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The Psychotherapist-Patient Privilege: A Therapeutic Jurisprudence View

BRUCE J. WINICK*

Although all fifty states recognize some form of psychotherapist-patient privilege,[1] the issue remains unresolved for the federal courts under the Federal Rules of Evidence. In the revisions to the Federal Rules of Evidence drafted by the Judicial Conference and approved by the Supreme Court in 1972, proposed Rule 504 explicitly provided for a psychotherapist-patient privilege for confidential communications made in connection with treatment.[2] Congress, however, rejected this proposed rule.[3] Instead, Congress adopted Federal Rule of Evidence 501, a general rule of privilege granting the federal courts wide discretion to recognize evidentiary privileges "in the light of reason and experience."[4] The lower federal courts are split on whether this broad language should be construed to recognize a psychotherapist-patient privilege,[5] and now

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1. Jaffee v. Redmond, 51 F.3d 1346, 1356 & n.17 (7th Cir.), *cert. granted*, 116 S. Ct. 334 (1995); Anne D. Lamkin, *Should Psychotherapist-Patient Privilege Be Recognized?*, 18 AM. J. TRIAL ADVOC. 721, 723-25 (1995) (all fifty states and the District of Columbia have recognized the psychotherapist-patient privilege in some form); *e.g.*, ALASKA R. EVID. 504 (1995); CAL. EVID. CODE §§ 1010-26 (West 1994); COLO. REV. STAT. § 12-43-214 (1995); FLA. STAT. § 90.503 (1994); UTAH R. EVID. 506 (1994); VA. CODE ANN. § 8.01-400.2. (1994).

2. *Rules of Evidence for United States Courts and Magistrates*, 56 F.R.D. 183, 240-41 (1972). The proposed Rule set forth 10 specified privileges, including a psychotherapist-patient privilege. *Id.* at 230-58.

3. *Cf.* Act of Jan. 2, 1975, ch. 157, 88 Stat. 1926 (establishing rules of evidence, not including proposed Rule 504).

4. FED. R. EVID. 501.

5. *Compare In re* Doe, 964 F.2d 1325 (2d Cir. 1992) *and In re* Zuniga, 714 F.2d 632 (6th Cir.), *cert. denied*, 464 U.S. 983 (1983) (both recognizing a psychotherapist-patient privilege) *with* United States v. Burtrum, 17 F.3d 1299 (10th Cir.) (holding that the privilege does not apply in the context of a child sex abuse case), *cert. denied*, 115 S. Ct. 176 (1994) *and In re* Grand Jury Proceedings, 867 F.2d 562 (9th Cir.) (no psychotherapist-patient privilege for target of grand jury), *cert. denied*, 493 U.S. 906 (1989) *and* United States v. Corona 849 F.2d 562 (11th Cir.

the Supreme Court has granted review of a case that recognized the privilege and applied it to psychiatric social workers.[6] In that case, *Jaffee v. Redmond*, the Court will decide whether the psychotherapist-patient privilege should be recognized in federal cases that do not require application of state law on the issue.

The facts of the case are interesting and reveal the importance of the privilege question. Mary Lou Redmond, an Illinois police officer, responded to a call concerning a fight in progress at an apartment complex. Arriving at the scene alone, she was advised that there had been a stabbing in the building. In the events that followed, Officer Redmond fired her gun and killed Ricky Allen.

The facts were in dispute. According to Redmond's testimony, Allen was chasing another man in the building with a butcher knife and had failed to heed the officer's warnings.[7] In contrast, testimony by several of Allen's relatives who were witnesses to the shooting suggested that Allen was not armed and that Officer Redmond had emerged from her police car with her gun drawn and shot Allen without warning.[8] Allen's surviving family members brought an action against Redmond in federal district court in Illinois, alleging that the officer's unnecessary use of force had infringed Allen's constitutional rights in violation of the Federal Civil Rights Act and that she had caused his death in violation of the Illinois wrongful death statute.[9]

Several days after the shooting, Officer Redmond began to visit Karen Beyer, a clinical social worker licensed under the law of Illinois and employed by the village for which Redmond worked.[10] Redmond saw her several times a week for counseling over approximately a six-month period.[11] The plaintiffs in the civil court action thereafter sought discovery of statements Redmond had made to her therapist and copies of Beyer's therapy notes. The trial court denied Redmond's motion to quash these discovery orders on the basis of a psychotherapist-patient privilege, finding that the Federal Rules of Evidence did not recognize

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1988) (no physician-patient or psychotherapist privilege under the common law in federal criminal trials), *cert. denied*, 489 U.S. 1084 (1989) *and* United States v. Meagher, 531 F.2d 752 (5th Cir.) (no physician-therapist privilege under the common law in federal criminal trials), *cert. denied*, 429 U.S. 853 (1976).

6. Jaffee v. Redmond, 51 F.3d 1346 (7th Cir. 1995).

7. *Id.* at 1349.

8. *Id.*

9. *Id.* at 1348.

10. *Id.* at 1350. Under Illinois law, a licensed clinical social worker must have a master's or doctoral degree in social work from an accredited graduate school of social work and at least three years of supervised clinical social work experience. *Id.* at 1350 n.3 (citing ILL. REV. STAT. ch. 225, para. 20/9 (1994)).

