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SHOULD STATEMENTS MADE BY PATIENTS DURING PSYCHOTHERAPY FALL WITHIN THE MEDICAL TREATMENT HEARSAY EXCEPTION? AN INTERDISCIPLINARY CRITIQUE

PHILIP K. HAMILTON*

I. INTRODUCTION

In recent years, courts have permitted juries to consider hearsay testimony about what patients have said to their psychotherapists. In the typical case, the therapist testifies to statements made by the patient during therapy sessions, and this testimony is admitted in evidence "to prove the truth of the matter asserted" in the statements. That is, the jury is invited to treat the patient's statements, as related by the therapist, as true. Such testimony would ordinarily be barred by the rule against hearsay. Judges admit it by resorting to a longstanding hearsay exception that is based on certain assumptions about the accuracy of statements made by patients who are seeking treatment for physical injuries and illnesses. However, those assumptions do not apply to mental health problems and their treatment. Due to the nature of psychotherapy, patient statements to psychotherapists often do not communicate objectively accurate information. The failure of judges to understand this has led to the widespread introduction of evidence that can undermine the reliability of trials, when, as is often the case, the patient's hearsay statements are significant evidence.

The rule against hearsay generally prohibits the receipt in evidence of statements made out of court if those statements are offered as evidence of the truth of the facts that they assert. The purpose of the rule is to guarantee a certain degree of reliability in the evidence that the jury is asked to consider. Testimony about

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out-of-court statements is excluded because, if admitted, the jury would be allowed to treat those statements as having the same evidentiary importance as the testimony of a witness testifying in court, yet the person who makes the statement, the hearsay declarant, is not subject to the trial's testimonial safeguards when he makes the statement. That is, unlike the witness who testifies in court, the declarant is not under oath and is not subject either to cross examination regarding the statement or to the jury's evaluation of his demeanor when determining whether he might be lying, jesting or mistaken about what he has said. Given that the statement was made without those particular safeguards, the out-of-court statement is considered less reliable than the testimony of an in-court witness, presumptively too unreliable to be admitted in evidence. The importance of the hearsay rule as a guarantor of reliability was considerably increased by the Supreme Court's 2004 decision in *Crawford v. Washington*,[1] which held that the Confrontation Clause of the Sixth Amendment does not require a separate judicial determination of the reliability of hearsay evidence that is offered against the defendant in criminal trials.[2]

Of course the hearsay rule does not bar all out-of-court statements. Some such statements are obviously more reliable

1. 541 U.S. 36, 52 (2004).

2. *Id.* at 51-52. Until 2004, the Confrontation Clause of the Sixth Amendment was understood to require either the production of the out-of-court declarant for cross-examination or a separate determination by the judge that the proffered hearsay was reliable. In *Crawford*, the court concluded that the clause does not prohibit the prosecution's use of unreliable hearsay, but instead prohibits its use of "testimonial" hearsay. Although the court declined to define "testimonial," most statements made in psychotherapy would not fit into even the most expansive formulation cited in the opinion: "statements that were made under circumstances which would lead an objective witness reasonably to believe that the statement would be available for use at a later trial." *Crawford*, 541 U.S. at 52 (citing Amicus Brief of National Association of Criminal Defense Lawyers). Certainly, some statements made for the purpose of mental treatment could be "testimonial" under this formulation. For example, sexual assault treatment is often provided by a team of medical professionals who are trained to fulfill the dual role of treatment provider and evidence collector, and it is possible that statements made by sexual assault victims in that context could be considered "testimonial." *See* OFFICE ON VIOLENCE AGAINST WOMEN, U.S. DEPT. OF JUSTICE, *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents*, 23-26 (2004) (describing the coordinated team approach to the sexual assault medical forensic examination process). However, aside from sexual assault treatment, it is very unusual for mental health treatment to be provided in other circumstances that would lead the patient to believe that the statements would be used in a later criminal prosecution. *See* Christina L. Lewis, Comment, *The Explotation of Trust: The Psychotherapist Patient Privilege in Alaska as Applied to Prison Group Therapy*, 18 ALASKA L. REV. 295 (2001) (explaining the confidentiality of the patient-therapist relationship as the foundation for successful psychotherapy).

than others, and all jurisdictions recognize exceptions to the hearsay prohibition. Nearly all of those exceptions are based on the same rationale: The circumstances in which the statement was made provide "guarantees of trustworthiness."[3] For example, a statement in a business record has greater evidentiary reliability because the business that produced the record relies on the accuracy of such statements in conducting its regular activities.[4] Similarly, a statement acknowledging the declarant's indebtedness, or his fault in an accident, is likely to be accurate because most people do not make such "declarations against interest" unless they are "satisfied for good reason that they are true."[5] The probable reliability of the out-of-court statement is enhanced by such circumstances, and therefore the statement is allowed to be received in evidence in spite of the fact that it was made without the usual benefits of the testimonial protections of an oath, cross examination and the opportunity for the jury to observe the speaker's demeanor.

One of the most widely recognized of such hearsay exceptions allows the admission of statements made for the purpose of obtaining medical treatment for an injury or an illness. It is thought that a patient seeking treatment will speak truthfully and carefully because an inaccurate communication might result in ineffective or damaging treatment. This motivation to speak accurately, which Professor Mosteller has aptly called the "selfish treatment interest,"[6] is the "guarantee of trustworthiness" that underpins this hearsay exception. The exception is limited to those of the patient's statements that pertain directly to the treatment sought, because the motive to speak truthfully and carefully applies only to that limited class of factual assertions.[7] Thus, the patient's recitation of such facts as the type of pain, its location and its time of onset will be covered by the exception, and

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3. FED. R. EVID. Article VIII advisory committee's introductory note: The Hearsay Problem.

4. FED. R. EVID. 803(6) and advisory committee's note.

5. FED. R. EVID. 804(3) and advisory committee's note.

6. Robert B. Mosteller, *Child Sexual Abuse and Statements for the Purpose of Medical Diagnosis or Treatment*, 67 N.C. L. REV. 257, 259 (1989).

7. A typical formulation of the exception is that of Rule 803(4) of the Federal Rules of Evidence:

> The following are not excluded by the hearsay rule, even though the declarant is available as a witness:
>
> . . .
>
> (4) STATEMENTS FOR PURPOSES OF MEDICAL DIAGNOSIS OR TREATMENT. Statements for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment.

FED. R. EVID. 803(4).

will be admitted in evidence, whereas the patient's statements that relate facts that are not pertinent to the treatment, such as a description of the person who inflicted the injury, will be excluded by the hearsay rule, unless covered by another exception.

This "medical treatment exception,"[8] was originally limited to statements made to physicians (and later to other medical personnel) for the purpose of obtaining diagnosis and treatment of physical injuries and ailments. However, in recent years it has been extended, allowing the admission of statements made to psychiatrists, psychologists and other practitioners of psychotherapy, such as social workers and counselors, for the diagnosis and treatment of mental health problems.[9] This Article will argue that this extension of the exception to mental health treatment is unwarranted and inadvisable and that it has resulted from judges' misunderstanding of mental health treatment and the role of patient statements in that treatment. The article will examine the fundamentals of mental health treatment to show that the use of patient statements in that treatment does not produce the "guarantees of trustworthiness" that would justify excusing such statements from the application of the hearsay rule.[10]

The earliest and still the most common application of the medical treatment hearsay exception to admit statements made for mental health purposes has been in child abuse cases, to

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8. Professor Mosteller suggests, perhaps ironically, that "medical examination exception" would be a more appropriate name for the exception as it is used in child abuse cases, because of the widespread willingness of courts to admit in those cases the statements of children sent to a pediatrician for a second opinion and not for treatment. *Id.* at 47; *see also* Robert B. Mosteller, *The Maturation and Disintegration of the Hearsay Exception for Statements for Medical Examination in Child Sexual Abuse Cases*, 65 LAW & CONTEMP. PROBS. 47 (2002) (providing a detailed analysis of hearsay exceptions in child sexual abuse cases). However, this scenario does not seem to occur in the cases admitting adult statements and "medical treatment exception" properly emphasizes the fundamental justification for the exception, the patient's motivation to speak accurately because treatment is anticipated.

9. *See* Tracy A. Bateman, Annotation, *Admissibility of Statements Made for the Purposes of Medical Diagnosis or Treatment as Hearsay Exception Under Rule 803(4) of the Uniform Rules of Evidence*, 38 A.L.R. 5TH 433 (1996) (collecting cases applying versions of Rule 803(4) to statements made for mental health diagnosis or treatment).

10. The article does not argue that the unreliability of statements made in mental health treatment is a reflection of any defect in mental health treatment itself. Reliable treatment can result from unreliable statements because, to a great extent, mental health treatment does not depend on the accuracy of the information contained in the statements. Nor does the article argue that statements made to mental health professionals without medical degrees are less likely to be reliable than those made to doctors. This article's argument applies to all such statements, regardless of the credentials or training of the treating professional.

enable examining medical personnel to testify to statements made by alleged victims, usually when the victims themselves are unable to testify due to their age or vulnerability. From there, it has been but a short step for courts to extend the exception to cover mental health statements when they are made by adults.

This Article will focus on statements by adults. Although the arguments against applying the medical treatment exception to mental health statements are the same regardless of whether the declarant is an adult or a child, the exigencies of child abuse prosecution can obscure the inappropriateness of using the exception to admit a child victim's statements. When the declarant is an adult, the unsuitability of the exception is more clearly evident. In addition, the widespread adoption of statutory "tender years" hearsay exceptions[11] would seem to make it increasingly unnecessary to resort to the medical treatment exception in child abuse cases, whereas judges' inclination to apply the exception to adults' statements is likely to remain strong.

Part II of this Article will provide some basic information about mental health treatment, what it consists of and how it can generate a wide range of statements that may be relevant in later court proceedings. Part III will examine the reasons why a patient's statements to a mental health provider, even when made during the patient's treatment, are not reliable enough to escape the ban against hearsay. Part IV will address the use of the medical treatment exception to admit mental health statements that are made for diagnosis only, without any view to treatment. Part V will propose corrective measures.

II. WHAT MENTAL HEALTH TREATMENT IS AND HOW IT CAN PRODUCE A WIDE RANGE OF HEARSAY EVIDENCE

A. How Mental Health Treatment Is Delivered and the Kinds of Statements That Are "Reasonably Pertinent"

The hearsay rule applies only to statements of fact. Because of the nature of mental health practice, patients in psychotherapy typically divulge far more facts than do patients seeking diagnosis or treatment of physical problems.

