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Professional Attitudes Toward Informed Consent in Psychotherapy: Findings from Switzerland

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Abstract

Ethical and legal frameworks in psychology emphasize that obtaining informed consent from patients is a fundamental condition for initiating psychotherapy. While this requirement is well established, little is known about psychotherapists' actual views on informed consent and the ways it is applied in clinical practice. An online survey was completed by 155 psychotherapists practicing in Switzerland to explore their perspectives on informed consent. The majority of respondents agreed on key elements that should be communicated to patients. Nearly all emphasized the importance of explaining confidentiality and its limits (95%) as well as supporting patients' autonomous decision-making (97%). More than 80% considered information about treatment fees and empirical evidence of effectiveness as essential. About 60% valued the disclosure of therapists' personal information. In addition, broader objectives linked to therapy were rated highly, such as fostering patient autonomy (97%), clarifying treatment goals (93%), and encouraging hope (80%). Most practitioners viewed informed consent not as a single event at the outset of therapy, but as a continuous process. Factors such as age, type of postgraduate training, therapeutic setting, and patient population influenced their attitudes. Findings suggest that psychotherapists see informed consent as both a demanding and beneficial aspect of their work. Continued research is needed to refine its clinical and ethical implementation.

Keywords: Informed consent, Psychotherapy, Autonomy, Paternalism, Ethics, Expectations

Background

Informed consent (IC) is both a legal requirement and an ethical duty, making it a central element of psychotherapy [1–5]. Despite its recognized importance, limited empirical research exists on how IC is applied and understood in clinical practice. Evidence to date indicates that psychotherapists interpret both the meaning and implementation of IC in diverse ways [1, 6]. Exploratory work with therapists in training has also revealed uncertainty, with some trainees admitting to not carrying out IC at all or expressing confusion about who bears responsibility for it [7].

Professional ethical codes in psychology generally highlight patient autonomy as the primary principle guiding IC [e.g., 8, 9]. Therapists are expected to provide clear and transparent information without waiting for patients to ask, rejecting paternalistic views that justify withholding details. For example, the American Psychological Association (APA) instructs its members to inform patients as early as possible about the nature and likely course of therapy, applicable fees, third-party involvement, and the limits of confidentiality, while also allowing space for questions and discussion (10.01) [8]. Nevertheless, past research has shown inconsistency in practice: confidentiality was addressed by most therapists, but issues such as treatment alternatives and potential risks were mentioned far less often [6, 10]. Explanations given for omitting information included beliefs that it was irrelevant, insufficient knowledge to

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discuss it adequately, inability to describe methods used, assumptions that patients were already informed, or concerns that disclosure might harm the therapeutic relationship [10].

The APA [8] also notes that IC should occur "as early as is feasible," which acknowledges that in psychotherapy it is often unrealistic to provide all relevant details during the first session [11]. This has led to the suggestion that IC should be seen as an evolving process rather than a one-time event, extending throughout the course of therapy [12–14]. Poppe described this as a "procedural approach," in which elements of therapy are disclosed gradually as treatment progresses [14]. Critics, however, argue that postponing key information is problematic: patients, who invest time, money, and assume potential risks, deserve access to critical facts before beginning treatment, not only once therapy is underway [15].

Differences in theoretical orientation further complicate the implementation of IC. Each therapeutic school offers distinct perspectives and rationales, shaping what information is prioritized. Somberg and colleagues [10] reported that cognitive-behavioral therapists were more likely than psychoanalytic or eclectic therapists to stress treatment duration and alternatives. Similarly, Croarkin *et al.* found that interpersonal therapists evaluated IC more favorably overall than psychoanalysts [16]. By contrast, Dsubanko-Obermayr and Baumann [6] observed no significant differences between cognitive-behavioral and psychodynamic therapists regarding the amount of information shared, though they did find variation in emphasis: CBT therapists highlighted treatment methods and goals, while psychodynamic therapists placed more weight on financial transparency. These findings point to diverse attitudes among psychotherapists, reflected in inconsistent IC practices. Failure to adequately discuss certain information, however, may undermine patients' ability to make autonomous, well-informed decisions about their care.

