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The Privilege Study: An Empirical Examination of the Psychotherapist--Patient Privilege

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THE PRIVILEGE STUDY: AN EMPIRICAL EXAMINATION OF THE PSYCHOTHERAPIST-PATIENT PRIVILEGE

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The recognition of a privileged relationship between psychotherapist and patient that grants the patient the right to bar the introduction of some relevant evidence in judicial proceedings, is based on the assumption that without such an assurance of confidentiality there will be no effective therapy. In this Article Professors Shuman and Weiner examine this assumption and the opposing belief that granting a privilege seriously undermines the judicial process. Their research focuses on the effect of enactment of a privilege statute in Texas, as perceived by therapists, patients, lay-persons and judges. The authors conclude that both proponents and opponents of the privilege have overstated their case; the existence of the privilege is of consequence to few patients and in few cases. Through their analysis the authors have clarified the stakes in the controversy and have made it possible to weigh the competing policy interests more intelligently.

I. INTRODUCTION

The recognition of a privileged relationship, a rule of evidence that confers upon a person a right to prevent introduction of relevant evidence in judicial proceedings, stands in stark contrast to the predilection of courts to receive all relevant evidence in judicial proceedings.[1] A privilege is the result of a balancing process; the relationship in question and its underlying values must be thought more important than the accurate outcome of judicial proceedings,

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1. Testimonial exclusionary rules and privileges contravene the fundamental principle that "the public . . . has a right to every man's evidence." *United States v. Bryan*, 339 U.S. 323, 331 (1950). As such, they must be strictly construed and accepted "only to the very limited extent that permitting a refusal to testify or excluding relevant evidence has a public good transcending the normally predominant principle of utilizing all rational means for ascertaining truth." *Elkins v. United States*, 364 U.S. 206, 234 (1960) (Frankfurter, J., dissenting). Accord, *United States v. Nixon*, 418 U.S. 683, 709-10 (1974). Trammel v. United States, 445 U.S. 40, 50-51 (1980).

and the absence of the privilege must threaten to destroy the relationship and its underlying values.[2] Most commentators who have examined the physician-patient privilege have concluded that, while the physician-patient relationship is extremely important, on balance, the absence of a privilege does not pose a sufficient threat to the physician-patient relationship to justify the enactment of a privilege.[3] This conclusion has been tempered, however, with respect to a narrow category of health professionals treating mental or emotional problems—psychotherapists.[4]

Psychotherapist-patient relationships, it is thought, are unlike physician-patient relationships; while a person with a broken leg may not hesitate to consult a physician in the absence of a privilege, a person troubled by an extramarital affair or compulsion to steal may hesitate to consult a therapist in the absence of a privilege. It is assumed that unless patients are assured that their communications on sensitive and potentially embarrassing subjects will be kept inviolate, no effective therapy for mental or emotional problems will occur. Thus, those commentators who examined the psychotherapist-patient privilege have uncritically accepted the requirement of a privilege for effective psychotherapeutic relationships.[5]

Although superficially sound, the acceptance of the requirement of a psychotherapist-patient privilege for effective psychotherapy rests upon untested hunches. There is good reason to question these assumptions. The United Kingdom[6] and the common-law provinces in Canada[7] do not recognize a phy-

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2. The traditional analysis of this balancing process is credited to Dean Wigmore. See 8 J. Wigmore, Evidence § 2285 (McNaughton rev. ed. 1961). Another approach to this question is David Louisell's. See Louisell, Confidentiality, Conformity and Confusion: Privileges in Federal Court Today, 31 Tul. L. Rev. 101 (1957).

3. E.g., Chafee, Privileged Communications: Is Justice Served or Obstructed by Closing the Doctor's Mouth on the Witness Stand?, 52 Yale L.J. 607 (1943); Ladd, A Modern Code of Evidence, 27 Iowa L. Rev. 213 (1942); Purrington, An Abused Privilege, 6 Colum. L. Rev. 388 (1906).

4. E.g., Guttmacher & Weihofen, Privileged Communications Between Psychiatrist and Patient, 28 Ind. L.J. 32 (1952); Louisell & Sinclair, The Supreme Court of California, 1969-70—Foreword: Reflections on the Law of Privileged Communications—The Psychotherapist-Patient Privilege in Perspective, 59 Calif. L. Rev. 30 (1971); Slovenko, Psychiatry and a Second Look at the Medical Privilege, 6 Wayne L. Rev. 175 (1960).

Who is a psychotherapist? Do only psychiatrists and psychologists qualify, or does the term also embrace psychiatric social workers and lay analysts? See Comment, Underprivileged Communications: Extension of the Psychotherapist-Patient Privilege to Patients of Psychiatric Social Workers, 61 Calif. L. Rev. 1050 (1973); Note, The Social Worker-Client Relationship and Privileged Communications, 1965 Wash. U.L.Q. 362. To avoid prolonged debate on that question at this juncture, psychotherapist, as used in this Article, will be limited by the definition of psychotherapist-patient set forth in Proposed Fed. R. Evid. 504(a)(2), which is restricted to physicians treating mental or emotional conditions and psychologists:

> A "psychotherapist" is (A) a person authorized to practice medicine in any state or any nation or reasonably believed by the patient to be so, while engaged in the diagnosis or treatment of a mental or emotional condition, including drug addiction, or (B) a person licensed or certified as a psychologist under the laws of any state or nation, while similarly engaged.

5. See note 4 supra.

6. 30 Halsbury's Laws of England, Medicine, Pharmacy, Drugs and Medicinal Products § 19 (4th ed. 1980).

7. Dickens, Legal Protection of Psychiatric Confidentiality, 1 Int'l J.L. & Psychiatry 255, 260 (1978). Quebec, with its French civil-law roots does, like France, recognize a physician-pa-

sician-patient or a psychotherapist-patient privilege. Psychotherapists in the United Kingdom and the common-law provinces in Canada, therefore, treat patients without the benefit of a privilege and have not claimed, as have psychotherapists in the United States, that its absence prevents effective therapy. In the United States, psychotherapy has grown despite the nonexistence of a privilege in some states and only a qualified privilege in others.[8] Yet no empirical research supporting the need for a privilege is cited by the drafters of psychotherapist-patient privileges nor is any to be found in the literature favorable to the privilege.[9] Courts and legislatures have been asked to choose between psychotherapist-patient relationships and accurate judicial proceedings without empirical evidence of the need for the privilege in therapy or its effect on the conduct of judicial proceedings. The consequences of an erroneous choice may be substantial—the curtailment of effective therapy for many thousands of emotionally troubled people or inaccurate decisions in judicial proceedings when life, liberty or property is at stake. Given these risks, a more accurate basis for accommodating these interests than untested hunches is necessitated.

This Article, the result of an empirical study conducted by a lawyer and a psychiatrist, attempts to examine these issues. It was triggered by the passage of a psychotherapist-patient privilege statute by the Texas Legislature in 1979.[10] Prior to 1979 Texas had no general physician-patient or psychotherapist-patient privilege statute. The statute's passage raised a host of questions: Would the statute result in an increased number of persons seeking therapy?

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tient privilege. Id. See also Tollefson, Privileged Communications in Canada (Common Law), 4 Int'l Symp. on Comp. L. 32, 44-45 (1967).

8. Fleming & Maximov, The Patient or His Victim: The Therapist's Dilemma, 62 Calif. L. Rev. 1025, 1038-39 (1974).

9. For example, the proposed psychotherapist-patient privilege of Rule 504 of the Federal Rules of Evidence was supported by a quotation from the report of the Group for the Advancement of Psychiatry, Report No. 45, Confidentiality and Privileged Communication in the Practice of Psychiatry (Report No. 45, 1960) [hereinafter cited as GAP Report]:

> Among physicians, the psychiatrist has a special need to maintain confidentiality. His capacity to help his patients is completely dependent upon their willingness and ability to talk freely. This makes it difficult if not impossible for him to function without being able to assure his patients of confidentiality and, indeed, privileged communication. Where there may be exceptions to this general rule . . . , there is wide agreement that confidentiality is a *sine qua non* for successful psychiatric treatment. The relationship may well be likened to that of the priest-penitent or the lawyer-client. Psychiatrists not only explore the very depths of their patients' conscious, but their unconscious feelings and attitudes as well. Therapeutic effectiveness necessitates going beyond a patient's awareness and, in order to do this, it must be possible to communicate freely. A threat to secrecy blocks successful treatment.

Proposed Fed. R. Evid. 504 advisory committee note (quoting GAP Report, supra, at 92), reprinted in 56 F.R.D. 183, 242 (1973). This quotation contains a myriad of assumptions about patient behavior—for example, that patients seek assurances of confidentiality and privilege, or that they behave differently in therapy without these assurances. Instead of being given evidence that these assumptions are correct, we are asked to accept as true the conclusions of the GAP Report.

10. Act of May 17, 1979, ch. 239, 1979 Tex. Gen. Laws 512 (codified at Tex. Rev. Civ. Stat. Ann. art. 5561h (Vernon Supp. 1982)). See Wilcox, Release of Medical Information to Patients and Insurance Companies, 76 Tex. Med. 69 (1980); Comment, The Psychotherapist-Patient Privilege in Texas, 18 Hous. L. Rev. 137 (1980).

Would the statute change the therapeutic relationship? Had patients expressed concern about confidentiality prior to the privilege's enactment? If so, how were these concerns addressed by therapists? Had therapists been compelled by courts to reveal confidential patient communications prior to the privilege's enactment? If so, how frequently did that occur and what effect did it have on the course of therapy and the accuracy of judicial proceedings? Would the statute result in less accurate judicial proceedings? To attempt to answer these questions, which underlie the psychotherapist-patient privilege, we designed and conducted a multifaceted research project.

We employed four questionnaires: a therapist questionnaire,[11] a patient questionnaire,[12] a lay questionnaire[13] and a judicial questionnaire.[14] The therapist questionnaire was mailed to psychiatrists practicing in the Dallas area. The patient questionnaire was distributed by psychiatrists to patients in therapy. The lay questionnaire was distributed to students at evening adult education classes at a nearby university. And the judicial questionnaire was administered to state and federal judges in Dallas County. In addition, we secured data from Blue Cross/Blue Shield of Texas showing the number of billings for psychotherapy before and after the enactment of the privilege statute.[15]

Before proceeding to this research, however, it is useful to examine the theoretical justifications for this privilege in greater detail.

II. THE PRIVILEGE AND ITS JUSTIFICATION

A. *Psychotherapy*

> We pledge him to obey the *fundamental rule* of analysis, which is henceforward to govern his behavior towards us. He is to tell us not only what he can say authentically and willingly, what will give him relief like a confession, but everything else as well that his self observation yields him, everything that comes into his head, even if it is *disagreeable* for him to say it, even if it seems *unimportant* or actually *nonsensical*.[16]

Psychotherapy is the treatment of mental or emotional disorder by verbal or other symbolic communication between patient and therapist.[17] Psychotherapy is frequently augmented by drugs, but it is often employed as the sole mode of treatment, especially for interpersonal problems or for dealing with certain thoughts, feelings or actions that people find disagreeable to themselves or others. Although there are many types of psychotherapy, the model

11. See Table 3, Appendix infra.
12. See Table 2, Appendix infra.
13. See Table 1, Appendix infra.
14. See Table 4, Appendix infra.
15. See Table 5, Appendix infra.
16. 23 S. Freud, An Outline of Psychoanalysis, in Standard Edition of the Complete Psychological Works of Sigmund Freud 141 (1964) (emphasis in original).
17. J. Kovel, A Complete Guide to Therapy 264 (1976).

upon which privilege arguments primarily rest is psychoanalysis,[18] originated by Sigmund Freud.

Based on his experience in treating emotional disorders, Freud theorized that certain types of emotional problems result from the rekindling of repressed emotional conflicts from early childhood.[19] Those conflicts are repressed into the unconscious portion of the mind because they are unacceptable to the conscious self. The treatment brings these conflicts to consciousness so that the patient can more adequately deal with or resolve them. Free association is the technique by which the psychoanalyst and patient gain access to the patient's unconscious mind.[20] Hence, Freud's fundamental rule for a patient in psychoanalysis, stated above, is that the patient must disclose to the therapist *all* of his thoughts or feelings. Freud concluded that withholding material of any sort from the therapist served the purpose of resistance, an automatic attempt by the patient's mind to block the emergence of material from the unconscious. The work of psychoanalysis is removing the patient's resistance to discovery of what has been repressed.[21] Unless the patient is assured that the therapist has no authority over him—for example, through disclosure of their communications in court—the built-in resistance to full disclosure cannot be overcome.[22] The patient must trust the therapist; this can occur only if the patient alone holds the key to disclosure of matters revealed in therapy.[23]

There are many reasons for a patient to resist the full disclosure thought necessary in psychoanalysis. Many people view mental illness as more embarrassing than physical illness.[24] Given the social stigma our society attaches to mental illness,[25] many individuals with serious mental or emotional problems may avoid even the initial consultation of a psychotherapist, fearing that others' knowledge of the inception of the relationship will result in their being stigmatized as mentally ill.

Effective psychotherapy frequently entails revelation of intimate and dis-

18. See, e.g., R. Slovenko, Psychotherapy, Confidentiality and Privileged Communications 40-42 (1966). The arguments for the psychotherapist-patient privilege use psychoanalysis as a springboard because of its theory that the patient's problems result from conflicts repressed in the unconscious that must be probed to treat the patient. See text accompanying notes 19-23 infra. However, not all psychotherapies seek to deal with the unconscious. See text accompanying notes 47-52 infra.

