

The Psychotherapist-Patient Privilege in the Family Court: An Exemplar of Disharmony Between Social Policy Goals, Professional Ethics, and the Current State of the Law

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I. INTRODUCTION

*As asepsis is to surgery, so is confidentiality to psychiatry.*¹

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1. Jerome S. Beigler, *Tarasoff v. Confidentiality*, 2 BEHAV. SCI. & L. 273 (1984).

All of the mental health professions believe in the importance of confidentiality in the psycho-therapeutic relationship and the concomitant effect that this confidentiality has on the effectiveness of treatment. To this end, the professional ethical standards of the various mental health professions require that therapists and counselors protect confidential information obtained in the course of treatment. A psychotherapist-patient testimonial privilege prohibits the compulsory disclosure of confidential psychotherapist information in legal actions and is recognized by the common law in the federal courts and by statutes in each of the fifty states. However, in the states, the statutory schemes provide uncertain protection of this confidential information in child custody disputes and virtually no protection in child abuse and neglect cases. Additionally, although courts are exercising greater control and demanding greater accountability over expert testimony, this is not the case in child custody actions where the best interest of the child standard is employed. In disputed child custody cases and child protection proceedings, mental health professionals are frequently asked to provide the court with information, recommendations, and opinions on the ultimate issue in the case. These professionals are often asked to report the results of a court-ordered evaluation, but courts regularly call treating therapists to testify against their patients' interests and require them to reveal confidential information obtained in psychotherapy sessions.

The abrogation of the psychotherapist-patient privilege is widely believed to be necessary for the protection of the children involved in family court proceedings. This article challenges this assumption and examines whether the evidence obtained in this manner is reliable, meaningful, and truly necessary for a proper adjudication of these cases such that it actually serves to foster the important public policy goal of protecting our children. It evaluates the conflict between the need for confidentiality in the therapist-patient relationship and the need to protect children in a way that more accurately reflects the true interests at stake. This article demonstrates that the wholesale abrogation of these privileges carries a significant cost in that it drastically reduces the likelihood of a successful therapeutic encounter. It also demonstrates that the interest in the protection of children is not significantly furthered since the evidentiary benefit resulting from the abrogation of the privilege is slight.

Part II of this article begins with a discussion of the development of privileges in general and follows with a discussion of the development of the psychotherapist-patient privilege. This section presents the U.S. Supreme Court's 1997 decision in *Jaffee v. Redmond*, in which the Court recognized this privilege in the federal courts. Part III presents the results of empirical studies that have been conducted during the last twenty years by social scientists who have sought to assess the effect of confidentiality on the therapeutic relationship. Overall, these studies demonstrate that the lack of confidentiality unequivocally affects patients' willingness to disclose

sensitive information which, in turn, directly impacts the outcome of therapy.

Part IV focuses on the exceptions to the psychotherapist-patient privilege. It surveys the development and present status of the exceptions that have been recognized by the federal and state courts. It focuses on the abrogation of the privilege in contested child custody actions and child protection proceedings. It includes a review of a sample of opinions from the Michigan Court of Appeals arising from parental rights termination cases in which a therapist's testimony was cited by the court as a factor in its decision. These cases demonstrate the slight value of this evidence since the treating therapists' compelled testimony was not necessary for a proper adjudication of any of the cases. Part V presents criticisms of the present legal framework and offers suggestions for alternatives to the existing policies and procedures.

II. THE HISTORY OF PRIVILEGES AND THE DEVELOPMENT OF THE PSYCHOTHERAPIST-PATIENT PRIVILEGE

Privileges are a unique aspect of the law of evidence in that unlike other rules of evidence that are designed to improve the reliability of the fact-finding process, the rules governing the scope and effect of privileges operate to impede the search for truth by excluding highly probative evidence.² Privileges are justified by the need to protect the privacy of certain relationships and the need to encourage open communications within these relationships.³ The most common privileges include an individual's right to be free from compelled self-incrimination and the privileges that protect confidential communications between spouses, attorneys and their clients, and physicians and their patients.⁴ These privilege rules protect against the forced disclosure on the witness stand of statements and communications at the option of the witness, client, penitent, patient, or spouse.⁵

The law of privileges has developed from several sources. Some privileges are provided for in the Constitution, such as the privilege against self-incrimination. In the states, privileges are generally statutory, whereas the federal law of privileges originates from the common law.⁶ One of the earliest privileges to be recognized was the Roman law rule that refused to compel an attorney to testify against his client during the pendency of a

2. CHRISTOPHER B. MUELLER & LAIRD C. KIRKPATRICK, EVIDENCE § 5.1, at 285 (3d ed. 2003).

3. *Id.*

4. KENNETH S. BROUN ET AL., MCCORMICK ON EVIDENCE § 72, at 114-15 (John W. Strong ed., 5th ed. 2006).

5. BLACK'S LAW DICTIONARY 1078 (Henry Campbell Black ed., 5th ed. 1979).

6. PAUL C. GIANNELLI, UNDERSTANDING EVIDENCE 566 (2d ed. 2006).

case.⁷ Additional privileges came into existence during the early Middle Ages, beginning with recognition of the priest-penitent privilege. This privilege, which had its origin in the Seal of Confession and Canon law, prohibited priests from revealing confessional confidences.⁸ Saint Thomas asserted that “the priest should conform himself to God, of whom he is the minister, and as God does not reveal the sins made known to him in confession, so the priest should be equally reticent.”⁹

7. Daniel W. Shuman, *The Origins of the Physician-Patient Privilege and Professional Secret*, 39 Sw. L.J. 661, 667 (1985). This early attorney-client privilege was subsequently extended to disallow testimony by an attorney on behalf of a client. *Id.* While the initial privilege seems to be based on the attorney’s role as a servant of the client and likely arose from the rule that prohibited a slave from testifying against a master, the subsequent rule appears to be based on a relational privilege. *Id.* The author suggests that the rationale for this privilege is deontological: to require a person to divulge a secret is itself a breach of a moral duty and, therefore, wrong. *Id.*

8. *Id.* at 668. Confessions were initially public affairs and took place in front of the entire congregation. *Id.* However, they became private sometime during the fifth century. Shuman, *supra* note 7, at 668. The Seal of Confession existed to prevent the risk of prosecution or personal humiliation that might deter confessions. *Id.* Canon law, the exclusive law governing disputes between members of the Christian Church, prohibited a priest from revealing confidential information received in the confessional. *Id.*

9. *Id.* at 668 n.29 (citing HENRY CHARLES LEA, *A HISTORY OF AURICULAR CONFESSION AND INDULGENCES IN THE LATIN CHURCH* 415 (1896)). Priests could be dismissed for revealing confessional confidences, and in certain circumstances, greater sanctions were imposed. *Id.* at 669. What some believe to be the first reported instance of the exclusionary rule occurred at Toulouse in 1579. *Id.* at 668-69. An innkeeper murdered a guest and buried his body in his cellar. Shuman, *supra* note 7, at 668-69. The innkeeper confessed the crime to a priest who, enticed by a reward, reported the crime to the magistrates. *Id.* The murderer confessed but reported that no one other than the priest could have betrayed him. *Id.* Following an investigation, the Parlement of Toulouse released the criminal and hung the priest. *Id.*

Many contemporary scholars believe that that common law of England did not recognize the priest-penitent privilege. *Id.* at 670 n.40 (citing Edward A. Hogan, *A Modern Problem on the Privilege of the Confessional*, 6 LOY. L. REV. 1, 1-2, 13 (1951)). Prior to Henry VIII, the law of England and the law of the Roman Catholic Church were intertwined. *Id.* (citing Edward A. Hogan, *A Modern Problem on the Privilege of the Confessional*, 6 LOY. L. REV. 1, 8 (1951)). During this period, the Seal of Confession effectively served as a priest-penitent privilege. Shuman, *supra* note 7, at 670 n.40 (citing Edward A. Hogan, *A Modern Problem on the Privilege of the Confessional*, 6 LOY. L. REV. 1, 8 (1951)). However, after Henry VIII’s break with the church, English courts rejected the privilege. *Id.* (citing Edward A. Hogan, *A Modern Problem on the Privilege of the Confessional*, 6 LOY. L. REV. 1, 2, 13 (1951)). The first U.S. case to recognize this privilege was *People v. Phillips*, decided by a New York court in 1813. Karen L. Ross, *Revealing Confidential Secrets: Will It Save Our Children*, 28 SETON HALL L. REV. 963, 977 (1998). In 1828, New York became the first state to enact a clergy-communicant privilege statute. *Id.* at 975-76. Although all fifty states recognize some form of clergy-communicant privilege, it is not absolute. *Id.* at 976. Most but not all of the states require a member of the clergy report incidents of child abuse. *Id.* at 977.

The first privilege recognized under the common law of England was the attorney-client privilege, initially recognized during the reign of Elizabeth I.¹⁰ The rationale for this privilege is thought to have been a “‘point of honor,’” that gentlemen should not reveal confidences entrusted to them.¹¹ These early privileges are grounded in deontology,¹² the school of ethics that maintains that acts are wrong or right in and of themselves simply because of the types of acts they are and not because of the consequences of the action.¹³ The deontological approach to privileges focuses on the importance of the societal values encompassed in the privilege and recognizes that disclosure of certain confidences is in and of itself wrong.¹⁴ According to Professor David Louisell, privileges are “‘primarily . . . a right to be let alone, a right to unfettered freedom, in certain narrowly prescribed relationships, from the state’s coercive or supervisory powers and from the nuisance of its eavesdropping.’”¹⁵ Additionally, “‘the fact that the existence of these guarantees sometimes results in the exclusion from a trial of probative evidence is merely a secondary and incidental feature of the privileges’

10. Recognition of the attorney-client privilege followed the passage of the Statute of Elizabeth in 1562-1563, which provided penalties for a witness’s refusal to testify following service of process and the offer of payment of the witness’s expenses. Shuman, *supra* note 7, at 669 (citing 8 JOHN HENRY WIGMORE, EVIDENCE IN TRIALS AT COMMON LAW § 2290, at 542-43 (John T. McNaughton ed., rev. ed. 1961)). The source of the privilege is open to speculation. *Id.* at 670. Although the earliest common law cases made no reference to Roman law, scholars believe that the jurists had ample opportunity to study and be influenced by Roman jurisprudence. *Id.* at 671. Also significantly persuasive is the fact that the first decision to recognize the attorney-client privilege was rendered by the Court of Chancery, a court of equity based on Roman law. *Id.*

11. *Id.* at 671 (quoting 8 JOHN HENRY WIGMORE, EVIDENCE IN TRIALS AT COMMON LAW § 2290, at 543 (John T. McNaughton ed., rev. ed. 1961)).

12. Paul S. Appelbaum, *Privacy in Psychiatric Treatment: Threats and Responses*, 159 AM. J. PSYCHIATRY 1809, 1809-10 (2002).

13. ENCYCLOPEDIA OF ETHICS 63 (Susan Neiburg Terkel & R. Shannon Duval eds., 1999). Contemporary ethical theories can be divided into two distinct categories: deontological and teleological. Teleological, which encompasses utilitarianism, is the “‘ethics of ends and consequences.’” 1 JOHN K. ROTH, ETHICS 367 (John K. Roth ed., 2005). Teleological theories prioritize the good over the right. *See id.* The good is defined as “‘the end or purpose of human actions; for example, ‘the greatest happiness for the greatest number.’” *Id.* These theories evaluate moral actions in terms of whether they contribute to the good.” *Id.* Thus, according to teleological theories, consequences or results will determine the rightness or wrongness of moral actions. *Id.* This is contrasted with deontological theories, which argue for the “‘independence of the right from the good.’” *Id.* at 364.

14. Shuman, *supra* note 7, at 664 (quoting David Louisell, *Confidentiality, Conformity and Confusion: Privileges in Federal Court Today*, 31 TUL. L. REV. 101, 101 (1956)).