Accordingly, the present study set out to examine psychotherapists' perspectives on IC. The guiding research question was: *What attitudes do psychotherapists hold toward informed consent in psychotherapy?* This overarching question was further divided into specific sub-questions:

(a) What information do therapists consider essential for IC, and how do they rate its importance?

(b) Should certain information ever be withheld to avoid possible harm to the therapeutic process?

(c) Does IC shape patients' understanding of their disorder?

(d) Can the mechanisms of psychotherapy be explained beforehand, or can they only be understood through personal experience?

(e) Is IC perceived as a continuous process or a single event?

(f) Do therapists believe IC influences patients' initial expectations of therapy?

Methods

Design and procedure

This study employed an anonymous online survey distributed to board-certified psychotherapists and postgraduate trainees in psychotherapy across Switzerland. The questionnaire was originally developed in German, translated into French by the first author, and reviewed by two bilingual experts for accuracy and consistency. Data collection was conducted via SoSciSurvey.

Survey questionnaire

The survey was designed by the first and last author in line with the research objectives. A pilot test with 10 psychotherapists informed subsequent revisions. The final version included 20 items assessing attitudes toward informed consent (IC). For instance: *"How important do you consider it to inform patients of their right to terminate therapy as part of IC?"* Responses were recorded on a five-point Likert scale ranging from "not important at all" to "very important," with an additional "no answer" option. Data were analyzed using IBM SPSS Statistics® version 26.

Recruitment and participants

Participants were recruited via email through professional associations (Swiss Federation of Psychologists, FSP; Swiss Federation of Applied Psychology, SBAP) and postgraduate psychotherapy training institutes. Recruitment took place between September and November 2019.

To examine the potential role of context, participants reported their clinical setting (outpatient, inpatient, or day-clinic). Educational background was also assessed, distinguishing medical psychotherapists, psychological psychotherapists, and specialized psychologists.

Statistical analyses

Analyses were conducted in two steps. First, descriptive statistics were generated for the full sample. Second, subgroup comparisons were performed based on *gender, age, patient group, setting,* and *postgraduate training status*. Likert-scale data were treated as parametric. Independent-samples *t*-tests were used to compare means, with variance homogeneity tested in advance. Where variances were unequal, Welch's *t*-test was applied [17]. Effect sizes were computed using psychometrica.de.

Sample representativeness was assessed using chi-square goodness-of-fit tests, comparing demographic characteristics of the sample to population-level data on psychotherapists in Switzerland. Reference data were taken from the Swiss Federation of Psychologists (2018) and the Swiss Office for Labour and Social Policy Studies.

Results

Descriptive statistics

A total of 155 psychotherapists completed the questionnaire. The sample was broadly representative of Swiss psychotherapists in terms of *gender* ($\chi^2(1) = 1.331$, $p = 0.249$) and *setting* ($\chi^2(1) = 2.141$, $p = 0.343$). However, significant differences were observed for *patient group* and *educational background*. In particular, therapists working with children and adolescents were overrepresented ($\chi^2(1) = 19.246$, $p < 0.001$). Chi-square adjustment tests were not conducted for *age* and *postgraduate training status* due to the absence of current reference data. Detailed sociodemographic characteristics are presented in **Table 1**.

Table 1. Sociodemographics

Characteristics	N	%	M	SD	R
Gender					
Female	128	82.6			
Male	27	17.4			
Age			38.75	11.288	25–78
20–40 years	104	67.1			
41–80 years	51	32.9			
Education					
Psychological psychotherapist	136	87.7			
Medical psychotherapist	6	3.9			
Others	12	7.7			
Not answered	1	0.6			
Setting					
Outpatient	110	71			
Partially inpatient	7	4.5			
Inpatient	37	23.9			
Not answered	1	0.6			
Group of patients					
Children and adolescents	39	25.5			
Adults < 65 years	111	71.6			
Adults > 65 years	5	3.2			
Postgraduate training					
Completed	70	45.2			
In postgraduate training	85	54.8			

N total = 155

SD, standard deviation; R, range

Attitudes towards informed consent

Psychotherapists demonstrated varying attitudes regarding different components of informed consent

(**Table 2**). Nearly all participants considered *confidentiality and its exceptions* (95%) and *patients' right to self-determined decision-making* (97%) as important (rated "rather important" or "very important"). Similarly, the disclosure of *treatment fees* and the *empirical effectiveness of the therapy provided* was judged important by approximately 80–85% of respondents. In contrast, only 60% considered the disclosure of *personal information about the therapist* to be important.