11. *Id.* at 1350.

extending such a privilege to psychiatric social workers.[12] When Beyer refused to answer certain questions at the deposition and produce her notes, the plaintiffs moved to compel, and the trial court ordered further discovery on the issue. When Officer Redmond refused to answer questions concerning what she had said to the therapist about the shooting, and Beyer produced only redacted portions of her therapy notes, the trial court permitted a jury instruction allowing the jury to draw an adverse inference resulting from Redmond's refusal to comply with discovery.[13] The jury returned a verdict for the plaintiffs. On appeal, the United States Court of Appeals for the Seventh Circuit reversed, finding that the trial court had erred in refusing to recognize a therapist-patient privilege under the Federal Rules of Evidence.[14]

In refusing to adopt a psychotherapist-patient privilege legislatively, Congress expressed its intent "not to freeze the law of privilege."[15] Instead, Congress left the issue to the federal courts, inviting them to develop a federal common law of evidentiary privilege.[16] With the federal circuit courts of appeals divided, the Supreme Court now will decide the issue: Should a federal psychotherapist-patient privilege be recognized; and should it apply to psychiatric social workers?

The issue before the Supreme Court is not a constitutional question, although it arises in a context in which the relevant constitutional values push strongly in the direction of construing the Federal Rules to recognize the privilege. Among those areas of constitutional privacy that are a part of the liberty protected by the Due Process Clauses of the Fifth and Fourteenth Amendments is "the individual interest in avoiding dis-

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12. *Id.* In contrast, Illinois recognizes a privilege for psychiatric social worker-patient communiations. *See id.* at 1351 (citing ILL. REV. STAT. ch. 740, para. 110/2, 110/10 (1994)).

13. *Id.*

14. *Id.* at 1358.

15. Trammel v. United States, 445 U.S. 40, 47 (1980). In rejecting the proposed codification contained in Rule 504, Congress did not intend to disapprove or foreclose any of the specified privileges contained therein. The legislative history reflects that Congress did not reject proposed Rule 504 on the merits, but that the resolution of the controversy it created would unduly delay the adoption of the entire rules package that had been submitted. *See* S. REP. No. 1277, 93d Cong., 2d Sess. 6 (1974); *see also* 120 CONG. REC. 40,891 (1974) (statement of Rep. Hungate) ("[T]he privilege section of the rules of evidence generated more comment or controversy than any other section.").

16. *See* S. REP. No. 1277, *supra* note 15, at 13:

> It should be clearly understood that, in approving this general rule as to privileges, the action of Congress should not be understood as disapproving any recognition of a psychiatrist-patient, or husband-wife, or any other of the enumerated privileges contained in the Supreme Court rules. Rather, our action should be understood as reflecting the view that the recognition of a privilege based on a confidential relationship and other privileges should be determined on a case-by-case basis.

See also 120 CONG. REC. 40,891 *supra* note 15 (statement of Rep. Hungate) ("Rule 501 is not intended to freeze the law of privilege as it now exists.").

closure of personal matters."[17] Another is the liberty interest in making personal health care decisions.[18] A refusal to recognize the therapist-patient privilege would frustrate both these interests. But the issue before the Court is not the constitutionality of a federal rule of evidence denying the privilege. The Federal Rules do no such thing. Indeed, they explicitly leave open issues of evidentiary privilege, allowing the federal courts the authority to develop a federal common law of privilege.[19] However, because recognizing a therapist-patient privilege would further these constitutional values, and rejecting it would frustrate them, the task of rule construction inevitably will be affected by the constitutional questions lurking in the background. While they do not decide the issue, these constitutional values certainly point toward recognition of the privilege.

Apart from constitutional considerations, what factors should guide the Court in reaching its decision? The recognition of any privilege, by depriving the courts of probative evidence, will inevitably harm the truth-determination process. The question is whether the value of recognizing a specific privilege outweighs this harm.[20]

In addressing the question presented in *Jaffee v. Redmond*—whether the Federal Rules of Evidence should be construed to permit a psychotherapist-patient privilege, and if so, whether it should extend to psychiatric social workers—the Court is directed to construe the federal rules in a way that permits the development of a common law of federal evidence in accordance with "reason and experience."[21] These words

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17. Whalen v. Roe, 429 U.S. 589, 599 (1977).

18. *See, e.g.*, Riggins v. Nevada, 504 U.S. 127, 137 (1992) (recognizing a constitutional liberty interest in avoiding unwanted antipsychotic medication); Washington v. Harper, 494 U.S. 210, 229 (1990) (same); Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 278 (1990) ("The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."); Bruce J. Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1705, 1732-35 (1992) (discussing liberty interest in making personal health care decisions).

19. FED. R. EVID. 501.

20. In a classic formulation of the standard for recognition of an evidentiary privilege, Dean Wigmore stated:

> (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 litigation.

8 JOHN H. WIGMORE, EVIDENCE § 2285, at 527 (John T. McNaughton ed., 1961).

21. *Id.*

suggest that the Court should be sensitive to the consequences of its action. "The life of the law," Holmes told us, "has not been logic: it has been experience."[22] Among the many public policy considerations that might enter into this determination, the Court should examine closely the therapeutic or antitherapeutic consequences of its decision.[23] A therapeutic jurisprudence analysis of the issues before the Court suggests that significant positive therapeutic consequences would follow if the psychotherapist-patient privilege were to be recognized, and corresponding negative therapeutic consequences would ensue if it is not.