The treatment of "mental" (i.e. emotional or behavioral) disorders is now accomplished through a wide variety of

11. A "tender years" hearsay exception is tailored to admit statements made by child victims of abuse under certain circumstances commonly encountered in abuse cases. Most states have adopted such an exception, either by statute or by rule. *See* Andrea D. Blohm, Comment, *State v. Hinnant: Limiting the Medical Treatment Hearsay Exception in Child Sexual Abuse Cases*, 79 N.C. L. REV. 1089, 1090 n.7 (2001) (providing a list of state statutes and rules).

therapies.[12] Psychoanalysis is the original form of modern mental health treatment. It usually consists of frequent sessions, several times a week, between therapist and patient for periods of several years. A psychoanalyst "helps the patient to recall and examine events, memories and feelings from the past, many of them long forgotten, as a means of helping the patient understand present feelings and behavior and make changes as necessary."[13] Thus, in psychoanalysis facts about virtually any aspect of a patient's life are likely to be discussed as an integral part of the treatment. Although psychoanalysis is no longer one of the more common forms of treatment, its influence continues in the practices of most of the current "psychodynamic" or "talking" psychotherapies, which are also characterized by a series of regularly scheduled meetings in which the patient and therapist discuss the patient's problems and feelings.[14]

Currently, many of the most commonly used psychotherapies are short-term, extending for weeks or months, instead of the multi-year periods that have characterized psychoanalysis.[15] Some of them are not talking therapies at all, and are far less likely to be focused on the past. For example, Cognitive Behavioral Therapy (CBT), now one of the most widely used therapies, is directed exclusively to the here-and-now, helping the patient to identify current, troubling (negative, dysfunctional) patterns of thinking, and to modify those patterns.[16] Although CBT and similar short-term therapies are focused on the patient's current condition rather than the events of his past, a patient in such

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12. American Psychiatric Association, *What Are the Most Common Treatments Psychiatrists Use?*, http://healthyminds.org/commontreatments.cfm (last visited Nov. 13, 2007).

13. *Id.*

14. *See generally* Michael Bond, *Psychodynamic Psychotherapy in the Treatment of Mood Disorders, Current Opinion in Psychiatry*, http://www.medscape.com/viewarticle/519710 (last visited Nov. 13, 2007).

15. *See* Mark Olfson, Steven C. Marcus, Benjamin Druss & Harold Alan Pincus, *National Trends in the Use of Outpatient Psychotherapy*, 159 AM. J. PSYCHIATRY 1914, 1917 (2002) (reporting that in 1997 only 10.26% of responding psychotherapy patients visited the therapist more than 20 times.).

16. *See generally* Holly Hazlett-Stevens & Michelle G. Craske, *Brief Cognitive-Behavioral Therapy: Definition and Scientific Foundations*, http://media.wiley.com/product_data/excerpt/22/04700213/0470021322.pdf (last visited Nov. 13, 2007). These authors explain that there are also biomedical therapies, such as drug treatment, electroconvulsive therapy and light therapy, all of which are increasingly used in the treatment of disorders like depression and anxiety. *Id.* These are not psychotherapies at all and are usually employed by medical doctors who may have little or no training in psychiatry and who require little information from the patient beyond a description of the patient's symptoms, their onset and their frequency. Because they rely on such a small range of information from the patent, such therapies are very unlikely to be the source of relevant hearsay evidence, and the arguments in this article do not apply to them.

therapy would still typically describe his symptoms by describing his reactions in certain situations, often situations that involve actions by others, such as, "I feel that way whenever my boss reprimands me." Although the here-and-now psychotherapies do not elicit as wide a range of facts from the patient as the talking therapies do, the facts they do call forth are just as "reasonably pertinent" to the treatment and could just as easily be relevant in a subsequent legal proceeding.

In fact, the requirement of "reasonable pertinence" is not much of a limitation on the admissibility of facts divulged in psychotherapy. Many more facts are typically pertinent to the treatment of a mental or emotional condition than would be the case with a physical condition. When a patient consults an ordinary medical provider, the patient's statements of fact either will describe his symptoms, for instance, "I have a pain in my stomach," or will recite facts that are not symptoms, such as time of onset of the symptoms, the activities he was performing at the time or onset and prior occurrences of the symptoms. Statements of symptoms are almost always "reasonably pertinent to diagnosis or treatment," and therefore admissible under the medical treatment hearsay exception. Statements of symptoms are also the most likely to be motivated by the selfish treatment interest, since it is usually the symptoms from which the patient is seeking relief.

It is the non-symptom facts that can be problematic and require extra scrutiny. The hearsay exception in Rule 803(4) permits the introduction of non-symptom facts of "medical history" or of "the inception or general character of the cause" of the symptoms, but only as long as they are "reasonably pertinent to diagnosis or treatment." If a patient consults an internist about his back pain, the fact that the pain began when he lifted a heavy box will be "reasonably pertinent" to the treatment of his injury, but probably not the fact that his boss asked him to lift the box and certainly not the fact that his wife has threatened to leave him if he does not change jobs.[17] In the diagnosis and treatment of physical injuries and illnesses, the sets of facts that are "reasonably pertinent" to the diagnosis or treatment are quite limited, and in many such cases the limits are evident to a judge as well as to the doctor.

But a much larger set of facts can constitute the "history" and "cause" of a psychiatric disorder, and thus be "reasonably pertinent to diagnosis or treatment." This is true both because of the great variety of factors that may influence a mental condition[18]

17. FED. R. EVID. 803(4) advisory committee's note.

18. *See generally* S.L. HALLECK, EVALUATION OF THE PSYCHIATRIC PATIENT: A PRIMER 7 (PLENUM MEDICAL BOOK CO., SHERWYN M. WOODS ED., 1991).

and because the treatment of those conditions often must be based an assessment of such variables as the patient's "physical status, medical history, age, sex, education, family situation, intelligence, legal status, personality traits, occupational status, psychological mindedness, current levels of stress, previous treatment, and previous patterns of achievement and motivation."[19] In traditional medicine, the history necessary for diagnosis and treatment is fairly limited to that immediately surrounding the presenting symptoms, but the facts that are pertinent to the diagnosis and treatment of mental conditions are far more diffuse, and can span the patient's entire milieu. This is especially true in the "talking" therapies.

Mental or emotional disturbance is often precipitated by events, often involving perceived mistreatment of the patient, and those events typically involve the actions of people other than the patient himself. The patient's statements made to the treating mental health professional are likely to include the patient's version of such events. Those non-symptom facts are usually considered by the therapist to be "reasonably pertinent to diagnosis or treatment" of the patient and it is those facts, not the patient's description of his symptoms, that are most likely to be relevant in a subsequent legal action. Ordinarily, when a patient seeking physical treatment makes statements of medical history, and those statements are offered in evidence (e.g., in personal injury cases, workers compensation cases, etc.) the facts that are most relevant in the trial – usually to prove damages – are the same facts that were most important to the diagnosis and treatment of the physical condition, (e.g., nature and severity of pain, its location, time of onset, apparent causes), and the patient's expression of these facts is often the result of pointed questioning by the doctor. When the mental health patient's statements of history are offered in evidence, it is almost invariably the facts about people and events (e.g., details of assault, relationship to defendant, acts of co-workers, etc.) that are relevant. Although pertinent to the patient's treatment, those facts were generally much less central to the diagnosis or treatment of the patient's mental condition than the patient's statements about his feelings and his other symptoms, which are seldom of much probative value in a trial.[20] Thus, unlike in the medical-treatment situation, the facts that are sought to be proven in court through a patient's hearsay statements in mental health treatment tend to be precisely those facts that are least likely to have been explored in the treatment. Consequently, a great deal of patient history can be

19. *Id.* at 11.

20. *See id.* at 77 (stating that inaccuracy or incompleteness of information related to the patient's history, as opposed to the patient's behavior, does not carry a high risk of diagnostic error).

characterized as "reasonably pertinent" to mental health treatment even though neither patient nor clinician was much concerned about its accuracy when the patient recited the history.

B. The Extent and Nature of Courts' Use of the Medical Treatment Exception to Admit Statements Made in Mental Health Treatment

As already noted, the hearsay exception for statements made for the purpose of medical diagnosis or treatment has been applied most frequently to admit statements by child victims in prosecutions for child sexual abuse. As one would expect, the hearsay statements admitted in evidence in those cases were overwhelmingly statements of non-symptom facts, such as the child's description of the abuse and identification of the abuser. This use of the exception appears to have begun in the 1980's, when the scope of child sexual abuse was beginning to be recognized,[21] and it continues in sexual abuse cases to the present day.[22] In those cases, the child victim had typically been examined by a medical professional immediately after the abuse had been discovered or alleged, and the child had described the abuse to the professional. At the time of trial, the child was often unavailable to testify because of age or fear of re-traumatization, and the medical treatment exception was invoked to allow the professional to testify to the child's statements. If some of the child's statements describing the incident were not directly pertinent to the treatment of any physical injury, it was not unusual for courts to admit them under the exception anyway, on the ground that they were pertinent to treatment of the child's assumed psychological injuries, even when the examining doctor or nurse was not a mental health professional and there was no evidence that the child actually received any psychological treatment.[23]

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21. This development has been described and analyzed by Professor Robert Mosteller in two comprehensive articles. *See* Mosteller, *supra* note 6, at 281-83 (discussing problems related to the trustworthiness of psychological patient hearsay statements); Mosteller, *supra* note 8, at 49.

22. *See, e.g.*, State v. Anderson, 864 A.2d 35, 50 (2005) (holding statements to pediatric nurse practitioner, ten days after medical exam, describing abuse in detail, were admissible under the exception because "pertinent to proper diagnosis and treatment of the resulting physical and psychological injuries of sexual assault"); *In re* Kya, 857 A.2d 465, 472 (D.C. 2004) (finding "no error whatever" in admitting statements to school nurse describing abuse and identifying the perpetrator, because the statements were admissible under the exception since they related to "the psychological and emotional consequences of the abuse"). The resort to the medical treatment exception can be rendered unnecessary by the adoption of a "tender years" hearsay exception, which typically allows the admission of a child victim's statement in abuse cases under certain commonly encountered circumstances. BLOHM, *supra* note 11, at 1090 n.7.