19. H. Kaplan, A. Freedman & B. Sadock, Comprehensive Textbook of Psychiatry 2128 (3d ed. 1980) [hereinafter cited as Comprehensive Textbook of Psychiatry].

20. Id. at 2115. See also R. Greenson, The Technique and Practice of Psychoanalysis 32-33 (1967).

21. Greenson, supra note 20, at 59-66.

22. Dubey, Confidentiality as a Requirement for the Therapist: Technical Necessities for Absolute Privilege in Psychotherapy, 131 Am. J. Psychiatry 1093, 1094 (1974); Plaut, A Perspective on Confidentiality, 131 Am. J. Psychiatry 1021, 1022 (1974).

23. Uchill, Deviation from Confidentiality and the Therapeutic Holding Environment, 7 Int'l J. Psychoanalytic Psychotherapy 208, 210 (1978-79).

24. M. Guttmacher & H. Weihofen, Psychiatry and the Law 271 (1952); Developments in the Law, Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1193, 1200 (1974).

25. See Goldstein & Katz, Psychiatrist-Patient Privilege: The GAP Proposal and the Connecticut Statute, 36 Conn. B.J. 175, 178 (1962).

turbing details of a very personal nature[26]—"the patient's inner most fears and fantasies."[27] Patients are thought to be less likely to disclose this type of information if there is a chance it will become public knowledge.[28] To obtain disclosure of this information the therapist must be "able to assure patients that their confidences will be protected."[29] "[C]onfidentiality is the *sine qua non* for successful psychiatric treatment."[30]

Based upon these assumptions, five basic premises for a psychotherapist-patient privilege are advanced:

1. *The absence of a privilege deters people from seeking needed therapy.*

In the absence of a privilege, potential patients may refrain from seeking help for fear of being labeled mentally ill because of the stigma attached to a label of mental illness. The advantage of a privilege at this stage is the assurance of privacy, that the individual's status as the patient of a psychotherapist will not be revealed to others.

2. *The absence of a privilege delays people from seeking needed therapy.*

Although the potential stigma that flows from the mental illness label may not result in a failure to seek therapy, it may result in a delay in seeking therapy, thereby extending the duration of a patient's emotional problems. Thus, a privilege may result in more rapid consultation with a therapist.

3. *The absence of a privilege impairs the quality of therapy.*

Successful treatment requires frank disclosure that cannot occur without the assurance of confidentiality that aids in developing the trust necessary between therapist and patient.

4. *The absence of a privilege causes premature termination of therapy.*

The psychotherapist-patient relationship is based upon trust. If the therapist reveals a confidential patient communication under court order, that trust will be destroyed and the relationship will terminate prematurely. The privilege avoids the possibility of compelled judicial disclosure.

5. *The absence of a privilege leads to compelled judicial disclosure of patient communications, which results in psychological harm to patients.*

The absence of a privilege permits a court to order a therapist to disclose relevant patient communications. These communications, containing "the patient's inner most fears and fantasies," touch upon

26. Heller, Some Comments to Lawyers on the Practice of Psychiatry, 30 Temp. L.Q. 401, 405 (1957). See also M. Guttmacher & H. Weihofen, supra note 24, at 273.

27. Louisell & Sinclar, supra note 4, at 52.

28. Love & Yanity, Psychotherapy and the Law, Med. Trial Tech. Q. 405, 424 (1974).

29. Cal. Evid. Code § 1014 Senate Comm. on Judiciary comments (West 1966). See Davidoff, The Malpractice of Psychiatrists (1973); Slovenko, supra note 4, at 185-87. See also Proposed Fed. R. Evid. 504 advisory committee note, reprinted in 56 F.R.D. 183 (1973).

30. GAP Report, supra note 9, at 92.

very sensitive components of the patient. Public revelation of this information will result in psychological harm to the patient.

These five theoretical premises raise questions to which no satisfactory empirical answers have been provided. Do patients actually know about the privilege and consider it when deciding to seek therapy or reveal information in therapy? Do patients terminate therapy when their therapist is compelled to testify? Are they harmed by disclosure? These five premises provide the core questions for the empirical study discussed in part IV of this Article.

An argument in favor of the privilege that is not based upon any particular model of psychotherapy is that of the right to privacy. It rests upon the notion that there are certain areas of human relations that ought to be left undisturbed by the state.[31] Included among these islands of immunity from state molestation, it is argued, should be the psychotherapist-patient relationship. On its face this argument turns on a choice between competing values not at all subject to empirical validation. Which should society value more, privacy in psychotherapy or accuracy in judicial decisions?[32] Upon scratching the surface, however, one finds an empirical component to this question.

Few proponents of a right to privacy contend that it should be absolute.[33] These individuals recognize that there may be values even more important than privacy. Once it is conceded that the right to privacy is not absolute, the complexion of the choice between privacy and accurate judicial decision-making changes. How will the loss of privacy in a particular situation affect the interests sought to be protected and how will the loss of relevant evidence affect the conduct of trials? These questions are subject, at least in part, to empirical research.

Even if one concludes that the nonutilitarian-privacy argument for the psychotherapist-patient privilege is totally devoid of assumptions subject to empirical research, this research project is nonetheless important. The proposed psychotherapist-patient privilege of the Federal Rules of Evidence,[34] the California Evidence Code[35] and the Connecticut Evidence Code,[36] the most significant recent psychotherapist-patient privilege proposals with written legislative histories, have relied exclusively on the utilitarian justification.[37] It is therefore appropriate that these privileges be tested through empirical research.

Other justifications for the psychotherapist-patient privilege have also been advanced. It has been argued that psychiatric jargon is confusing be-

31. Krattenmacker, Testimonial Privileges in Federal Courts—Alternative to the Proposed Federal Rules of Evidence, 62 Geo. L.J. 61, 85-86 (1973); Louisell, supra note 2, at 110.

32. 23 C. Wright & K. Graham, Federal Practice and Procedure § 5422 (1980).

33. See, e.g., Saltzburg, Privileges and Professionals: Lawyers and Psychiatrists, 66 Va. L. Rev. 597, 622 (1980).

34. Proposed Fed. R. Evid. 504.

35. Cal. Evid. Code §§ 1010-1026 (West Supp. 1981).

36. Conn. Gen. Stat. Ann. § 52-146(c) (West Supp. 1981) (psychologist-patient privilege).

37. Proposed Fed. R. Evid. 504 advisory committee note, reprinted in 56 F.R.D. 183, 242 (1973); Cal. Evid. Code § 1014, Senate Comm. on Judiciary comments (West 1966); Goldstein & Katz, supra note 25.

cause many words psychotherapists use have specialized meanings although these same words when used by lay persons have other common meanings; thus, judicial determinations should not rely on inherently confusing psychiatric evidence.[38] However, claims concerning the confusing aspects of psychiatric testimony are not unique to psychiatric testimony resulting from confidential communication.[39] They pervade most psychiatric testimony. These claims may provide the basis for certain across-the-board limitations on psychiatric testimony,[40] but they provide no basis for singling out testimony resulting from confidential communications for special restrictions.

Some proponents of the privilege argue that it should exist to protect psychotherapists from the inconvenience and annoyance that witnesses frequently suffer.[41] Although the law may recognize certain privileged relationships, not even the President of the United States is, by his office, immune from the compulsory process of the courts to provide relevant evidence in a judicial proceeding.[42] "[T]he public . . . has the right to every man's evidence."[43] Psychotherapists ought not, therefore, to enjoy any unique immunity from compulsory process. Only if the theoretical justifications for the privilege withstand scrutiny should the public's right to "every man's evidence" be limited. However, even before subjecting these theories to empirical scrutiny, the theories themselves require closer examination.

B. Problems with the Privilege's Theoretical Justifications

1. The absence of a privilege deters people from seeking needed therapy.

This premise assumes that the privilege will cloak the existence of the psychotherapist-patient relationship, thereby avoiding the label of mental illness on the patient. However, the physician-patient privilege has not been construed, in its varying form from state to state, to protect against disclosure of an individual's status as a patient unless to do so would reveal the substance of the communication;[44] rather it protects against compelled disclosure of information communicated. Although there may be a better argument in favor of protecting the identity of the patient under the privilege in psychotherapy,

38. GAP Report, supra note 9, at 92-93; Slovenko, Psychotherapist-Patient Testimonial Privilege: A Picture of Misguided Hope, 23 Cath. U.L. Rev. 649 (1974).

39. See, e.g., J. Ziskin, Coping with Psychiatric and Psychological Testimony (1970).

40. See Dix, Mental Health Professionals in the Legal Process: Some Problems of Psychiatric Dominance, 6 Law & Psychiatry Rev. 1 (1981); Ennis & Litwack, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 Calif. L. Rev. 693 (1974). But see Hoffman, Mental Health Professionals in the Legal Process: A Plea for Rational Applications of the Clinical Method, 6 Law & Psychiatry Rev. 21 (1981).

41. See Katz, Privileged Communications: A Proposal for Reform, 1 Dalhousie L.J. 597 (1974); Slovenko, supra note 38. The proposition that psychotherapists should be immunized from the inconveniences suffered by other witnesses is closely akin to the proposition that privileges are professional status symbols. Ladd, Privileges, 1969 Law & Soc. Ord. 555, 556.

42. See United States v. Nixon, 418 U.S. 683 (1974).

43. United States v. Bryan, 339 U.S. 323, 331 (1950).

44. C. McCormick, Handbook in the Law of Evidence § 9, at 215-16 (2d ed. 1962).

this argument has yet to be recognized by the courts.[45] Indeed, to claim the privilege, the existence of a bona fide psychotherapist-patient relationship must be shown as a preliminary matter,[46] thereby defeating any absolute claim to protect the identity of the patient. Thus the first premise is based upon an erroneous assumption concerning the operation of privilege law.

The first premise also fails to take into account the existence of medical insurance to pay for therapy. Unless an individual intends to pay for psychotherapy without third-party reimbursement, regardless of the privilege, people other than the patient and therapist will learn of the relationship. Thus, even if the privilege were to protect against disclosure of an individual's status as a patient, the use of medical insurance to pay for psychotherapy will result in the loss of a complete cloak of secrecy for the relationship.[47]

2. The absence of a privilege delays people from seeking therapy.

For the same reasons described within subsection 1, the presence of a privilege offers no additional protection for the person who is worried that his status as a patient of a psychotherapist will be known.

3. The absence of a privilege impairs the quality of therapy.

This premise assumes that without full disclosure by the patient, successful psychotherapy cannot take place and that this full disclosure cannot occur without the privilege. Crucial to this theory is the assumption that when full disclosure occurs, psychotherapy is reasonably effective in resolving mental or emotional problems. There is substantial debate on this point, and no generalization is possible at present. One reviewer concludes that "[t]he record suggests that some forms of therapy can lay an undisputed claim to efficacy in treating mental illness. The evidence is strong, for example, that people suffering from nonpsychotic depression or moderate anxieties may be helped. But beyond generalizations of that kind, little has been demonstrated in a way that satisfies the demand for hard scientific proof of effectiveness."[48]

45. 2 J. Weinstein & M. Berger, Weinstein's Evidence ¶ 504[05], at 504-23 (1981). The argument turns upon the assumption that "[n]on-divulgence of a patient's identity may be essential for maintaining the psychotherapist-patient relationship." Id. But see Tex. Rev. Civ. Stat. Ann. art. 5561h § 2(b) (Vernon Supp. 1982); Ex parte Abell, 613 S.W.2d 255 (Tex. 1981) (limiting the disclosure of the identity of those patients of a psychotherapist who had sexual relations with the therapist).

46. Although this question will normally be determined by the judge who can, through protective devices, limit public disclosure (see Fed. R. Evid. 104(a) & (c)), some degree of disclosure, if only to the judge and attorneys, will be required.

47. Although many patients in psychotherapy do not use their medical insurance for fear of revealing that they are in therapy, it is thought that the majority of patients in psychotherapy do use their medical insurance. See Begler, Privacy and Confidentiality, in Law and Ethics in the Practice of Psychiatry (C. Hoflind ed. 1980).

48. Marshall, Psychotherapy Works, But for Whom?, 207 Sci. 506, 508 (1980). See also G. Glass, T. Miller & M. Smith, The Benefits of Psychotherapy (1980). Critics of psychotherapy question the scientific basis for Freud's psychological theories and point to the studies which conclude that genetically triggered bio-chemical factors rather than psychological factors determine mental illness. If these theorists are correct, psychotherapy is unlikely to be effective for individu-

The theoretical model upon which the third premise rests is drawn from the Freudian school of thought. There are now, however, well over a hundred schools of psychotherapy. These schools and their corresponding therapies include psychoanalysis, psychoanalytic psychotherapy, behavior therapy, hypnosis, group psychotherapy, psychodrama, family therapy, marital therapy, transactional analysis, gestalt therapy, reality therapy, rational-emotive therapy, cognitive therapy and logotherapy,[49] to name a few.