In an increasingly complex and stressful society, characterized by erosion of family and community, it is not surprising that mental illness is so prevalent. A recent study estimated that more than fifty-two million Americans suffer from a specific diagnosable mental disorder each year.[24] This represents more than twenty-eight percent of the adult population, or more than one in four.[25] Moreover, the statistics present a conservative picture.[26] Close to nine million of those with mental disorder develop the problem for the first time each year.[27] Another eight million of these suffer from a relapse of a condition developed earlier.[28] This study also estimated that of the more than fifty-two million Americans who suffer from mental illness each year, only 28.5 percent get help.[29]

Were more to get help, the many individual and social problems engendered by this high prevalence rate of mental illness would be considerably reduced. Were mental health treatment and counseling to be sought by more Americans, many of the severe social problems that characterize modern life—including divorce, child abuse and neglect, alcoholism and drug abuse, homelessness, poverty, employee absentee-

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22. OLIVER W. HOLMES, JR., THE COMMON LAW 1 (Gryphon Editions 1982) (1881).

23. *See generally* DAVID B. WEXLER & BRUCE J. WINICK, ESSAYS IN THERAPEUTIC JURISPRUDENCE (1991) (analyzing law's role as a therapeutic agent and suggesting that social science be used to assess the impact of law on the mental and physical health of the people it affects); LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE (David B. Wexler & Bruce J. Winick eds., forthcoming 1996) (containing examples of therapeutic jurisprudence analysis of various areas of the law as well as commentary on therapeutic jurisprudence).

24. *See* Darrel A. Regier et al., *The de Facto U.S. Mental and Addictive Disorders Service System*, 50 ARCHIVES GEN. PSYCHIATRY 85, 88 (1993); *see also* Daniel Goleman, *Mental Disorders Common, but Few Get Treatment, Study Finds*, N.Y. TIMES, March 17, 1993, at C13 (discussing study by Regier).

25. Regier et al., *supra* note 24, at 88, 90.

26. The researchers counted only people who met all the official psychiatric diagnostic criteria for a disorder. People with "problems in living," such as marital difficulties, were excluded. Goleman, *supra* note 24, at C13.

27. Regier et al., *supra* note 24, at 88.

28. *Id.*

29. *Id.* at 90.

ism, and even crime—would be diminished. Many mental health problems are preventable with only a minimal amount of counseling that can help the individual to solve a personal problem, reduce stress, or cope with difficulties. Many mental disorders respond effectively to the broad range of treatment modalities currently available.[30]

Why, then, don't more people with mental health problems seek treatment, and how can we encourage more of them to do so? While at one level, the problem may involve the supply of therapists and the expense of obtaining their services, at another it may involve concern, particularly in our increasingly litigious society, that the most intimate and personal details of human life, revealed within the therapeutic relationship, might be the subject of subpoena and court-ordered disclosure.

The existing empirical literature is inconclusive concerning whether legal recognition of a psychotherapist-patient privilege is an important factor in whether people seek mental health treatment. Some studies suggest that people generally are unaware of legal rules relating to evidentiary privileges for professional communications and that their behavior in regard to obtaining or avoiding treatment is little affected by such legal rules.[31] This is consistent with studies showing little impact on patients' behavior in seeking therapy resulting from the *Tarasoff* rule,[32] which imposes a duty on therapists to warn individuals who are at risk of harm at the hands of their patients when revelations in therapy suggest such a threat.[33] These findings, however, are far from conclusive.[34]

Professors Daniel Shuman and Myron Weiner have performed three separate studies of the consequences of the psychotherapist-patient privilege.[35] The first study sought to assess the impact of a Texas statute

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30. *See* Allen E. Bergin & Michael J. Lambert, *The Effectiveness of Psychotherapy, in* HANDBOOK OF PSYCHOTHERAPY AND BEHAVIOR CHANGE 3, 143 (Allen E. Bergin & Sol L. Garfield eds., 4th ed. 1994).

31. *See* Daniel W. Shuman et al., *The Privilege Study (Part III): Psychotherapist-Patient Communications in Canada*, 9 INT'L J.L. & PSYCHIATRY 393 (1986); Daniel W. Shuman & Myron F. Weiner, *The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege*, 60 N.C. L. REV. 893 (1982); Myron S. Weiner & Daniel W. Shuman, *Privilege—A Comparative Study*, 12 J. PSYCHIATRY & L. 373 (1984).

32. *See* James C. Beck, *When the Patient Threatens Violence: An Empirical Study of the Clinical Practice After* Tarasoff, 10 BULL. AM. ACAD. PSYCHIATRY & L. 189 (1982); Shuman & Wiener, *supra* note 31, at 914-15; Note, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of* Tarasoff, 31 STAN. L. REV. 165 (1978).

33. Tarasoff v. Regents of Univ. of Cal., 551 P.2d. 334 (Cal. 1976) (en banc). The court vacated and modified its previous opinion, Tarasoff v. Regents of Univ. of Cal., 529 F.2d 553 (Cal. 1974) (en banc), after rehearing. *Tarasoff*, 551 P.2d at 334.

34. *See* Shuman & Weiner, *supra* note 31, at 927 (concluding that both sides of the debate "have overstated their cases").