15. *Id.* at 666 n.17 (quoting David Louisell, *Confidentiality, Conformity and Confusion: Privileges in Federal Court Today*, 31 TUL. L. REV. 101, 110-11 (1956)).

vitality.”¹⁶ Most importantly, the deontological school of thought views privacy as “an essential ingredient of a democratic society.”¹⁷

Some two hundred years after the attorney-client privilege was first recognized in English common law, the English courts were called upon to address the physician-patient privilege in the 1776 bigamy trial of Elizabeth, the Duchess of Kingston.¹⁸ During her trial, the Duchess’s physician was called to the stand and asked whether the Duchess had told him of a prior marriage. The court refused to recognize a physician-patient privilege, stating:

If a surgeon was voluntarily to reveal these secrets, to be sure he would be guilty of a breach of honour, and of great indiscretion; but, to give that information in a court of justice, which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatsoever.¹⁹

This decision is viewed as a critical turning point in the law of privilege because it was at this point that courts began to apply a utilitarian test to privileges, where the need for the evidence replaced ethics as the standard for recognition of privileges.²⁰

16. *Id.* at 664 (quoting David Louisell, *Confidentiality, Conformity and Confusion: Privileges in Federal Court Today*, 31 TUL. L. REV. 101, 101 (1956)).

17. *Id.* at 666 (citing ALAN F. WESTIN, *PRIVACY AND FREEDOM* 32 (1967)). This concept of privacy was incorporated into the Fourth Amendment to the United States Constitution. Justice Brandeis recognized this in his dissent in *Olmstead v. United States*, where he stated:

The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. . . . They sought to protect Americans in their beliefs, their thoughts, their emotions, and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men.

Olmstead v. United States, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).

18. *Rex v. Duchess of Kingston*, (1776) 20 How. St. Tr. 355, 572-73 (H.L.) (Eng.).

19. *Id.* at 573.

20. 8 JOHN HENRY WIGMORE, *EVIDENCE IN TRIALS AT COMMON LAW* § 2286, at 531 (John T. McNaughton ed., rev. ed. 1961). *Rex v. Duchess of Kingston* is the first known case to address the issue of a physician-patient privilege. Shuman, *supra* note 7, at 671. Scholars speculate that the reason this question was not raised earlier is that medical science was of little assistance to courts prior to the eighteenth century given the state of medical science at that time. *Id.* Others theorize that it was simply assumed that physicians could be compelled to testify, hence the matter was not litigated. *See id.* at 671-72. English courts continue to refuse to recognize the physician-patient privilege, and legislative attempts to recognize this privilege have not been successful. *Id.* However, legislative abrogation of this common law rule has occurred in the United States with the State of New York being the first state to enact a physician-patient privilege in 1828. *See id.* at 676.

In France and other civil law European countries, the restriction on the power of courts to compel the disclosure of certain confidential communications is referred to as the

In the utilitarian approach, privileges are viewed as obstructions to the truth-finding process and as fostering a disregard for the fundamental principle that “the public . . . has a right to every man’s evidence.”²¹ Dean Wigmore identified four requirements necessary for the recognition of a privilege: (1) the communications must originate in a confidence that they will not be disclosed; (2) confidentiality must be essential to the full and satisfactory maintenance of the relationship between the parties; (3) the relationship must be one that, in the opinion of the community, ought to be sedulously fostered; and (4) the injury to the relationship caused by the disclosure of the communications must be greater than the benefit gained for the correct disposal of litigation.²² The U.S. Supreme Court has adopted this approach to the recognition of privileges, stating that privileges should be utilized “only to the very limited extent that permitting a refusal to testify or excluding relevant evidence has a public good transcending the normally predominant principle of utilizing all rational means for ascertaining truth.”²³

A. THE EVOLUTION OF THE MENTAL HEALTH PROFESSION AND THE DEVELOPMENT OF THE PSYCHOTHERAPIST-PATIENT PRIVILEGE

The origins of psychiatry can be traced to the practice of medicine within asylums for the insane during the nineteenth century. It was here that physicians first began to attribute the deviant behavior of inmates to diseases of the mind and began to search for ways to treat their mentally ill patients.²⁴ During the nineteenth and early twentieth centuries, new varied

professional secret. *Id.* at 678-79. In France, the physician-patient privilege had its origins in Roman law, which became the law of the territory now known as France when it was incorporated into the Roman Empire. Shuman, *supra* note 7, at 679. Professional secrets disappeared for centuries following the invasion by the Teutons and other Germanic tribes. *Id.* They were re-established into French law when the Catholic Church reintroduced Roman law to Western Europe. *Id.* The attorney-client professional secret was incorporated into the Decree of Gratian, which became the foundation for the Canon Law Code. *See id.* at 679. The physician-patient professional secret has been traced to the incorporation of the Hippocratic Oath in the Constitution of the Paris Medical School during the eighteenth century. *Id.*

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

22. 8 JOHN HENRY WIGMORE, EVIDENCE IN TRIALS AT COMMON LAW § 2285, at 527 (John T. McNaughton ed., rev. ed. 1961).

23. *See, e.g.,* Trammel v. United States, 445 U.S. 40, 50 (1980) (quoting *Elkins v. United States*, 364 U.S. 206, 234 (1960) (Frankfurter, J., dissenting)).

24. RALPH REISNER ET AL., LAW AND THE MENTAL HEALTH SYSTEM, CIVIL AND CRIMINAL ASPECTS 43 (4th ed. 2004). Before that time, ancient Romans and Greeks kept the seriously mentally ill restrained by family members, imprisoned, or exiled. *Id.* During the medieval and renaissance periods, the mentally ill were either imprisoned or later confined to mental hospitals. *Id.* In either setting, the emphasis was on restraint rather than treatment. *Id.*

techniques were introduced to treat mental illness.²⁵ However, it was the development of psychotropic medications in the 1940s that revolutionized the treatment of serious mental disorders,²⁶ and, as a result, psychopharmacology currently is used to treat a broad range of psychotic and less serious mental conditions.²⁷

Psychotherapy, or nonbiological treatment techniques, was first introduced in the early twentieth century. Psychotherapy is defined as the “treatment of mental or emotional disorder by verbal or other symbolic communication between patient and therapist.”²⁸ Psychoanalysis, developed by Sigmund Freud, was the first major approach to psychotherapy and rests upon two major assumptions—that much of mental life is unconscious and that past experiences, principally those in early childhood, shape how a person feels and behaves throughout life.²⁹ Freud believed that certain types of emotional problems stem from the rekindling of repressed emotional conflicts that originated in early childhood; hence, a key objective of psychoanalysis is to bring these repressed conflicts to the surface in order to allow the patient to resolve them. However, Freud also believed that individuals are resistant to allowing these repressed thoughts and feelings to emerge and that this cannot occur unless the patient has control over the disclosure of the information revealed during therapy.³⁰ Confidentiality and trust are, therefore, viewed as the cornerstones for an effective psychoanalytic relationship.³¹

25. *Id.* These included “malarial fever therapy,” which involved inducing malaria in a patient; lobotomies, which involved excision of the frontal lobes of the brain; coma therapy; and electroconvulsive therapy. *Id.*

26. REISNER ET AL., *supra* note 24, at 43. In the late 1940s, it was discovered that lithium could be employed to treat bipolar affective disorders. *Id.*

27. *Id.* at 23.

28. Daniel W. Shuman & Myron S. Weiner, *The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege*, 60 N.C. L. REV. 893, 896 (1982) (citing JOEL KOVEL, A COMPLETE GUIDE TO THERAPY 264 (1976)).

29. REISNER ET AL., *supra* note 24, at 10. This type of therapy is also referred to as psychodynamic therapy. *Id.* Freud also believed that the personality has three distinct component parts: the id, ego, and superego. *Id.* The id is the unconscious part of one’s personality that is the caldron of raw drives, such as sex and aggression. *Id.* The superego is a person’s conscience that develops in the early years and is learned from parents and teachers. *Id.* The ego is the rational part of the personality whose role is to mediate between the conflicting tensions of the id and superego. *Id.* When an imbalance between the id and the ego occurs, a person exhibits psychological distress and displays symptoms of mental disorder. REISNER ET AL., *supra* note 24, at 10. The therapist’s role is to assist the individual in understanding these conflicts by uncovering the secrets of the unconscious mind. *Id.*

30. See Shuman & Weiner, *supra* note 28, at 897 (citing Anne Beth Uchill, *Deviation from Confidentiality and the Therapeutic Holding Environment*, 7 INT’L J. PSYCHOANALYTIC PSYCHOTHERAPY 208, 210 (1978)).

31. See REISNER ET AL., *supra* note 24, at 23. Other versions of the classical form of psychoanalysis have developed and are termed ego psychology, object relations theory,

Other approaches to the treatment of mental or emotional disorders have emerged after Freud that reject the psychoanalytical concept of the unconscious mind. These include behaviorism and behavior modification, first introduced in the early twentieth century by B.F. Skinner and J.B. Watson;³² cognitive-behavioral therapy;³³ and humanistic therapy, whose philosophical roots can be traced to the nineteenth-century philosopher Soren Keirkegaard.³⁴ Although there are distinctive orientations to psychotherapy among these approaches, most therapists describe themselves as eclectic in their practice, employing a variety of treatment approaches.³⁵

Mental health services are currently provided by three distinct categories of professionals: psychiatrists, psychologists, and clinical social workers.³⁶ While psychiatrists were the dominant providers of mental health care

interpersonal psychology, and self-psychology. *Id.* Although these various therapies differ in theory and approach, they have two critical concepts in common. *Id.* The first involves the role of the past in shaping the present. *Id.* The second critical concept that is common to all forms of psychoanalysis is the belief in the unconscious mind. *Id.* Therefore, a significant part of any form of psychodynamic therapy is developing an awareness of one's unconscious, which allows the patient to understand the origins of his behavior. *Id.* at 33.

32. REISNER ET AL., *supra* note 24, at 10. This approach is also referred to as behavior therapy. *Id.* at 34. Its focus is on observable, overt behaviors that are learned from one's environment. *Id.* The environment plays a critical role in behavior modification therapy because it provides the positive and negative reinforcements that contribute to sustaining or eliminating certain behaviors. *Id.* at 10. In behaviorism theory, learning is viewed as behavior change that has been molded by experience and is accomplished through either operant or classical conditioning. *Id.* Classical conditioning's foundation is the research of Ivan Pavlov, the Russian physiologist whose dogs learned to salivate at the sound of a bell after Pavlov repeatedly paired the sight of food with the sound of a bell. *Id.* Operant conditioning is a form of learning in which a voluntary response becomes strengthened or weakened depending on its connection with positive or negative consequences. REISNER ET AL., *supra* note 24, at 34.

33. *Id.* This has developed as a variant of behavior modification. *Id.* It incorporates cognitive psychology, the study of the mental processes, including perception, reason, memory and decision making, into the therapeutic process. *Id.* The therapeutic focus is on the patient's present thoughts and actions with the goal of changing defective perceptions, replacing them with thoughts and feelings that promote adaptive behaviors. *Id.* This approach to therapy believes that people take an active role in deciding what to learn rather than the passive role put forth in classic behaviorism theory. *Id.* at 11. It also incorporates cognition—what a person perceives or interprets—in attempting to understand and therefore change behavior. REISNER ET AL., *supra* note 24, at 11.