Psychoanalysis, the only type of psychotherapy that requires total self-disclosure by the patient,[50] is not the most common type of psychotherapy. Because of the long period of training, psychoanalysts are few in number. And because, for a variety of reasons, people do not involve themselves in a therapy that may require four to five sessions per week for four to seven (or even more) years, only a small percentage of people with emotional problems are treated by psychoanalysis.[51] Most psychotherapy done outside of psychiatric institutions is done once a week and does not require full disclosure of all aspects of the patient's life, thoughts, feelings and behavior.

Many forms of psychotherapy require that the therapist and patient deal primarily with the disturbing symptoms and actively attempt to exclude other aspects of the patient's life from consideration.[52] Gestalt therapy, for example, focuses on the "here and now" of the patient's awareness of external stimuli during therapy, thus not requiring total disclosure of the patient's innermost fears and fantasies.[53]

Confidentiality is necessarily violated in many forms of psychotherapy that require the inclusion of others as part of the treatment. Family therapy, couples therapy and group therapy are examples of this type of treatment. Family therapists find that opening up certain family secrets for discussion contributes significantly to the well-being of the entire family.[54] In psychiatric hospitals, personal information about the patient deemed important in the treatment process is shared with the professional members of the treatment team.

Not all people in psychotherapy seek to avoid public disclosure; some people are thought to disclose information as a "cry for help" with the hope that others will intercede.[55] Other people in analysis seem to view their treatment as a status symbol.[56]

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als whose mental illness results from their genetic coding rather than repressed conflicts from early childhood. M. Gross, The Psychological Society 93-141, 195-231 (1978).

49. See Comprehensive Textbook of Psychiatry, supra note 19, at 2113-2256.

50. See Plaut, supra note 22.

51. Indeed, only twenty percent of the money for mental health care in the United States is spent on the psychotherapies, of which psychoanalysis is but one. The remainder is spent on other therapies such as hospitalization, chemotherapy, electroshock therapy and psychosurgery, which do not require candid disclosure of confidential communications. See Marshall, supra note 45.

52. See Weiner, The Psychotherapeutic Impasse, 35 Dis. Nerv. Sys. 259 (1974).

53. Comprehensive Textbook of Psychiatry, supra note 19, at 2238.

54. I. Glick & D. Kessler, Marital and Family Therapy 308 (2d ed. 1980).

55. Fleming & Maximov, supra note 8, at 1039-40.

56. M. Gross, supra note 48, at 147.

Although many psychotherapists stress that confidentiality is at the core of the relationship between patient and therapist, most are not of the opinion that it should be absolute.[57] Peer review, supervision and teaching seminars all involve discussion of cases. In many instances not all hints of the patient's true identity can be concealed.[58] Indeed, the Model Law on Confidentiality of Health and Social Service Records proposed by the American Psychiatric Association[59] provides for numerous instances in which a patient's records may be disclosed without his consent.[60] This proposed law would permit disclosure, for example, to auditors and surveyors, clinical supervisors and trainers, and in cases of child abuse or civil commitment.[61]

4. The absence of a privilege causes premature termination of therapy.

This premise assumes that the therapist's disclosure of confidential patient communications will destroy the trust necessary for an effective relationship, causing its premature termination. Here, again, it is noteworthy that psychotherapists have not generally advocated an absolute privilege.[62] Instead, they have recognized a panoply of circumstances in which disclosure should occur without the patient's consent. Psychotherapists' recognition that the privilege should not be absolute implies either that therapists do not think that disclosure without the patient's consent will result in premature termination of the relationship or that they recognize concerns in society more important than those protected by the privilege.

5. The absence of a privilege leads to compelled judicial disclosure of patient communications, which results in psychological harm to patients.

The operating assumption underlying this premise is that the disclosure that will occur in the absence of a privilege is psychologically harmful to patients. Again, the various exceptions to the privilege proposed by psychotherapists weaken this argument. Either they question the likelihood of psychological harm in the event of disclosure or they conclude that it is outweighed by the harm that would flow from nondisclosure. In either case the theoretical argument in favor of the privilege is weakened.

Thus, the theoretical justifications for the psychotherapist-patient privi-

57. Uchill, supra note 23, at 208.

58. Lowenthal, The Vicissitudes of Discretion in Psychotherapy, 28 Am. J. Psychotherapy 235 (1975).

59. 136 Am. J. Psychiatry 138 (1979).

60. The Model Law on Confidentiality of Health and Social Science Records permits disclosure of confidential information without patient consent to clinical supervisors, auditors, and fellow employees or to protect an abused child or commit a patient.

61. For a discussion of the wisdom of excepting the privilege in civil commitment proceedings, see Shuman, The Road to Bedlam: Evidentiary Guideposts in Civil Commitment Proceedings, 55 Notre Dame Law. 53, 69-71 (1979).

62. See note 60 supra.

lege are not as sound as they appear on the surface. Upon this questionable foundation is constructed the body of law that supports the existence of this privilege.

C. *The Law of Privilege*

Accurate knowledge of some past event is frequently necessary to decide correctly the issues in judicial proceedings that hold the potential for loss of life, liberty or property. However, once an event has occurred, any attempt to acquire "unassailably accurate knowledge" of that event in a judicial proceeding will necessarily fail. Instead, the best that might be expected is to acquire knowledge of what probably happened.[63] Because knowledge of what probably happened is likely to increase as more relevant evidence is introduced, rational systems of evidence are structured to accept all relevant evidence unless there is a strong policy justifying its exclusion.[64]

One use of this policy justifying exclusion of relevant evidence is the creation of relational privileges. A variety of relationships including, *inter alia*, attorney-client,[65] priest-penitant,[66] husband-wife[67] and physician-patient[68] have been accorded an evidentiary privilege in various jurisdictions, thereby limiting these relational communications as a source of evidence in judicial proceedings. The creation of these privileges had its origin in the history of trials at common law.

In England, prior to the 1400s, the jury served both as trier and witness.[69] The use of other witnesses, as we now think of witnesses, was uncommon.[70] Persons who sought to give testimony as ordinary witnesses were unwelcome, were viewed as meddlers and were subject to suit for maintenance, supporting the litigation of another.[71] Gradually, the inadequacy of this method of trial, which "turned more on argument than fact,"[72] was recognized and the efforts against it culminated in 1562-63 in the Statute of Elizabeth.[73] This Statute imposed penalties for refusal to attend as a witness after service of process and tender of expenses, did away with the threat of suit for maintenance[74] and paved the way for the concept of the duty of a witness to give evidence—the "fundamental maxim that the public . . . has a right to everyman's evidence."[75]

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63. In re Winship, 397 U.S. 358, 370 (1970) (Harlan, J., concurring).
64. J. Thayer, A Preliminary Treatise on Evidence at the Common Law 530 (1898).
65. 8 J. Wigmore, supra note 2, § 2290.
66. Id. § 2394.
67. Id. § 2332.
68. Id. § 2380.
69. Id. § 2190, at 62.
70. Id.
71. Id. at 63-64.
72. R. Lempert & S. Saltzburg, A Modern Approach to Evidence 608 (1977).
73. 8 J. Wigmore, supra note 2, § 2190, at 65.
74. Id.
75. Id. § 2192, at 70.

Prior to the Statute of Elizabeth, little need existed for the concept of privilege in common-law trials.[76] After the possibility of testimonial compulsion existed in common-law trials, the concept of privilege developed in the 1600s. Originally privilege existed as a notion of honor among gentlemen.[77] This was later transformed into an attorney-client privilege, the oldest relational privilege,[78] based upon the "honorable obligation" of the attorney rather than any need for a privilege to protect the attorney-client relationship.[79] Professor Wigmore contends[80] that the "honor among gentlemen" rationale for privileges was abandoned in 1776 in the famous *Duchess of Kingston's Case*,[81] which refused to recognize a physician-patient privilege based upon the physician's honor. Thereafter, Professor Wigmore suggests, a more stringent, utilitarian basis was required to recognize a privilege.[82] In the case of the attorney-client privilege—the only privilege recognized at common law—it was theorized that the privilege was necessary because attorneys could represent clients effectively only if they knew all the facts available to the client and that the client would not reveal these facts if the lawyer could be forced to reveal them in court.[83]

Professor Wigmore's articulation of the more stringent basis required to support a privilege is found in his own four requirements, according to which proposed privileges should be measured:

(1) The communications must originate in a *confidence* that they will not be disclosed.
(2) This element of *confidentiality must be essential* to the full and satisfactory maintenance of the relation between the parties.
(3) The *relation* must be one which in the opinion of the community ought to be sedulously *fostered*.
(4) The *injury* that would inure to the relation by the disclosure of the communications must be *greater than the benefit* thereby gained for the correct disposal of the litigation.[84]

These criteria have come to be accepted by most evidence scholars as the appropriate test for any proposed privilege.[85]

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76. Id. § 2290, at 542-43.
77. Id. § 2286, at 530-31.
78. Id. § 2290, at 542.
79. Id. § 2286, at 530-31.
80. Id.
81. 20 How. St. Tr. 355 (1776). In 1776 the Duchess was tried, before the House of Lords, for bigamy. To prove the existence of her first marriage, the Crown sought the testimony of a physician who had attended the Duchess and to whom she had admitted the first marriage. Lord Mansfield's response to the physician's request for clarification of his obligation to keep these communications secret is the oft quoted common-law refusal to recognize a physician-patient privilege: "If a surgeon was voluntarily to reveal these secrets, to be sure he would be guilty of a breach of honour and of great indiscretion; but to give that information in a court of justice, which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatever." Id. at 573.
82. 8 J. Wigmore, supra note 2, § 2286, at 531.
83. Id. §§ 2290-2291.
84. Id. § 2285, at 527.
85. R. Lempert & S. Saltzburg, supra note 72, at 615.

However, other respected evidence scholars disagree with Professor Wigmore that the practical justification is now, or ever was, the test for privilege.[86] These scholars, led by David Louisell, have argued that privileges protect "significant human values in the interest of the holders of the privilege and that the fact that the existence of these guarantees sometimes results in the exclusion from a trial of probative evidence is merely a secondary and incidental feature of the privilege's vitality."[87] This noninstrumental[88] view rests upon the conclusion that personal privacy, which encompasses the power to control dissemination of information about oneself, is so important that it should not be curtailed by a limit on testimonial privileges.[89] Supporting this conclusion are the social goals in our democracy furthered by this notion of privacy: privacy facilitates the personal autonomy necessary for the development of individuality;[90] privacy permits an emotional release outside the bounds of "our carefully controlled public etiquette";[91] privacy permits self-evaluation of experiences as against personal codes;[92] privacy permits confidential communications.[93]

The choice between the instrumental versus noninstrumental support for relational privileges is not mutually exclusive. Both rationales have been used to justify the same privileges.[94] Moreover, it is not at all clear that those two approaches, which differ so in theory, differ markedly in their application. Consider the case of the psychotherapist-patient privilege.

The instrumental justification for the psychotherapist-patient privilege is that it is essential for effective psychotherapy and that goal is more important than that of accurate fact finding in judicial proceedings. The noninstrumental justification for the privilege is that the right to control the dissemination of personal information communicated to a psychotherapist furthers important social goals. Because the noninstrumentalists do not contend that the privilege should be absolute, they must balance the goals furthered by the privilege against another social goal—accuracy in judicial proceedings. Both justifications raise empirical questions:[95] Do patients contemplating psychotherapy consider the privilege in their decision to institute therapy? Are people thwarted by an absence of privilege in their attempts to develop individuality? Both justifications require a balance that ultimately cannot be

86. Krattenmacker, supra note 31, at 85; Louisell, supra note 2. However, judicial scrutiny of proposed privileges typically utilizes Wigmore's criteria. See, e.g., In re Hampers, 651 F.2d 19, 22-23 (1st Cir. 1981); Garner v. Wolfinbarger, 430 F.2d 1093, 1100-04 (5th Cir. 1970), cert. denied, 401 U.S. 974 (1971).

87. Louisell, supra note 2, at 101.

88. See 23 C. Wright & M. Graham, supra note 32, § 5422, at 671.

89. Krattenmacker, supra note 31, at 86-87.

90. Id. at 87.

91. Id. at 87-88.

92. Id. at 88.

93. Id.

94. 23 C. Wright & K. Graham, supra note 32, § 5422, at 672.

95. Professors Wright and Graham disagree with this proposition. Id. at 672-73. They contend that the instrumental justifications for privilege are subject to empirical scrutiny while the noninstrumental justifications are not.

resolved empirically: Given the need for the privilege in therapy or for the development of individuality, which should society value as more important, that need or accurate factfinding in judicial proceedings?

Although both instrumentalists and noninstrumentalists have supported a psychotherapist-patient privilege,[96] the drafters of the Federal Rules of Evidence and the California Evidence Code used an exclusively utilitarian justification for their proposed psychotherapist-patient privilege.[97] And, although instrumentalists and noninstrumentalists have failed to provide empirical support for the privilege, they have persuaded every state legislature but two to abrogate the common law, which did not recognize a physician-patient or psychotherapist-patient privilege.[98] Legislative abrogation began in 1828 with the passage of the first physician-patient privilege in New York.[99] At present forty states and the District of Columbia have enacted a physician-patient privilege and all but two—South Carolina and West Virginia—have enacted either a physician-patient, psychiatrist-patient, psychologist-patient or psychotherapist-patient privilege.[100]

Although these privilege statutes vary widely, they tend to have certain

96. See articles cited at notes 4 & 86 supra.

97. Proposed Fed. R. Evid. 504 advisory committee note, reprinted in 56 F.R.D. 183, 242 (1973); Cal. Evid. Code § 1014, Senate Comm. on Judiciary comments (West 1966).