23. This practice has been especially common in admitting the child's hearsay statements identifying the abuser. Courts have been willing to admit

It is easy to see the motivation for extending the medical treatment exception to statements made by children under those circumstances. Child sexual abuse is an abhorrent crime, the child and the perpetrator are often the only witnesses to the abuse and the child may be unable to testify because of age or possible re-traumatization. The child's statements to an examining doctor or nurse might be the only direct evidence of the crime or of the perpetrator's identity. The use of the medical treatment exception to admit the child's statements as pertinent to psychological treatment, although subject to criticism,[24] has been widespread. The concerns raised by the critics have been overwhelmed by the urgent need for the evidence and the difficulty of putting the child on the witness stand. In addition, proponents argue that certain considerations peculiar to children enhanced the reliability of the statements, considerations such as a child's assumed motivation to speak truthfully to authority figures and a child's appreciation of the serious purpose of the medical examination.[25] The practice of admitting the child's statements under the medical treatment exception has been widespread.[26]

That practice has led to a similar willingness to admit statements made by adults during mental health treatment, with reviewing courts often citing the child abuse cases as authority for approving the admission of those statements. After all, under the medical treatment exception the rationale for admitting a child's

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such evidence, even while acknowledging that it is not pertinent to medical treatment, on the ground that child abuse involves psychological injury and the identification of the perpetrator is pertinent to treatment of those injuries. *See, e.g.*, United States v. Renville, 779 F.2d 430, 441 (8th Cir. 1985) (statement made to a specialist in family practice); Hawkins v. State, 72 S.W.3d 493, 498 (Ark. 2002) (statement made to a "physician"); Galindo v. United States, 630 A.2d 202, 211 (D.C. 1993) (statement made to a pediatrician); State v. Vosika, 731 P.2d 449, 450 (Or. Ct. App. 1987) (statement made to a pediatrician); State v. Rucker, 847 S.W.2d 512, 519 (Tenn. Ct. App. 1992) (statement made to an emergency room nurse); State v. Butler, 766 P.2d 505, 520 (Wash. Ct. App. 1989) (statement made to a nurse); Goldade v. State, 674 P.2d 721, 722 (Wyo. 1983) (statement made to a nurse).

24. *See* Mosteller, *supra* note 6, at 281-83 (criticizing the use of children's hearsay statements as related to psychological treatment); John J. Capowski, *An Interdisciplinary Analysis of Statements to Mental Health Professionals Under the Diagnosis or Treatment Hearsay Exception*, 33 GA. L. REV. 353, 405-7 (1999); Lynne Celander DeSarbo, *The Danger of Value-Laden Investigation in Child Sexual Abuse Cases: Are Defendants' Constitutional Rights Violated when Mental Health Professionals Offer Testimony Based on Children's Hearsay Statements and Behaviors?*, 2 U. PA. J. CONST. L. 276, 293-303 (1999); Mosteller, *supra* note 8, at 48.

25. These assumptions regarding a child's motivation to speak accurately to an examining physician are certainly not beyond dispute. However, that dispute is beyond the scope of this article, which addresses only statements by adults.

26. *See generally* Mosteller, *supra* note 8.

statement is rooted in his status as a patient, not as a child, so why should the same rationale not apply to an adult patient's statement?

Also, although the admission of children's statements has generally been limited to cases involving alleged abuse and to statements describing the abuse, adult statements have been admitted in a far greater variety of cases.

In homicide cases, courts have used the exception to admit the victim's descriptions of prior violence by the defendant, made in treatment for emotional problems,[27] the victim's description of the crime, made in an emergency room evaluation for psychological trauma,[28] the defendant's statements to a jail psychiatrist, offered to rebut the defendant's later claim of remorse,[29] a videotape of the defendant's reenactment of the crime, made in the course of psychiatric evaluation,[30] the victim's description of her prior suicide attempts, offered by the defendant as evidence that the victim's death was a suicide,[31] and statements of the victim, made in psychological treatment for anxiety and depression, describing the defendant's sexual abuse of one's daughter, offered to rebut the defendant's claim that the victim's allegations of that abuse were untrue.[32]

In sexual assault cases, courts have used the exception to admit the victim's description of the crime, made in post-incident evaluation for psychological injury[33] and in subsequent treatment for psychological problems.[34] In employment discrimination cases, courts have used the exception to admit the plaintiff's statements describing harassment by supervisors and fellow workers, made in subsequent treatment for depression, anxiety and similar emotional problems.[35]

Courts have also admitted patient statements in cases alleging witness tampering,[36] tax fraud,[37] domestic violence,[38]

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27. *See, e.g.*, Capano v. State, 781 A.2d 556, 611 (Del. 2001); State v. Richards, 552 N.W.2d 197, 209 (Minn. 1996); State v. Evans, 992 S.W.2d 275, 283 (Mo. App. S.D. 1999); State v. Wyss, 370 N.W.2d 745, 759 (Wis. 1985).

28. *See, e.g.*, State v. Woods, 23 P.3d 1046, 1070 (Wash. 2001).

29. *See, e.g.*, Cameron v. State, 988 S.W.2d 835, 852 (Tex. App. 1999).

30. *See, e.g.*, State v. Yamada, 57 P.3d 467, 480 (Haw. 2002).

31. *See, e.g.*, State v. Jaeger, 973 P.2d 404, 409 (Utah 1999).

32. *See, e.g.*, State v. Wood, 545 A.2d 1026, 1031-32 (Conn. 1988).

33. *See, e.g.*, United States v. Haner, 49 M.J. 72, 76 (C.A.A.F. 1998); People v. Rogers, 780 N.Y.S.2d 393, 397 (N.Y. App. Div. 2004) (admitted under New York business records exception, which allows admission of such statements "as long as they are germane to medical diagnosis or treatment"); State v. Janda, 397 N.W.2d 59, 63 (N.D. 1986).

34. *See, e.g.*, State v. Geboy, 764 N.E.2d 451, 462 (Ohio Ct. App. 2001).

35. *See, e.g.*, Swinton v. Potomac Corp., 270 F.3d 794, 808 (9th Cir. 2001); Guzman v. Abbott Labs, 59 F. Supp. 2d, 747, 755 (N.D. Ill. 1999).

36. *See, e.g.*, State v. Roberts, 622 A.2d 1225, 1233 (N.H. 1993).

37. *See, e.g.*, U.S. v. Madoch, 935 F. Supp. 965, 965 (N.D. Ill. 1996).

negligence,[39] legal malpractice,[40] and police brutality,[41] all made in treatment for psychological problems that followed the events from which the litigation arose.

Reviewing courts seldom identify the mode of mental health treatment that was employed when the patient's statements were made, but as this brief review of cases demonstrates, regardless of the type of treatment, the relevant statements were assertions of non-symptom facts and were admitted because of their apparent pertinence to the patient's treatment, though they were offered primarily as evidence of the litigated incident itself. All of those statements were hearsay and would have been inadmissible except for the medical treatment exception. Most of them would not have been admissible under that exception if the statement had been made for the treatment of a physical condition. Facts such as prior incidents of violence, the details of the crime, the quality of the victim's relationship with the defendant, the actions of follow workers, are simply not "reasonably pertinent" to the diagnosis or treatment of physical illness or injury.

In approving the admission of such statements under the medical treatment exception, reviewing courts typically recite a rationale that simply equates psychological treatment with medical treatment. Sometimes the rationale is accompanied by some acknowledgment of problems of reliability in admitting statements relating to mental health and an assurance that such problems can be dealt with by rules providing for the exclusion of any material that is unfairly prejudicial[42] (although it appears that the statements are seldom if ever excluded for that reason, once they are found admissible under the medical treatment exception).

Even courts that apply a more careful analysis, acknowledging the differences between medical treatment and psychological treatment, show little understanding of how those differences can affect the reliability of the statements. An example of this occurred in *State v. Roberts*,[43] a 1993 decision of the New

38. *See, e.g.*, State v. Cureton, C.A. No. 01CA3219-M, 2002 WL 31313120 (Ohio Ct. App. 2002).

39. *See, e.g.*, Reed v. Abrahamson, 423 S.E.2d 491 (N.C. Ct. App. 1992); Knor v. Parking Co. of Am., 596 N.E.2d 1059, 1063 (Ohio Ct. App. 1991).

40. *See, e.g.*, Vallinoto v. DiSandro, 688 A.2d 830 (R.I. 1997).

41. *See, e.g.*, Parker v. Town of Swansea, 310 F. Supp. 2d 356, 374 (D. Mass. 2004).

42. An example of such a rule is Rule 403 of the Federal Rules of Evidence which provides that:

> Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence.

FED. R. EVID. 403.

43. *Roberts*, 622 A.2d at 1225.

Hampshire Supreme Court affirming a conviction for witness tampering. The charges were filed in 1987, and the prosecution's principal witness was to be a seventeen-year-old boy named Bryar who had a history of drug and alcohol abuse.[44] Earlier in 1987, Bryar had been adjudicated delinquent and sent to a chemical treatment facility for thirty days.[45] While there, he underwent counseling and disclosed to the counselor that he had a sexual relationship with the defendant and had received cocaine and money from the defendant in exchange for sex.[46] After his discharge, Bryar contacted the police and the defendant was charged with obscenity, prostitution and conspiracy to acquire cocaine.[47] Five months later, Bryar was arrested for attempted extortion of the defendant and he was placed in another residential treatment program.[48] In that program, he participated in psychotherapy and told the treating psychologist that the defendant had offered him a car, money and an apartment in Canada if he would not testify in the defendant's trial on the obscenity, prostitution and drug charges.[49] Bryar subsequently met with a police officer, and the defendant was indicted for witness tampering.[50] In 1988, before the witness-tampering trial, Bryar committed suicide.[51] In that trial, the judge allowed the counselor and the psychologist to testify to Bryar's statements, made to them, that the defendant had engaged in a sexual relationship with Bryar and had given him money and cocaine in exchange for sex and that the defendant had offered to give Bryar a car, money and an apartment if he did not testify against him.[52] Bryar's statements were admitted under New Hampshire's version of the medical treatment exception to the hearsay rule, which provides the same coverage as federal Rule 803(4), but requires, in addition, that the court affirmatively find "that the proffered statements were made under circumstances indicating their trustworthiness."[53]

The New Hampshire Supreme Court approved the admission of those statements. It agreed with the trial court that Bryar's general cooperation with the psychotherapy program indicated that his purpose in making the statements was to receive diagnosis and treatment for his chemical dependency and his psychological problems, even though his placement in that

44. *Id.* at 1228.
45. *Id.*
46. *Id.* at 1229.
47. *Id.*
48. *Id.*
49. *Id.*
50. *Id.*
51. *Id.*
52. *Id.* at 1231.
53. *Id.* at 1230-32 (citing N.H.R.EVID. 803(4)).

treatment was involuntary.[54] As evidence of the pertinence of Bryar's statements to his psychological treatment, the court relied on the testimony of the counselor and the psychologist that the disclosure of the sexual relationship and the defendant's inducements were important in the treatment of Bryar's problems.[55] In determining the psychological pertinence of the defendant's identity, the court cited child-abuse cases holding that the identity of the perpetrator is pertinent to the treatment of child abuse.[56] The trial court had found that Bryar's statements met the New Hampshire rule's requirement of trustworthiness because Bryar had made the statements in confidence to persons providing treatment, rather than to the police, that Bryar had an "open and honest professional relationship" with both the counselor and the psychologist, that Bryar "cried spontaneously for twenty minutes" when he first admitted his sexual relationship with the defendant, and that the acknowledgment of that relationship placed Bryar "in a light where others may look unfavorably upon him."[57] The reviewing court agreed, giving short shrift to Bryar's motive to harm the defendant, evidenced by his expression of desire to seek revenge for the defendant's treatment of him and by the fact that he had actually been charged with attempting to extort money from the defendant.[58]