35. *See supra* note 31.

that, for the first time, had adopted a psychotherapist-patient privilege.[36] Shuman and Weiner administered questionnaires to groups of psychiatrists, patients, laypersons (a sample of evening adult education students), and judges. The authors found that, at the outset of therapy, confidentiality was articulated as a concern by only fifty-four percent of the patients, and that only twenty-seven percent of the patients were aware of the new psychotherapist-patient privilege.[37] In addition, fifty-five percent of the psychiatrists reported themselves as unaware of the existence of the new privilege,[38] while seventy-four percent of those in the layperson sample were unaware of the privilege.[39]

Laypersons not in therapy were used to assess the extent to which a privilege would be a significant factor in their hypothetical decision whether to enter therapy should they encounter problems.[40] The authors concluded that patients are probably not deterred from seeking therapy to any significant degree by the absence of a privilege.[41] Because ninety-three percent of the lay sample would have sought therapy for serious emotional problems, even though seventy-four percent of the group were unaware of the existence of the privilege, the authors concluded that "the existence of a privilege could not have provided an incentive or avoided a barrier to therapy for these persons."[42]

Even leaving aside a variety of methodological problems with this study—small sample sizes, large non-response rates, selection of the patient sample by the psychiatrists in a non-randomized fashion, and the assumption that lay adult education students without mental health problems behave in a way similar to individuals that have such problems—the data do not seem to support the conclusion that the privilege does not play an important role in patient decisionmaking about whether to seek therapy. Let us assume that patients generally are unaware of the existence of a psychotherapist-patient privilege, as this Texas study demonstrated soon after enactment of a statute adopting such a privilege. If they are unaware of the privilege, then of course it would not affect their decisions whether to seek therapy. Can it be assumed, however, that patients will be unaware of the privilege question once the Supreme Court has decided the issue and it receives the usual extensive publicity that follows Supreme Court decisions on matters of public interest? The important question, left unanswered by this

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36. Shuman & Weiner, *supra* note 31, at 896-97.
37. *Id.* at 920.
38. *Id.* at 938.
39. *Id.* at 930.
40. *Id.* at 919.
41. *Id.* at 924-25.
42. *Id.* at 925.

research, is whether a Supreme Court opinion on this question will significantly increase awareness of the privilege, and whether such awareness will affect patient decisionmaking concerning whether to seek therapy. A new state statutory enactment of a psychotherapist-patient privilege is unlikely to make the front pages or the evening news, while a Supreme Court decision *denying* such a privilege will.

In fact, the Shuman and Wiener research in Texas suggests that people's awareness of the absence of a psychotherapist-patient privilege will dramatically affect their behavior. Without mentioning the existence of a privilege, the lay group was asked whether they would reveal to a therapist information concerning a series of subjects that included speeding, cheating on income taxes, physical violence, sexual fantasies, and work failure. A high percentage responded that they would reveal information concerning all of these categories. The group was then asked whether they would discuss these issues with a therapist in the absence of a psychotherapist-patient privilege, and "the response rate declined markedly."[43] Thus, if patients become aware of the absence of a privilege, as it can be assumed they would were the Supreme Court to decide against the privilege, the Shuman and Wiener study suggests that patient behavior would very much be affected.

Shuman and Wiener conducted a second study relating to privilege in South Carolina and West Virginia, which at the time were the only two states that did not have a psychotherapist-patient privilege.[44] This study suffered from similar methodological problems as the Texas study, and had an even higher non-response rate.[45] Once again, patients were shown to be unaware of the status of the psychotherapist-patient privilege in their state. Forty-one percent of the South Carolina/West Virginia patients incorrectly assumed that they possessed a privilege.[46] The authors again concluded that the existence of the privilege has little effect on patient decisionmaking concerning whether to enter therapy, but their conclusion is subject to the same limitations as previously discussed with regard to the Texas study. One may question whether the widespread misunderstanding on the part of patients in South Carolina and West Virginia concerning the existence of the privilege would apply after a high visibility Supreme Court decision rejecting a privilege. This study, therefore, also provides little support for a conclusion that patient

43. *Id.* at 919-20. The items most affected by this change in response rate had legal consequences. *Id.*

44. Wiener & Shuman, *supra* note 31, at 374-78.

45. *Id.* at 377 (43% of patients in the South Carolina and West Virginia studies responded to questionnaires, compared to 51% in Texas; 45% of therapists in the Texas study responded, compared to only 19% in the South Carolina and West Virginia study).

46. *Id.* at 381.

behavior concerning therapy would be unaffected by a Supreme Court decision rejecting the privilege.

In a third study, Shuman, Wiener, and a Canadian colleague, Professor Gilbert Pinard, compared responses by psychiatrists, patients, judges, and a lay group of university students in two Canadian provinces, Ontario, which had no privilege, and Quebec, which had a form of the psychotherapist-patient privilege.[47] Here, too, the study found widespread lack of awareness concerning the presence or absence of a privilege, leading the authors to conclude that privilege had little bearing on patient decisionmaking concerning therapy.[48] Once again, it is not surprising that a factor concerning which patients were unaware or confused had little bearing on their decisionmaking. Once again, it may be questioned whether a high visibility Supreme Court decision on the issue would give rise to an entirely different situation. In summary, these three studies shed little light on the question of whether a Supreme Court decision rejecting existence of a psychotherapist-patient privilege would affect patient decisionmaking concerning whether to enter therapy.

Even though the empirical evidence is inconclusive, an adverse impact on patients' willingness to enter therapy can be hypothesized should the Supreme Court reject the privilege. For most people, public revelation of private therapy disclosures would be extremely unpleasant and embarrassing. Moreover, it could produce significant negative consequences that might be harmful to them in such important areas of their lives as the family and the workplace. As a result, behavioral psychology would predict that people who are aware of this possibility may be seriously deterred from engaging in therapy.