98. See Duchess of Kingston's Case, 20 How. St. Tr. 335, 573 (1776). See also Note, Confidential Communications to a Psychotherapist: A New Testimonial Privilege, 47 Nw. U.L. Rev. 384 (1952). But see Allred v. State, 554 P.2d 411, 416-18 (Alaska 1976).

99. C. DeWitt, Privileged Communications Between Physician and Patient 15 (1958).

100. The following table describes this pattern:

STATE	PHYSICIAN-PATIENT PRIVILEGE	PSYCHIATRIST-PATIENT PRIVILEGE	PSYCHOLOGIST-PATIENT PRIVILEGE	PSYCHOTHERAPIST-PATIENT PRIVILEGE
Alabama		Yes Ala. Code § 34-26-2 (Supp. 1981)	Yes Ala. Code § 34-26-2 (Supp. 1981)	
Alaska	Yes Alaska R. Civ. P. § 43(h)(4) (Supp. 1966)			
Arizona	Yes Ariz. Rev. Stat. Ann. § 12-2235 (1982)		Yes Ariz. Rev. Stat. Ann. § 32-2085 (Supp. 1981)	
Arkansas	Yes Ark. Stat. Ann. § 28-1001, Unif. R. Evid. 503 (1979)		Yes Ark. Stat. Ann. § 28-1001, Unif. R. Evid. 503 (1979)	Yes Ark. Stat. Ann. § 28-1001, Unif. R. Evid. 503 (1979)
California	Yes Cal. Evid. Code §§ 990-1007 (West 1966 & Supp. 1981)	Yes Cal. Evid. Code §§ 1010-1026 (West Supp. 1981)	Yes Cal. Evid. Code §§ 1010-1026 (West Supp. 1981)	Yes Cal. Evid. Code §§ 1010-1026 (West Supp. 1981)

features in common. Application of the privileges requires that a person consult one whom he reasonably believes to be a physician or psychotherapist for

STATE	PHYSICIAN-PATIENT PRIVILEGE	PSYCHIATRIST-PATIENT PRIVILEGE	PSYCHOLOGIST-PATIENT PRIVILEGE	PSYCHOTHERAPIST-PATIENT PRIVILEGE
Colorado	Yes Colo. Rev. Stat. § 13-90-107(d) (1973)		Yes Colo. Rev. Stat. § 13-90-107(g) (1973)	
Connecticut		Yes Conn. Gen. Stat. Ann. § 52-146(d) (West Supp. 1981)	Yes Conn. Gen. Stat. Ann. § 52-146(c) (West Supp. 1981)	
Delaware	Yes Del. Unif. R. Evid. 503 (1981)		Yes Del. Unif. R. Evid. 503 (1981)	Yes Del. Unif. R. Evid. 503 (1981)
District of Columbia	Yes D.C. Code Ann. § 14-307 (1981)		Yes D.C. Code Ann. § 2-1704.16 (1981)	
Florida		Yes Fla. Stat. Ann. § 90.503 (West 1979)	Yes Fla. Stat. Ann. § 90.503 (West 1979)	Yes Fla. Stat. Ann. § 90.503 (West 1979)
Georgia	Yes Ga. Code Ann. § 38-418(b) (1981)	Yes Ga. Code Ann. § 38-418(a)5. (1981)	Yes Ga. Code Ann. § 84-3118 (1981)	
Hawaii	Yes Hawaii Rev. Stat. § 621-1, Hawaii R. Evid. 503 (Supp. 1980)		Yes Hawaii Rev. Stat. § 621-1, Hawaii R. Evid. 503 (Supp. 1980)	
Idaho	Yes Idaho Code § 9-203.4 (Supp. 1981)		Yes Idaho Code § 54-2314 (1979)	
Illinois	Yes Ill. Rev. Stat. ch. 51, § 5.1 (1966)		Yes Ill. Ann. Stat. ch. 111, § 5306 (Smith-Hurd 1978 & Supp. 1981)	
Indiana	Yes Ind. Code § 34-1-14-5 (Supp. 1980)		Yes Ind. Code § 25-33-1-17 (1974)	
Iowa	Yes Iowa Code Ann. § 622.10 (Supp. 1981)			

STATE	PHYSICIAN-PATIENT PRIVILEGE	PSYCHIATRIST-PATIENT PRIVILEGE	PSYCHOLOGIST-PATIENT PRIVILEGE	PSYCHOTHERAPIST-PATIENT PRIVILEGE
Kansas	Yes Kan. Stat. Ann. § 60-427 (1976)		Yes Kan. Stat. Ann. § 74-5323 (1980)	
Kentucky		Yes Ky. Rev. Stat. § 421.215 (1970)	Yes Ky. Rev. Stat. § 319.111 (1977)	
Louisiana	Yes La. Rev. Stat. Ann. § 15:476 (West 1981)		Yes La. Rev. Stat. § 37:2366 (West 1974)	
Maine	Yes Me. R. Evid. 503			Yes Me. R. Evid. 503
Maryland		Yes Md. Cts. & Judic. Proc. Ann. § 9-109 (1980)	Yes Md. Cts. & Judic. Proc. Ann. § 9-109 (1980)	
Massachusetts				Yes Mass. Gen. Laws Ann. ch. 233, § 20B (West 1974)
Michigan	Yes Mich. Comp. Laws Ann. § 600.2157 (1980)		Yes Mich. Comp. Laws Ann. § 333.18401 (1980)	
Minnesota	Yes Minn. Stat. Ann. § 595.02(4) (West Supp. 1981)		Yes Minn. Stat. Ann. § 595.02(7) (West Supp. 1981)	
Mississippi	Yes Miss. Code Ann. § 13-1-21 (Cum. Supp. 1981)		Yes Miss. Code Ann. § 73-31-29 (Cum. Supp. 1981)	
Missouri	Yes Mo. Ann. Stat. § 491.060(5) (Vernon Supp. 1982)		Yes Mo. Ann. Stat. § 337.055 (Vernon Supp. 1982)	
Montana	Yes Mont. Rev. Code Ann. § 26-1-805 (1979)		Yes Mont. Rev. Code Ann. § 25-1-807 (1979)	

STATE	PHYSICIAN-PATIENT PRIVILEGE	PSYCHIATRIST-PATIENT PRIVILEGE	PSYCHOLOGIST-PATIENT PRIVILEGE	PSYCHOTHERAPIST-PATIENT PRIVILEGE
Nebraska	Yes Neb. Rev. Stat. § 27-504 (1979)			
Nevada	Yes Nev. Rev. Stat. § 49.215 (1979)		Yes Nev. Rev. Stat. §§ 49.215, .225 (1979)	
New Hampshire	Yes N.H. Rev. Stat. Ann. § 329:26 (Supp. 1981)		Yes N.H. Rev. Stat. Ann. § 330 A.19 (Supp. 1981)	
New Jersey	Yes N.J. Rev. Stat. § 2A:84A-22.2 (1976)		Yes N.J. Rev. Stat. § 45:14B-28 (1978)	
New Mexico			Yes N.M. Stat. Ann. § 61-9-18 (1978) & N.M.R. Evid. 504 (1978)	Yes N.M.R. Evid. 504 (1978)
New York	Yes N.Y. Civ. Prac. Law § 4504 (McKinney Supp. 1981)		Yes N.Y. Civ. Prac. Law § 4507 (McKinney Supp. 1981)	
North Carolina	Yes N.C. Gen. Stat. § 8-53 (1981)		Yes N.C. Gen. Stat. § 8-53.3 (1981)	
North Dakota	Yes N.D.R. Evid. 503 (Supp. 1981)			Yes N.D.R. Evid. 503 (Supp. 1981)
Ohio	Yes Ohio Rev. Code Ann. § 2317.02(B) (Page 1981)		Yes Ohio Rev. Code Ann. § 4732.19 (Page 1981)	
Oklahoma	Yes Okla. Stat. Ann. tit. 12, § 2503 (West Supp. 1981)	Yes Okla. Stat. Ann. tit. 12, § 2503 (West Supp. 1981)	Yes Okla. Stat. Ann. tit. 12, § 2503 (West Supp. 1981)	Yes Okla. Stat. Ann. tit. 12, § 2503 (West Supp. 1981)
Oregon	Yes Or. Rev. Stat. § 44.040(d) (1979)		Yes Or. Rev. Stat. 44.040(h) (1979)	Yes Or. Rev. Stat. §§ 44.040(h) (1979) & 675.010 (Supp. 1981)
Pennsylvania	Yes Pa. Cons. Stat. Ann. § 5929 (Purdon Supp. 1981)		Yes Pa. Cons. Stat. Ann. § 5944 (Purdon Supp. 1981)	

STATE	PHYSICIAN-PATIENT PRIVILEGE	PSYCHIATRIST-PATIENT PRIVILEGE	PSYCHOLOGIST-PATIENT PRIVILEGE	PSYCHOTHERAPIST-PATIENT PRIVILEGE
Rhode Island	Yes R.I. Gen. Laws § 5-37.3-4 (Cum. Supp. 1981)		Yes R.I. Gen. Laws § 5-37.3-4 (Cum. Supp. 1981)	
South Carolina				
South Dakota	Yes S.D. Codified Laws Ann. §§ 19-13-6 to -11 (1979)			Yes S.D. Codified Laws Ann. §§ 19-13-6 to -11 (1979)
Tennessee		Yes Tenn. Code Ann. § 24-1-207 (1980)	Yes Tenn. Code Ann. § 63-1117 (1976)	
Texas	Yes Tex. Rev. Civ. Stat. Ann. art. 4495b, § 5.08 (Vernon Supp. 1982)		Yes Tex. Rev. Civ. Stat. Ann. art. 5561h (Vernon Supp. 1982)	Yes Tex. Rev. Civ. Stat. Ann. art. 5561h (Vernon Supp. 1982)
Utah	Yes Utah Code Ann. § 78-24-8(d) (1977)		Yes Utah Code Ann. § 58-25-8 (Supp. 1979)	
Vermont	Yes Vt. Stat. Ann. tit. 12, § 1612 (Supp. 1980)			
Virginia	Yes Va. Code Ann. § 8.01-399 (1977)		Yes Va. Code Ann. § 8.01-399 (1977)	
Washington	Yes Wash. Rev. Code Ann. § 5.60.060(4) (Supp. 1981)		Yes Wash. Rev. Code Ann. § 18.83.110 (1978)	
West Virginia				
Wisconsin	Yes Wis. Stat. Ann. § 905.04 (West Supp. 1980)		Yes Wis. Stat. Ann. § 905.04 (West Supp. 1980)	
Wyoming	Yes Wyo. Stat. § 1-12-101(a)(i) (1977)		Yes Wyo. Stat. § 33-27-103 (1977)	

the purpose of treatment or diagnosis in contemplation of treatment.[101] For example, examinations to prepare for judicial testimony or as a prerequisite for employment are outside the privilege.[102] The information communicated to the physician or psychotherapist must be intended to be confidential and must bear upon treatment.[103] For example, communications made in the presence of nonessential third persons or solely for social purposes are outside the privilege.

Although all but two states have enacted some form of physician-patient, psychiatrist-patient, psychologist-patient or psychotherapist-patient privilege, the legal effect of these statutes is neutralized by the many exceptions that exist.[104] Many states do not apply the privilege in criminal cases,[105] civil commitment proceedings[106] or worker's compensation proceedings.[107] Other states reject the privilege in personal injury proceedings brought by the patient,[108] will contests[109] or child abuse proceedings.[110] Still other states' statutes provide that the judge may permit an exception to the privilege when necessary for the proper administration of justice.[111] Thus, the existence of a privilege, if known by a patient, provides a false sense of security against compelled judicial disclosure.

The concept of confidentiality must be distinguished from the law of privilege. An evidentiary privilege is a law that permits a person to prevent a court from requiring revelation of relational communications. Confidentiality refers to a duty, frequently an ethical limitation imposed by a profession, not to disclose relational communications.[112] These ethical limitations prohibit gratuitous disclosure of patient communications—for example, to one's spouse or friend. Thus, they provide substantial assurances that, in the ordinary course of events, nothing told to one's therapist will be disclosed to others. But they do not abrogate the duty to respond to compulsory judicial process.[113]

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101. C. McCormick, supra note 44, § 99, at 213.

102. See id. at 214.

103. Id. §§ 100-101.

104. Shuman, supra note 61, at 61.

105. E.g., Or. Rev. Stat. § 44.040(d) (1979); Wash. Rev. Code Ann. § 5.60.060(4) (Supp. 1981).

106. Conn. Gen. Stat. Ann. § 52-146f(b) (West Supp. 1981); Del. Uniform R. Evid. 503(d)(1) (1981).

107. "More than half the states which have the privilege provide that it shall not apply in Workmen's Compensation proceedings." C. McCormick, supra note 41, § 104, at 223 n.77.

108. E.g., Cal. Evid. Code § 1016 (West 1966); Conn. Gen. Stat. Ann. § 52-146f(e) (West 1981).

109. E.g., Cal. Evid. Code § 1022 (West 1966); N.J. Rev. Stat. § 2A:84A-22.3 (1976).

110. Cal. Evid. Code § 1027 (West Supp. 1981); Del. Uniform R. Evid. 503(d)(4) (1981); Idaho Code § 9-203.4(A) (Supp. 1981).