Similarly, in *Capano v. State*,[59] the Supreme Court of Delaware acknowledged that mental health treatment differs from physical treatment,[60] but failed to examine that difference in holding that hearsay statements made in mental health treatment could be admitted under the medical treatment exception.[61] *Capano* was a murder prosecution. The defendant, a prominent lawyer, was charged with killing a woman whom he had been dating for two years prior to the murder.[62] In the trial, three mental health professionals who had treated the victim for anxiety, depression, anorexia and compulsive-obsessive disorder were allowed to testify to statements that the victim had made to them, including that she was fearful that the defendant would harm her if she broke off the relationship, that she sought to end the relationship because it was unhealthy, that the defendant was incredibly controlling and possessive, that she was concerned that the defendant would kidnap her, that the defendant had come to

54. *Id.* at 1232.
55. *Id.* at 1233.
56. *Id.* at 1232-33.
57. *Id.* at 1230.
58. *Id.* at 1237.
59. 781 A.2d 556 (Del. 2001).
60. *Id.* at 623-26.
61. *Id.*
62. *Id.* at 582-83.

her apartment late at night, bolted the door shut and yelled at her because she had begun to date someone else and that he was unwilling to let her pull away from that relationship.[63] One mental health professional testified further that the victim had said that the defendant had gotten into her apartment, became very angry and threatened to take back gifts he had given her so they would not be present while she dated someone else. [64]

The trial court admitted all of this testimony, and the Supreme Court affirmed the defendant's conviction, ruling that those statements were admissible under the Delaware equivalent of FRE 803(4), because they were reasonably pertinent to the victim's mental health treatment. Acknowledging that "in some cases statements of the patient made to the professional in the course of psychodiagnosis or psychotherapy may be unreliable, inappropriately far-ranging, or unduly prejudicial,"[65] the court emphasized the need for a firm foundation with respect to the qualifications of the psychotherapist, and the application of the two-part reliability test first developed in *United States v. Iron Shell*,[66] i.e., the declarant's motive must be consistent with the purpose of promoting treatment, and doctors must reasonably rely on this sort of information in diagnosis or treatment. It also admonished trial courts to determine that the probative value of the evidence was not substantially outweighed by the risk of unfair prejudice.[67] It concluded that, if these safeguards are applied, "[W]e find no supportable reason why there should be a blanket exclusion of statements made to psychotherapists as compared to the general acceptance of statements made to doctors or medical paraprofessionals for physical ailments."[68]

It would be hard to argue that the victim's descriptions in *Capano* were not "reasonably pertinent" to her treatment for such mental health problems as anxiety and depression. As we have seen, and as the *Capano* court acknowledged, much of a patient's life experience can be reasonably pertinent to his psychological treatment. However, neither the qualifications of the therapist, nor the patient's sincerity in seeking treatment, nor the reasonableness of the therapist's reliance on the statements, the "safeguards" proposed by the *Capano* court, have much bearing on the factual accuracy of the information that the patient relays to the therapist.

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63. *Id.* at 606 n.119.
64. *Id.* at 612 n.141.
65. *Id.* at 624.
66. *Id.* at 624. In *United States v. Iron Shell*, 633 F.2d 77 (8th Cir. 1980), the statements in question were those of a child victim of an attempted sexual molestation, made to an examining physician.
67. *Capano*, 781 A.2d at 624.
68. *Id.* at 625.

In highly charged cases like *Roberts* and *Capano*, where the declarant has died and is therefore not available for cross examination anyway, and where the defendant is arguably responsible for the death, there will be an understandable temptation to admit statements like these, which can be highly relevant to the defendant's guilt. The medical treatment exception is a convenient vehicle for pursuing that particular temptation. Because it is a longstanding and familiar exception to the hearsay rule, resorting to it appears to dispense with any need for further examination of how reliable the statements truly are.

But in both *Roberts* and *Capano*, the victim's statements describe a troubled relationship from the viewpoint of only one of the participants. The accuracy of such descriptions, uttered in a supportive setting that encourages emotional openness, can easily be distorted by anger, resentment and a need for self-justification. If the victim had been able to testify as a witness, the victim's descriptions of the relationship, of the defendant and of the incidents would surely have been probed and clarified by cross examination. If the victim had made the statements to a friend, a clergyperson, a police officer, or to anyone other than a mental health professional, they would have been excluded as hearsay. They are admitted in cases like *Roberts* and *Capano* only because the court has assumed that the therapeutic setting ensures their reliability.

But what is the source of this assumed reliability? From what do patient statements in psychotherapy derive such a "guarantee of trustworthiness" that they should be exempted from the operation of the hearsay rule? Cases like *Roberts* and *Capano*, which extend the exception to mental health treatment because it applies already to medical treatment, are based on an assumption that mental health treatment is the functional equivalent of physical treatment, in that it inspires in the patient a comparable motivation to speak carefully and accurately. That, however, is not the case.

III. WHY HEARSAY STATEMENTS MADE FOR THE PURPOSE OF MENTAL HEALTH TREATMENT ARE NOT SUFFICIENTLY RELIABLE TO BE EXCEPTED FROM THE HEARSAY RULE

How reliable must a statement be to qualify for admission under the medical treatment exception? Reliability, of course, is a matter of degree, and the several hearsay exceptions admit statements that vary in their likelihood of being accurate because the circumstances in which the statements are made, and the situations that provide their "guarantees of trustworthiness," differ. Yet, for all statements that are admitted under the medical treatment exception, that "guarantee" is the same: It is the patient's "selfish treatment interest," the perceived need to speak

accurately in order to receive appropriate treatment (and relief from the presenting symptoms). Whether the patient's statement was made in mental health treatment or in treatment of a physical malady, its reliability is predicated on the patient's strong motivation to be truthful in order to receive the diagnosis and treatment that will ultimately relieve the patient's suffering from the malady. So, in order for the exception to encompass a statement made to a psychotherapist, it would seem that the statement should be motivated by a "selfish treatment interest" that is roughly the same as the interest that motivates a patient to speak carefully and truthfully when undergoing treatment for a physical malady. And in fact, the courts that have admitted patient statements made in mental health treatment have generally assumed that the patient does have the same kind of selfish treatment motivation as the patient seeking treatment of a physical injury.

That assumption, however, does not seem to be based on any comparison of psychological and physical treatment methods or even on a clear understanding of what transpires in mental health treatment. Even a cursory review of some basic texts on psychological treatment suggests that the use of patient statements in such treatment differs fundamentally from their use in the treatment of physical conditions, and differs in ways that directly affect the patient's motivation to speak truthfully and accurately. This is true even though the statements may be very "pertinent to diagnosis or treatment."

Statements that courts have admitted under the medical treatment exception because they were pertinent to psychological diagnosis or treatment have been made in three different settings. The majority of such statements were made during the actual course of psychological treatment by a mental health professional, the setting that most closely resembles the exception's paradigmatic patient-to-treating-medical-professional situation; this was the situation in *Roberts* and *Capano*, both described above. Another significant group of admitted statements are those that were made during medical (not psychological) treatment after a traumatic experience. Those statements are usually admitted through the testimony of the examining medical professional on the ground that, when the statements were made, the medical professional was not only treating the patient's physical injuries but was also evaluating the patient for expected referral to mental health services for treatment of any psychological injuries caused by the traumatic event. This formulation has enabled the court to admit statements containing facts, such as threats made by the defendant and other aggravating circumstances of the crime, that are not pertinent to the medical treatment that the professional was actually performing but that may be pertinent to the

diagnosis or the future treatment of the patient's mental condition. The third setting from which patient statements have been admitted is the situation in which a mental health professional is examining the patient for a trial-related diagnosis (such as diminished capacity or ability to stand trial), with no intention of providing treatment.

This section will examine the patient's motivation to speak carefully and truthfully in the first two situations, which give rise to the "selfish-treatment interest" rationale for admitting the patient's statements. Because the "diagnosis-only" statements are admitted for an entirely different reason, they will be discussed separately, in Part IV.

A. Statements Made During Mental Health Treatment

Statements made to a mental health professional during the course of treatment would seem to be the functional equivalent of the patient-to-doctor statements on which the medical treatment exception was originally based. The patient knows he is in treatment, he knows for what he is being treated and he probably knows that his statements are related in some way to the treatment. Of the three situations described above, this is the one in which the patient's assertions seem most likely to be motivated by his "selfish-treatment interest" and therefore most reliable. But it is precisely in this treatment situation that the differences between psychological treatment and physical treatment can most clearly be seen to produce in the mental health patient a much reduced motivation to speak accurately. Following is an examination of some of those differences and their effect on the reliability of the patient's assertions.

1. The Goal of the Inquiry and the Role of the Clinician in the Interview

The first such difference is in the focus of the interview itself. A physician seeking to diagnose or treat a physical malady is primarily interested in obtaining information about the objective causes and symptoms of the presenting condition. The mental health clinician, on the other hand, is most interested in a mutual exploration, with the patient, of the patient's feelings associated with the information the patient relates, not with the accuracy of the information itself.[69] Central to the clinician's ability to engage

69. *See generally* HALLECK, *supra* note 18 (intended for medical students and psychiatric residents), JOHN SOMMERS-FLANAGAN & RITA SOMMERS-FLANAGAN, CLINICAL INTERVIEWING (3d ed., John Wiley & Sons, 2003) (intended for psychology students), LUCAS, SUSAN RIES, WHERE TO START AND WHAT TO ASK: AN ASSESSMENT HANDBOOK (W.W. Norton & Co. 1993) (intended for social work students).

the patient in this exploration is the formation of a supportive clinician-patient relationship.[70]

This difference in the goals of medical and psychological interviewing results in very different participation by the professional in the interview. A Dutch study several years ago compared questioning techniques in initial medical and psychological interviews.[71] It found that the typical medical interview was characterized by pointed questioning, interruptions and abrupt topic shifts, all initiated by the doctor,[72] whereas the psychological interviews involved no such intervention by the interviewer. In the "exploratory" (diagnostic) psychological interview, the interviewer simply sought further information and clarification of topics introduced by the patient.[73] In the "collaborative" (diagnostic and treatment) psychological interview, the interviewer's predominant mode of participation was to paraphrase what the patient said, (as a way of getting the patient actively involved in the formulation of the problem being treated).[74]

Thus, in the medical interview, the doctor takes the patient's information and challenges and clarifies it according to the doctor's own agenda of symptoms and causes. This filtering and clarifying by the doctor cannot help but enhance the accuracy of the information provided by the patient. Additionally, if the patient is not aware at the outset of the doctor's need for accurate information, he certainly learns this from the dynamics of the interview.