It stands to reason that this consideration will affect human behavior in precisely this way. The case before the Court is illustrative. Would a member of a police force involved in a shooting that became the subject of a lawsuit for police misconduct seek out counseling concerning his or her job-related stress if intimate details revealed in therapy could be the subject of an evidentiary fishing expedition conducted by the civil plaintiff? Would the victim of a sexual assault seek counseling if she knew that the perpetrator's attorney could seek discovery of what she said in therapy in order to impeach her with it at trial? Would individuals undergoing the heartache and stress of divorce seek treatment knowing that their intimate disclosures could be used in divorce litigation or could be sought by the adverse spouse for use as a club in settlement negotiations?

47. Shuman et al., *supra* note 31, at 393.

48. *Id.* at 411-12.

The potential of future negative consequences will affect human behavior only if people can predict those consequences and are aware of the risk of their occurrence. Behavior is not reflexive or automatic; it is cognitively mediated.[49] Shuman and Weiner's research suggests that people are unaware of the existence or nonexistence of the psychotherapist-patient privilege,[50] but the previous analysis questions this conclusion in the context of Supreme Court resolution of the privilege question.

While the issue of the psychotherapist-patient privilege may not occur to some people, it doubtless would be a concern to many deciding on whether to seek needed mental health treatment.[51] The publicity that surely would follow a Supreme Court decision on whether the privilege should be recognized will predictably bring the issue to heightened public awareness. Were the Court to reject the existence of the privilege, people considering whether to enter therapy would learn of it. Not only would they learn of it through the usual intense media coverage of Supreme Court decisions on issues of public interest, but clinicians would have an ethical duty to divulge to their patients that patient-therapist communications may not be totally confidential, and may be revealed in judicial proceedings.[52] This will have a predictable chilling

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49. Albert Bandura, *Behavior Theory and the Models of Man*, 29 AM. PSYCHOLOGIST 859, 860 (1974); Bruce J. Winick, *Harnessing the Power of the Bet: Wagering with the Government as a Mechanism for Social and Individual Change*, 45 U. MIAMI L. REV. 737, 755 (1991).

50. *See* Shuman et al., *supra* note 31, at 411-12; Shuman & Weiner, *supra* note 31, at 930; Weiner & Shuman, *supra* note 31, at 381. Whether they understand the distinction between confidentiality and the existence of an evidentiary privilege, other empirical evidence strongly suggests that patients believe that what they tell their psychotherapists will be held in strictest confidence. Paul S. Appelbaum et al., *Confidentiality: An Empirical Test of the Utilitarian Perspective*, 12 BULL. AM. ACAD. PSYCHIATRY & L. 109, 110 (1984) (reviewing studies).

51. *See* 2 JACK B. WEINSTEIN & MARGARET A. BERGER, WEINSTEIN'S EVIDENCE 504-18 (1995) ("Unlike the patient with physical ailments or complaints, who will likely consult a physician regardless of whether confidentiality is guaranteed, a neurotic or psychotic individual may seek help only if he is assured that his confidences will not be divulged, even in a courtroom."); GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, REPORT NO. 45, at 92 (1960) [hereinafter GAP REPORT], *cited with approval in Revised Draft of Proposed Rules of Evidence for the United States Courts and Magistrates*, 51 F.R.D. 315, 367 (1971) (Advisory Comm. Notes); Ralph Slovenko, *Psychiatry and a Look at the Medical Privilege*, 6 WAYNE L. REV. 175, 184 (1960).

52. The *Ethical Principles of Psychologists and Code of Conduct*, Standard 5.01, provides:

> (a) Psychologists discuss with persons and organizations with whom they establish a scientific or professional relationship (including, to the extent feasible, minors and their legal representatives) (1) the relevant limitations on confidentiality, including limitations where applicable in group, marital, and family therapy or in organizational consulting, and (2) the foreseeable uses of the information generated through their services.
>
> (b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

effect on the willingness of individuals to enter or remain in therapy.

At precisely the time when more Americans need the services of mental health professionals, a total rejection by the Supreme Court of the psychotherapist-patient privilege will, therefore, have the predictable effect of discouraging those seeking such professional help. One reason that people with mental health problems do not seek treatment relates to the historic stigma associated with mental illness.[53] Although there have been many efforts to destigmatize mental illness, sadly such stigma continues. As a result, many people with mental health problems will enter therapy only if they can be assured that their doing so will not come to public attention. Should the Supreme Court reject the existence of a psychotherapist-patient privilege, people with mental health problems concerned about avoiding the embarrassment and social disadvantages of stigmatization will be discouraged from entering therapy.

Rejection by the Supreme Court of a psychotherapist-patient privilege can therefore have significant negative effects on the mental health of the nation. People with mental health problems will be discouraged from seeking therapy and their problems will only worsen, sometimes causing social catastrophe. This is a problem that affects more than just the one in four adult Americans suffering from a diagnosable mental disorder. Most of us will face one or more devastating experiences in our lives—death of a loved one, loss of a job, divorce, becoming the victim of a crime or a natural disaster, for example. Many are unable successfully to cope with these events, and could benefit from professional counseling. Research is increasingly showing that talking about these difficulties can improve mental health, while not talking about

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Ethical Principles of Psychologists and Code of Conduct, Standard 5.01, *in* 47 AM. PSYCHOLOGIST 1597, 1606 (1992). Similarly, the Code of Ethics of the National Association of Social Workers provides that "[t]he social worker should inform clients fully about the limits of confidentiality in a given situation, the purposes for which information is obtained, and how it may be used." NATIONAL ASS'N OF SOCIAL WORKERS, NASW CODE OF ETHICS § II.H.2 (1990).