Table 2. Descriptive statistics for the item: *"How important do you consider addressing the following aspects in the informed consent?*

Item	M	SD	(1) (%)	(2) (%)	(3) (%)	(4) (%)	(5) (%)
Self-determined decision making	4.77	0.477	0	0	2.58	17.42	80
Confidentiality and its exemptions	4.76	0.523	0	0	4.52	14.84	80.65
Discussion of treatment goals	4.50	0.687	0	1.94	5.16	34.19	58.71
Promotion of hope	4.48	0.733	0	1.94	8.39	29.03	60.65
Right to therapy termination	4.41	0.804	0	3.23	10.32	28.39	58.06
Promotion of positive expectations	4.14	0.801	0.65	1.29	18.06	43.23	36.77
Frequency of consultations	4.08	0.837	0	5.16	15.48	45.16	34.19
Risks	3.77	0.818	0	4.52	33.55	41.94	20
Fee	3.73	1.250	5.81	14.19	17.42	26.45	36.13
Treatment duration	3.55	0.839	0.65	9.68	34.19	44.52	10.97
Empirical effectiveness	3.36	0.904	1.94	15.48	34.84	40	7.74
Personal information about therapist	2.86	0.990	5.81	34.19	33.55	21.29	5.16

M, mean; SD, standard deviation
(1) not important at all; (2) not important; (3) neutral; (4) rather important; (5) very important

Additional aspects of informed consent

Beyond the direct components of informed consent, several overarching therapeutic goals were also rated consistently across participants. Nearly all psychotherapists emphasized the importance of *patients' self-determined decision-making* (97%). A large majority also valued the *discussion of treatment goals* (93%) and the *promotion of hope* (80%).

Significant subgroup differences emerged depending on the therapists' work setting, patient group, training status, and age. Inpatient therapists rated the *right to discontinue therapy* (d = −0.39; 95% CI [−0.77, −0.02]) and *discussion of treatment goals* (d = −0.42; 95% CI [−0.80, −0.05]) as more important compared to outpatient therapists. Psychotherapists working with children and adolescents placed greater emphasis on *confidentiality and its limits* than those treating adults (d = −0.52; 95% CI [−0.89, −0.15]).

Training level also influenced perspectives. Board-certified psychotherapists rated *discussion of fees* (d = −0.58; 95% CI [−0.90, −0.26]) and *sharing personal information about the therapist* (d = −0.34; 95% CI [−0.66, −0.02]) as more important, whereas trainees attached greater importance to *fostering positive expectations* (d = 0.33; 95% CI [0.01, 0.65]).

Age differences followed a similar pattern: older therapists gave significantly higher weight to discussing *fees* (d = 0.50; 95% CI [0.16, 0.84]) and *personal information about the therapist* (d = 0.60; 95% CI [0.25, 0.94]).

Detailed subgroup comparisons are presented in **Table 3**.

Table 3. Mean value comparisons

Item	Gender Female versus male t (df)	Setting Outpatient versus inpatient t (df)	Patient group Children and adolescents versus adults t (df)	Postgraduate training Board-certified versus in postgraduate training	Age category 20–40 years versus 41–80 years t (df)