The mental health professional, on the other hand, is not primarily interested in eliciting accurate information from the patient, at least not about the non-symptom facts underlying the patient's perceived problem. Far more important to mental health treatment than an accurate description of people and events is the patient's willingness to disclose and explore his feelings about those things, and that requires the establishment of a trusting relationship with the patient.[75] "A warm, personable and confiding relationship is a significant therapeutic factor common to virtually all forms of counseling and psychotherapy."[76] In other words, the

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70. *See generally* HALLECK, *supra* note 18 (intended for medical students and psychiatric residents); SOMMERS-FLANAGAN, *supra* note 69 (intended for psychology students); LUCAS, *supra* note 69.

71. Tony Hak & Fijgje de Boer, *Formulations in First Encounters*, 25 JOURNAL OF PRAGMATICS 83 (1996).

72. *Id.* at 85-88.

73. *Id.* at 88-91.

74. *Id.* at 91-96.

75. SOMMERS-FLANAGAN, *supra* note 69, at ch. 5.

76. Hak & de Boer, *supra* note 71, at 102-3; *see also* ESSENTIAL PSYCHOTHERAPIES (Alan S. Gurman, Stanley B. Messer, eds., 2d ed., The Guilford Press 2003) (describing twelve psychotherapies: traditional

efficacy of treatment will depend to a significant degree on the ability of the clinician to establish and maintain that kind of relationship with the patient. Such a relationship is universally acknowledged to assist the patient in disclosing and confronting the causes of the illness, although the mechanism by which this happens is characterized in different ways by the different schools of therapy (e.g., as "transference" in psychoanalytic therapy,[77] as "trustworthiness" in some behavioral therapies[78] and as "mutuality" in feminist therapy[79]). As a result of this focus on the clinician-patient relationship, the mental health interview is characterized by the clinician asking the patient to expand on his story and asking for more information on the patient's contextually grounded experiences of events.[80] The patient's description of the people and events that he perceives to have caused or contributed to his problem, far from being subject to the probing of the medical interview, is ordinarily not questioned by the mental health clinician: The inquiry here is into the patient's feelings about those people and events.[81] In fact, counseling texts specifically warn against jeopardizing the relationship by challenging the patient's version of the problem in early interviews.[82]

This is not to suggest that a psychotherapist will never question a patient's statement of the facts. Although most therapists assume truthfulness on the part of patients and do not attempt to detect or challenge factual inaccuracy,[83] there have been some alarms sounded regarding deception by patients.[84]

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psychoanalytic treatment, relational approaches to psychoanalytic psychotherapy, person-centered psychotherapy, existential-humanistic psychotherapies, behavior therapy, cognitive therapy, postmodern approaches to psychotherapy, integrative approaches to psychotherapy, brief psychotherapies, family therapies, marital therapies, group psychotherapies).

77. SOMMERS-FLANAGAN, *supra* note 69, at 114.

78. *Id.* at 124-26.

79. *Id.* at 127-30.

80. Hak & de Boer, *supra* note 71, at 89.

81. One of the goals of the psychological interview is to enable the clinician to complete a "mental status exam," which requires information about the patient in categories like the following: appearance, behavior/psychomotor activity, attitude toward interviewer, affect and mood, speech and thought perceptual disturbances, orientation and consciousness, memory and intelligence, reliability, judgment and insight. The focus is on evaluating the patient's cognitive processes, not the accuracy of the facts he recites. SOMMERS-FLANAGAN, *supra* note 69, at 214-38.

82. *See, e.g.*, LUCAS, *supra* note 69, at 2 ("If you disagree with the client's perception of the problem, this is not the time to say so.").

83. CLINICAL ASSESSMENT OF MALINGERING AND DECEPTION 1 (Richard Rogers ed., The Guilford Press 1997).

84. *See, e.g.*, EKKEHARD OTHMER & SIEGLINDE OTHMER, THE CLINICAL INTERVIEW USING DSM-IV-TR: VOL 2: THE DIFFICULT PATIENT 315, 353-88 (American Psychiatric Publishing, 2002); CLINICAL ASSESSMENT OF

However, the primary concern of those voices has been the patient lying about symptoms (malingering), not about precipitating events, and it is the events, not the patient's symptoms, that are likely to be most relevant in a subsequent trial. One of the few texts that advocates challenging a patient's apparent deception about non-symptom facts also acknowledges that it is difficult for the therapist to pursue such a course.[85] One would therefore expect such challenges by the therapist to be relatively rare.

So, it would appear that the nature of the psychiatric interview, based on the need to create and nurture a supportive patient-therapist relationship and focus on the patient's subjective experience of events and not on an accurate communication of the events themselves, is far less likely than the typical medical interview to instill in the patient a sense of the importance of full and accurate disclosure of underlying, non-symptom facts. In addition to that, the same reasons that bring the patient into mental health treatment are themselves likely to inhibit the patient from giving a complete and accurate description of underlying facts.

2. *The Patient's Reluctance to Report Fully and Accurately*

It is widely recognized among psychiatrists that psychiatric patients are more likely than other medical patients to misreport, through distortion, incomplete disclosure, or deliberate deception.[86] They may be motivated by distorted thinking due to their illness,[87] by fear (of stigmatization or of mental illness itself) or, very commonly, by a desire to avoid responsibility or humiliation. [88]

MALINGERING AND DECEPTION (Richard Rogers ed., The Guilford Press 1997).

85. OTHMER, *supra* note 84, at 362-64. The authors suggest that patient deception about events can only be detected when there is a divergence between the patient's description and the patient's "genuine emotions" as perceived by the therapist. Skillful deceivers can minimize such a divergence, *id.* at 356, and health practitioners are reluctant to confront deception even when they detect it, *id.* at 315-16.

86. HALLECK, *supra* note 18, at 4.

87. This does not refer to the serious distortions that characterize the thinking of a patient suffering from psychosis or any other condition that seriously impairs the patient's perception of reality. Those distortions (e.g., "God told me to kill him") are usually obvious or can be exposed through the cross examination of the testifying therapist. The focus of this article is on the ordinary patient in psychotherapy, whose condition may color his perception (e.g., by inclining him to attribute malicious motives to certain of his intimates), but does not seriously compromise his grasp on reality. However, even this kind of low-level disturbance can motivate a patient to report events inaccurately when the facts related by the patient have been filtered through the patient's interpretation (e.g., "My boss humiliated me in front of the other employees.").

88. *Id.* at 30-35; *see also* SULLIVAN, HARRY STACK, THE PSYCHIATRIC INTERVIEW 218-24 (H.S. Perry and M.L. Gawel, eds., W.W. Norton & Co., 1954) (describing how to handle anxiety in a psychiatric interview); Edward

Psychotherapy often requires the disclosure of situations that the patient believes will reveal previously hidden shortcomings, and such disclosure can engender in the patient a feeling of shame.[89] This would seem to be especially true in many of the situations that might be relevant to future litigation, in which the patient's statements might be offered in evidence, situations, for example, involving sexual contact, violent relationships, child abuse or neglect, job performance and even negligence.

The prevalence of communication-inhibiting feelings of shame in mental health patients was confirmed in a recent British study of people referred to psychotherapy by their primary care physicians.[90] The study, which was conducted immediately before the patients entered psychotherapy, found that sixty-eight percent of the emotions reported by the patients in the study had not been disclosed to anyone else (compared to a non-disclosure rate of about ten percent in similar studies of non-clinical samples of respondents) and that the non-disclosure was highly correlated with fear that disclosure of the emotional experience would make the respondents feel shame or fear about how others might see them.[91] This could indicate that one of the reasons why people enter psychotherapy is because of a predisposition not to disclose such facts.[92] If that is the case, it raises serious questions about whether the information communicated by a patient in psychotherapy, especially in the early stages of psychotherapy, is likely to be complete or even entirely accurate. In addition, mental health professionals acknowledge that the accuracy of a patient's reporting can be very difficult to assess.[93] In light of this, the evidentiary reliability of the patient's statements to the therapist looks even more questionable.

3. The Lack of an Obvious Connection Between Providing Accurate Information and Receiving Symptom-Relieving Treatment

As already noted, the medical treatment hearsay exception is based on a belief that the patient is motivated to speak truthfully and accurately to a clinician because he recognizes that the clinician must have accurate information to be able to provide a correct diagnosis and appropriate treatment. The patient seeking

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M. Weinshel, *Some Observations on Not Telling the Truth*, 27 J. AM. PSYCHOANALYTIC ASS'N 503 (1979).

89. HALLECK, *supra* note 18, at 30-31.

90. *See* James Macdonald & Ian Morley, *Shame and Non-Disclosure: A Study of the Emotional Isolation of People Referred for Psychotherapy*, 74 BRIT. J. MED. PSYCHOL. 1 (2001).

91. *Id.* at 1.

92. Over eighty percent of the participants in this study who discussed an undisclosed emotional experience stated to the interviewer that non-disclosure was "a recurrent or habitual pattern." *Id.* at 7.

93. *See. e.g.*, OTHMER, *supra* note 84, at 319-21.

treatment for an injury or an illness is typically experiencing pain or other unpleasant symptoms and he will take care to be accurate in describing the events leading up to the pain, because he wants relief from those symptoms and understands that the doctor's ability to provide relief depends on the doctor having a correct understanding of the pain's cause. However, this connection between the accurate reporting of non-symptom facts and the quality of the resulting treatment is likely to be far less clear to the patient who is providing such information to a mental health clinician.

Even the patient who is voluntarily seeking treatment for clearly acknowledged mental symptoms, such as depression or anxiety, is unlikely to think that his treatment depends on his providing the therapist with accurate and complete information about the people or the events that the patient associates with those symptoms. Unlike infection and injury, a mental or emotional problem seldom results from a clear, single-event cause and treatment is rarely based on identifying such a cause. Although the efficacy of mental health treatment does depend on accurate information about symptoms, it does not depend substantially on the accuracy of the patient's statements about the events leading to the patient's distress.[94] As we have seen, the process of mental health treatment reflects this in the relative absence of probing questioning by the clinician, the kind of questioning that could help the patient make the connection between accurate information and the relief of his symptoms. This lack of obvious relationship between accuracy and symptom-relief is especially problematic when, as noted above, the very condition that brought the patient into therapy may motivate him to provide incomplete and inaccurate information to the therapist.[95]

This would presumably be even more the case with patients whose submission to treatment is not voluntary. If the patient is in mental health treatment because of a medical or court referral or because of pressure from family or friends, the patient himself may have neither a clear recognition of his symptoms nor much desire to relieve them. The fact that the patient has been compelled or pressured to seek treatment may even suggest a motivation to give a self-serving version of the facts rather than an accurate one, or to rebel against the circumstances by dissembling.