53. *See* REPORT OF THE TASK PANEL ON PUBLIC ATTITUDES AND USE OF MEDIA FOR PROMOTION OF MENTAL HEALTH, *in* 4 TASK PANEL REPORTS SUBMITTED TO THE PRESIDENT'S COMM'N ON MENTAL HEALTH 1864, 1870 (1978); Bruce J. Winick, *The Side Effects of Incompetency Labeling and the Implications for Mental Health Law*, 1 PSYCHOL. PUB. POL'Y & L. 6, 11 n.40 (1995). Former patients have eloquently articulated the personal costs of the stigma of mental illness. *See* JUDI CHAMBERLIN, ON OUR OWN 107-11 (1978); Betty Blaska, *First Account: What It Is Like To Be Treated Like a CMI*, 17 SCHIZOPHRENIA BULL. 173 (1991); Judi Chamberlin, *The Ex-Patients' Movement: Where We've Been and Where We're Going*, 11 J. MIND & BEHAV. 323, 324-25 (1990). The National Alliance for the Mentally Ill (NAMI), the nation's largest support and advocacy organization for individuals with mental illness and their families, has recently launched a comprehensive, five-year education campaign, endorsed by the National Institute of Mental Health (NIMH), to fight stigma and discrimination. *National Anti-Discrimination Campaign Announced at Convention*, 17 NAMI ADVOCATE 1, July-Aug. 1995, at 1, 4.

them may be unhealthy in a number of respects.[54] Psychologist James Pennebaker's research shows that the act of inhibition of thoughts and feelings imposes severe stress that, over time, gradually undermines the body's defenses, affecting immune function, the actions of the heart and vascular systems, and even the biochemical workings of the brain and nervous systems.[55] While inhibition is harmful, Professor Pennebaker has found that confiding our hidden thoughts and feelings can have profound health benefits.[56]

In general, it is best for the individual to disclose serious problems to a professional therapist, one licensed under state law who by reason of education and training has been certified as competent to perform this special function. Yet, the willingness of many people to seek out such professional therapists will be undermined to the extent they lack confidence in the therapist's ability to maintain confidentiality. Recognition of the psychotherapist-patient privilege will bolster this confidence. Refusing to do so may destroy it.

Moreover, a rejection of the privilege may seriously diminish the effectiveness of therapy for individuals who are in or decide to undertake therapy. It can be predicted that many patients, out of concern for potential disclosure, will inhibit their own disclosure to the therapist. Shuman and Weiner's research demonstrates this by showing a significant diminution in patients' willingness to disclose information to a therapist once they are told that such information will not be privileged.[57] The "fundamental rule" of psychotherapy, Freud wrote, is that the patient be totally forthcoming with the therapist, revealing everything no matter how insignificant it may seem.[58] Inhibition by the patient thus can thus doom the therapeutic enterprise.

To succeed, mental health treatment requires a high degree of trust and confidence by the patient in the therapist.[59] Establishing this trust

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54. *See generally* JAMES W. PENNEBAKER, OPENING UP: THE HEALING POWER OF CONFIDING IN OTHERS (1990) (reporting extensive research).

55. *Id.* at 13.

56. *Id.* at 14, 21.

57. *See supra* note 43 and accompanying text.

58. *See* 23 SIGMUND FREUD, *An Outline of Psycho-Analysis, in* STANDARD EDITION OF THE COMPLETE PSYCHOLOGICAL WORKS OF SIGMUND FREUD 174 (James Strachey ed. & trans., 1964); *see also* GAP REPORT, *supra* note 51 (The psychiatrist's "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.").

59. *See* Mark B. DeKraai & Bruce D. Sales, *Privileged Communications of Psychologists*, 13 PROF. PSYCHOLOGIST 372, 372 (1982) (the establishment of a relationship of trust between client and therapist "has been deemed so essential by some that it has been argued that psychotherapy is rendered worthless in its absence"); Bruce J. Winick, *The Right to Refuse Mental Health Treatment: A Therapeutic Jurisprudence Analysis*, 18 INT'L J.L. & PSYCHIATRY 99, 111-12

and confidence at the outset of the therapeutic relationship may be essential for its ultimate success.[60] It is precisely at this point that a therapist will feel ethically obligated to reveal to the patient that the confidentiality of the patient's communications cannot be fully protected.[61] For at least some patients, the specter of their therapist as a weapon in the hands of an adversary in litigation will prevent formation of the therapeutic alliance.[62] Concern about disclosure of intimate and personal information confided in a therapist thus can have profoundly antitherapeutic effects for the individual, producing a distrust of the therapist that can make the therapeutic process impossible.

Would any positive therapeutic consequences result from a decision denying recognition of a psychotherapist-patient privilege? Jeffrey Klotz suggests that there may be potential therapeutic advantages in eliminating the privilege in certain circumstances.[63] He urges a future crimes exception, under which patient communications of a desire or intent to commit a crime would be exempt from the privilege. Klotz hypothesizes that patients, aware that their disclosures concerning a future crime could be used against them in court, may avoid behavior that might necessitate judicial intervention.[64] Fear of future disclosure, in Klotz's view, could have the therapeutic effect of deterring future criminal conduct. Klotz's proposal already is largely reflected in state law exceptions to the privilege.[65] Would such a future crimes exception

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(1994); *see also* Ryan D. Jagim et al., *Mental Health Professionals' Attitudes Toward Confidentiality, Privilege, and Third Party Disclosure*, 9 PROF. PSYCHOLOGIST 458, 458-59 (1978) ("The concept of confidentiality of client-therapist communications is at the core of the psychotherapeutic relationship.").