34. *Id.* at 34-35. It is also termed existential, experiential, or gestalt therapy. *Id.* at 34. The immediate experience of the client is the central focus of humanistic therapy, which is rooted in the subjective experiences of the client with a concern for human growth. *Id.* at 35. A critical aspect of humanistic therapy is the relationship that is created between the therapist and the client. *Id.* The therapist serves as the client's guide in "an exploration of self-discovery," seeking greater self-knowledge and an "expansion of inherent human potential." *Id.*

35. REISNER ET AL., *supra* note 24, at 35.

36. *See, e.g., id.*

until the 1970s,³⁷ clinical social workers currently provide as much as sixty-five percent of all psychotherapy and mental health services.³⁸ All of these professionals engage in psychotherapy, but the education and training required by these professions is significantly different.³⁹

Given psychiatry's origin within the medical profession, it is not surprising that the historical foundation of psychotherapeutic confidentiality is thought to be the Hippocratic Oath, which states in part: "Whatsoever I shall see or hear in the course of my profession as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets."⁴⁰

The right of individuals to control the disclosure of personal medical information is also closely tied to the notion of personal privacy that was first acknowledged as a legal concept in the United States at the end of the nineteenth century.⁴¹ Justice Brandeis initially conceived of the right to

37. *Id.* at 43.

38. *Id.* (citing Jeffrey Cohen, *Managed Care and the Evolving Role of the Clinical Social Worker in Mental Health*, 48 SOC. WORK 34, 50 (2003)).

39. *See id.* at 42-49. A psychiatrist is a licensed physician who has completed a psychiatric residency program and is the only mental health professional that may prescribe psychotropic medications. *Id.* at 43-46. Psychologists emerged as significant providers of mental health services in the mid-1940s. REISNER ET AL., *supra* note 24, at 46-47. Prior to this time, psychology was largely an academically based profession. *Id.* at 46. However, the Veterans Administration's large-scale employment of clinical and counseling psychologists during World War II was the impetus for psychologists to emerge as practitioners in the mental health field. *Id.* at 47. Clinical psychologists quickly outnumbered psychiatrists, with one study indicating the number of practicing psychologists with a Ph.D. or Psy.D. outnumbering psychiatrists more than two to one. *Id.* Beginning in the 1970s, many states began to allow persons with a master's degree to practice clinical psychology. *See id.* at 48. There are currently no national standards governing the qualifications necessary to practice as a clinical psychologist, and the licensing criteria vary by state. *Id.*

Clinical social workers typically hold a master of social work degree. REISNER ET AL., *supra* note 24, at 49. This degree requires a field placement along with two years of graduate study. *Id.* Although they typically function as part of a treatment team, twenty percent of clinical social workers are currently engaged in private practice. *Id.* at 49. This is attributed to the states' willingness to license social workers and the corresponding entitlement to third-party reimbursement, along with the influence of managed care. *Id.* at 49-52.

40. Howard B. Roback & Mary Shelton, *Effects of Confidentiality Limitations on the Psychotherapeutic Process*, 4 J. PSYCHOTHERAPY PRAC. & RES. 185 (1995). The first recorded administration of the Hippocratic Oath in a medical school setting was at the University of Wittenberg in Germany in 1508. Howard Markel, "I Swear by Apollo"—On Taking the Hippocratic Oath, 350 NEW ENG. J. MED. 2026, 2026 (2004). It did not become a standard part of a formal medical school graduation ceremony until 1804, when it was incorporated into the commencement exercises at Montpellier, France. *Id.* Today, nearly every U.S. medical school administers some type of professional oath to its share of about 16,000 annual graduates. *Id.*

41. REISNER ET AL., *supra* note 24, at 297.

privacy as “the right to be left alone.”⁴² While some have argued that the psychotherapist-patient privilege is protected by the constitutional right to privacy, a liberty interest contained in the Fifth and Fourteenth Amendments to the U.S. Constitution,⁴³ these arguments have largely been unsuccessful.

In 1952, the Cook County Circuit Court in the State of Illinois became what some believe to be the first U.S. court to recognize a psychotherapist-patient privilege.⁴⁴ In *Binder v. Ruvell*, Dr. Roy Grinker, a prominent psychiatrist, and Michael Reese Hospital were summoned to produce the medical records of a Mrs. Binder, who was a recent patient at the hospital.⁴⁵ Mrs. Binder was not a party to the case but was somehow related to the plaintiff, Samuel Binder.⁴⁶ Both the hospital authorities and Dr. Grinker refused to testify or otherwise reveal Mrs. Binder’s medical information.⁴⁷ Judge Harry M. Fisher ruled that the information provided by a patient to a psychiatrist during psychotherapy sessions was protected from disclosure, even though the State of Illinois, at the time, did not recognize a physician-patient privilege.⁴⁸ Judge Fisher focused on the distinction between a physician-patient privilege and the relationship between a psychiatrist and a patient, noting that the latter relationship more closely resembled the confessional nature of the priest-penitent relationship.⁴⁹ In determining whether Illinois law should recognize this new privilege, Judge Fisher adopted the utilitarian approach and analyzed the psychotherapist-patient privilege in terms of the four elements proposed by Dean Wigmore.⁵⁰ He concluded that

42. *Id.* (quoting Louis D. Brandeis & Samuel D. Warren, *The Right to Privacy*, 4 HARV. L. REV. 193, 193 (1890)).

43. Bruce J. Winick, *The Psychotherapist-Patient Privilege: A Therapeutic Jurisprudence View*, 50 U. MIAMI L. REV. 249, 251 (1996).

44. *Binder v. Ruvell*, No. 52C2535 (Cir. Ct. of Cook County June 24, 1952), available at <http://jaffee-redmond.org/cases/binder.htm>. At the time this case was filed, the State of Illinois did not recognize a physician-patient privilege. *Id.*

45. *Id.*

46. *Id.* The court opinion does not identify Mrs. Binder’s first name nor does it explain the relationship between her and the plaintiff. *Id.*

47. *Id.*

48. *Binder v. Ruvell*, No. 52C2535 (Cir. Ct. of Cook County June 24, 1952), available at <http://jaffee-redmond.org/cases/binder.htm>.

49. *Id.*

50. *Id.* These factors are: (1) the communications must originate in a confidence that they will not be disclosed, (2) the element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties, (3) the relation must be one that in the opinion of the community ought to be sedulously fostered, and (4) the injury that would inure to the relation by the disclosure of the communication must be greater than the benefit thereby gained for the correct disposal of litigation. *Id.*

the protection of the confidences that arise in the psychotherapist-patient relationship far outweighs the “correct disposal of a particular case.”⁵¹

During the mid- to late-1950s, the idea that therapy patients might need unique legal protections took hold, and the concept of the psychiatrist-patient privilege was actively debated.⁵² Numerous articles and texts were published in which the authors openly advocated for the privilege, arguing that public policy grounds justify the existence of the privilege because the psychiatric patient has a special need for protection of his confidential communications.⁵³

51. *Id.*

52. Paul W. Mosher, *Psychotherapist-Patient Privilege: The History and Significance of the U.S. Supreme Court’s Decision in the Case of Jaffee v. Redmond* (1999) (unpublished manuscript, available at <http://jaffee-redmond.org/articles/mosher.htm>).

53. *See, e.g.*, MANFRED S. GUTTMACHER & HENRY WEIHOFEN, *PSYCHIATRY AND THE LAW* 272 (1952). In explaining the need for a privilege for “psychiatric patients,” the authors of the text were clearly speaking of psychoanalysis or psychoanalytic psychotherapy. *See id.* They explain:

The psychiatrist must insist on very personal data, and must explore the relationship of the patient’s acts to his basic drives, which can only be adequately revealed by his deepest and most secret thoughts and feelings. This is true not only in psychoanalysis but in all psychotherapy [i.e., psychoanalytic psychotherapy]. The possibly neurotic nature of even such patently criminal acts as forgery or theft cannot be determined without exploring their patient’s attitudes and behavior in regard to masturbation, homosexuality, etc.

What is more, the patient’s statements may reveal to his therapist much more than the patient intends or realizes. The psychiatric patient confides much more utterly than anyone else in the world. He exposes to the therapist not only what his words directly express; he lays bare his entire self, his dreams, his fantasies, his sins, and his shame. Most patients who undergo psychotherapy know that this is what will be expected of them, and that they cannot get help except on that condition. It is extremely hard for them to bring themselves to the point where they are willing to expose the dark recesses of their mind to the psychiatrist; often patients have undergone therapy for a year or more before they begin to reveal anything significant. It would be too much to expect them to do so if they knew that all they say—and all that the psychiatrist learns from what they say—may be revealed to the whole world from a witness stand.

Id.

About the same time, Ralph Slovenko published an influential law review article in the *Wayne Law Review* in which he argued that, unlike the ordinary health care situation, the psychiatrist’s relationship with his patient fully satisfies the criteria of Dean Wigmore. *See* Ralph Slovenko, *Psychiatry and a Second Look at the Medical Privilege*, 6 WAYNE L. REV. 175 (1960). The article concluded: “The following is by way of recommendation: The confidential relations and communication between psychiatrist and patient in a treatment relationship is absolutely privileged, subject to express waiver by the patient, and upon his death, when waiver can fairly be presumed.” *Id.* at 203.

In 1960, the Group for the Advancement of Psychiatry (GAP) issued a report entitled *Confidentiality and Privileged Communication in the Practice of Psychiatry*, which included this frequently quoted passage that amply articulated the need for the privilege:

Among physicians, the psychiatrist has a special need to maintain confidentiality. His capacity to help his patients is completely dependent upon their willingness and ability to talk freely. This makes it difficult if not impossible for him to function without being able to assure his patients of confidentiality and, indeed, privileged communication There is wide agreement that confidentiality is a sine qua non for successful psychiatric treatment. The relationship may well be likened to that of the priest-penitent or the lawyer-client. Psychiatrists not only explore the very depths of their patients' conscious, but their unconscious feelings and attitudes as well. Therapeutic effectiveness necessitates going beyond a patient's awareness and, in order to do this, it must be possible to communicate freely. A threat to secrecy blocks successful treatment.⁵⁴

The report concluded with a proposed model statute, which read: "The confidential relationship and communication between psychiatrist and patient shall be placed on the same basis as regards privilege, as provided by law, between attorney and client."⁵⁵ The GAP proposal was not accepted by legal scholars or therapists.

Subsequently, the State of Connecticut formed a committee under the auspices of the Connecticut branch of the American Psychiatric Association and the Connecticut Mental Health Association.⁵⁶ Committee members included representatives of the American Psychiatric Association, along with attorneys from the community and faculty from Yale Law School.⁵⁷ This committee's work ultimately resulted in the enactment of a psycho-

54. Mosher, *supra* note 52 (quoting GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, CONFIDENTIALITY AND PRIVILEGED COMMUNICATION IN THE PRACTICE OF PSYCHIATRY 92 (1960)).

55. *Id.* (quoting GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, CONFIDENTIALITY AND PRIVILEGED COMMUNICATION IN THE PRACTICE OF PSYCHIATRY 92 (1960)).

56. *Id.*

57. *Id.*

therapist-patient privilege statute in Connecticut.⁵⁸ The statute applied in civil and criminal cases and in legislative and administrative proceedings.⁵⁹ It covered communications between patients and psychotherapists and extended the privilege to communications between patients and individuals working under the supervision of the therapist, such as psychologists and social workers.⁶⁰ It included three exceptions to the privilege: (1) proceedings to hospitalize a patient, (2) court ordered psychiatric examinations, and (3) cases in which a patient has introduced his mental condition into a case in a civil proceeding.⁶¹ Several states subsequently enacted similar laws, and the Connecticut law ultimately formed the basis for the U.S. Supreme Court's subsequent proposal for a psychotherapist-patient privilege in the Federal Rules of Evidence.⁶²

The proposed Federal Rules of Evidence submitted to Congress in 1969 by the Supreme Court initially included provisions for the recognition of nine federal privileges,⁶³ including a psychotherapist-patient privilege, which was set forth in proposed Federal Rule of Evidence 504.⁶⁴ The pro-

58. *Id.* (citing Abraham Goldstein & Jay Katz, *Psychiatrist-Patient Privilege: The GAP Proposal and the Connecticut Statute*, 118 AM. J. PSYCHIATRY 733 (1962)).