				t (df)	
Confidentiality	— 0.18 (153)	— 0.43 (145)	3.99 (148)***	1.5 (153)	— 0.06 (153)
Right to therapy termination	1.36 (153)	2.58 (102)**	1.7 (89)	— 0.39 (153)	— 1.06 (153)
Empirical effectiveness	— 0.53 (153)	— 0.65 (145)	— 0.37 (148)	— 0.59 (153)	— 0.3 (153)
Risks	— 0.29 (153)	1.59 (88)	— 1.02 (148)	— 0.23 (127)	— 0.87 (81)
Personal information	— 0.4 (153)	— 1.83 (145)	— 0.38 (148)	2.14 (153)**	— 3.24 (86)***
Frequency of meetings	1.55 (33)	0.69 (145)	0.37 (148)	— 0.75 (153)	0.88 (153)
Treatment duration	— 0.51 (153)	1.34 (145)	0.65 (148)	— 0.17 (153)	— 0.35 (153)
Fee	— 0.06 (153)	— 1.97 (48)**	1.24 (84)	3.69 (153)***	— 3.05 (112)***
Promotion of hope	0.89 (153)	0.97 (145)	— 0.44 (148)	— 1.98 (153)	1.57 (153)
Promotion of positive expectations	0.75 (153)	1.18 (145)	— 1.45 (148)	— 2.03 (153)**	1.77 (153)
Discussion of treatment goals	1.06 (153)	2.53 (78)**	— 0.8 (148)	0.06 (153)	— 0.17 (153)
Self-determined decision making	0.85 (153)	0.52 (145)	— 0.67 (148)	— 0.07 (153)	— 1.77 (123)
Promotion of positive expectation through IC	0.38 (145)	0.9 (138)	0.44 (141)	— 0.41(145)	— 0.54 (145)
To not address risks	— 1.35 (31)	— 1.63 (144)	— 1.89 (90)	1.24 (152)	— 1.17 (83)
To not address alternatives	— 0.51 (147)	— 0.44 (80)	— 0.07 (143)	1.24 (126)	— 1.2 (147)
IC and understanding of the disorder	0.18 (136)	1.27 (129)	— 0.79 (131)	— 1.04 (106)	0.71 (65)
Liberty to implement IC as I see fit	— 0.07 (150)	— 3.5 (143)***	— 1.48 (145)	2.41 (150)**	— 2.37 (150)**
In my practice, I have enough time resources to implement IC as I see fit	— 1.62 (151)	— 4.49 (51)***	0.67 (146)	3.94 (151)***	— 4.29 (134)***
The mode of action of a therapy cannot be explained in advance. It can only be experienced individually by patients during treatment	— 0.7 (151)	— 0.54 (143)	— 0.84 (147)	— 0.07 (151)	— 0.95 (151)
IC is an ongoing process during the whole course of therapy. Therefore, IC is never completely terminated	0.67 (148)	— 0.37 (140)	0.54 (143)	— 0.79 (148)	— 0.27 (75)

df, degrees of freedom; IC, informed consent
$^{**}p < 0.05$; $^{***}p < 0.01$

Process and practical implementation of informed consent

Most participants (92%) viewed informed consent (IC) as a continuous process throughout therapy rather than as a single event, and none rejected this view entirely **(Table 4)**. Subgroup analyses showed no significant differences in this regard. Similarly, the belief that IC can shape patients' expectations was widely shared: 79% agreed ("rather agree" or "fully agree"), while only 4% disagreed. Again, responses did not vary significantly across subgroups.

Regarding the disclosure of *potential risks* and *treatment alternatives*, 74% of respondents supported their inclusion in IC, with no significant differences by gender, setting, patient group, age, or training status. Opinions were more divided on whether IC helps patients understand their disorder, with 35% of respondents selecting "neutral" or providing no answer. No subgroup differences were found.

In terms of practical feasibility, 86% reported having sufficient freedom to implement IC according to their professional judgment. However, this perception varied by setting, training status, and age: outpatient therapists (d = 0.66; 95% CI [0.28, 1.04]), board-certified therapists (d = 0.38; 95% CI [0.06, 0.71]), and older practitioners (d = 0.41; 95% CI [0.07, 0.75]) felt significantly more autonomous than their respective counterparts.

When asked about *time resources*, 76% indicated they had adequate time to conduct IC properly, while 14% reported insufficient time. Here, too, significant subgroup differences were observed: outpatient therapists (d = 0.98; 95% CI [0.59, 1.37]), board-certified psychotherapists (d = −0.63; 95% CI [−0.71, −0.06]), and older therapists (d = 0.66; 95% CI [0.32, 1.01]) all reported greater time availability compared to inpatient practitioners, trainees, and younger colleagues, respectively. Detailed results are presented in **Table 4**.