60. Winick, *supra* note 59, at 111-14.

61. "Mental health professionals must alert their patients at the outset of therapy about special conditions under which complete confidentiality cannot be maintained." REPORT OF THE TASK PANEL ON LEGAL AND ETHICAL ISSUES, *in* 4 TASK PANEL REPORTS SUBMITTED TO THE PRESIDENT'S COMM'N ON MENTAL HEALTH, *supra* note 53, at 1399; *see also supra* note 52 (quoting ethical guidelines of psychologists and social workers).

62. *See* Winick, *supra* note 59, at 113-14.

63. Jeffrey A. Klotz, *Limiting the Psychotherapist-Patient Privilege: The Therapeutic Potential*, 27 CRIM. L. BULL. 416 (1991).

64. *Id.* at 429.

65. *Id.* at 429 n.58; *see, e.g.*, ALASKA R. EVID. 504(d)(2) (1995) ("crime or fraud"); CAL. EVID. CODE § 1018 (West 1995); CONN. GEN. STAT. § 52-146c(b)(3) ("risk of imminent personal injury . . . or risk of imminent injury to . . . property"); ILL. ANN. STAT. ch. 740, para. 110/11(vi) (1993) (threats of violence); LA. CODE EVID. 510(B)(2)(e), (C)(2)(b) (1995); MASS. GEN. L. ch. 112, § 129A(2)-(3) (1991) (threat or clear and present danger that patient will kill or inflict serious injury); 1995 NEV. STAT. 640, § 19 ("immediate threat that the patient will harm himself or other persons"), R.I. GEN. LAWS § 5-37.3-4(4) (Supp. 1994) (when third party "is in danger from a patient"); S.C. CODE ANN. § 19-11-95(C)(3) (Supp. 1994) ("intention . . . to commit a crime or harm himself"); W. VA. CODE § 27-3-1(b)(4) (1992) "[t]o protect against a clear and substantial danger of imminent injury"); WYO. STAT. § 33-27-123(a)(iv) (Supp. 1995) (immediate threat of physical violence against a readily identifiable victim"); *see also* United States v. Snelenberger, 24

to the privilege have this desired effect? Would it instead deter patients who intend to commit a crime from entering therapy, or from disclosing their intentions in therapy, in either case foreclosing the potential that a therapeutic intervention might prevent the crime? These are interesting and unresolved empirical questions that deserve investigation.

In any event, even if Klotz is correct and if more criminal behavior can be avoided by recognizing this exception than by refusing to do so, allowing a future crimes exception does not argue for rejecting the privilege altogether. The case before the Supreme Court does not require resolution of whether a future crimes exception should be recognized. It merely involves the question of whether the Federal Rules of Evidence should be read to permit a general privilege for psychotherapist-patient communications. Whether a future crimes exception or other exceptions should be recognized can await another day, perhaps when more information concerning the consequences of various exceptions will be available. The privilege recognized by the court of appeals in *Jaffee v. Redmond* is not an absolute one, but expressly contemplates possible exceptions.[66] The Supreme Court, therefore, can affirm *Jaffee*'s general recognition of a psychotherapist-patient privilege and leave the details of when it should be overcome by countervailing needs to the lower federal courts to be developed in light of "reason and experience."[67]

That the psychotherapist-patient privilege recognized by *Jaffe* is less than absolute does not undermine its therapeutic potential. The court of appeals acknowledged that, in appropriate circumstances, the need for the information sought could outweigh the interest in preserving confidentiality.[68] Allowing the trial judge to engage in this weighing process strikes the balance appropriately between the interest in ascertaining truth and the privacy and therapeutic concerns involved. In this sense, the privilege functions as a cloak of confidentiality, generally preserving the privacy of sensitive disclosures made in therapy, but a cloak that can be removed in appropriate circumstances when the demands of the justice system require it. The privilege makes such communications presumptively protected from disclosure and, in effect, places on the party seeking disclosure the burden of demonstrating the heightened relevance to the proceedings of obtaining the information in question. Only when such information is essential to the proof of crucial facts should the intimacy of the therapeutic relationship be invaded.

F.3d 799, 802 (6th Cir. 1994) (applying future crimes exception under FED. R. EVID. 501), *cert. denied*, 115 S. Ct. 433 (1994).

66. *See* Jaffee v. Redmond, 51 F.3d 1346, 1357 (7th Cir. 1995).

67. FED. R. EVID. 501.

68. *See Jaffee*, 51 F.3d at 1357.

Even though the psychotherapist-patient privilege would not be absolute, recognition of its existence by the Supreme Court would provide an important signal to those considering whether to enter therapy that the confidentiality of their disclosures will generally be protected. The opposite signal would encourage litigants to seek confidential information from therapists even when such information is not crucial, as a means of harassment and in an effort to force a settlement that would avoid disclosure of embarrassing or personal information. The absence of a privilege would encourage significant abuse by unscrupulous lawyers that will be difficult and expensive for trial judges to control.