111. E.g., Va. Code § 8.01-399 (1977).

112. See, e.g., Model Rules of Professional Conduct, comments to rule 1.7 (ABA) (discussion draft 1980) ("Two sets of rules govern disclosure by a lawyer of information concerning his client. One is the law of evidentiary privilege. The other, which may be called the rule of client-lawyer confidentiality, is a professional rule that information concerning a client must in general be kept confidential.").

113. The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, § 9, 130 Am. J. Psychiatry 1058, 1059 (1973) specifically excepts disclosures required by law: "The

The privilege provides the patient with the opportunity to prevent his therapist from testifying about their confidential communications. Therein lies the heart of the opposition to the privilege. Even if the communications are highly relevant, and even if the communications are the only source of information on a crucial issue in a lawsuit, the patient may invoke an applicable privilege and prevent the therapist from disclosing this information. The factfinder may then be left with an erroneous picture of some critical occurrence and therefore decide the case wrongly.

The objections to the privilege rest upon the assumption that, in a reasonable number of cases, relevant information is known only to the therapist and is not available through nonprivileged sources. In addition, these objections assume that this information, made unavailable because of the privilege, would change the outcome of the litigation. These assumptions will be examined in light of the judicial study in part IV.

III. PREVIOUS STUDIES

No empirical study supporting or opposing a physician-patient or psychotherapist-patient privilege is cited by any of the drafters of privilege statutes in support of these statutes.[114] Instead, we are left to believe that legislative decisions on the privilege are a testament to effective lobbying and not the result of informed decision-making. There are, however, studies in the legal and scientific journals that merit examination.

A. Studies Reported in Legal Journals

In 1962, the Yale Law Journal published a student Comment entitled *Functional Overlap Between the Lawyer and Other Professionals*.[115] The Comment reported a questionnaire study by the Journal of 35 psychotherapists, 51 psychologists, 25 marriage counselors, 125 lawyers, 47 judges and 108 lay people. Seventy-one percent of the lay people questioned reported that they would be less likely to make "free and complete disclosure" to a psychiatrist, psychologist, marriage counselor, or social worker if that person had a legal obligation to disclose confidential information if asked to do so by a lawyer in

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physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of his patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community."

Principle 6 of the Ethical Standards of Psychologists, which describes the duty of a psychologist to maintain the confidences of a patient (see 18 Am. J. Psychiatry 56 (1963)), contains no express reference to disclosures required by law. Although a private organization may impose obligations upon its members, it cannot, as a private entity, contravene the obligations of its members as defined by the courts or legislature.

114. See note 9 supra.

115. Comment, Functional Overlap Between the Lawyer and Other Professionals: Its Implications for the Privileged Communications Doctrine, 71 Yale L.J. 1226 (1962).

court.[116] Thirty-one percent of this group had sought counseling at some point in time.[117] Although the high percentage of lay people who would hesitate to disclose fully without some protection argues in favor of the privilege, there is a flaw in this conclusion. The questionnaire informed the lay people of the possibility, if not the probability, of judicial disclosure. This assumes away the major question: Do people contemplate the possibility of judicial disclosure and accurately evaluate the effect of the privilege prior to communicating with a therapist? If people are not cognizant of the privilege and its operation—if people do not contemplate the possibility of judicial disclosure—the privilege cannot provide the inducement to candid discussions its proponents claim. In a similar vein, the questionnaire did not ask those lay people who had consulted a psychiatrist or psychologist whether they considered the privilege or its absence and the possibility of judicial disclosure prior to communicating with their therapists.

Forty-three percent of the psychiatrists and thirty-three percent of the psychologists surveyed had been called upon to testify in court about present or past patients; however, only three psychiatrists and six psychologists had been asked to disclose confidential information.[118] Thus, for the psychiatrists and psychologists surveyed and their patients, the legal effect of a privilege would have been minimal; the issue rarely arose in the courts.

The psychiatrists and psychologists surveyed agreed that the privilege was desirable.[119] However, the answers to the question fail to explain whether the psychiatrists and psychologists merely dislike the inconvenience of testifying or have a more substantial basis for their conclusion.

It is significant that none of the judges surveyed, and few of the lawyers, found the privilege disruptive of the trial process.[120] However, nearly one-third of the lawyers polled stated that the privilege excluded information unavailable from nonprivileged sources.[121]

In 1976 the Supreme Court of California decided *Tarasoff v. Regents of the University of California*,[122] in which it held that therapists owe a duty to use reasonable care to protect persons threatened by their patients. The decision was greeted by psychotherapists with prophecies of doom; they predicted that it would result in the destruction of trust between therapist and patient and thus preclude effective therapy.[123] One year after the *Tarasoff* decision,

116. Id. at 1255.
117. Id.
118. Id. at 1256 nn.192 & 196.
119. Id. at 1256 nn.204-05.
120. Id. at 1261 n.233.
121. Id. at 1261.
122. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).
123. Gurevitz, *Tarasoff*: Protective Privilege versus Public Peril, 134 Am. J. Psychiatry 289 (1977); Stone, The *Tarasoff* Decisions: Suing Psychotherapists to Safeguard Society, 90 Harv. L. Rev. 358 (1976). But see Wexler, Patients, Therapists and Third Parties: The Victimological Virtues of *Tarasoff*, 2 Int'l J.L. & Psychiatry (1979) (arguing that the *Tarasoff* court may have, unwittingly, encouraged therapists to use couples or conjoint therapies suggested by the literature on victimology but rejected by psychoanalytically oriented therapists).

the Stanford Law Review conducted an empirical survey of California therapists to ascertain the effects of *Tarasoff*.[124]

The survey consisted of a mail questionnaire completed by 179 psychologists and 1,093 psychiatrists.[125] Respondents in the study had a mean age of forty-five years, had been in practice for fourteen years, and a majority were psychoanalytically oriented.[126] These therapists treated an average of 240 patients each year.[127] More than eighty percent reported seeing at least one potentially dangerous patient each year.[128]

Seventy-nine percent of the therapists responded that, in their opinion, their patients would feel inhibited if they knew that their communications were not governed by strict confidentiality.[129] However, the majority thought that it was sometimes proper to breach confidentiality.[130] Only eleven percent always discussed confidentiality with patients; a majority did so occasionally.[131]

Nearly one-quarter of the therapists observed some reluctance of patients to discuss violent tendencies once told that a loss of confidentiality might occur.[132] One-quarter of the therapists reported losing patients because the patients feared a breach of confidentiality.[133] Twenty-three percent of the therapists said their patients refused further treatment, and eleven percent said the patient returned to treatment or was successfully referred to someone else.[134] Sixty-three percent did not know what happened to the patient.[135]

The *Tarasoff* decision, with its conditional abrogation of confidentiality, did not result in the destruction of effective therapeutic relationships as its critics had prophesied. Even prior to *Tarasoff* therapists had warned persons threatened by their patients.[136] *Tarasoff* did, however, increase the frequency with which dangerousness and confidentiality were discussed in therapy, thereby altering the therapeutic dialogue.[137]

B. Studies Reported in Scientific Journals

Two articles in the scientific literature report studies that are of interest to those studying the psychotherapist-patient privilege. *Massachusetts Psychiatry*

124. Note, Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of *Tarasoff*, 31 Stan. L. Rev. 165 (1978).
125. Id. at 174.
126. Id. at 175.
127. Id. at 175-76.
128. Id. at 176.
129. Id. at 176 n.63.
130. Id. at 176 n.65.
131. Id. at 176.
132. Id. at 177.
133. Id. at 177 n.67. Therapists reporting losses due to patients' fears of a breach of confidentiality lost a median of three patients.
134. Id.
135. Id.
136. Id. at 178-79 n.74.
137. Id. at 187.

and Privileged Communications[138] describes a 1966 questionnaire study of Massachusetts psychiatrists. Sixty-three percent of Massachusetts' 814 psychiatrists responded.[139] One-quarter of the respondents were not aware that Massachusetts lacked an applicable privilege, although ninety-two percent favored a privilege with a variety of exceptions.[140] Twenty-eight percent said that in at least one case in the past five years privilege had been a significant factor; however, in response to a request for illustrative cases, only nine cases were cited in which psychiatric records were obtained involuntarily.[141]

This study, like the Yale study, suggests that even in the absence of a privilege most therapists are never faced with compelled judicial disclosure of confidential patient communications. And, for the few who are, the situation occurs quite rarely, thus limiting the legal effect of a privilege.

The second study, *Informed Consent: Consequences for Response Rate and Response Quality in Social Surveys*,[142] was designed to discern the effects of informed consent in social science research and the consequences of assuring confidentiality to respondents. The respondents were asked a series of questions involving nonsensitive and sensitive matters such as marijuana use and sexual behavior. One-third were told their responses were protected by absolute confidentiality, one-third were told their responses were protected by qualified assurances of confidentiality and one-third were not told anything about confidentiality.[143]

The assurance of confidentiality had no statistically significant effect on response rate in general. However, it did have a small effect on the response rate for some of the sensitive questions.[144] For example, when asked if they ever smoked marijuana more than three times a week, the non-response rates for those assured of absolute confidentiality was 3.1 percent,[145] considerably less than the non-response rate for those to whom confidentiality was not mentioned (7.5 percent), and the non-response rate for those given qualified assurance of confidentiality (10.6 percent).[146]

These studies are informative but leave a number of important questions unanswered. For example, these studies suggest that people alerted to the risk of compelled judicial disclosure in the absence of a privilege are less likely to disclose fully, but do not indicate whether patients consider the possibility of compelled judicial disclosure or the existence and scope of protection a privilege provides before seeking therapy or making disclosures in therapy. Are patients aware of whether their state recognizes a privilege? If not, how can

138. Suarez & Balcanoff, Massachusetts Psychiatry and Privileged Communications, 15 Archives Gen. Psychiatry 619 (1966).

139. Id. at 620.

140. Id. at 621.

141. Id. at 623.

142. Singer, Informed Consent: Consequences for Response Rate and Response Quality in Social Surveys, 43 Am. Soc. Rev. 144 (1978).

143. Id. at 146.

144. Id. at 149, 151.

145. Id. at 151.

146. Id.

the lack of a privilege deter or delay people from seeking therapy or affect their disclosures in therapy? Are patients psychologically harmed by disclosure of their confidential communications; do they terminate therapy when this occurs? To answer these questions, this study was undertaken.

IV. THE PRIVILEGE STUDY

A. Methodology

Prompted by the absence of empirical evidence on the critical questions underlying the psychotherapist-patient privilege, and the passage of a psychotherapist-patient privilege statute in Texas in 1979, we undertook this study. Because of the inherent limitations on social science research,[147] we sought a number of different windows on the questions before us.

Proponents of the privilege contend that the lack of privilege deters or delays people from seeking therapy. If so, the existence of a privilege should avoid this deterrence or delay and result in more people seeking therapy. To study this question we obtained data on claims from Blue Cross/Blue Shield of Texas for the years preceding and following passage of the privilege, and sought to determine whether there was a change in claims for psychotherapy over this time that might be attributable to the passage of the privilege statute.

Proponents of the privilege contend that the absence of a privilege deters or delays therapy and impairs the quality of therapy. If so, people who contemplate therapy must know of the privilege's status in their state and consider that in their decision to institute therapy and to make disclosures in therapy. To study this question we sampled a group of patients in therapy and a group of lay people.

The lay questionnaire was distributed at evening adult education classes at a nearby university. Students were told by their instructors that the questionnaire was a survey on privileged communications, that the respondents' names were not known to the investigators, and that students were free not to participate. Of the 200 questionnaires distributed, 121 were returned to the instructor at the end of the class.

The patient questionnaire was distributed by thirty-one psychiatrists who agreed to give at least five questionnaires each to patients in therapy, to explain that the questionnaire was part of a research project, that the respondent's names were not known to the investigators and that patients were free not to participate. Fifty percent of the 160 questionnaires distributed were returned.

Proponents of the privilege contend that the lack of privilege results in premature termination of therapy and psychologically harmful judicial disclosures. If so, therapists should have been judicially compelled to reveal confi-

147. H. Kalven & H. Zeisel, The American Jury 33 (1966). In the ideal research project, only one parameter is varied at a time. Unfortunately, in social science research this possibility does not exist; therefore, it is useful to develop more than one measurement technique to verify any conclusions.

dential communication resulting in premature termination of therapy and psychological harm to patients during the years in which no psychotherapist-patient privilege existed in Texas. To study this, we questioned therapists. The therapist questionnaire was sent to the 186 members of the North Texas Psychiatric Society. Eighty-four of the questionnaires were returned.

Opponents of the privilege contend that it results in the exclusion of relevant evidence rendering judicial proceedings inaccurate. If so, during the years in which no psychotherapist-patient privilege existed in Texas, therapists should have been compelled to reveal confidential communications that were extremely important in judicial proceedings and contained information not available from other sources. Conversely, now that the privilege exists in Texas, courts should be denied extremely important information not available from nonprivileged sources. To study this question, we surveyed judges. The judicial questionnaire was administered to forty-eight of the fifty-six state and federal judges in Dallas County, Texas, with generally unlimited jurisdiction over civil and criminal cases.