4. The Special Case of Statements Made in Treatment for Trauma

The lack of an obvious connection between the patient's accuracy and the relief of symptoms creates a somewhat different problem in evaluating the accuracy of statements made in mental

94. *See supra* notes 69-85 and accompanying text.
95. *See supra* notes 86-93 and accompanying text.

health treatment after trauma. Because of increased understanding of the psychological effects of trauma, such as serious beating or sexual assault, it has become common for the emergency medical personnel who treat trauma victims' physical injuries to screen and refer victims for psychological treatment.[96] Thus, although the patient voluntarily enters mental health treatment, his motivation for doing so often results from the urging of the medical professional and not from his own symptoms. In fact, he may not be experiencing what he recognizes as psychological symptoms at all. The most distressing psychological symptoms of the trauma, which can include flashbacks and dreams about the event, insomnia, irritability, poor concentration, exaggerated startle response and fearfulness, are associated with Post Traumatic Stress Disorder (PTSD) and are often delayed, sometimes occurring only weeks or months after the traumatic event.[97] The patient who is referred for mental health treatment immediately after the trauma will most likely not be seeking relief of those symptoms. That patient is more likely to be experiencing an acute stress reaction (Acute Stress Disorder, or ASD), which can manifest itself in a passive withdrawal or in agitation and acute anxiety.[98] Clinicians who encounter trauma victims at this stage are taught to focus the interview on assuring the client that his reaction is normal and on identifying needs for safety, comfort, support and medical attention.[99] They are cautioned not to prompt the victim to talk about the trauma unless he wishes to.[100] While the patient is experiencing this stress reaction, his processes of thinking and decision-making will likely be impaired.[101] In fact, one of the diagnostic criteria for ASD is "dissociative amnesia" (the inability to recall an important aspect of the trauma).[102] Thus, the reliability of information he provides about the traumatic event is likely to be diminished.

In the weeks and months following a trauma, some patients will experience PTSD, the symptoms of which include a number of

96. In fact, treatment for sexual assault is often provided by a designated team of professionals, including a nurse-examiner who is trained to assess both physical and emotional trauma. *See, e.g.*, Commonwealth of Massachusetts, Executive Office of Health and Human Services, *Massachusetts Sexual Assault Nurse Examiner Program, SANE Protocols for Ages 12 and Above*, 9 (2003).

97. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS ("DSM-IV"), 426-29 (4th ed. 1994).

98. ANNE-MARIE DOYLE & SUSAN THORNTON, PSYCHOLOGICAL ASSESSMENT OF SEXUAL ASSAULT, IN THE TRAUMA OF SEXUAL ASSAULT: TREATMENT, PREVENTION AND PRACTICE 99, 103-4 (Jenny Petrak & Barbara Hedge eds., John Wiley & Sons 2002).

99. *Id.* at 104; *see also* SOMMERS-FLANAGAN, *supra* note 69, at 194-95.

100. DOYLE & THORNTON, *supra* note 98, at 104.

101. *Id.* at 103.

102. American Psychiatric Association, *supra* note 97, at 432.

memory-distorting aspects, including psychic numbing, avoidance, amnesia and hyperarousal.[103] At this stage, the patient will certainly be aware that he is experiencing serious symptoms and will presumably be motivated to relieve them. However, now his condition also makes him less able to provide reliable information about the traumatic event. Questioning the patient about the trauma may cause him to re-experience it.[104] This may produce acute distress on the patient's part, but it is unlikely to disclose reliable information because in PTSD an apparently indelible emotional memory (which compels the patient to re-experience the stress of the event) coexists with impaired declarative memory (which would ordinarily enable the patient to recall of the details of the event.).[105] So, although the patient can reproduce the emotions of the traumatic experience, his ability to remember the details is impaired.[106]

Trauma also damages its victims' capacity for trust, impairing their ability to establish a supportive relationship with a therapist. As a well known authority on trauma puts it, "The patient enters the therapeutic relationship prey to every sort of doubt and suspicion. She generally assumes that the therapist is either unable or unwilling to help. Until proven otherwise, she assumes that the therapist cannot bear to hear the true story of the trauma."[107] One would not expect a client in this state to be motivated to give the therapist a full and accurate description of events, even if she could.

Finally, even the patient who is not so traumatized as to be suffering from these serious deficits, may feel that he has contributed to causing the trauma itself (e.g., an automobile accident, sexual assault by an intimate, domestic violence). If so, feelings of shame or responsibility may motivate him to conceal his contribution rather than to tell the full truth.[108]

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103. *Id.* at 428-29; *see also* Bessel A. van der Kolk, *The Body Keeps the Score: Memory and the Evolving Psychobiology of Posttraumatic Stress*, 1 HARV. REV. PSYCHIATRY 253, 254 (1994); DOYLE & THORNTON, *supra* note 98, at 110-11.

104. SOMMERS-FLANAGAN, *supra* note 69, at 194-95.

105. van der Kolk, *supra* note 103, at 258-61. This article explains the physiological causes of PTSD, showing what parts of brain are implicated and suggesting that the "emotional" memory may be permanently imprinted (although its effect can be ameliorated with drugs) and that cognitive evaluation of experience and semantic representation may be interfered with by the same processes that create such vivid and long-lasting emotional memories.

106. A diagnostic criterion for PTSD is "persistent avoidance of stimuli associated with the trauma," including "inability to recall an important aspect of the trauma." American Psychiatric Association, *supra* note 97, at 428.

107. JUDITH LEWIS HERMAN, TRAUMA AND RECOVERY 138 (Basic Books 1992).

108. DOYLE & THORNTON, *supra* note 98, at 104-5; *see also infra* notes 113-19 and accompanying text.

Thus, to the extent that the "selfish treatment" motivation depends on the patient recognizing that accurate information will lead to relief of symptoms, that motivation is much less present in mental health treatment than in physical treatment. Moreover, in mental health treatment for trauma, the trauma itself appears to add additional risks of inaccuracy.

5. The Inability to Verify the Patient's Version of Events

When a patient complains to a doctor of pain or of a physical illness, the patient's body usually displays physical manifestations of that condition. The doctor can observe the injury and can test for elevated temperature, abnormal blood count and other objective indicators that are consistent with the patient's description of the condition and of its cause. This physical evidence can be used to corroborate the patient's complaints, but it can also expose inconsistencies, omissions and fabrications in the patient's statements. The patient's knowledge that the doctor can check his statements through this other evidence enhances the patient's motivation to speak accurately and not to omit anything that seems pertinent to his condition. This is an aspect of the "selfish treatment interest" that increases the reliability of the patient's statements and justifies admitting them into evidence in spite of the hearsay rule.

The facts that are recited by the patient in mental health treatment are ordinarily much less susceptible to verification by the clinician. The symptoms of mental and emotional conditions are far less likely than those of physical conditions to be reflected in verifiable bodily changes.[109] Facts relating to the patient's history (non-symptom facts) are also less likely to be verifiable, for several reasons. First, the number of historical facts that are pertinent to diagnosis or treatment is usually very large,[110] and not all of them are equally important to the clinician. Second, some of the important events described may be long past and could not be verified easily even if the clinician wanted to seek objective evidence of them.[111] Third, and most important, the mental health professional, as we have seen, is not particularly concerned about verifying the patient's description of underlying events, even recent ones, because it is the patient's feelings about the events

109. This is not always true, of course. One of the symptoms of PTSD, for example, is a heightened response to certain stimuli, especially reminders of the trauma and intense neural stimuli, such as sudden noises. This response can be reflected in increases in such physiological signs as heart rate, skin conductance and blood pressure. van der Kolk, *supra* note 103, at 254-58. However, the verification of symptoms through laboratory testing is seldom a part of clinical treatment of mental or emotional conditions.

110. *See supra* notes 18-19 and accompanying text.

111. HALLECK, *supra* note 18, at 76.

and not their objective reality that are seen as far more important to the cause and the treatment of the mental condition.[112] Unlike the physician seeking clarification of a patient's physical complaints, the mental health clinician is unlikely to jeopardize the therapeutic relationship by probing or otherwise challenging the patient's version of events.

The patient thus has no reason to think that his statements will be subject to cross checking and he cannot have the enhanced motivation to speak accurately that an expectation of cross-checking would provide.

6. The Self-Serving Nature of Many of the Patient's Statements

There is a high risk that the accuracy of statements made in mental health treatment may be distorted by self-serving motivations of various kinds. It has already been noted that situations discussed in mental health treatment often engender feelings of shame in the patient.[113] Those feelings can create a need for self-justification which can be a powerful motive for incomplete disclosure, or even fabrication.[114] This would seem to be especially true of many of the situations that produce patient statements that are relevant evidence in subsequent litigation involving, for example, damages due to mental distress, violence that may have been provoked or contributed to by the victim-declarant (such as assault by an intimate), or other kinds of alleged maltreatment (such as discrimination or harassment). In all of these situations, the patient may well feel a need to convince the clinician of the patient's own lack of responsibility or the importance of the patient's feelings of injustice. That kind of motivation is unlikely to produce reliable accounts of the underlying events.

Exacerbating this risk of self-serving distortion is the fact that the patient will ordinarily know that he has control over the therapist's ability to repeat his statements. The therapist has a professional obligation to preserve the confidentiality of most such statements and, except in exceptional circumstances, to disclose them only with the patient's permission.[115] Advising the patient of that obligation is considered good therapeutic practice.[116] It also,

112. *See supra* notes 75-85 and accompanying text.

113. *See supra* notes 86-93 and accompanying text.

114. *See generally* HALLECK, *supra* note 18.

115. AMERICAN PSYCHIATRIC ASSOCIATION, THE PRINCIPLES OF MEDICAL ETHICS WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY, ANNOTATIONS TO SECTION 4 (2001); American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct*, STANDARD 4 (June 2003); Clinical Social Work Federation, *Code of Ethics* III (1997), American Counseling Association, *ACA Code of Ethics*, SECTION B (2005).

116. American Psychiatric Association, *supra* note 115, at 4.

however, lets the patient know that he is very unlikely to be called to account for any inaccuracy in his statements, because the therapist cannot repeat them to anyone who might be able to verify or challenge them.

When patient statements are offered in evidence in a trial, privilege law provides another vehicle for patient control and should raise additional concerns about the accuracy of the statements. All states and the federal courts recognize a psychotherapist-patient privilege not to disclose confidential patient statements in a legal proceeding.[117] The patient is the holder of that privilege, and only the patient can waive it. Thus, a patient who is aware of the privilege and who anticipates litigation knows that he (or someone representing his interests) will be able to decide whether his statements that were made in mental health treatment will be offered at trial.[118] This ability to shape the evidence provides an additional incentive to report a self-serving version of events to the clinician.