All fifty states recognize a psychotherapist-patient privilege.[69] Although state law recognizes the privilege, if the Supreme Court were to refuse to do so under the Federal Rules of Evidence, a therapist would feel obligated to reveal to a patient that the federal courts do not protect the privilege.[70] When a patient first seeks therapy and the therapist is faced with the ethical duty of discussing confidentiality and its possible exceptions, it will be difficult to predict, if a lawsuit involving the patient should occur, whether it will be in state court or federal court.[71] The uncertainty engendered by this disclosure alone could have a serious deterrent effect on a patient's willingness to enter therapy and could therefore frustrate state policy that recognizes the privilege in order to foster mental health and to protect personal privacy.

Refusing to recognize the privilege thus will impose a number of serious social costs. People in need of therapy will be deterred from seeking it, and those already in therapy may participate in it with less than the full candor needed for treatment success. Against these costs must be weighed the loss of probative evidence. But how much probative evidence will be lost by recognition of a psychotherapist patient privilege? Because rejection of the privilege would deter patients from entering therapy or from participating in it with full candor, the very evidence sought—the patient's confidential communications to the therapist—would never have come into existence in the first place. As a result, refusal to recognize the privilege will not materially assist the truth-determination process. Because little evidence will accordingly be

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69. *See id.* at 1356; *see also* sources cited *supra* note 1.

70. Given the unanimity in the states concerning recognizing the privilege under state law, rejection of the privilege for the federal courts can produce the additional undesirable effect of promoting forum shopping. *Cf.* Erie R.R. v. Tompkins, 304 U.S. 64 (1938).

71. In cases in which the parties to a lawsuit are citizens of different states or in which the claim arises under federal law (such as the Federal Civil Rights claim involved in *Jaffee*), a civil plaintiff may file suit in either state or federal court. *See* 28 U.S.C. § 1331 (1995) (federal question jurisdiction); *id.* § 1332 (diversity jurisdiction).

lost, the therapeutic benefits of recognizing the privilege outweigh the social costs of non-recognition.

If the privilege is recognized, it should be extended to all mental health professionals licensed by the state, including psychiatric social workers. Given the largely unmet mental health needs of the nation, it is essential that psychiatric social workers play the significant therapeutic role that this expanding profession has served so well in recent years. There are approximately 30,642 psychiatrists, 56,000 psychologists and 81,000 psychiatric social workers practicing mental health counseling today.[72] In reality, an increasing amount of patient contact involves psychiatric social workers, rather than psychiatrists and psychologists. Recognizing a privilege that extends to psychiatrists alone, or to psychiatrists and psychologists, but not to psychiatric social workers, would in effect create a second-class professional relationship for people lacking the financial means to hire the more expensive psychiatrist or psychologist. The psychiatric social worker has become "the poor person's psychiatrist."[73] In addition to being unwise and antitherapeutic, construing the privilege not to extend to psychiatric social workers thus would raise grave equal protection problems. In fashioning a privilege, the Court should focus on the function of the counseling relationship rather than on the identity of the counselor. Focusing on the purpose of the communication rather than on the occupation of the counselor avoids the social inequality created by granting a privilege to one type of counselor, such as psychiatrists and psychologists whose clients tend to be more affluent, while denying the privilege to another type, such as social workers, whose clients tend to be poor.[74]

The Supreme Court will not decide *Jaffee v. Redmond* on the basis of equal protection. But the equal protection tensions that would be created by recognizing a psychotherapist-patient privilege that did not extend to licensed psychiatric social workers argue strongly for a more extensive privilege. There simply is no avoiding the reality that our nation's mental health needs have eclipsed the ability of psychiatrists and psychologists to meet them. More and more services will be delivered by psychiatric social workers. More and more people need and will

72. Thomas H. Dial et al., *Human Resources in Mental Health, in* MENTAL HEALTH, UNITED STATES 1990, at 196, 208 (Ronald W. Manderscheid & Mary A. Sonnenschein eds., 1990).

73. *See Jaffee*, 51 F.3d at 1358 n.19 (citing *Developments in the Law—Privileged Communications*, 98 HARV. L. REV. 1530, 1550 (1985)); *see also* Comment, *Underprivileged Communications: Extension of the Psychotherapist-Patient Privilege to Patients of Psychiatric Social Workers*, 61 CAL. L. REV. 1050, 1050 (1973).

74. *See* Kerry L. Morse, Note, *A Uniform Testimonial Privilege for Mental Health Professionals*, 51 OHIO ST. L.J. 741, 745-47 (1990).

accept their services. It is in the mental health interests of the nation to promote their role.

Viewed in this light, there simply is no basis for concluding that psychiatrists and psychologists require the cloak of confidentiality to play their role effectively but that psychiatric social workers do not. With the exception of the medication that physicians alone may prescribe, the treatment approaches utilized by psychiatrists, psychologists, and psychiatric social workers do not differ significantly. Apart from the organic interventions reserved for psychiatrists, the practice of verbal psychotherapy, although it may differ based upon the therapist's particular clinical orientation, will not vary based on professional lines. All forms of psychotherapy require trust and confidence by the patient in the clinician. To the extent that the privilege is based upon a desire to foster the therapeutic relationship, there can be no principle basis for distinguishing psychotherapists based upon professional discipline. Given the large unmet mental health needs of the nation, we should not undermine the ability of psychiatric social workers to help in the battle.

The Supreme Court, therefore, should read the Federal Rules of Evidence to recognize a psychotherapist-patient privilege that includes psychiatric social workers. Fine-tuning of the privilege, including the circumstances in which it should be outweighed in particular cases, may be left for future decision. Endorsement by the Court of a general privilege for therapist-patient communications would bring federal practice in line with the approach uniformly followed in the states and would best serve both constitutional and therapeutic values.