B. Insurance Study

The existence of a psychotherapist-patient privilege, according to its proponents, should encourage people to seek psychotherapy because of the veil of privacy it provides. If this assumption is correct, following the enactment of a privilege, persons who refrained from seeking psychotherapy because of its absence will now seek it, resulting in increased numbers of patients in psychotherapy. Because a significant percentage of patients receiving psychotherapy use their medical insurance to pay for therapy,[148] an increase in claims for psychotherapy should follow the enactment of a privilege.

To test this assumption we obtained data from Blue Cross/Blue Shield of Texas for 1976 through 1980 detailing the number of billings for initial psychiatric interviews, one hour psychotherapy, half-hour psychotherapy, forty-five minute psychotherapy, and one and one-half hour group psychotherapy.[149] If the assumption described above is correct an increase in intial psychiatric interviews should have occurred following the privilege's passage in 1979, but the number of services billed for initial psychiatric interviews in 1980 (9,682) was lower than for 1976 (10,174) or 1977 (10,829) but higher than 1978 (8,560).[150] No increase in patients seeking initial psychiatric interviews occurred during the first full year of the privilege's operation.

In 1980 the number of psychotherapy services billed for in one hour increments (41,293) was slightly higher than 1978 (40,753), but a decrease from 1979 (47,873). In light of the vacillations in these figures—39,462 (1976),

148. See note 47 supra.

149. See Table 5, Appendix infra.

150. Id. Because the statute became effective on August 27, 1979 (Act of May 17, 1979, ch. 239, § 7, 1979 Tex. Gen. Laws 512) and we were unable to obtain monthly breakdowns for 1979, the data for that year is of limited use in ascertaining the impact of the privilege. Obviously, it will be useful, after the passage of several years, to reexamine these data.

35,405 (1977), 40,753 (1978), 47,873 (1979), and 41,293 (1980)—no clear picture of an increase in one hour psychotherapy sessions is depicted.

Services billed for group and forty-five minute psychotherapy have been rising, with decided increases in 1980. Group psychotherapy is typically not within the psychotherapist-patient privilege because of the presence of other patient-participants.[151] Thus, the rise in group psychotherapy appears attributable to factors other than the privilege.

The increase in psychotherapy services billed for in forty-five minute increments is substantial—4,789 (1977), 6,853 (1978), 9,023 (1979), and 18,581 (1980). Although this increase might be attributable to the passage of the psychotherapist-patient privilege statute, more likely it and the concomitant linear decrease in half-hour psychotherapy result from a change in reporting charges for treatment sessions.[152] The most persuasive evidence that no increase in treatment occurred is the total number of claims for each year, which reveals a slight downward trend from 1976 through 1980, consistent with the overall insurance enrollment.[153]

C. Lay Study

A group of students at evening adult education classes at a nearby university was selected to represent persons not currently in therapy for whom the existence of a privilege might be consequential in entering therapy.[154]Ninety-three percent of this group indicated that they would seek help from a psychiatrist or psychologist for a serious emotional problem.[155] Without any mention of a privilege, the group was asked if, having sought help, they would disclose to a therapist a series of subjects including speeding, sexual fantasies, work failure and income tax evasion, if these subjects were important issues.[156] They indicated that they would be least likely to disclose information about masturbation, sexual thoughts and sexual activities. They were then told that a privilege applied and asked the same question.[157] No significant difference in the response rate occurred. However, when asked whether they would discuss these subjects in the absence of a privilege,[158] the response rate declined

151. Cross, Privileged Communications Between Participants and Group Psychotherapy, 1970 Law & Soc. Ord. 191, 193-94. The Texas statute makes no specific reference to group psychotherapy. One author, however, argues that because communications between a patient and psychotherapist are presumed confidential under the Texas statute, confidentiality in fact need not exist, and group psychotherapy is covered under the Act. Comment, supra note 10, at 161. This issue has not been addressed by the courts in Texas and it remains to be seen whether the Texas courts will read into the statute an implicit requirement of confidentiality. When confidentiality ceases, privilege ceases. 8 J. Wigmore, supra note 2, § 2311, at 599.

152. See Table 5, Appendix infra.

153. Although no changes in the scope of coverage occurred during this period, the total number of persons enrolled did decline slightly. In January 1976, 1,484,161 individuals were enrolled with Blue Cross Blue Shield of Texas, and in December 1980, 1,307,778 individuals were enrolled.

154. See Table 1, Appendix infra.

155. Id. at Question 1.

156. Id. at Question 2.

157. Id. at Question 6.

158. Id. at Question 7.

markedly. The items most affected by the nonexistence of a privilege had legal consequences—speeding, physical violence, income tax evasion and theft. People were only slightly less willing to discuss sexual thoughts and acts or masturbation, the most sensitive items, when told that no privilege existed.

Three-fourths of the group was either unaware of the privilege or thought none existed;[159] only one-fourth realized that a privilege exists. In addition, few expressed concern about the risk of disclosure to an insurer, state agency, potential employer or in a trial setting should they seek therapy.[160] Thus, for these people, the absence of a privilege would not delay or deter therapy because the vast majority were unaware of the privilege's existence and would not consider the risk of disclosure to third parties in conjunction with therapy.

D. Patient Study

Seventy-nine patients in therapy responded to the patient questionnaire.[161] They ranged in age from seventeen to fifty-nine and had a median age of thirty-six with a female-to-male ratio of 3.5:1. They had been in therapy for a median of three years.

Only twenty-seven percent of the patients currently in therapy thought that an applicable privilege exists in Texas; seventy-three percent thought that no privilege exists or were unaware of the law.[162] However, for fifty-four percent, confidentiality was a concern when they first considered therapy.[163] Twenty-eight percent of the patients had asked their therapist about confidentiality;[164] however, only eight percent of the patients said that knowledge of a privilege statute would have encouraged them to seek treatment earlier.[165] Instead, ninety-six percent of these individuals relied more heavily on the therapist's ethics for confidentiality than on a privilege statute.[166]

Forty percent of the patients admitted to withholding information from their therapists.[167] Seventy percent of this information had to do with sexual acts (thirty-six percent) and thoughts (thirty-four percent).[168] Only nine percent of the information withheld concerned thoughts of violence.[169]

The prominent cause for withholding information did not appear to be the status of privilege but, instead, fear of the therapist's personal judgment. For most of these patients the enactment of a privilege statute was inconsequential; they relied more heavily on the therapist's ethics for confidentiality than the privilege; indeed, they were unaware of its existence. Therefore the

159. Id. at Question 4.
160. Id. at Question 3.
161. See Table 2, Appendix infra.
162. Id. at Question 1.
163. Id. at Question 2.
164. Id. at Question 4.
165. Id. at Question 6.
166. Id. at Question 7.
167. Id. at Question 11.
168. Id. at Question 12.
169. Id.

actions of the legislature in enacting a psychotherapist-patient privilege had no effect on the success or failure of their therapy.

E. Therapist Study

The eighty-four therapists who responded to the questionnaire were psychiatrists ranging in age from twenty-seven to seventy-four and had practiced from zero to forty-six years with a median of eleven years.[170] The majority were in full time private practice and saw from three to seventy-five patients each week, with their patients visiting them a median of once weekly. Although they employed a wide variety of psychotherapeutic techniques, the majority used psychoanalytic psychotherapy and supportive psychotherapy.

Forty-eight percent of the therapist population had been requested to disclose confidential patient communications in court; however, only fifteen percent had actually been required to disclose.[171] In the majority of cases some alternative was devised. A total of approximately 128 requests to disclose had been made, a median of two per therapist. We could not ascertain from our data the total number of judicial disclosures.

None of the therapists stated that he knew any of his patients had been harmed by his judicial disclosure,[172] although thirteen respondents were uncertain of the impact of their disclosure upon the patient. Twelve patients were in therapy at the time disclosure was made; two terminated therapy prematurely and the therapy of another two was affected.[173] In one case the disclosure became the focus of therapy, in the other the level of trust decreased.

Approximately twenty-three patients had terminated therapy prior to the time of disclosure. Of these, five returned for further therapy with the same psychiatrist. In one case, the former patient brought an action for malpractice against the therapist.

Forty of the therapists sampled had also warned nonprofessionals, such as family members not directly involved with the patient's treatment, of harm the patient might visit upon them.[174] Twenty-six warnings had been made in the previous year. The therapists gave a median of three warnings during a median professional lifetime of eleven years. Thus, warnings about dangerous patients were unusual events. The psychiatrists' warnings affected the treatment of their patients for sixteen of the forty psychiatrists who had given warnings. The effect varied from relief to violence. Four psychiatrists reported that patients terminated therapy prematurely.

Ninety-five percent of the therapists discussed patients with colleagues. In therapy, eighty-five percent of the therapists had taken the initiative in raising the question of confidentiality, but only fourteen (seventeen percent) did

170. See Table 3, Appendix infra.
171. Id. at Question 5.
172. Id. at Question 6.
173. Id. at Question 7.
174. Id. at Question 9.

so routinely. Eighteen percent did so only when legal problems or a possible courtroom appearance made it necessary to reassure a patient who raised the question of confidentiality, often a child or adolescent (seven, or eight percent), or when there was danger to the patient or others (six, or eight percent).

When asked by patients if communications were held in strict confidence, forty-seven percent of the respondents to this question said that confidentiality would be maintained unless the patient was dangerous to himself, twenty-two percent said that confidentiality would be maintained unless a court ordered disclosure, and twelve percent said that confidentiality was absolute.[175] Only one respondent wrote that he asked his patient, "Why do you ask?"

Fifty-five percent of the respondents did not know of the existence of a privilege statute,[176] and only twenty-two percent thought that the present legal status of confidentiality in Texas limited patients' disclosures.[177]

The responses to the questionnaire from the group of psychiatrists surveyed indicated that the enactment of the psychotherapist-patient privilege statute in 1979 had little impact on the practice of psychotherapy. Undoubtedly, a major contributing factor was the therapists' ignorance of the enactment of the privilege statute. On the other hand, issues related to confidentiality and to disclosure of information had a small but definite impact. Nearly half of the group had been requested to disclose in court at some time during the median practice time of eleven years, although only a third of the group requested to disclose did so. While the group reported no actual psychological harm done to patients by such disclosures, there were a few premature terminations of patients who were in therapy at the time, and in a few instances, the disclosure and the issue of trust became the focus of therapy. Some patients who had terminated therapy at the time of the disclosure returned later to the same therapist for continued treatment.

F. Judge Study

This questionnaire was administered to forty-eight of the fifty-six state and federal judges in Dallas County, Texas with generally unlimited jurisdiction over civil and criminal cases.[178] We were unable to interview eight of the judges.

The judges hearing civil cases were subdivided into those hearing domestic relations cases—divorce, child custody, juvenile, probate, mental health—and those hearing miscellaneous civil cases—personal injury, contract, property and so on.

We interviewed twenty-one judges who heard criminal cases exclusively.[179] The experience of these judges ranged from two to twenty years on

175. Id. at Question 12.
176. Id. at Question 14.
177. Id. at Question 13.
178. See Table 4, Appendix infra.
179. Id. at Question 1.

the bench, with a mean of 7.09 years.[180] Only five of these judges reported instances in which cases pending before them raised a question of the admissibility of a statement made in confidence by a patient to his therapist.[181] The number may be reduced even further; those judges who reported the issue arising referred to its occurrence in the context of examinations by court-appointed psychiatrists on the issue of competency to stand trial. Because of the purpose of these examinations—testimony rather than therapy—it is clear that they are not privileged communications.[182]

We interviewed seventeen judges assigned to hear civil cases other than those involving domestic or probate/mental health issues.[183] Their experience ranged from less than one year to eighteen years, with a mean of 8.91 years on the bench.[184] Seven of these judges had issues raised in cases before them involving confidential communications between patient and psychotherapist.[185] Notably, the two judges who had served eighteen years and the one who had served 17.75 years had never had the issue raised before them. Two judges with ten and eleven years experience each had the issue raised ten times, one with 3.5 years experience had it raised four times, one with two years experience had it raised once, and one with less than a year's experience had it raised twice.

Prior to the enactment of Texas' psychotherapist-patient privilege, these judges indicated that they admitted into evidence relevant confidential communications between patient and therapist.[186] Only one judge indicated that he had, prior to the statute's enactment, imposed a higher standard of relevance for such communications or a requirement that information be sought first from a nonconfidential source.[187]

The majority of judges who had experience with this issue were of the opinion that these confidential communications were important to the case and necessary for accurate resolution of contested judicial issues.[188] They also thought that the information was not available from a nonconfidential source and its admission was not sought to harass or encourage settlement.[189]

We interviewed eight judges who handled domestic cases.[190] These judges had served from 1.5 to thirteen years with a mean of 4.75 years.[191] Although these judges had served, on the average, for a shorter time than the other judges questioned, all but one of the domestic relations judges had the

180. Id. at Question 2.
181. Id. at Question 3.
182. C. McCormick, supra note 44, § 99.
183. See Table 4 at Question 1, Appendix infra.
184. Id. at Question 2.
185. Id. at Question 3.
186. Id. at Questions 4.a.1 & .2.
187. Id.
188. Id. at Question 5.a & .b.
189. Id. at Questions 5.c, .d & .e.
190. Id. at Question 1.
191. Id. at Question 2.

issue arise before them.[192] The judge with thirteen years experience estimated that it rose fifty times a year in this court, the judge with six years experience estimated that it arose five times, the judge with 1.5 years stated the issue arose twenty times, and four other judges stated that it arose once.