Table 4. Descriptive statistics for the items: "How much do you agree with the following statements on informed consent based on your personal experience?”

Item	M	SD	(1)	(2)	(3)	(4)	(5)	(6)
Informed consent (IC) is a continuous process throughout the entire course of therapy, never fully concluded	4.41	0.636	0%	1.29%	3.87%	45.81%	45.81%	3.23%
In my practice, I have the flexibility to apply IC according to my professional judgment	4.32	0.925	1.29%	6.45%	3.87%	34.19%	52.26%	1.94%
I have sufficient time in my practice to implement IC as I deem appropriate	4.02	1.121	3.23%	10.97%	8.39%	34.19%	41.94%	1.29%
The expectations patients have about therapy outcomes are shaped by the IC process	4.01	0.767	1.29%	2.58%	11.61%	57.42%	21.94%	5.16%
Providing IC at the start of therapy impacts how patients perceive their psychological distress	3.47	0.998	4.52%	9.68%	23.87%	41.29%	9.68%	10.97%
The therapeutic process cannot be fully explained beforehand; it must be individually experienced by patients during treatment	2.93	1.145	5.81%	41.29%	14.19%	28.39%	9.03%	1.29%
I recommend against discussing risks at the outset of therapy	2.09	1.006	30.32%	43.87%	12.26%	11.61%	1.29%	0.65%
I suggest avoiding discussion of treatment alternatives I do not offer at the beginning of therapy	2.06	1.028	30.32%	44.52%	9.03%	9.68%	2.58%	3.87%

M, mean; SD, standard deviation; IC, informed consent

(1) do not agree at all; (2) rather not agree; (3) neutral; (4) rather agree; (5) fully agree; (6) no answer

55% of the participants didn’t agree at all or rather not agreed with the statement that the mode of action of psychotherapy must be individually experienced and cannot be explained in advance whereas 37% of the therapists rather or fully agreed. The responses did not differ significantly between the different subgroups **(Table 4)**.

Discussion

Focus on information: Unequal importance

Therapists rated different elements of informed consent (IC) with varying levels of importance. Confidentiality and the patient’s right to discontinue therapy were considered the most essential components, whereas information about the empirical effectiveness of treatment and personal details about the therapist were rated as less important. These results align with previous studies, such as those by Somberg *et al.* [10], Croarkin *et al.* [16], and Dsubanko-Obermayr and Baumann [6], which also found confidentiality as central and personal therapist information as less critical. However, in the present study, differences between the importance of IC elements and between individual therapists were relatively modest **(Tables 2 and 3)**.

Notably, significant differences emerged between therapist subgroups. Unlike some previous studies, we observed that setting, patient group, age, and postgraduate training status influenced reported attitudes toward IC. This may reflect an increased contemporary awareness of IC, possibly due to more robust and binding ethical guidelines.

Focus on therapists: Variation across subgroups

Therapists working with children and adolescents placed greater importance on discussing confidentiality and its exceptions, likely because of the involvement of third parties such as parents or teachers, which often necessitates clarifying confidentiality boundaries.

Older therapists (41–80 years) and those with completed postgraduate training rated discussion of fees and personal therapist information as more important than younger or in-training therapists. This may be related to differences in work settings: younger and trainee therapists often work in inpatient environments where personal therapist information may be less relevant due to shorter treatment duration and involvement of multidisciplinary teams.

Similarly, inpatient therapists placed more importance on the right to discontinue therapy and discussing treatment goals compared with outpatient colleagues. This might be explained by the typically extrinsic motivation of inpatients or the structured nature and limited duration of inpatient programs, making clarity about treatment goals and patient rights particularly critical.

Informed consent: Ongoing process vs. one-time event

A substantial majority of therapists (92%) viewed IC as a process that continues throughout therapy rather than as a single event. This perspective aligns with prior research [13]. Nonetheless, from a legal and ethical standpoint, procedural IC cannot replace formal consent at the outset of treatment [15]. Therefore, IC as an ongoing process should complement, not substitute, initial formal consent [11].

