsman’s (2004) updated written question format, to inquire whether psychologists are addressing (a) therapy, (b) alternatives to
therapy, (c) confidentiality and its limitations, (d) fee arrangements, (e) insurance/managed care issues, and (f) general information in reference to the training and experience and licensure of the psychologist, would be of benefit to this topic of inquiry.

Based on the fact that empirical data support the positive impact of utilizing Pomerantz and Handelsman’s (2004) written informed consent documents, and the personal way that they have suggested the informed consent information be presented, future research in which clients/patients are asked about the extent to which their psychologist had actually carried out the informed consent obligation would be of benefit, in balancing the current information available to researchers. That is, the current research is based upon the self-report of psychologists who could likely be responding in a socially desirable manner in regard to how thorough they are in the informed consent process.

Closing Statement

Informed consent refers to consent given by a client for services provided by professional psychologists (Fisher & Oransky, 2008). Informed consent is of vital interest to consumers, practitioners, the APA, and to legislators who are seeking to ensure the therapeutic process employed by psychologists and other counseling professionals supports the autonomy of clients/patients and ensures that the professional has “gained the patient’s consent to treatment or release of records after the patient has been given necessary and appropriate information” (APA, 2002, p. 596). Despite the widely
Informed Consent

acknowledged ethical and legal importance of the informed consent process, there continues to be a limited amount of empirical research on how professional psychologists typically manage the informed consent process (Haslam & Harris, 2004). Although limited in its function, this study did offer positive indications that psychologists are working toward a more thorough informed consent process, encouraging client autonomy by employing both a written and verbal informed consent in their practice.
REFERENCES


DATE:

RE:  Voluntary Informed Consent

FROM:  V. Lynn Bristow, Graduate Student
        Psychology Department
        University of Central Missouri (UCM) \ UCM

As a graduate student who is conducting a study of psychologists’ practices in obtaining informed consent, I value your professional opinion. This study of informed-consent procedures used by practicing professionals can only be completed with the assistance of individuals within your field of expertise.

You received this mailing and were chosen for the purpose of this study on the basis of your listing on the Professional Registration as a practicing Psychologist in the State of Missouri. Your completion and return of the survey will be considered your consent to be a part of this study, and you will not be asked to give your name on the survey questionnaire.

If you would like a report of the findings of this research, please email your request to vlb40150@ucmo.edu, with Informed Consent Research as the subject line. Your email address will not be disseminated, and will be immediately erased after the study results are emailed to you.
Thank you for your valued participation in this study.

APPENDIX B

PSYCHOLOGISTS’ PRACTICES IN OBTAINING INFORMED CONSENT – PPOIC

<table>
<thead>
<tr>
<th>PLEASE CIRCLE THE MOST ACCURATE RESPONSE</th>
<th>YES</th>
<th>NO</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you use a written informed consent form in your practice?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Do you review informed consent verbally in your practice?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Do you personally review informed consent information with the clients / patients?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Does another staff member review the informed consent information with the clients / patients in your practice?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Do you discuss the advantages / limitations of your credentials with your clients / patients?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Do you discuss confidentiality with your clients / patients?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Do you discuss how the clients’ / patients’ insurance might influence therapy? (length, goals, etc.)?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Do you discuss with your clients / patients, what kind of information you will be required to give to their insurance company?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Do you discuss with your clients / patients, whether or not you follow a therapy manual with predetermined steps?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Please indicate your gender</td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>Please indicate the approximate number of journal articles you read per month.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please indicate the number of years you’ve been in practice.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please indicate your age in years.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please list the journals or journal articles that you read on a regular basis.