59. *Id.*

60. Mosher, *supra* note 52.

61. *Id.*

62. *Id.*

63. The proposed rules recognized privileges for court ordered or other legally required reports, an attorney-client privilege, a psychotherapist-patient privilege, a priest-penitent privilege, a spousal testimonial privilege, a trade secrets privilege, a political vote privilege, and privileges for secrets of state and informer identity. MUELLER & KIRKPATRICK, *supra* note 2, § 5.6, at 302.

64. Rules of Evidence for the United States Courts and Magistrates, 56 F.R.D. 183, 240-41 (1972) (setting out proposed Federal Rule of Evidence 504). Proposed Federal Rule of Evidence 504 reads:

Psychotherapist-Patient Privilege [Not enacted.]

(a) Definitions.

(1) A "patient" is a person who consults or is examined or interviewed by a psychotherapist.

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

(3) A communication is "confidential" if not intended to be disclosed to third persons other than those present to further the interest of the patient in the consultation, examination, or interview, or persons reasonably necessary for the transmission of the communication, or persons who are participating in the diagnosis and treatment under the direction of the psychotherapist, including members of the patient's family.

posed rule protected confidential communications between patients and physicians or psychologists made for the purpose of diagnosis or treatment of mental or emotional conditions.⁶⁵ The rule contained three specific exceptions that were essentially the same as those contained in the Connecticut statute. There was no privilege for communications made pursuant to proceedings to hospitalize a patient, for communications made in connection with court ordered psychiatric examinations, or for communications made in connection with civil proceedings in which a patient has introduced his mental condition into the case.⁶⁶

In 1973, the proposed rules were submitted to Congress for approval.⁶⁷ However, the proposed rules, and particularly article V dealing with privi-

(b) General Rule of Privilege. A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications, made for the purposes of diagnosis or treatment of his mental or emotional condition, including drug addiction, among himself, his psychotherapist, or persons who are participating in the diagnosis or treatment under the direction of the psychotherapist, including members of the patient's family.

(c) Who may claim the privilege. The privilege may be claimed by the patient, by his guardian or conservator, or by the personal representative of a deceased patient. The person who was the psychotherapist may claim the privilege but only on behalf of the patient. His authority so to do is presumed in the absence of evidence to the contrary.

(d) Exceptions.

(1) Proceedings for hospitalization. There is no privilege under this rule for communications relevant to an issue in proceedings to hospitalize the patient for mental illness, if the psychotherapist in the course of diagnosis or treatment has determined that the patient is in need of hospitalization.

(2) Examination by order of judge. If the judge orders an examination of the mental or emotional condition of the patient, communications made in the course thereof are not privileged under this rule with respect to the particular purpose for which the examination is ordered unless the judge orders otherwise.

(3) Condition an element of claim or defense. There is no privilege under this rule as to communications relevant to an issue of the mental or emotional condition of the patient in any proceeding in which he relies upon the condition as an element of his claim or defense, or, after the patient's death, in any proceeding in which any party relies upon the condition as an element of his claim or defense.

Id.

65. *Id.*

66. *Id.*

67. Edward J. Imwinkelried, *An Hegelian Approach to Privileges Under Federal Rule of Evidence 501: The Restrictive Thesis, the Expansive Antithesis, and the Contextual Synthesis*, 73 NEB. L. REV. 511, 512 (1994).

leges, got caught up in the political cross fire arising out of the Watergate scandal.⁶⁸ Unable to resolve the controversies surrounding these proposed rules, Congress ultimately decided to eliminate all of the proposed privileges and to substitute a single rule, rule 501.⁶⁹ Federal Rule of Evidence 501 provides that privileges “shall be governed by the principles of the common law” as interpreted “in the light of reason and experience,” and it applies uniformly to both criminal and civil cases.⁷⁰

In 1996, the U.S. Supreme Court was called upon to determine whether federal courts should recognize a psychotherapist-patient privilege. In *Jaffee v. Redmond*, seven members of the Supreme Court found that the communications between a patient and her therapist were protected from disclosure by a psychotherapist-patient privilege.⁷¹ The case involved Mary Lu Redmond, a police officer for the Village of Hoffman Estates, Illinois, who shot and killed a young man while on patrol duty.⁷² Following this incident, she received extensive therapy from a licensed clinical social worker.⁷³ Petitioner, the administrator of the decedent’s estate, filed a § 1983 action in federal court against the officer and the Village of Hoffman Estates, alleging that the respondents had violated the decedent’s constitutional rights by the use of excessive force.⁷⁴

During the pretrial discovery phase of the litigation, the petitioner sought access to the therapist’s notes of her sessions with Officer Redmond.⁷⁵ Respondents objected to the request on the ground that the infor-

68. *Id.* at 512-14. Hearings took place in both the House and Senate where testimony for and against proposed rule 504 was heard. *Id.* Importantly, proposed rule 504 was opposed by both the American Medical Association and the American Bar Association since article V did not provide for a physician-patient privilege, a privilege for spousal communications, or a journalist privilege. MUELLER & KIRKPATRICK, *supra* note 2, § 5.6, at 302.

69. Imwinkelried, *supra* note 67, at 514.

70. FED. R. EVID. 501. Federal Rule of Evidence 501 provides:

Except as otherwise required by the Constitution of the United States or provided by Act of Congress or in rules prescribed by the Supreme Court pursuant to statutory authority, the privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in light of reason and experience. However, in civil actions and proceedings, with respect to an element of a claim or defense as to which State law supplies the rule of decision, the privilege of a witness, person, government, State or political subdivision thereof shall be determined in accordance with State law.

Id.

71. 518 U.S. 1 (1996). Justice Scalia, joined by Justice Rehnquist, dissented. *Id.* at 18 (Scalia, J., dissenting).

72. *Id.* at 4 (majority opinion).

73. *Id.* at 5.

74. *Id.*

75. *Id.*

mation was protected by the psychotherapist-patient privilege.⁷⁶ The district court rejected this argument; however, neither Redmond nor her therapist complied with the order to disclose the contents of the notes.⁷⁷ At the close of the trial, the judge instructed the jury that the refusal to turn over the notes had no “legal justification” and, therefore, the jury could presume that the contents would have been detrimental to the defendants.⁷⁸ The jury awarded the petitioner \$545,000 in damages.⁷⁹ The Seventh Circuit Court of Appeals reversed and remanded the case.⁸⁰ The Supreme Court granted certiorari to decide whether “it is appropriate for federal courts to recognize a ‘psychotherapist privilege’ under Rule 501 of the Federal Rules of Evidence.”⁸¹

The Court began its discussion by noting that rule 501 of the Federal Rules of Evidence allows federal courts to recognize new privileges by interpreting “common law principles . . . in the light of reason and experience”⁸² and that it directed the federal courts to “continue the evolutionary development of testimonial privileges.”⁸³ However, it also recognized the general principle limiting the recognition of privileges, stating:

For more than three centuries it has now been recognized as a fundamental maxim that the public . . . has a right to every man’s evidence. When we

76. *Jaffee*, 518 U.S. at 5.

77. *Id.*

78. *Id.*

79. *Id.* at 6.

80. *Jaffee v. Redmond*, 51 F.3d 1346 (7th Cir. 1995), *aff’d*, 518 U.S. 1 (1996). The circuit court found that the “reason and experience” criterion of Federal Rule of Evidence 501 required the recognition of a psychotherapist-patient privilege. *Id.* at 1354-55. However, the court did not find the privilege to be unqualified; rather, it adopted a balancing test and ruled that the privilege would not apply if “in the interests of justice, the evidentiary need for the disclosure of the contents of a patient’s counseling sessions outweighs that patient’s privacy interests.” *Id.* at 1357. In applying the balancing test, the court observed that there were ample eyewitnesses to the shooting and, because of this, found that the evidentiary need for the psychotherapist-patient communications was diminished while Redmond’s interest in preventing disclosure of the contents of the communications was substantial. *Id.* at 1358.

81. *Jaffee*, 518 U.S. at 4. There was a split in the federal circuits over whether the “reason and experience” test in rule 501 compelled the recognition of the psychotherapist-patient privilege in civil and criminal cases. *See Jaffee*, 51 F.3d at 1354-55. The Second and Sixth Circuits had recognized the privilege. *See In re Doe*, 964 F.2d 1325 (2d Cir. 1992); *In re Zuniga*, 714 F.2d 632 (6th Cir. 1983). Conversely, the Fifth, Ninth, Tenth, and Eleventh Circuits rejected the privilege. *See United States v. Burtrum*, 17 F.3d 1299 (10th Cir. 1994); *In re Grand Jury Proceedings*, 867 F.2d 562 (9th Cir. 1989); *United States v. Corona*, 849 F.2d 562 (11th Cir. 1988); *United States v. Meagher*, 531 F.2d 752 (5th Cir. 1976).

82. *Jaffee*, 518 U.S. at 8.

83. *Id.* at 9 (quoting *Trammel v. United States*, 445 U.S. 40, 47 (1990)).

come to examine the various claims of exemption, we start with the primary assumption that there is a general duty to give what testimony one is capable of giving, and that any exemptions which may exist are distinctly exceptional, being so many derogations from a positive general rule.⁸⁴

The Court explained that exceptions from the rule disfavoring testimonial privileges may be justified by a public good.⁸⁵ Applying the utilitarian approach, it noted that deciding whether the psychotherapist-patient privilege was justified required the Court to determine whether the protection of confidential communications between a patient and her therapist advances considerably important interests so as to outweigh the need for relevant evidence.⁸⁶

The Court found that the psychotherapist-patient privilege does advance important private and public interests.⁸⁷ It found that private interests are served when the communications between a patient and her therapist are protected from involuntary disclosure because effective psychotherapy demands “an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears.”⁸⁸ The Court also remarked that the “mere possibility” of disclosure of confidential communications could obstruct the development of the confidential relationship required for treatment to be successful.⁸⁹ “Where there may be exceptions to this general rule . . . , there is wide agreement that confidentiality is a *sine qua non* for successful psychiatric treatment.”⁹⁰ The Court also found that the protection of confidential communications between patients and therapists serves an important public interests because it facilitates the provision of mental health services, remarking, “The mental health of our citizenry, no less than its physical health, is a public good of transcendent importance.”⁹¹

84. *Id.* (alteration in original) (quoting *United States v. Bryan*, 339 U.S. 323, 331 (1950)).

85. *Id.*

86. *Id.* at 9-10.

87. *Id.* at 10.

88. *Jaffee*, 518 U.S. at 10.

89. *Id.*

90. *Id.* at 10-11 (alteration in original) (quoting *Rules of Evidence for the United States Courts and Magistrates*, 56 F.R.D. 183, 242 (1972)). It equated the psychotherapist-patient privilege to the spousal and attorney-client privileges in that they are “rooted in the imperative need for confidence and trust.” *Id.* at 10 (quoting *Trammel v. United States*, 445 U.S. 40, 50 (1990)).

91. *Id.* at 11.

Continuing its analysis, the Court weighed the public and private interests served by the privilege against the value of the evidence expected to be produced in the absence of a privilege.⁹² The Court suggested that little valuable evidence would be produced in the absence of a privilege because patients would be hesitant to disclose confidential information. It noted:

If the privilege were rejected, confidential conversations between psychotherapists and their patients would surely be chilled, particularly when it is obvious that the circumstances that give rise to the need for treatment will probably result in litigation. Without a privilege, much of the desirable evidence to which litigants such as petitioner seek access—for example, admissions against interest by a party—is unlikely to come into being. This unspoken “evidence” will therefore serve no greater truth-seeking function than if it had been spoken and privileged.⁹³

The Court refused to identify exceptions to the privilege since it was not required to do so at that time.⁹⁴ Justice Stevens, however, hinted that the privilege might not apply in situations involving a “serious threat of harm to the patient or to others [that] can be averted only by means of a disclosure by the therapist.”⁹⁵

92. *Id.* at 11-12.