These judges admitted relevant confidential communications between patient and therapist before the enactment of Texas' privilege statute and only one imposed a higher threshhold of relevance.[193] Although the majority of judges thought the communications were important to the case,[194] four stated they were never necessary for accurate resolution of contested issues, while three thought they were.[195] The judges did, however, think this information was not available from nonprivileged sources and was not sought only to harass or force settlement.[196]

The two judges[197] we interviewed who heard probate/mental health cases had five and eight years of judicial experience.[198] One of these judges had not had the issue arise, while the other judge stated that it had arisen fifty times.[199] However, answers to other questions by the judge cast doubt on this figure. This judge admitted these communications prior to the privilege statute's enactment[200] and thought that the information was important and necessary for accurate resolution of judicial issues.[201]

The issue of admitting into evidence confidential communications between patient and therapist arises consistently only in domestic cases. Because of the jurisdiction of these courts, this information will bear upon questions of divorce, child custody and termination.

Although not reflected by specific answers to our questionnaire, it was apparent that judges, like patients and therapists, are often unaware of the existence of the privilege. For example, one criminal court judge admitted during the interview that he was unaware of the privilege and when given the statutory citation read it for the first time in front of the questioner. Other judges were less candid and asked for the citation so that they could examine some particular subsection of the statute.

V. FINDINGS

A. Does Lack of Privilege Deter Patients from Seeking Psychiatric or Psychological Help?

Our study indicates that patients are probably not deterred from seeking

192. Id. at Question 3.
193. Id. at Questions 4.a.1 & .2.
194. Id. at Question 5a.
195. Id. at Question 5b.
196. Id. at Question 5.c, .d, & .e.
197. Id. at Question 1.
198. Id. at Question 2.
199. Id. at Question 3.
200. Id. at Question 4.a.1.
201. Id. at Question 5.a & .b.

psychiatric help to any significant degree. Ninety-three percent of our lay sample would have sought help for serious emotional problems. Seventy-four percent of this group did not know whether there was a privilege statute or guessed incorrectly that there was no privilege statute. Thus, the existence of a privilege could not have provided an incentive or avoided a barrier to therapy for these persons. Less than a quarter considered the possibility of disclosure to an insurance carrier, a state agency, a potential employer, or a lawyer in a trial in answering the question whether they would seek help from a therapist.

Most of the patients were unaware of the privilege; thus it played no role in their decision to seek therapy. For ninety-six percent of the patients the therapist's ethics, not the state of the law, provided assurances of confidentiality. This conclusion is bolstered by the insurance data we obtained. No surge of new patients or psychotherapy sessions followed in the first full year of the privilege's enactment.

B. Does Lack of Privilege Delay Seeking Help?

Our patient questionnaire indicates that the existence of privilege would have encouraged only a few people to seek treatment earlier. It made no difference to ninety-one percent of the sample. The factor that seemed to account most for a patient seeking help at any given time was evident from the patients' comments on their questionnaires—the degree of emotional discomfort and the perceived seriousness and consequences of the emotional difficulty.

This conclusion is consistent with the Stanford Law Review study of *Tarasoff*.[202] People in California with emotional difficulties did not stop seeking therapy merely because of a change in the legal protection governing the therapist-patient relationship.

C. Does Lack of Privilege Impair the Quality of Treatment?

Unless a person in therapy is correctly aware of the privilege, or its absence, the state of the law can have no effect on his decision to reveal information to his therapist. The patients we questioned had been in therapy for a median of three years, yet seventy-three percent did not know whether there was a privilege statute or thought, incorrectly, that none existed. Similarly, seventy-four percent of the lay group questioned did not know whether there was a privilege statute or thought, incorrectly, that none existed. Of the twenty patients we sampled who were concerned about confidentiality, only ten asked that specific steps be taken to preserve confidentiality, and only one asked that no written record be kept.

Because the median duration of treatment of the patient group was three years, we may assume that this group of patients had basically stable, trusting relationships with their therapists. Even so, these people had been less than candid with their therapists. In this group, forty percent had withheld infor-

202. See text accompanying notes 124-37 supra.

mation. By far the most prominent categories of information withheld were sexual thoughts (thirty-four percent of items withheld) and sexual acts (thirty-six percent). Thoughts of violence, including suicide, accounted for only nine percent of the items withheld, and financial issues, another nine percent. It seemed clear that the types of information withheld had far more to do with projected concern about their therapists' personal responses to their thoughts and behavior than about the possibility of disclosing legally punishable actions. However, the Stanford Law Review study showed that the therapist's raising the issue of his duty to warn reduced communication about violent tendencies.[203]

Our group of patients very clearly viewed confidentiality as a requisite for the trust necessary for therapy. When asked on what they relied most heavily to guarantee the privacy of their communication with the therapist, patients stated that they relied much more strongly on the therapist's ethics than on a statutory guarantee of privilege. When the lay group was asked what they would reveal to a psychiatrist or a psychologist, their responses were the same when no comment was made about privilege as when privilege was specified. When a no privilege condition was specified, the overall disclosure rate dropped from seventy-six percent to fifty-three percent for all categories, nearly doubling the nondisclosure rate.

From the above data, we conclude that withholding information from therapists is common, but that it probably has little relationship to fear of disclosure, and would therefore probably not be greatly enhanced by a statutory privilege. The basic reason why patients withhold items is because they fear the judgment of their therapists.

The outcome is different when the therapist threatens to disclose or actually discloses. Threats of disclosure reduce the communication of violent urges and lead to premature termination of the patient-therapist relationship. Actual disclosure leads to premature termination in a few cases, but there is no positive evidence that emotional damage is done to patients who are called to account for their behavior in a court of law.

The above data suggest that for some patients the quality of treatment would be facilitated by a privilege statute, but that it would in no way lead to full disclosure. Full disclosure is a personal issue between therapist and patient, and people do not fully reveal themselves merely because they are guaranteed an absolute privilege.

D. Does Lack of Privilege Cause Premature Termination of Therapy?

The therapist's threat to disclose or his actual disclosure, whether or not it is voluntary, causes a small number of premature terminations from therapy and probably deters a large percentage of these people from seeking further help. Yet, even prior to the passage of the psychotherapist-patient privilege in Texas, therapists were required to disclose confidential patient communica-

203. See text accompanying notes 124-37 supra.

tions infrequently. Only fifteen percent of the therapists studied were ever required to disclose. In the vast majority of cases some alternative solution was devised.

E. Are Patients Psychologically Harmed by Their Therapists' Disclosures?

No convincing evidence exists that patients are harmed by their therapists' disclosures. The therapist questionnaires revealed no positive evidence of psychological harm. However, of the forty-eight respondents to this question, thirteen did not know whether psychological harm occurred, presumably because they were no longer following the patients concerned. One patient brought a malpractice suit against his former therapist, presumably because of damages that he or she thought were incurred as a result of the psychiatrist's testimony. A few patients about whom therapists testified after the termination of their initial treatment later returned to the same therapists for treatment.

F. Does the Presence of Privilege Render Judicial Proceedings Inaccurate?

Although confidential communications between patient and therapist are sought to be introduced occasionally in virtually all types of cases, they are most consistently sought to be introduced in domestic relations cases. Therapist testimony in these cases is most likely to bear upon child custody and termination of the parent-child relationship. Thus, the most profound legal effect the privilege may have is a limitation on the availability of evidence to adjudicate these issues correctly. Although the majority of the judges handling these cases thought that these communications were important to the case, the judges differed in their opinions on whether this testimony was necessary. Four judges thought these communications were not necessary for accurate resolution of contested issues, while three thought that they were. None of the judges thought that an alternative source of this information existed.

VI. RECOMMENDATIONS

Proponents of the psychotherapist-patient privilege contend that it is absolutely necessary for effective therapy; opponents deny this and contend that it seriously impairs the accuracy of judicial proceedings. Our findings suggest that both have overstated their cases. The existence of the privilege is consequential in the inception and conduct of a therapeutic relationship for only a small percentage of individuals who might consider psychotherapy for the treatment of an emotional problem. However, relevant evidence is regularly excluded through application of the privilege in only one category of cases, in which the judges differ over the necessity of this evidence for accurate decision making.

Although more research on this subject is necessary, some observations can be made now. Most major social policy issues involve questions that are subject to empirical testing and questions which are not. This is also true in

the case of privilege. For a small percentage of people the psychotherapist-patient privilege may have a marked bearing on the efficacy of their therapy and in a small percentage of judicial proceedings the psychotherapist-patient privilege may have a marked bearing on the accuracy of the proceedings. This much empirical research can suggest. Which is more important? This question is not subject to empirical validation but calls instead for weighing of values. Our research cannot choose between competing values; it can, however, clarify the stakes in this choice.

APPENDIX

Table 1

LAY QUESTIONNAIRE: DATA SUMMARY

Age: (n = 121)
Range = 17-57
Median = 24

Sex: (n = 120)
F = 71 (59%)
M = 49 (41%)
1.5:1

Marital Status: (n = 118)
Married = 39 (33%)
Single = 66 (56%)
Divorced = 12 (10%)
Widowed = 1 (1%)

Occupation: (n = 110)

Office/Clerical	28	25%
Professional	13	12%
Technician	12	11%
Student	11	10%
Unskilled labor	10	9%
Sales	9	8%
Managerial	8	7%
Skilled labor	8	7%
Housewife	5	5%
Beauty Operator	3	3%
Waitress	2	2%
Police	1	1%
	110	100%

1. If you had a serious emotional problem would you consider seeking help from a psychiatrist?
   Yes = 112 (92.5%)
   No = 9 (7.5%)

2. If you would consider seeking such help and the following subjects were important, would you reveal them to the psychologist or psychiatrist?

	2. No condition		6. Privilege		7. No condition		6-7.
a. Speeding	104	86%	104	86%	53	49%	37%
b. Sexual fantasies	88	73%	81	67%	66	55%	12%
c. Physical violence	104	86%	100	83%	69	57%	26%
d. Masturbation	84	69%	74	61%	62	51%	10%
e. Work failure	108	89%	102	84%	58	48%	36%
f. Other sexual acts	90	74%	85	70%	65	54%	24%
g. Cheating on income tax	95	79%	92	76%	71	59%	17%
h. Theft	96	79%	93	77%	69	57%	20%
TOTAL	769	79% avg.	731	76% avg.	513	53% avg.	
Avg. non-disclosure		21%		24%		47%	27%

3. When you answered questions 1 and 2, did you consider that your psychologist or psychiatrist might be asked about your conversation with him?

	Yes
a. By your insurance carrier	15 (12%)
b. By a state agency	17 (14%)
c. By a potential employer	18 (15%)
d. By a lawyer in a trial	27 (22%)

4. Is there a law in Texas that prevents a court from forcing a psychologist or psychiatrist called as a witness at a trial to state what his patient told him? Yes = 26% No = 7% D/K = 67%

5. If there is such a law, may the psychologist or psychiatrist be required to testify in any of the following situations?

	PRIVILEGE	
	YES	NO
a. You are charged with murder and what you told the psychologist or psychiatrist proves that you did it.	60%	36%
b. You sue someone for emotional injuries suffered in an accident, but the psychiatrist or psychologist thinks your problems started before the accident.	40%	55%
c. You and your spouse seek a divorce and fight over child custody and some things you told the psychologist or psychiatrist will not help your case.	60%	36%

6. Assume that the law in Texas does prevent a court from forcing a psychologist or psychiatrist called as a witness at trial to state what his patient told him and the following subjects were important to your discussions with him or her. Would you reveal to the psychiatrist or the psychologist:

[See answers to Question 2]

7. If there were no such law and a psychiatrist or psychologist could be forced to tell in court what you revealed in therapy, would it affect your discussion with the psychiatrist or psychologist of:

[See answers to Question 2]

Table 2

PATIENT QUESTIONNAIRE: DATA SUMMARY
(n = 79)

Age: (n = 78)
Range = 17-59
Median = 36

Sex: (n = 78)
F = 57 (73%)
M = 21 (27%)
3.5:1

Marital Status: (n = 79)
M = 42 (53%)
S = 22 (28%)
D = 14 (18%)
W = 1 (1%)

Occupation: (n = 71)

Professional	22	31%
Housewife	10	14%
Office/Clerical	7	9%
Student	6	8%
Managerial	5	7%
Unemployed	4	5%
Retired	3	4%
Unskilled labor	3	4%
Sales	2	3%
Artist/Photograper	2	3%
Skilled technical	2	3%
Technician	1	1%
Consultant	1	1%
Self-employed	1	1%
Beauty Operator	1	1%
Flight Attendant	1	1%
	71	96%

Therapy: Range = 1 week - 17 years; Median = 3 years, most seen once a week.