The literature emphasizes that patients should receive information about the risks, benefits, and available alternatives to recommended treatment, including the diagnosis, variable course of illness, potential for worsening without treatment, and empirical support for options [18, 5, 19]. Professional organizations such as the American Psychological Association also recommend including fees, third-party involvement, and limits of confidentiality [8]. However, the precise scope of IC at the beginning of therapy warrants further investigation.

Providing clear information about treatment goals, expectations, and options establishes a foundation of honesty and fulfills the therapist's fiduciary role [18]. Crawford *et al.* [20] highlighted the clinical importance of IC, showing that patients who could not describe their therapy or felt inadequately informed were more likely to experience negative effects (OR = 1.51 and OR = 0.65, respectively).

Beyond the initial session, IC should be revisited as therapy progresses, tailored to patient needs and treatment type. For example, manualized short-term therapies (e.g., cognitive-behavioral therapy) may require less frequent updates than long-term, open-ended psychodynamic therapies, where treatment may take unpredictable directions. Written and verbal communication throughout therapy can ensure patients understand benefits, risks, and alternatives, especially when treatment plans change due to patient condition or clinical findings [18, 2].

Liberty and time resources to implement informed consent

Over three-quarters of participants reported having sufficient autonomy and time to implement IC as they deemed appropriate, suggesting that most psychotherapists feel adequately equipped to tailor IC to individual patients. Nevertheless, differences emerged between subgroups. Outpatient therapists reported significantly greater liberty than their inpatient colleagues. This disparity may reflect structural differences: inpatient settings often involve higher time pressure, more guidelines for initial consultations, and frequent crisis situations that limit patients' decision-making capacity. Consequently, providing thorough IC in inpatient contexts can be more challenging, highlighting a need for further ethical and practical investigation into IC implementation in these settings.

Differences were also observed based on age and postgraduate training status. Therapists who had completed postgraduate training and those aged 41–80 years were more likely to report sufficient liberty and time to implement IC than younger or in-training therapists (20–40 years). This may be due to more experienced therapists having developed effective strategies for managing IC, resulting in greater confidence and efficiency in its implementation.

Limitations

As no psychometrically validated questionnaires were available for the present study, a new instrument was developed specifically for these research questions. While this allowed exploration of IC attitudes, some limitations were identified. For example, participants were asked whether IC is understood as an ongoing process or a one-time event, without the option to indicate that IC can be both: (a) a mandatory initial disclosure of diagnosis, treatment options, risks, costs, and format/duration, and (b) an ongoing discussion throughout therapy as new developments arise. Future studies could expand this framework and include questions on how psychotherapists might use IC to enhance patient expectations, minimize nocebo effects, support psychoeducation, or foster normalization and validation.

The recruitment method—emails sent via professional associations and postgraduate training institutes—did not allow determination of how many potential participants received or read the invitation, preventing calculation of a response rate. The sample was not fully representative of all Swiss psychotherapists, with an overrepresentation of child and adolescent therapists and trainees, which may bias the findings. Social desirability may have influenced responses, given the ethical significance of IC.

Conclusion

Psychotherapists in Switzerland rated patient autonomy and treatment confidentiality as the most important elements of IC, consistent with findings from the UK [7] and Austria [6]. Information about the therapist and treatment effectiveness was considered less critical. IC was also viewed as a potential tool to shape patients' treatment expectations and understanding of their illness, although the present data do not clarify exactly how psychotherapists could leverage IC to enhance expectations, reduce nocebo effects, support psychoeducation, or promote normalization and validation. This indicates a potentially underutilized opportunity to improve therapeutic outcomes, which should be explored in future research.

Challenges remain in areas such as explaining the mechanism of psychotherapy and ensuring sufficient time and resources to implement IC. Perceptions of IC varied according to treatment setting and therapists' training status. Future studies could examine these differences further, exploring how IC practices influence treatment processes, including expectation management, efficacy, and risk perception.

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