Statements made for treatment of a physical condition can, of course, also be self-serving, but in view of the vastly wider galaxy of facts that are "reasonably pertinent" to mental health treatment and the generally weaker controls on the accuracy of the latter statements, the risk of distortion by self-serving motivation seems significantly higher in statements that are made in mental health treatment.[119]

None of this is to suggest that patients in mental health treatment are generally untruthful or that truth-telling in the clinician-patient relationship is of no importance. What it does suggest is that the truth-telling motivation of a patient in psychotherapy is far less likely to be enhanced by the conditions of treatment than is that of the paradigmatic patient on which the medical treatment hearsay exception is based – one who seeks treatment of a physical injury or illness. If that is so, then the patient's statements in psychotherapy do not carry the additional

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117. *See* Jaffe v. Redmond, 518 U.S. 1 (1996) (recognizing a federal psychotherapist-patient privilege and acknowledging that all fifty states and the District of Columbia already recognized such a privilege in some form); *see also id.* at 12 n.11 (providing various state rules of evidence in which psychiatrist-patient privilege is acknowledged).

118. Of course, there will also be situations in which the privilege does not apply (e.g., when the patient speaks to a court-appointed mental health professional). In those situations, however, the patient's statement is usually offered against the patient and there is generally no need to resort to the medical treatment exception to admit it since the patient's statement can be admitted as an admission of a party opponent (if the patient is a party) or as a statement against interest (if the patient is unavailable to testify) or, for the limited purpose of impeaching the patient's testimony (if the patient testifies).

119. In addition, many jurisdictions, both federal and state, do not recognize a general physician-patient evidentiary privilege, whereas all recognize a psychotherapist-patient privilege.

"guarantee of trustworthiness" that justifies the admission of hearsay statements made for purposes of medical diagnosis and treatment. Most people try to speak accurately in most contexts, but the hearsay rule still applies to keep their out-of-court statements out of evidence. The factual statements that patients make to their mental health clinicians are no more likely than those excluded statements to be accurate, and therefore they should not escape the filter of the hearsay rule.

B. Statements Made in Anticipation of Mental Health Treatment

If a patient's statements that are made in the process of treatment itself, when the "selfish treatment interest" is presumably strongest, do not have the enhanced reliability that the hearsay exception requires, one would expect even less reliability in statements that the patient makes when the patient is not in treatment. Yet, some courts have been willing to admit such statements as "reasonably pertinent to psychological treatment" even when the statements were made when the patient was not being treated for mental or emotional complaints and thus had little, if any, "selfish-treatment interest" in speaking accurately.

This expansive use of the exception occurs most frequently in cases involving a traumatic injury, such as an assault. In the course of medical treatment for the resulting physical injuries, the patient speaks with a medical professional (not a mental health professional) and gives a description of the traumatic event. In a subsequent trial, the medical professional offers to testify to what the patient said about the event. The court, recognizing that parts of the patient's description have no pertinence to the treatment the patient was receiving, admits those statements anyway, on the ground that the medical professional was also evaluating the patient for referral to mental health treatment for the trauma.

A recent example of this treatment is *State v. Woods*,[120] decided by the Supreme Court of Washington in 2001. The defendant was charged with a brutal murder and attempted murder.[121] The trial court admitted statements of one of the victims under the Washington version of Rule 803(4).[122] The victim had told an emergency room physician that she had been awakened by the defendant, that he had hauled her out of bed, showed her the body of her beaten friend and threatened to do the same to her if she did not cooperate with him, that he had bound another of her friends and she had heard a bat swing and hit that

120. 23 P.3d 1046 (Wash. 2001).
121. *Id.* at 1054.
122. *Id.* at 1066-69.

friend in the head.[123] She recited the same facts to an emergency room nurse who examined her later that day, adding that the assailant had two knives.[124] None of these facts was pertinent to the treatment of her physical injuries. The victim later died in the hospital. Although the victim had not received any mental health treatment, the emergency room physician testified that he needed to have an idea of what happened in order to arrange counseling, "because people are going to have a certain amount of post traumatic stress."[125] On the basis of this, the trial court admitted the statements. The appellate court approved, observing that the victim's being subjected to viewing the body of one friend and hearing another being hit by a baseball bat were "reasonably pertinent to an assessment of [her] need for counseling," and that all of the statements the victim made to the emergency room doctor and nurse were "reasonably pertinent to either immediate physical or eventual psychological treatment" and were therefore admissible under the medical treatment exception.[126] There was no evidence that the victim herself was aware that her statements related to her mental health treatment, or even that such treatment was actually contemplated in her case. Since traumatic experiences often result in psychological symptoms, it would seem in the view of the *Woods* court that most statements describing a traumatic experience of any kind should be admitted as pertinent to psychological treatment, as long as they are made to a medical professional. Other courts have used a similar rationale to admit a victim's hearsay statements that were not pertinent to the treatment actually being delivered.[127]

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123. *Id.*

124. *Id.* at 1069.

125. *Id.* at 1070.

126. *Id.* at 1069-70.

127. *See, e.g.*, People v. Rogers, 780 N.Y.S.2d 393, 397 (App. Div. 2004) (sexual assault victim's statements in hospital record, not pertinent to treatment of physical injuries admissible because record "had a dual purpose of investigation and treatment of the victim's potential physical and psychological injuries," and "the history was germane to treatment." There is no indication in the opinion that the victim-declarant was aware that her statements would be pertinent to future mental health treatment); *see also* State v. Janda, 397 N.W.2d 59 (N.D. 1986) (duty nurse at hospital where adult sexual assault complainant was brought for examination after the alleged assault was allowed to testify to several of the complainant's statements, including that she had been attacked at her house by the defendant, who had held her arms down and told her not to tell anyone. The admission was approved because, although not pertinent to treatment of the complainant's physical injuries, such facts as the location of the attack, the kind and degree of restraint, and the imposition of fear through an admonition not to tell anyone, were all reasonably pertinent to psychological treatment and "[i]n addition to diagnosing and treating such physical injuries as cuts and bruises, health care providers examining one claiming to be the victim of a sexual assault must diagnose whether or not the alleged victim has suffered

In cases where traumatic injury has been inflicted upon the victim, the victim's out-of-court statements of important facts, such as the perpetrator's identity or the circumstances of the assault itself, are often the most probative evidence available, and a court's desire to admit them is understandable. But they are hearsay, and they often arise in situations that raise concerns about the accuracy of the victim's perception and memory[128] or the self-serving motivation of the victim.[129] They should not qualify for admission under the medical treatment exception. If the patient is not aware that his statements are pertinent to some kind of medical treatment, he does not have the selfish-treatment motive to speak accurately. Without that reliability-enhancing motivation, the medical treatment exception should simply not apply. When the patient relates to a medical professional such facts as the identity of the attacker, the location of the attack and a description of the attack, the patient has no way of knowing that those facts are pertinent to the patient's mental health treatment unless the medical professional makes that clear. There is no indication that such an explanation was offered in any of the cases admitting statements of that kind. Unless he knows that the accuracy of his account is pertinent to his treatment, the patient's motivation to speak accurately is no different than if he were speaking to a police officer or another investigator, and the hearsay rule does not provide an exception for a statement made in those circumstances.

One could argue, of course, that the patients in these cases knew that they were being treated for physical injuries and probably assumed, because of the context, that this information was also pertinent to that treatment, thus motivating them to speak accurately when providing it. But that reasoning would make virtually any statement made in medical treatment admissible, and the requirement that the statement be "reasonably pertinent" to the treatment would be rendered meaningless, as would the cautionary requirement, applied by some courts, that the statement not only be motivated by the patient's desire to promote treatment, but that doctors reasonably rely on that sort of information in providing that treatment.[130]

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psychological trauma and, if so, its nature and extent and treat that as well.")

128. Trauma can distort the memory of such a patient, and this is an additional reason for caution in dealing with the patient's hearsay statements shortly after the traumatic experience. *See supra* notes 96-108 and accompanying text.

129. For example, in *Rogers*, *Woods*, and *Janda*, the victim-declarant and the defendant were acquainted before the assault. A preexisting relationship should always raise questions of the declarant's motivation in describing the incident.

130. *See, e.g.*, *Iron Shell*, 633 F.2d at 83-84.

For these reasons, statements made during medical diagnosis or treatment should not be admitted under the medical treatment exception if they are not pertinent to the medical treatment being provided, but only to the anticipated treatment, by someone else, of the patient's mental health problems.

IV. STATEMENTS MADE FOR THE PURPOSE OF DIAGNOSIS ONLY

Prior to the adoption of the Federal Rules of Evidence, the medical treatment hearsay exception was normally applied only to statements made for the purpose of obtaining treatment.[131] It was generally agreed that when a patient consults a physician for diagnosis only, without an expectation of subsequent treatment (usually to obtain the physician's expert evidence at trial), the patient's statements are not motivated by the selfish-treatment interest in speaking accurately and therefore, are not sufficiently reliable to be admitted under the hearsay exception. Rule 803(4) of the Federal Rules of Evidence rejected that restriction. That rule covers statements made for the purposes of medical diagnosis *or* treatment, thus including statements made to a physician consulted with no treatment purpose, but only for the purpose of obtaining the physician's testimony.

The Advisory Committee's justification for this extension of the exception was purely pragmatic. The Committee reasoned that the testifying physician, who would ordinarily be offering an opinion in the trial, could usually testify to the patient's statements for the non-hearsay purpose of showing "the basis of his opinion," the jury then being instructed that it could not consider the patient's statements for their truth, but only to show the information on which the expert's opinion was based.[132] In the Committee's opinion, the jury was unlikely to be able to make that distinction and thus to confine those statements to that non-hearsay use, but would instead treat the statements as evidence of the matter asserted in them.[133] Its solution was to allow the full admission of the patient's statements by including them in the hearsay exception of Rule 803(4).[134] The Advisory Committee's Note ends with the cryptic statement, "This position is consistent

131. FED. R. EVID. 803(4), advisory committee's note; *see also* 2 JOHN W. STRONG, MCCORMICK ON EVIDENCE 284 (5th ed., West Group 1999) ("statements . . . made by a patient to a doctor consulted for treatment have almost universally been admitted as evidence of the facts stated . . .").

132. FED. R. EVID. 803(4), advisory committee's note.

133. *See id.* (describing the distinction called for as "most unlikely to be made by juries").