1. Do you think there is a law which prohibits psychiatrists from disclosing what patients tell them to: (n = 78)
   a. the psychiatrist's friends: Yes = 23 (29%); No = 43 (55%); D/K = 12 (15%)
   b. the psychiatrist's professional colleagues: Yes = 13 (17%); No = 50 (65%); D/K = 14 (18%)
   c. a court of law: Yes = 21 (27%); No = 39 (50%); D/K = 18 (23%)
2. Was the confidentiality of the doctor-patient relationship a consideration for you when you first started thinking about therapy? (n = 79) Yes = 43 (54%)

3. If your answer to (2) was "yes," was it: (n = 43)
   a. A *very* important consideration (you had great concern about the privacy of your communication) 16 (20%)
   b. A *not* important consideration (you wondered briefly if your communication to the doctor might be disclosed, but didn't think further about it) 17 (22%)
   c. Somewhere between (a) and (b).....10 (13%)
4. If you were concerned about the confidentiality of the relationship, did you ask the doctor about it?
   (n = 79) Yes = 22 (28%)
5. Did you take any steps to insure the confidentiality of the relationship, like ask the doctor not to keep written records or obtain his word that he would not disclose what you told him?
   (n = 72) Yes = 10 (13%)
   a. What did you do?

      Asked that sessions not be taped 2
      Asked that the physician not disclose his written record 1
      Asked the doctor not to keep record 1
      Asked the doctor not to disclose 1
6. If you had known there was a law prohibiting psychiatrists from disclosing what patients tell them, would you have sought treatment earlier?
   (n = 77) Yes = 6 (8%) No = 70 (91%) N/A = 1 (1%)
7. On what did you most strongly rely to guarantee the privacy of your communication to the psychiatrist?
   a. His ethics 96%
   b. The generally accepted principle that the doctor-patient relationship is confidential 93%
   c. A law forbidding disclosure 12%
8. Have you ever wondered if there is a law prohibiting the psychiatrist from telling what you tell him?
   (n = 78) Yes = 35 (45%)
9. Have you ever asked if such a law exists?
   (n = 79) Yes = 8 (10%)
10. If you answered (8) "yes" and (9) "no," why not?

    Relied on doctor's ethics or trust of the doctor 9
    Weren't concerned greatly 5
    Assumed there was such a law.....3
    Didn't consider problems to be of a legal matter 3
    Didn't wonder until receiving the form.....2

Knew of law's existence 1
Felt doctor would have been insulted 1
Was very non-assertive 1
Assumed release would be required 1
Had discussed legal aspects 1
Attorney felt Texas had no effective privilege 1
Knew there was none and it wouldn't do any good if there was 1
Was informed by doctor that there was such a law 1

11. Was there anything withheld from your psychiatrist? (n = 79) Yes = 31 (40%)

12. What kind of information did you withhold? (n = 53)

a.	Thoughts of violence	5	(9%)
b.	Acts of violence	0	(0%)
c.	Sexual thoughts	18	(34%)
d.	Sexual acts	19	(36%)
e.	Financial issues	5	(9%)
f.	Possible crimes	2	(4%)
g.	Drugs or medications taken	2	(4%)
g.	Other	2	(4%)

One patient noted that withholding information may not be related to legal privilege.

Table 3

THERAPIST PRIVILEGE QUESTIONNAIRE: DATA SUMMARY

Questionnaires mailed = 186 Questionnaires returned = 84 (45%)

Respondent characteristics (n = 84)

Age:	Sex:	Years in Practice:
Range = 27-74 years	F = 16	Range = 0-46
Median = 44	M = 58	

1. Type of Practice

Full-time outpatient (private)	28	(33%)
Full-time inpatient and outpatient (private)	27	(32%)
Part-time practice (less than 20 hours/week)	13	(15%)
Institutional practice	16	(20%)
	84	(100%)

2. Number of Patients Seen Per Week:
   Range = 3-75 Average = 29.64

3. Usual Frequency of Visits/Patient/Week:
   Range = 1-5 Median = 1

4. Type of Psychotherapy Practiced (Multiple answers allowed)

Psychoanalytic Psychotherapy	76	(90%)
Supportive Psychotherapy	63	(75%)
Marital Counseling	45	(53%)
Behavior Therapy	15	(18%)
Psychoanalysis	13	(15%)
Cognitive Therapy	12	(14%)
Hypnosis	11	(13%)

   (Also listed: Rational-Emotive Therapy, Gestalt Therapy, Family Therapy, Play Therapy, Pharmacotherapy, Transactional Analysis, Interpersonal, Crisis Intervention)

5. Have you ever been requested to disclose in court information revealed to you in therapy?
   (n = 81) Yes = 39 (48%) No = 42 (52%)

   a. How many times has this happened to you?
      (n = 35) Range = 0-40 Median = 2

   b. Were you forced to disclose at any time?
      (n = 56) Yes = 13 (16% of 81)

   c. If your answer to 5b was "no" for one or more cases, how did you avoid disclosure?

Wasn't necessary	1

Granted privilege 3
Negotiated prior to court 1
Lied 1
Felt best interest of patient 1

6. If you did disclose, were any of your patients psychologically harmed?
(n = 48) Yes = 0 No = 20 D/K = 13 N/A = 15

7. How many of the patients about whom you disclosed were in therapy at the time? (n = 25)

0 = 15 respondents
1 = 7 respondents
2 = 1 respondent
all = 1 respondent
few = 1 respondent

a. Did any terminate prematurely because of the disclosure?
(n = 23) Yes = 2 No = 21 N/A = 1

b. Was therapy affected, and if so, in what way?
(n = 8) Yes = 2 N/A = 5 ? = 1

8. How many of the patients about whom you disclosed had terminated therapy with you? (n = 30)

N/A = 5 respondents
0 = 10 respondents
1 = 10 respondents
2 = 2 respondents
3 = 1 respondent
All = 1 respondent
Few = 1 respondent

a. Did any return to therapy afterward? (n = 32) N/A = 11 respondents Yes = 5 respondents No = 16 respondents

b. If not, why not?
Patient brought malpractice suit 1
Patient moved from Dallas 1
Deceased 1
Patient was a child 1
Could not afford 1
Imprisoned 1

9. Have you ever warned a person who was not a professional directly involved in your patient's treatment that you thought your patient might harm him?
(n = 79) Yes = 40 (51%) No = 39 (49%)

a. How many times last year? (n = 42)
Total = 26 warnings Average = 0.3 warnings

0 = 13 respondents
1 = 12 respondents
2 = 9 respondents
3 = 4 respondents
? = 1 respondent

b. How many times in your career? (n = 39)
Range = 0-40 Median = 3

c. If your answer to 9 was "yes," did it affect your therapy of your patient? (n = 38)
Yes = 16 No = 20 ? = 1 N/A = 1

1) If "yes," in what way? (n = 19)

It scared all of us 1
I work with children, usually prelude to hospitalization 1
Variable = anger to relief 11
Became a focus of therapy—issue of confidentiality and self-control 1
Violence 1
Hospitalized patient 3
Patient helped or relieved 7
Changed therapists at my request 1
Usually conflict about my viewpoint 1

2) If "yes," did the patient terminate prematurely?
(n = 26) Yes = 4 (15%) No = 22 (85%)

10. Do you ever discuss patients with colleagues?
(n = 76) Yes = 72 (95%) No = 4 (5%)

a. If "yes," what do you discuss? (n = 65)

Diagnosis and problems in treatment 36
Psychodynamic issues 10
All aspects 6
Only with patient's approval 2
Issues related to collaboration 3
Dangerousness to self, others 1
Convict 1
Other 6

11. Do you ever take the initiative in raising questions of confidentiality with your patients?
(n = 79) Yes = 67 (85%) No = 12 (15%)

a. If "yes," under what circumstances? (n = 54)

Routine 14
Where legal problems or courtroom appearance possible 14

When patient concerned 8
When therapist wishes to share, or wants outside information, or is asked for information 8
To reassure patient (usually a child, adolescent) 7
When there is danger to patient or others 6
When patient is V.I.P. 1
When patient is friend or relative of someone I know or work with 1

12. What do you tell patients if they ask you if you will keep what they say in strict confidence?

I will keep confidence unless self or others endangered	36	(47%)
I will keep confidence unless ordered by court	17	(22%)
I will keep confidence as far as law allows	10	(13%)
I will keep confidence absolute	9	(12%)
I will keep confidence unless patient involves others, such as third party payor	3	(4%)
I ask why	1	(1%)
I say there is no confidentiality	1	(1%)
Total responses	77	(100%)

a. How do your patients react?

Accepting (positive, reassured, relieved)	67	(79%)
Varies	10	(11%)
Defensively, angrily, hesitantly	4	(5%)
Surprised	3	(3%)
Occasionally leave therapy	1	(1%)
They explore their reasons for asking	1	(1%)
Total responses	86	(100%)

13. Do you think that the present status of confidentiality in Texas limits some of what your patients tell you? (n = 75)

Yes = 16 (22%) No = 57 (76%) ? = 1 (1%) N/A = 1 (1%)

a. If so, why? (n = 17)

Patients don't know how or are not concerned 5
Legal reasons, fear of family.....4
We don't have it 1
Records can be subpoenaed 1
We have confidentiality 2
Patients don't feel free to confide deepest urges or fantasies.....1

14. Do you think there is a legal privilege protecting communications between a psychotherapist and his patient in Texas? (n = 77)
Yes = 35 No = 33 D/K = 9
55% didn't know or were wrong.

Table 4

JUDICIAL QUESTIONNAIRE: DATA SUMMARY
(n = 48)

1. What types of cases do you hear?

   a. Domestic..... 8
   b. Criminal 21
   c. Probate/Mental Health (MH)..... 2
   d. Miscellaneous Civil.....17

2. How long have you been a judge of this court?

	Domestic	Criminal	Probate/MH	Misc. Civ.	Total
0 - 1 years =	0	0	0	1	1
2 - 5 years =	5	8	0	5	18
6 - 10 years =	2	5	2	4	13
11 - 15 years =	1	5	0	3	9
16 - 20 years =	0	2	0	3	5

3. In how many cases you have heard has a question arisen concerning the admission of a statement made in confidence by a patient to his psychiatrist?

	Domestic	Criminal	Probate/MH	Misc. Civ.	Total
0 - 5	6	15	0	15	36
6 - 20	0	3	0	2	5
11 - 20	1	0	0	0	1
21 - 30	0	1	0	0	1
31 - 40	0	0	0	0	0
41 - 50	0	0	1	0	1
51 - up	1	1	0	0	2

4. On August 27, 1979, House Bill 1163 creating a psychotherapist-patient privilege became effective.

   a. Before this statute became effective, when a confidential communication between a psychiatrist and patient was sought to be admitted, how did you resolve this issue?

      1. Always admitted if relevant:

	Yes	No
Domestic	3	0
Criminal	2	0
Probate/MH	1	0
Misc. Civil	4	0
	10	0

2. Imposed a more stringent standard of relevance:

	Yes	No
Domestic	1	1
Criminal	0	0
Probate/MH	0	0
Misc. Civil	1	1
	2	2

3. Admitted only if information not available from a non-confidential source:

	Yes	No
Domestic	0	1
Criminal	0	0
Probate/MH	0	0
Misc. Civil	1	0
	1	1

4. Other:

Never admitted = 1 (Misc. Civil)

b. How many times did the question of privileged communication between psychotherapist and patient arise between August 27, 1979, and September 1, 1980?

	Domestic	Criminal	Probate/MH	Misc. Civil	Total
0 =	2	1	1	4	8
1 =	1	1	0	1	3
2 =	0	0	0	1	1
3 =	0	0	0	0	0
4 =	1	0	0	0	1
5 =	0	0	0	0	0

c. Please estimate how many times this occurred in the year prior to the enactment of the statute.

	Domestic	Criminal	Probate/MH	Misc. Civil	Total
0 =	1	1	1	1	4
1 =	2	0	0	1	3
2 =	0	1	0	0	1
3 =	1	0	0	0	1
4 =	0	0	0	0	0
5 =	0	0	0	1	1

5. When the question of admitting confidential communications between psychotherapist and patient arose in a case, were you of the opinion that the information involved was (check appropriate blank):

	Often	Rarely	Never
a. Important to the case			
Domestic	4	1	2
Criminal	5	1	2
Probate/MH	1	0	0
Misc. Civil	3	0	1
	13	2	5
b. Necessary for accurate resolution of contested factual issues			
Domestic	3	0	4
Criminal	3	2	3
Probate/MH	1	0	0
Misc. Civil	3	0	1
	10	2	8
c. Available from non-privileged sources			
Domestic	0	0	3
Criminal	1	0	3
Probate/MH	1	0	0
Misc. Civil	0	1	3
	2	1	9
d. Sought to encourage settlement			
Domestic	0	1	5
Criminal	0	2	3
Probate/MH	0	0	0
Misc. Civil	0	2	2
	0	5	10
e. Sought only to harass			
Domestic	0	1	5
Criminal	0	0	5
Probate/MH	0	1	0
Misc. Civil	1	2	3
	1	4	13
f. Other (specify)			
Domestic	0	0	0
Criminal	0	0	0
Probate/MH	0	0	0
Misc. Civil	0	0	0
	0	0	0

Table 5

BLUE CROSS/BLUE SHIELD OF TEXAS

	1976	1977	1978	1979	1980
Initial Psychiatric Interview	10,174	10,829	8,560	10,230	9,682
Psychotherapy, 1 hour	39,462	35,405	40,753	47,873	41,293
Psychotherapy, half-hour	130,171	134,252	113,072	102,933	100,734
Psychotherapy, 45 minutes	—	4,789	6,853	9,023	18,581
Psychotherapy, Group, 1½ hours	9,256	8,051	8,631	8,995	13,180
Total Number of Patient Visits	189,063	193,326	177,869	179,054	183,470