93. *Jaffee*, 518 U.S. at 11-12. The Court ruled that the psychotherapist-patient privilege pertains with equal force to psychologists and clinical social workers. *Id.* at 15-17. In doing so, it recognized the role these professionals currently play in mental health treatment. *Id.* Its ruling is consistent with the vast majority of states, which also extend the privilege to licensed social workers. *Id.* at 16-17. The Court rejected the case by case balancing test that was applied by the court of appeals on the grounds that a balancing test would effectively destroy the privilege, stating:

Making the promise of confidentiality contingent upon a trial judge’s later evaluation of the relative importance of the patient’s interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the privilege. . . . [T]he participants in the confidential conversation “must be able to predict with some degree of certainty whether particular discussions will be protected. An uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all.”

Id. at 17-18 (quoting *Upjohn v. United States*, 449 U.S. 383, 393 (1981)).

94. *Id.* at 18.

95. *Jaffee*, 518 U.S. at 18 n.19. Justice Scalia dissented and was joined by Chief Justice Rehnquist. *Id.* at 18-36 (Scalia, J., dissenting). He criticized the majority for ignoring the “traditional judicial preference for the truth,” *id.* at 19, and for “creating a privilege that is new, vast, and ill defined,” *id.* at 19-20. He questioned whether the privilege truly serves personal interests and whether there is a public benefit resulting from the privilege. *Id.* at 22. He asked:

In recognizing the psychotherapist-patient privilege, the Supreme Court has acknowledged what psychiatrists and other mental health professionals have long believed—that confidentiality is essential to the therapeutic relationship. The American Psychoanalytic Association believes that analysis cannot proceed without the formation of a rational, trusting therapeutic alliance⁹⁶ and that the threat that a therapist might reveal a patient's most revealing secrets in a court of law would “stand as a permanent obstacle to development of the necessary degree of patient trust,” which would pose a “significant, and for many patients an insurmountable, barrier to effective treatment.”⁹⁷

When is it, one must wonder, that *the psychotherapist* came to play such an indispensable role in the maintenance of the citizenry's mental health? For most of history, men and women have worked out their difficulties by talking to, *inter alios*, parents, siblings, best friends, and bartenders—none of whom was awarded a privilege against testifying in court. Ask the average citizen: Would your mental health be more significantly impaired by preventing you from seeing a psychotherapist, or by preventing you from getting advice from your mom? I have little doubt what the answer would be. Yet there is no mother-child privilege.

Id. at 22.

96. Brief for the American Psychoanalytic Association et al. as Amici Curiae in Support of Respondents at 5, *Jaffee v. Redmond*, 518 U.S. 1 (1996) (No. 95-266) (citing HAROLD KAPLAN & BENJAMIN SADOCK, *COMPREHENSIVE TEXTBOOK OF PSYCHIATRY* 1775 (6th ed. 1995)).

97. *Id.* (citing ROBERT LANGS, *THE TECHNIQUE OF PSYCHOANALYTIC PSYCHOTHERAPY* 193 (1973)). Disclosure of the content of therapy in court would be embarrassing or job threatening. *Id.* at 4. Given the social stigma that remains attached to psychotherapy, the mere disclosure that an individual is in therapy could be detrimental. *Id.* The association further considers confidentiality to be essential in the therapist-patient relationship as it allows patients to fully disclose thoughts and feelings without fear of disclosure. *Id.* at 7. Full disclosure is an essential component of psychoanalytic therapy that assumes that conscious thoughts and feelings are caused by unconscious factors. *Id.* at 7-8 (citing CHARLES BRENNER, *AN ELEMENTARY TEXTBOOK OF PSYCHOANALYSIS* 9 (1973)). It is through full disclosure and the process known as “free association” that the therapist and patient can successfully bring unconscious material “into the light of consciousness.” Brief for the American Psychoanalytic Association et al. as Amici Curiae in Support of Respondents at 9, *Jaffee v. Redmond*, 518 U.S. 1 (1996) (No. 95-266). Anna Freud has noted: “[C]onfidentiality of the material . . . is a prerequisite for free association. No analysis succeeds in divesting himself of all defenses or controls unless he can be certain that the derivatives of his id will not become known beyond the confines of the analytic situation.” *Id.* at 11 (alterations in original) (quoting 4 ANNA FREUD, *THE WRITINGS OF ANNA FREUD* 417 (1968)). The disclosure of this “private personality,” although necessary for successful treatment, could be “devastating if revealed to ordinary scrutiny.” Ralph Slovenko, *Psychiatry and a Second Look at the Medical Privilege*, 6 WAYNE L. REV. 175, 194 (1960). The establishment of a psychotherapist-patient privilege is necessary because in a psychotherapeutic situation, treatment is directed towards feelings and attitudes that are unacceptable to the patient and to society. *See id.*

Similarly, the American Psychological Association has noted that the establishment of trust between the therapist and the patient “has been deemed so essential by some that it has been argued that psychotherapy is rendered worthless in its absence.”⁹⁸ The association has argued against the recognition of exceptions to the privilege for court proceedings, stating: “The privilege would have little value if it could be abrogated whenever information from therapy sessions might have a significant impact on the outcome of the case.”⁹⁹

In keeping with the need to protect the confidentiality of the therapeutic relationship, the various professions engaged in the mental health field

98. Brief Amicus Curiae of the American Psychological Association in Support of Respondents at 12, *Jaffee v. Redmond*, 518 U.S. 1 (1996) (No. 95-266) [hereinafter American Psychological Association Brief] (quoting Mark B. DeKraai & Bruce D. Sales, *Privileged Communications of Psychologists*, 14 PROF. PSYCHOL. 372, 372 (1982)).

99. American Psychological Association Brief, *supra* note 98, at 23. Countless others have expressed the need for trust and openness in the therapeutic relationship for which confidentiality is the cornerstone. See Patricia Honea-Boles & Jean E. Griffin, *The Court Mandated Client: Does Limiting Confidentiality Preclude a Therapeutic Encounter?*, 29 TEX. COUNSELING ASS’N J. 149, 150 (2001). The authors present numerous works and studies that support the proposition that the stronger the therapeutic relationship the more beneficial the therapy to the patient. The major psychotherapeutic theories indicate that successful therapy outcomes are dependent upon the relationship between the therapist and the patient. *Id.* at 150 (citing Charles J. Gelso & Jean A. Carter, *Components of the Psychotherapy Relationship: Their Interaction and Unfolding During Treatment*, 41 J. COUNSELING PSYCHOL. 296 (1994)). The therapists’ warmth or acceptance and empathic resonance are positively correlated with therapeutic outcome. *Id.* (citing David E. Orlinsky & Kenneth I. Howard, *Process and Outcome in Psychotherapy*, in MICHAEL J. LAMBERT, HANDBOOK OF PSYCHOTHERAPY AND BEHAVIOR CHANGE 311-81 (Sol L. Garfield & Allen E. Bergin eds., 5th ed. 2004)). A therapist’s unconditional regard for the patient allows for therapeutic change. *Id.* (citing Carl R. Rogers, *The Necessary and Sufficient Conditions of Therapeutic Personality Change*, 21 J. COUNSELING PSYCH. 95 (1957)). A strong working alliance has been demonstrated to result in positive outcomes and is viewed as the most fundamental factor of the therapeutic relationship. *Id.* at 150-52. Alliance is viewed as consisting of three components: (1) an agreement on the goals of the relationship, (2) agreement on the tasks, and (3) the development of an intimate bond between the parties with trust at the center. Honea-Boles & Griffin, *supra* at 151 (citing Edward S. Bordin, *The Generalizability of the Psychoanalytic Concept of the Working Alliance*, 16 PSYCHOTHERAPY THEORY, RES. & PRAC. 252, 252-59 (1992)). Three factors have been found to correlate with positive therapeutic outcomes:

- (1) Role investment: an investment of energy, by both the client (expressed through self-expression and emotional attachment to the therapist) and the therapist (through active participation);
- (2) Empathic resonance: mutual nondefensiveness, mutual trust and mutual comfortableness; and,
- (3) Mutual affirmation: mutual good will, born out of respect for autonomy, which encourages and accepts another’s independence.

Id. (citing David E. Orlinsky & Kenneth I. Howard, *Process and Outcome in Psychotherapy*, in MICHAEL J. LAMBERT, HANDBOOK OF PSYCHOTHERAPY AND BEHAVIOR CHANGE 311-81 (Sol L. Garfield & Allen E. Bergin eds., 5th ed. 2004)).

employ a code of ethics that imposes on its members a duty to protect patients' confidences.¹⁰⁰ Sanctions for violation of these ethical duties include censure, expulsion from professional organizations, and the potential for suspension or loss of one's professional license.¹⁰¹ These ethical rules are enforced independently of the evidentiary rules of privilege and, in some ways, may provide more protection than legal privileges. While privileges protect against the disclosure of confidential communications, they apply only to testimony in legal proceedings. Conversely, the duty of confidentiality is not limited to judicial settings and applies to matters not covered by privileges, such as nonconfidential communications and secrets that are not communications. Absolute confidentiality, however, can only be assured if an evidentiary privilege applies alongside a professional duty of confidentiality. In the absence of a privilege, a person called as a witness can be com-

100. See, e.g., AM. PSYCHOLOGICAL ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT § 4 (2002), available at <http://www.apa.org/ethics/code2002.pdf>. Some relevant subsections of American Psychological Association's code of conduct are as follows:

4.01 Maintaining Confidentiality

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. . . .

4.02 Discussing the Limits of Confidentiality

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. . . .

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant. . . .

4.05 Disclosures

(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.

Id.

101. MUELLER & KIRKPATRICK, *supra* note 2, § 5.3, at 290.

pelled to disclose confidential communications despite a professional ethical requirement of confidentiality. In fact, most ethical standards provide an exception to the confidentiality requirement when the disclosure is required by law.¹⁰²

III. THE EMPIRICAL STUDIES: SUPPORT FOR THE PSYCHOTHERAPIST-PATIENT PRIVILEGE

The major psychoanalytic theories, along with opinions of the various associations of mental health professionals, stress the importance of confidentiality in the patient-therapist relationship to the successful outcome of therapy. Additionally, the *Jaffee v. Redmond* decision represents a significant affirmation by the Supreme Court of the necessity for absolute confidentiality in psychotherapy. However, it has been suggested by some that the need for confidentiality may not be as important as represented and that those who have examined the psychotherapist-patient privilege have “uncritically accepted” the need for this privilege.¹⁰³ The following section presents a synopsis of the empirical research in this area, which overwhelmingly contradicts this assertion and reaffirms the necessity for the privilege.

One of the earliest studies reported in legal journals on this topic is a 1962 student comment published in the *Yale Law Journal* entitled *Functional Overlap Between the Lawyer and Other Professionals*.¹⁰⁴ This article presented a questionnaire study of psychiatrists, marriage counselors, psychologists, lawyers, judges, and lay people. It reported that the majority of lay people were unaware of a privilege for communications with marriage counselors, psychologists, and psychiatrists.¹⁰⁵ Even so, approximately forty-four percent of the lay people questioned indicated they would be less likely to make a “free and complete disclosure” to psychologists and psychiatrists if the therapist had a legal obligation to disclose the information to a court.¹⁰⁶

102. See AM. PSYCHOLOGICAL ASS'N, *supra* note 100, § 4.05(b) (“Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.”).

103. Daniel W. Shuman & Myron S. Weiner, *The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege*, 60 N.C. L. REV. 894 (1981).

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

105. *Id.* at 1261.

106. *Id.* at 1262.