134. It should be noted that this part of Rule 803(4) should be read to admit the patient statements only if the examining medical expert actually testifies and presents an expert opinion at trial. Otherwise the rationale for admitting the statement (that the jury will hear it anyway as the basis of the expert's opinion) does not apply.

with the provision of Rule 703 that the facts on which expert testimony is based need not be admissible in evidence if of a kind ordinarily relied upon by experts in the field."[135] However, Rule 703 merely permits an expert opinion to be based on inadmissible material. It does not allow that inadmissible material to be presented to the jury. Rule 803(4), on the other hand, goes much further and permits a court to admit, as substantive evidence, otherwise inadmissible hearsay solely because it can be the basis of the expert's opinion.[136]

With the adoption by states of evidence codes based on the federal rules, the extension of the medical treatment hearsay exception to include statements made for diagnosis only has been widespread. However, it has been subject to much scholarly criticism[137] and has been rejected by some courts and legislatures.[138] In addition, its rationale has been undermined by a subsequent amendment to the Federal Rules of Evidence. Effective December 1, 2000, Rule 703 was amended to provide that otherwise inadmissible facts or data supporting an expert's opinion are not to be disclosed to the jury "unless the court determines that their probative value in assisting the jury to evaluate the expert's opinion substantially outweighs their prejudicial effect."[139] That provision would ordinarily prohibit the disclosure of hearsay statements by the expert witness. However, under Rule 803(4) such statements, if made by the patient, are not "otherwise inadmissible" if made to a *medical* expert, even to a non-treating one. Thus, the 803(4) hearsay exception for these statements, which was justified because the statements could be heard anyway as the basis of the expert's opinion, continues to admit such statements even though they would now be much less likely to be heard as the basis of the expert's opinion. Of all the

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135. *Id.*

136. Judge Weinstein and Professor Berger interpret this language to reflect a judgment that "a fact reliable enough to serve as the basis for a diagnosis is also reliable enough to escape the hearsay objection." 5 JACK B. WEINSTEIN & MARILYN A. BERGER, WEINSTEIN'S FEDERAL EVIDENCE § 803.06[2], 803-41 (Joseph M. McLaughlin ed., 2d ed., Matthew Bender 1998). However, as Professor Capowski has pointed out, as an argument for reliability this interpretation ignores the likely bias of many experts who are employed by a particular party to support a particular theory of the case. Capowski, *supra* note 24, at 366.

137. *See, e.g.*, Mosteller, *supra* note 6, at 281-83; Capowski, *supra* note 24, at 405-7; CHRISTOPHER B. MUELLER & LAIRD C. KIRKPATRICK, EVIDENCE UNDER THE RULES, 835-36 (5th ed., Aspen 2004).

138. These states include Louisiana, Maryland, Michigan, North Carolina, Pennsylvania, Tennessee and Virginia. *See* Mosteller, *supra* note 8, 76-80 (discussing various state restrictions on hearsay rules). In addition, some states have imposed a condition of "trustworthiness" (Mississippi and New Hampshire) or "good faith" (New Jersey). *See id.*

139. FED. R. EVID. 703.

experts who testify in modern trials, this unusual situation applies only to medical experts, since no other experts have their own hearsay exception.

The few reported cases involving adult statements made for mental diagnosis only are strikingly inconsistent, perhaps reflecting discomfort with the anomalous state of the rule. All of them are criminal cases. In each of them, the criminal defendant offered statements that he made in the course of an examination for a psychiatric diagnosis, either to evaluate his competence to stand trial or to support a defense of diminished capacity. In an early case of this type, the Supreme Court of Nebraska held that the state's version of Rule 803(4), although exactly the same as the federal rule, did not permit the admission of exculpatory statements made by an accused to a psychiatrist for the diagnosis of a mental condition.[140] Similarly, the Supreme Court of North Carolina has upheld the exclusion of such statements under the state's medical treatment exception (identical to federal Rule 803(4)) because the statements were made primarily for the purpose of preparing for litigation,[141] and the Supreme Court of Montana has also refused to admit these self-serving diagnosis-only statements.[142]

The Supreme Court of Colorado, on the other hand, citing the Advisory Committee's reasoning in Federal Rule of Evidence 803(4), from which the language of the Colorado rule was taken,

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140. *See* State v. Hardin, 326 N.W.2d 38, 42-43 (Neb. 1982) In *Hardin*, the defendant was convicted of murdering his wife, and the issue was whether the trial judge had erred in refusing to give a manslaughter instruction. *Id.* The only evidence potentially supporting a theory of manslaughter consisted of the defendant's statements. These statements were made to a psychiatrist and a psychologist, both retained to assess the defendant's mental state: he and his wife quarreled immediately before he killed her. *Id.* The Nebraska Supreme Court thought that the trial court had refused to grant the manslaughter instruction because it regarded the experts' testimony as merely giving the basis of their opinions of the defendant's mental state (a non-hearsay use) and not as evidence of the facts stated to them by the defendant (a hearsay use). *Id.* The Nebraska Supreme Court supported that view of the defendant's statements, in spite of the "diagnosis or treatment" language of Neb. Rev. Stat. sec. 27-803(3), a verbatim copy of federal Rule 803(4). *Id.*

141. *See* State v. Harris, 449 S.E.2d 462, 466-67 (N.C. 1994). In *Harris*, the trial court excluded the murder defendant's statements, nine months after the crime, to a defense-retained psychiatrist who testified that the defendant had a passive, dependent personality. *Id.* The excluded statements gave a version of the crime in which the defendant shifted the blame to another. *Id.* The Supreme Court of North Carolina affirmed, distinguishing between diagnosis for trial preparation and diagnosis with a view to treatment, and holding that the former are not covered by the state's version (and verbatim copy) of Federal Rule 803(4). *Id.*

142. *See* State v. Van Dyken, 791 P.2d 1350, 1360 (Mont. 1990) ("defendant has no constitutional right to have these hearsay statements placed in evidence").

has held that such statements are admissible, as long as there is evidence that the statements were reasonably pertinent to the diagnosis and were relied on by the psychiatrist in arriving at an expert opinion on the mental condition in issue.[143] In 2002, the Supreme Court of Hawaii, taking the same position, held that it was error under the state's version of Rule 803(4) to exclude the audio portion of a defendant's videotaped reenactment of his role in the crime (the killing of his ex-wife and her daughter) because his non-treating consulting psychologist relied on the videotape in diagnosing the defendant and testified that it was good practice in the field of forensic psychology.[144]

This inconsistency is a direct result of the abandonment by the federal rule (and its state counterparts) of the previous requirement that statements made to medical professionals must be motivated by the selfish treatment interest in order to qualify for exception from the hearsay rule. For all other exceptions in Rule 803 a "circumstantial guarantee of trustworthiness" was required and the selfish treatment motivation was the circumstantial guarantee that qualified medical treatment statements to be included in that rule. The situation in which patient statements are made to a consulting expert – whether medical or psychiatric – far from motivating the patient to be truthful and accurate, invites distortion and untruthfulness. It is no wonder that so many jurisdictions have been unwilling to admit patient statements made in this "diagnosis-only" context. In view of the 2000 amendment to Federal Rule of Evidence 703, Rule 803(4) should be amended to eliminate the admission of statements made for purposes of diagnosis only.

V. CONCLUSION AND SUGGESTIONS FOR REMEDIATION

Courts should discontinue the use of the medical treatment hearsay exception to admit statements made by patients in mental

143. *See* King v. People, 785 P.2d 596, 597-604 (Colo. 1990) In *King*, the defendant was convicted of the murder of his wife and her sister. *Id.* at 597. At trial, a defense-retained psychiatrist testified that the defendant was suffering from severe depression and "emotional overload" at the time of the killings and had suddenly redirected his suicidal impulse to homicide. *Id.* at 598. The trial judge would not allow the psychiatrist to testify to the statements of the defendant that underlay his opinion, describing how he obtained the murder weapons with the intention of threatening to shoot himself and that he did not intend to shoot his victims. *Id.* The Colorado Supreme Court held that the statements should have been admitted under the state's version of Rule 803(4) and expressly overruled a prior case that imposed a requirement that the defendant offering such a statement must independently establish that his motive in making the statement was "consistent with the rationale behind of the rule" (presumably to guarantee the trustworthiness of the statement). *Id.* at 603.

144. State v. Yamada, 57 P.3d 467, 481 (Haw. 2002).

health treatment or in contemplation of such treatment. Such statements are inherently unreliable because of the nature of mental health treatment. The treatment itself invites the patient to disclose a large number of non-symptom facts but the efficacy of the treatment does not depend on the accuracy of those facts, and the clinician, whose primary concern is to nurture a positive relationship with the patient, does not challenge the patient's version of those facts. In addition, the problems that bring patients into mental health treatment often motivate them to report such facts inaccurately or incompletely. Such a setting does not give the patient a "selfish-treatment interest" to speak truthfully and carefully when relating those facts to a therapist. Without that motive, the statements do not have the "guarantee of truthfulness" that would justify excusing them from the general prohibition against hearsay.

Even if psychotherapy did engender a "selfish treatment motive" in the patient, there would be no basis for assuming that the motive – and the hearsay exception – would extend to statements made in a general medical examination where the doctor, but not the patient, knows that the statements might be pertinent to the future diagnosis or treatment of a possible mental health problem, for which the examining doctor is contemplating a referral to a mental health clinician.

Finally, the exception should never be used to admit statements made to a mental health professional who is consulted for diagnosis only. Such a situation fails to create a "selfish treatment interest" and often adds litigation advantage to the patient's other motivations to communicate an inaccurate version of relevant events.

Those abuses of the medical treatment exception could be diminished, if not eliminated, by the following changes to Federal Rule of Evidence 803(4):

> The following are not excluded by the hearsay rule, even though the declarant is available as a witness.
>
> . . .
>
> Statements for the purposes of medical ~~diagnosis or~~ treatment. Statements made for the purposes of medical ~~diagnosis or~~ treatment *of a physical illness or injury* and describing medical history, or past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment.

These changes would remove from the exception both statements made for mental health treatment and statements made for diagnosis only, whether of a physical or a mental condition, without the intention of undergoing treatment.

Ultimately, the changes should be made not only in the Federal Rules of Evidence, but also in the Uniform Rules of Evidence and in the state rules that are based on the language of Federal Rule 803(4). Although this may sound like a vast undertaking, it would probably be greatly advanced simply by making this change in Federal Rule 803(4). Because of the historic preeminence of the Federal Rules in establishing the scope of modern evidence law on the state level, it seems likely that a change in the federal rule would result in a similar change in many of the rule systems that were modeled after the Federal Rules.

These changes in the rule would restore the medical treatment exception to the same footing as that of the other hearsay exceptions in Rule 803, that is, statements that avoid the hearsay prohibition because they "possess circumstantial guarantees of trustworthiness sufficient to justify non-production of the declarant in person at the trial even though he may be available."[145]

145. FED. R. EVID. 803 advisory committee's note.