A. THE SHUMAN AND WEINER STUDIES

Researchers Daniel Shuman and Myron Weiner conducted three separate empirical studies on the effects of privilege on the psychotherapist-patient relationship and its concomitant effect on the quality of therapy.¹⁰⁷ The first study was conducted in 1979 and was prompted by the passage of a psychotherapist-patient privilege in Texas.¹⁰⁸ The second study was conducted three years later in South Carolina and West Virginia.¹⁰⁹ At the time, these were the only two states in the United States that did not recognize a psychotherapist-patient privilege, which afforded Shuman and Weiner an opportunity to observe psychotherapist-patient communications and court proceedings in the absence of a privilege.¹¹⁰

The third study was conducted in Montreal and Toronto, Canada and was prompted by the difference in the law of privileges in Quebec, a civil law jurisdiction, and Ontario, a common law jurisdiction.¹¹¹ While the common law has traditionally limited disclosure of communications only in the attorney-client context, the civil law prohibits disclosure of confidential communications in a variety of relationships, including attorney-client, physician-patient, notaries-client, and dentist-patient.¹¹²

107. Daniel W. Shuman & Myron S. Weiner, *The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege*, 60 N.C. L. REV. 893 (1981) [hereinafter *Privilege Study I*]. The second and third studies are Daniel W. Shuman & Myron F. Weiner, *Privilege—a Comparative Study*, 12 J. PSYCHIATRY & L. 373 (1984) [hereinafter *Privilege Study II*], and Gilbert Pinard, Daniel W. Shuman & Myron F. Weiner, *The Privilege Study (Part III): Psychotherapist-Patient Communications in Canada*, 9 INTER. J.L. & PSYCHIATRY 393 (1987) [hereinafter *Privilege Study III*], respectively.

108. *Privilege Study I*, *supra* note 107, at 895-96.

109. *Privilege Study II*, *supra* note 107, at 373.

110. *See id.* at 374.

111. *Privilege Study III*, *supra* note 107, at 393, 406, 409. Professor Gilbert Pinard, a professor of psychiatry and chairman of the department of psychiatry at the medical school at McGill University in Montreal, Canada, also participated in the study. *Id.* at 393.

112. *Id.* The authors note that Canadian judges in common law jurisdictions appear to be uncomfortable with the absence of a physician-patient privilege, which has given way to the existence of an “underground privilege.” *Id.* at 396. The authors discuss numerous cases that appear to recognize this privilege. *See, e.g.*, Slavutych v. Baker, [1975] 1 S.C.R. 254 (Can.) (declining to admit an evaluation for tenure given with the understanding that it would be confidential); Shakotko v. Shakotko, [1976] 27 R.F.L. 1 (Can.) (citing English cases for the proposition that the common law favors marital reconciliation and should not aggravate that objective by destroying the confidentiality of marital therapy); Dembie v. Dembie, [1963] 21 R.F.L. 46 (Can.) (finding it “shocking” that a woman could encourage her husband to visit her psychiatrist, subsequently summon the psychiatrist to court, and have the court force her psychiatrist to disclose everything her husband said to the psychiatrist in confidence, and refusing to call a psychiatrist who saw a husband and wife for counseling to testify to what occurred in therapy). *Id.* at 396-401. The authors also point out that although Quebec recognizes the professional secret, there are numerous exceptions to these privileges. *Id.* at 405. For example, Canadian federal criminal law does not recognize a

The hypotheses and methodology were identical in all three of the studies. The authors set out to test the correctness of the following premises: (1) that “[t]he absence of a privilege deters people from seeking needed therapy”;¹¹³ (2) that “[t]he absence of a privilege impairs the quality of therapy”;¹¹⁴ and (3) that “[t]he absence of privilege leads to compelled judicial disclosure of patient communications, which results in psychological harm to patients.”¹¹⁵

The researchers employed the same four questionnaires in all three studies and sent them to the same category of individuals: practicing psychiatrists, current patients, “lay persons,”¹¹⁶ and judges.¹¹⁷

The researchers concluded that the lack of a psychotherapist-patient privilege would not deter patients from seeking psychiatric help nor would the lack of a privilege necessarily impair the quality of therapy.¹¹⁸ However, they found that a significant percentage of the respondents were either unaware of whether their jurisdiction had a privilege statute or believed that the therapists’ professional code of ethics provided adequate assurances of confidentiality.¹¹⁹

physician-patient privilege. *Privilege Study III, supra* note 107, at 393. Furthermore, the physician-patient privilege is not applicable in physician discipline proceedings, medical malpractice actions, psychiatric detention proceedings, or child abuse proceedings. *Id.* at 405-06.

113. *Privilege Study I, supra* note 107, at 898; *Privilege Study III, supra* note 107, at 394-95.

114. *Privilege Study I, supra* note 107, at 898; *Privilege Study III, supra* note 107, at 394-95.

115. *Privilege Study I, supra* note 107, at 898; *Privilege Study III, supra* note 107, at 394-95.

116. Lay persons were defined as individuals that were not in therapy. *Privilege Study I, supra* note 107, at 917. The first study identified lay persons as students in night classes at a university but did not necessarily rule out individuals in therapy. *Id.*

117. See *Privilege Study I, supra* note 107, at 917; *Privilege Study II, supra* note 107, at 374; *Privilege Study III, supra* note 107, at 406-09.

118. *Privilege Study I, supra* note 107, at 924-25. In the Texas study, ninety-three percent of the lay people responded that they would seek help for serious emotional problems. *Id.* at 925. Seventy-four percent of the lay people indicated that they were unaware of the Texas privilege statute, whereas ninety-six percent believed that the therapists’ ethics provided adequate assurances of confidentiality. *Id.* Shuman and Weiner did not find statistically significant differences in responses to their questionnaires in the South Carolina and West Virginia study compared to the Texas study. *Privilege Study II, supra* note 107, at 378-80. As in the Texas study, the authors concluded that the absence of a privilege statute did not seem to have a significant impact on the conduct of therapy nor did it appear to significantly impede the process of psychotherapy. *Id.*

119. In the West Virginia and South Carolina studies, a significant portion (forty-one percent) of the patients responded that they were unaware that their state did not have a privilege statute. *Id.* at 381. Interestingly, and similar to the Texas study, eighty-six percent of the patients indicated that they relied upon the professional ethics of their therapist to guarantee the privacy of their communications. *Privilege Study III, supra* note 107, at 414.

The authors did find that there was an impact on the therapeutic relationship once a therapist threatened to disclose or actually disclosed confidential communications. Their data demonstrated that patients' willingness to disclose actions that carry legal consequences is significantly affected by the lack of privilege,¹²⁰ particularly those actions involving violent urges, speeding, physical violence, theft, and tax evasion.¹²¹

The authors were unable to determine whether patients were psychologically harmed by their therapists' disclosures, but a small number of therapists reported that patients terminated therapy following a report or that the level of trust in the relationship was significantly diminished.¹²²

There did appear to be a slight difference in responses among the judges that were surveyed in the three studies.¹²³ Not all of the judges believed that recognition of the privilege would render judicial proceedings inaccurate.¹²⁴ Judges in both Canadian jurisdictions reported that the admis-

In Canada, equal percentages of patients in Toronto and Montreal believed a privilege statute was in existence. *Id.* at 407. Both groups reported that they relied more on the therapist's personal and professional ethics than the privilege to protect their confidentiality. *Id.* at 411-12.

120. The Texas patient surveys indicated that thirty-four percent of the items patients withheld from their therapists involved sexual thoughts, while thirty-six percent involved sexual acts. *Privilege Study I, supra* note 107, at 926. Thoughts of violence were reported to be withheld only nine percent of the time. *Id.* In the West Virginia and South Carolina study, as in the Texas study, when posed with questions testing the willingness to disclose or discuss selected subjects, the topics that were most likely to have legal consequences were the most affected by the lack of the privilege. *Privilege Study III, supra* note 107, at 413-14. In Canada, the respondents in both groups indicated that they would be less willing to discuss sexual acts and thoughts with a therapist. *Id.* at 407, 410. Additionally, both groups of respondents indicated that they would be significantly less likely to respond to questions about speeding, physical violence, and work failure. *Id.*

121. *Privilege Study I, supra* note 107, at 926. The lay people also indicated that they would be less likely to discuss masturbation, sexual thoughts, and sexual activities with a therapist in the absence of a privilege. *Id.*

122. *Id.* Almost thirty percent of the therapists reported that they did not know whether their patients had experienced harm as the result of their disclosures. *Id.* at 921, 927. The therapists' responses indicated that twelve patients were in therapy at the time the therapist disclosed confidential communications. *Id.* Of the twelve, two terminated therapy with the therapist, and the therapy of another two patients was reported to be affected by the diminished level of trust. *Id.*

123. Surprisingly, the researchers found that the Texas judges were often unaware of the privilege. *Privilege Study I, supra* note 107, at 924.

124. *See id.* at 927. Four of the Texas judges who were involved in family law matters reported that these communications were necessary, while three reported that disclosure of confidential therapist-patient communications was not necessary for an accurate resolution of the cases. *Id.* Forty-five percent of the responding judges in West Virginia and South Carolina indicated that the question of whether to admit confidential psychotherapist-patient communications had arisen before them. *Privilege Study III, supra* note 107, at 415. Of this group, sixty-one percent believed that disclosure was necessary for an accurate determination of the contested issues. *Id.*

sibility of confidential therapist-patient communications arose most frequently in family law and child custody cases.¹²⁵ Interestingly, the judges in both jurisdictions reported that they would not compel disclosure of this information in the absence of patient consent.¹²⁶

Although the authors concluded that there is little empirical evidence to support the proposition that a privilege is necessary for effective psychotherapy,¹²⁷ they appear to base this conclusion principally on the fact that the respondents were either largely unaware of the privilege law within their respective jurisdictions or misunderstood the capacity of their therapists to maintain confidentiality.¹²⁸ Additionally, even though the results suggest that patients' self-disclosures of certain kinds of information decreased once they were informed of the lack of privilege,¹²⁹ the researchers failed to test the effect that the level of risk of disclosure could have on patients' self-disclosures in therapy. Without properly taking this factor into account, their overall conclusion that the absence of a privilege will not affect the quality of therapy appears unjustified.

Interestingly, Professor Shuman revisited the issue of the effect of the psychotherapist-patient privilege on the therapeutic relationship following the Supreme Court's decision in *Jaffee v. Redmond*.¹³⁰ In his article, Shuman noted that *Jaffee* appears to have a limited impact on an individual's decision to enter therapy or on the conduct of the therapy.¹³¹ However, unlike the conclusions in his previous three studies, this time Shuman explained that *Jaffee*'s limited impact is likely due to patients discounting the risk of litigation or "inflating the capacity of their therapists to prevent disclosure."¹³² He admitted that correcting these misconceptions may cause

125. *Id.* at 412.

126. *Id.*

127. *Id.* at 417-18. They advocate for reliance on the deontological approach to privilege where intrusion into the sacredness of the psychotherapist-patient relationship is objectionable for its own sake, not because it is seen as destructive to the therapeutic relationship. *Id.* at 417. They do not, however, advocate for an absolute psychotherapist-patient privilege. *Privilege Study III, supra* note 107, at 417-18. Rather, they propose an interest-balancing approach and would recognize a privilege where, considering the particular circumstances of the case, the interest in privacy outweighs the public interest in the administration of justice. *Id.* This approach was specifically rejected by the U.S. Supreme Court ten years later in *Jaffee v. Redmond*. *Jaffee v. Redmond*, 518 U.S. 1, 17-18 (1996).

128. *Privilege Study III, supra* note 107, at 417-18.

129. *See supra* notes 107-122 and accompanying text.

130. Daniel W. Shuman & William Foote, *Jaffee v. Redmond's Impact: Life After the Supreme Court's Recognition of a Psychotherapist-Patient Privilege*, 30 PROF. PSYCHOL.: RES. & PRAC. 479, 479-87 (1999).

131. The article was co-authored by William Foote. *Id.* at 479.

132. *Id.* at 482. The authors identified three levels of risk of disclosure. *Id.* at 484. In the first level, the low end of the risk continuum, the patient seeks therapy to deal with mental health issues but is not currently involved in litigation. *Id.* at 484-85. Further, the issues

patients to be less self-disclosing, which will have a resulting effect on the therapeutic relationship.¹³³

B. THE EVANS-MARSH STUDY

Following the United States Supreme Court's decision in *Jaffee v. Redmond*,¹³⁴ one researcher set out to test the strength of the empirical evidence in support of the Court's findings regarding the effect of the psychotherapist-patient privilege on the therapeutic relationship, specifically whether the existence of a privilege would affect an individual's willingness to disclose certain emotional conditions.¹³⁵ She recruited subjects at random and assigned them to a "privilege condition" and a "no-privilege condition."¹³⁶ Each person was asked to complete a questionnaire that was composed of several scenarios, each involving an exception to the psychotherapist-patient privilege.¹³⁷ Each questionnaire required the participant to provide their opinion of the protagonists' willingness to disclose information in a different type of therapeutic setting.¹³⁸ In essence, the participants were asked to indicate how a hypothetical patient would behave under a hypothetical set of circumstances.¹³⁹ The scenarios included a depressed

addressed in therapy do not hint at the potential for the patient's involvement in litigation. *Id.* In the middle of the risk continuum, the individual is not presently involved in litigation but the subject matter of the therapy indicates that there is a high risk that litigation may occur. Shuman & Foote, *supra* note 130, at 485. Here the authors say that the patient should be made aware that there is a significant risk that communications between therapist and patient may be subject to compelled disclosure. *Id.* They also suggest that the patient may want to minimize disclosures that weaken the privilege claim. *Id.* Finally, the high end of the risk continuum involves a situation where the individual is presently involved in litigation. *Id.* at 485-86. Here, the authors suggest that the patient and therapist should consider limiting the range of issues discussed in therapy due to the risk of compelled disclosure. *Id.* at 485.

133. *Id.*

134. 518 U.S. 1 (1996).

135. Jennifer Evans Marsh, *Empirical Support for the United States Supreme Court's Protection of the Psychotherapist-Patient Privilege*, 13 ETHICS & BEHAV. 385 (2003). She recruited one hundred twenty-nine people at Union Station in Washington, D.C. *Id.* at 389-90.

136. *Id.* at 388.

137. *Id.* at 389.

138. *Id.* at 388-89.

139. *See id.* at 389. The questionnaires were of two types: the N form, in which the communications were not privileged, and the P form, in which the communications were privileged. Marsh, *supra* note 135, at 389. Participants indicated their belief as to how willing a hypothetical patient would be to disclose information about a given topic by placing a mark along a linear analog scale. *Id.*

and suicidal individual,¹⁴⁰ a patient with anorexia nervosa,¹⁴¹ a physically abusive parent,¹⁴² and a sexually abusive patient.¹⁴³

She found statistically significant differences in the willingness to disclose among those in the “privilege condition” group compared to those in the “no-privilege condition” group in all of the differing scenarios.¹⁴⁴ Based on the results of her study, she concluded that there is strong empirical support for the *Jaffee* decision.¹⁴⁵

140. *Id.* at 390. The first scenario involved a patient who was depressed and suicidal and a candidate for involuntary hospital commitment. *Id.* Sixty-eight percent of the participants in the privilege condition group indicated that a patient would disclose these facts compared to seventeen percent in the no-privilege condition group. *Id.* at 391.

141. *Id.* The second scenario involved a patient with anorexia nervosa who starved herself to the point of requiring hospitalization. Marsh, *supra* note 135, at 391. Fifty-five percent of the persons in the privilege condition group believed that patients would disclose this information compared to nineteen in the no-privilege condition group. *Id.* at 391-92.

142. *Id.* at 392. The third scenario involved a patient who had physically injured her child and who was facing an upcoming child custody hearing. *Id.* Forty-eight percent of the participants in the privilege condition group reported that a patient would disclose the information whereas only twelve percent in the no-privilege condition group indicated that they thought the patient would do so. *Id.* at 391-92.

143. *Id.* at 392. Similar findings were reported for the “sexually abusive patient scenario,” where a patient had sexually abused his stepdaughter and was facing the possibility of criminal prosecution. Marsh, *supra* note 135, at 392. She also included a “police officer who shot a suspect scenario,” involving a police officer who shot an allegedly armed man in the course of apprehending him. *Id.* at 393. In both of these scenarios, participants in the privilege condition group had statistically higher willingness to disclose scores than the individuals in the no-privilege condition group. *Id.* at 392-93. Her results were as follows:

| | Privilege Yes | Privilege No |
|----------------------------|---------------|--------------|
| Suicidal patient | 67.80 | 17.30 |
| Gravely disabled patient | 54.98 | 19.28 |
| Physically abusive patient | 47.73 | 12.54 |
| Sexually abusive patient | 5.73 | 2.13 |
| Police officer | 51.43 | 26.50 |

Id. at 391. The author notes that the results demonstrate that the privilege condition was “more highly correlated with individuals’ ratings of a hypothetical patient’s willingness to disclose than were therapy experience, demographic variables, and four dimensions of general disclosiveness (intent, amount, control of depth, honesty-accuracy).” *Id.* at 397. The researcher used the general disclosiveness scales to assess a person’s predisposition to disclose to others. *Id.* at 388-89. The demographics of the participants were as follows: 57% were female, 43% were male, 83% were white, 8.5% were black, 4.7% were Asian, and 1.6% were Native American. Marsh, *supra* note 135, at 388.

144. *Id.* at 391-93.

145. *Id.* at 397. The author also tested whether participants with previous psychotherapy experience would have higher willingness-to-disclose scores than those without. *Id.* at 387. This turned out to be untrue. *See id.* at 393. There were no significant differences in

C. THE TAUBE AND ELWORK STUDY

Daniel Taube and Amiram Elwork set out to ascertain the circumstances under which confidentiality becomes important to patients.¹⁴⁶ Individual psychotherapy outpatients were ranked according to the severity of their mental disorders¹⁴⁷ and placed into an “uninformed group,” which was given limited written information regarding the right to privacy and the limits to confidentiality in psychotherapy, and an “informed” group, who received extensive information on the current state of the law.¹⁴⁸ The participants were then given a questionnaire that inquired into the extent to which they would disclose select issues that included substance abuse, harm to self or others, socially controversial sexual practices, and abusive child care.¹⁴⁹ None of the patients were informed that they were research participants.¹⁵⁰

The researchers reported significant differences in the responses obtained from the informed and uninformed groups.¹⁵¹ They found that “the

the willingness to disclose scores between those participants with previous therapy and those without. *Id.*

146. Daniel O. Taube & Amiram Elwork, *Researching the Effects of Confidentiality Law on Patients' Self-Disclosures*, 21 PROF. PSYCHOL.: RES. & PRAC. 72, 72-75 (1990). The authors note the conflicting research on the effects that confidentiality has on patients' self-disclosures. *Id.* at 72. They cite the 1982 Shuman and Weiner study for the conclusion that assurances of privacy do not have a significant effect on patients' disclosures in therapy. *Id.* However, they also cite three other studies conducted between 1983 and 1987 that demonstrate the position that privacy is essential to furthering full disclosure. *Id.* (citing John M. McGuire, Phillip Toal & Burton Blau, *The Adult Client's Conception of Confidentiality in the Therapeutic Relationship*, 16 PROF. PSYCHOL.: RES. & PRAC. 375 (1985); Thomas V. Merluzzi & Cheryl S. Brischetto, *Breach of Confidentiality and Perceived Trustworthiness of Counselors*, 30 J. COUNSELING PSYCHOL. 245 (1983); Leon VandeCreek, Russell D. Miars & Cindy E. Herzog, *Client Anticipations and Preferences for Confidentiality of Records*, 34 J. COUNSELING PSYCHOL. 62 (1987)).

147. *Id.* at 73. There were thirty-one women and eleven men ranging in age from eighteen to seventy-four years. *Id.* at 72. The subjects were placed into “high” or “low” psychopathology groups based on scores from the Minnesota Multiphasic Personality Inventory. Taube & Elwork, *supra* note 146, at 73.

148. *Id.* Participants were given a written questionnaire to test their understanding regarding the privacy instructions. *Id.* Both the informed and the uninformed groups averaged eighty-five percent or higher on this legal comprehension questionnaire, leading the authors to conclude that the participants understood the information. *Id.*

149. *Id.*

150. *Id.* The researchers commented that while most of the previous studies were based on opinion surveys or therapy simulations, this is one of the few that utilized real patients, real clinical tasks, and real clinical materials. Taube & Elwork, *supra* note 146, at 73.

151. *See id.* at 74. They found that the patients in the informed group admitted to having fewer socially unacceptable sexual thoughts and behaviors and did not admit to as many child neglect and punishment behaviors as the uninformed group. *Id.* The uninformed patients who displayed high psychopathology revealed that they had thoughts about harm to

extent to which patients are informed about the law, and the extent to which the law is consequential for them, are . . . factors that determine whether limitations to privacy will affect patients' self-disclosures."¹⁵² The authors suggest that the results of this study have implications for the effectiveness of current laws since the findings indicate that laws requiring the disclosure by therapists of certain patient "confessions" may discourage patients from being forthright, may hinder treatment, and, therefore, may ultimately fail in their intended objective of protecting society.¹⁵³

D. OTHER EMPIRICAL STUDIES

The results of the Taube and Elwork study are supported by other research. One study demonstrated that the individuals in a "no-confidentiality" group provided the most socially desirable responses and reported being the least troubled by psychopathological symptoms.¹⁵⁴ Conversely, subjects in a "confidentiality" condition group reported more psychological symptoms and provided fewer socially desirable responses than the subjects in the no-confidentiality group.¹⁵⁵ A 1993 study conducted by David Nowell and Jean Spruill confirmed that informing subjects about confidentiality impacts the type of information individuals are willing to communicate.¹⁵⁶ Additionally, these researchers found an overall unwill-

self or others more frequently than the informed group. *Id.* Finally, the results indicated that the subjects in the high psychopathology/informed group disclosed a greater frequency of substance abuse behaviors than the subjects in the other groups, which was not surprising since disclosures about drug and alcohol abuse are legally protected. *Id.*

152. *Id.*

153. Taube & Elwork, *supra* note 146, at 73. The authors explain that the study also demonstrates the value of professional ethical standards that require patients be fully apprised of their privacy rights before treatment commences. *Id.*; *see also* AM. PSYCHOLOGICAL ASS'N, *supra* note 100, § 4.02(a) (requiring therapists to discuss the limits of confidentiality and the "foreseeable uses" of the information obtained in therapy).

154. Roback & Shelton, *supra* note 40, at 189 (citing Robert Meyer & Deborah Wil- lage, *Confidentiality and Privileged Communication in Psychotherapy*, in *NEW DIRECTIONS IN PSYCHOLEGAL RESEARCH* 237-46 (Paul Lipsitt ed., 1980)).

155. *Id.* The study was conducted using sixty-three undergraduate students. *Id.*

156. *See* David Nowell & Jean Spruill, *If It's Not Absolutely Confidential, Will In- formation Be Disclosed?*, 24 *PROF. PSYCHOL.: RES. & PRAC.* 367, 368-69 (1993). The sub- jects were seventy-five undergraduate students enrolled in an introductory psychology class at a southern university. *Id.* at 368. The participants were assigned to one of three groups and were given a "Psychology Clinic Client Awareness Form," which provided information about the services offered, fees, appointment cancellation policy, and limits of confidential- ity. *Id.* All of the information was the same with the exception of the information about confidentiality. *Id.* The first group was told that all the information they disclosed would be absolutely confidential. *Id.* The second group was provided with some information about confidentiality but was informed that the therapist would disclose information if he had reason to believe the client might harm himself or others. *Id.* The third group was provided with detailed information regarding other specific exceptions to confidentiality, including

ingness to disclose aggressive behaviors irrespective of whether they were assured of confidentiality.¹⁵⁷

Aside from information regarding the limits of confidentiality, other factors have been found to affect patients' self-disclosures. One study involving current psychotherapy patients found that although all of the patients considered confidentiality to be important, inpatients were more concerned about violations of the confidentiality rules than outpatients.¹⁵⁸ Another study demonstrated that the level of concern over potential breaches of confidentiality varied according to the recipient of the information, with eighty percent of the adult patients indicating that they would be angry if their psychological information was released to their employers.¹⁵⁹

Unique issues arise in the case of mandatory reporting statutes, particularly in situations involving suspected instances of child abuse and neglect,¹⁶⁰ where a therapist may be required by law to report confidential patient communications. Although these issues involve a breach of professional ethics rather than the abrogation of a privilege, they confirm the im-

suspected child abuse and court subpoenas. Nowell & Spruill, *supra* at 368. The subjects were then given a questionnaire designed to assess their willingness to disclose information about a variety of clinical concerns, including depression, substance abuse, physical aggression, suicidal thought, and psychotic thoughts and behaviors. *Id.*

157. *Id.* at 369. The study also found that participants were more willing to disclose information about aggressive thoughts than suicidal thoughts, while they were less willing to disclose information regarding substance abuse than depression. *Id.* at 368.

158. Roback & Shelton, *supra* note 40, at 187 (citing John M. McGuire et al., *The Adult Client's Conception of Confidentiality in the Therapeutic Relationship*, 16 PROF. PSYCHOL. 375 (1985)). This study employed a survey of fifty psychotherapy outpatients and twenty-six nonpsychotic psychiatry inpatients at a regional medical center. John M. McGuire et al., *The Adult Client's Conception of Confidentiality in the Therapeutic Relationship*, 16 PROF. PSYCHOL. 375, 377-78 (1985). The authors suggest that since inpatients tend to be more ill than outpatients, they would have more to fear if word of their condition was made public. *Id.* at 380.

159. *Id.* (citing Donald Schmid et al., *Confidentiality in Psychiatry: A Study of the Patient's View*, 34 HOSP. COMMUNITY PSYCHIATRY 353 (1983) (noting that only forty percent of the patients felt strongly about the release of this information to members of their family)).

160. It is mandatory in every state to report suspected cases of child abuse and neglect. Margaret Meriwether, *Child Abuse Reporting Laws: Time for a Change*, 20 FAM. L.Q. 141, 142 (1986). Although each state has a mandatory reporting statute for child abuse and neglect, there is a lack of uniform treatment. Karen L. Ross, *Revealing Confidential Secrets: Will It Save Our Children*, 28 SETON HALL L. REV. 963, 966 (1998). Mandatory reporting laws abrogate the professional duty to maintain confidentiality imbedded in the various professional codes of ethics. *Id.* Typical statutes will include a definition of reportable conditions, the persons required to report abuse, the level of certainty required before a report is made, a description of the sanctions for failure to report, immunity provisions, and the abrogation of certain privileges. *Id.* Most states require reporting by persons engaged in the health, education, social work, and law enforcement professions. *Id.* at 967. Some but not all states require clergy to report suspected child abuse and neglect. *Id.*

portance of confidentiality in the therapist-patient relationship. In a study conducted at the Johns Hopkins Sexual Disorders Clinic, the researchers concluded that mandatory reporting laws dissuade undetected abusers from entering treatment.¹⁶¹ This was based on a severe drop in the number of instances of self-reported child sexual abuse after the State of Maryland implemented mandatory reporting statutes requiring psychotherapists to report suspected cases of child abuse.¹⁶² In another study, researchers also found that more than twenty-five percent of patients terminated their therapy immediately following a report made by their therapist.¹⁶³ Additionally, the therapists reported that the patients who remained in therapy following a mandated report went through a period of mistrust and resistance that, in some cases, was never overcome.¹⁶⁴

In summary, these studies provide ample empirical evidence in support of the necessity for the psychotherapist-patient privilege. Although Shuman initially reached an opposite conclusion, his early conclusion appears to be based principally on the fact that patients and lay persons alike were either largely unaware of the existence of privilege statutes or had an

161. Fred S. Berlin et al., *Effects of Statutes Requiring Psychiatrists to Report Suspected Sexual Abuse of Children*, 148 AM. J. PSYCHIATRY 449, 452 (1991) (“[Mandatory reporting] appears to have deterred honest disclosure by patients in treatment and to have deterred unidentified potential patients from entering treatment.”).

162. *Id.* at 451.

163. Murray Levine, *A Therapeutic Jurisprudence Analysis of Mandated Reporting of Child Maltreatment by Psychotherapists*, 10 N.Y.L. SCH. J. HUM. RTS. 711, 730 (1993) (citing Holly Watson & Murray Levine, *Psychotherapy and Mandated Reporting of Child Abuse*, 59 AM. J. ORTHOPSYCHIATRY 246, 252-53 (1989)). This number does not reflect the number of clients who psychologically dropout but cannot physically terminate therapy because they are embroiled in child protection or criminal justice systems. Holly Watson & Murray Levine, *Psychotherapy and Mandated Reporting of Child Abuse*, 59 AM. J. ORTHOPSYCHIATRY 246, 254 (1989). The problem is compounded when a mandated report is ultimately determined to be unsubstantiated. Levine, *supra* at 726-27. Sixty-six percent of reports to child protection agencies are unsubstantiated. *Id.* at 726. State mandatory reporting statutes generally require a person to report based upon a “reasonable suspicion” of harm. *See id.* at 718.

164. Roback & Shelton, *supra* note 40, at 188. Even mere knowledge of reportable offenses was found to result in reluctance on the part of patients to discuss violent tendencies. Murray Levine et al., Paper Presentation at the Annual Meeting of American Psychological Association: *Mandated Reporting and the Therapeutic Alliance in the Context of the Child Protection System* (Aug. 1991). One-quarter of responding psychotherapists reported reluctance on the part of their patients to discuss violent tendencies after the patients had been informed about reportable offenses, which indicates that patient concerns over confidentiality affected the therapeutic relationship. Toni P. Wise, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff*, 31 STAN. L. REV. 165 (1978). Furthermore, clients’ knowledge of the limits of confidentiality was found to result in a severe decrease in disclosures of instances of child abuse. Levine, *supra* note 163, at 725 (citing Fred S. Berlin et al., *Effects of Statutes Requiring Psychiatrists to Report Suspected Sexual Abuse of Children*, 148 AM. J. PSYCHIATRY 449, 451 (1991)).

erroneous understanding of the ability of a therapist to prevent disclosure of confidential information. Other studies, however, have clearly demonstrated that a patient's willingness to self-disclose sensitive information is significantly higher once they are informed that a psychotherapist-patient privilege exists. Conversely, patient self-disclosures and their willingness to continue in therapy are especially low when the risk of disclosure by the therapist of confidential information is high, as evidenced in the Johns Hopkins study.

IV. EXCEPTIONS TO THE PSYCHOTHERAPIST-PATIENT PRIVILEGE AND THE USE OF THERAPIST TESTIMONY IN SELECTING JUDICIAL PROCEEDINGS

A. EXCEPTIONS IN THE FEDERAL COURTS

Following *Jaffee v. Redmond*,¹⁶⁵ every jurisdiction now recognizes some form of privilege for patient communications made in conjunction with mental health treatment.¹⁶⁶ However, the present legal framework fails to provide strong or consistent protection for these confidential communications. Many federal circuit courts have carved out exceptions to this privilege even though the Supreme Court refused to recognize any specific exceptions in *Jaffee*. In the states, the law of privilege is riddled with exceptions and has been described as a "crazy quilt pattern of legislation across the country"¹⁶⁷ where social policy goals, professional ethics, and legal requirements are all at odds with each other.

Many federal courts have recognized a patient-litigant exception to the psychotherapist-patient privilege,¹⁶⁸ which was provided for in proposed Federal Rule of Evidence 504(d)(3). The proposed rule crafted an exception for "communications relevant to an issue of the mental or emotional condition of the patient in any proceeding in which he relies upon the condition as an element of his claim or defense."¹⁶⁹ The majority of federal cases interpreting *Jaffee* have involved this exception,¹⁷⁰ which arises most frequently in claims in civil cases for emotional distress purportedly the result

165. 518 U.S. 1 (1996).

166. Harriet L. Glossoff et al., *Privileged Communication in the Counselor-Client Relationship*, 78 J. COUNSELING & DEV. 454 (2000).

167. *Id.* at 455. The authors present a table of exceptions to the privilege by state and the District of Columbia. *Id.* at 458.

168. Melisa L. Nelken, *The Limits of Privilege: The Developing Scope of Federal Psychotherapist-Patient Privilege Law*, 20 REV. LITIG. 1, 19 (2000).

169. Rules of Evidence for the United States Courts and Magistrates, 56 F.R.D. 183, 241 (1972).

170. Nelken, *supra* note 168, at 20.

of the defendant's conduct.¹⁷¹ Many of the courts that have considered the patient-litigant exception have defined it broadly, finding the exception applies whenever a plaintiff alleges emotional distress irrespective of whether the party plans to introduce expert testimony evidence at trial.¹⁷² Other more-cautious courts, however, have held that the mere allegation of emotional distress is not enough to trigger the exception.¹⁷³ Instead, the privilege remains intact until the party takes affirmative steps to use the privileged material in furtherance of their case.¹⁷⁴

There is a current split of authority over whether federal courts should recognize a dangerous person exception to the psychotherapist-patient privilege based on the duty that was originally set forth in *Tarasoff v. Regents of the University of California*.¹⁷⁵ *Tarasoff* requires mental health professionals to warn third parties of threats that are made by a patient in therapy.¹⁷⁶ The Tenth and Fifth Circuits¹⁷⁷ have allowed the exception, whereas the Sixth and Ninth Circuits have not.¹⁷⁸ The Tenth Circuit was the first federal court after *Jaffe* to examine this question.¹⁷⁹

United States v. Glass involved a defendant, Archie Monroe Glass, who was voluntarily admitted to the mental health unit at Hillcrest Hospital in February 1996.¹⁸⁰ During his stay, he told his psychotherapist, Dr. Sharntharam Darbe, that he "wanted to get in the history books like Hinkley [sic]

171. *Id.* at 21; *see also In re Sims*, 534 F.3d 117 (2d Cir. 2008) (failing to recognize the exception); *Doe v. Oberweis Dairy*, 456 F.3d 704 (7th Cir. 2006) (recognizing the exception); *Schoffstall v. Henderson*, 223 F.3d 818 (8th Cir. 2000); *Vanderbilt v. Town of Chilmark*, 174 F.R.D. 225 (D. Mass. 1997).

172. Nelken, *supra* note 168, at 21 n.88 (citing *Equal Employment Opportunity Comm'n v. Danka Indus., Inc.*, 990 F. Supp 1138, 1142 (E.D. Mont. 1997)).

173. Nelken, *supra* note 168, at 25 n.106 (citing *Booker v. City of Boston*, Nos. 97-CV-12534-MEL, 97-CV-12675-MEL, 1999 WL 734644, at *1 (D. Mass. Sept. 10, 1999)).

174. *Id.* (citing *Booker v. City of Boston*, Nos. 97-CV-12534-MEL, 97-CV-12675-MEL, 1999 WL 734644, at *1 (D. Mass. Sept. 10, 1999)).

175. 551 P.2d 334 (Cal. 1976).

176. *See id.* at 342-48.

177. *See United States v. Auster*, 517 F.3d 312 (5th Cir. 2008) (finding the privilege did not apply where the circumstances demonstrate that the patient did not have a reasonable expectation of privacy when his statements were made); *United States v. Glass*, 133 F.3d 1356 (10th Cir. 1998) (recognizing the exception but refusing to apply it where there was no showing of the need for the evidence).

178. *See United States v. Hayes*, 227 F.3d 578 (6th Cir. 2000). In *United States v. Chase*, the court refused to apply the exception, stating, "[t]here is not necessarily a connection between the goals of protection and proof." 340 F.3d 978, 987 (9th Cir. 2003). It noted that if a patient is dangerous at the time of the required disclosure but stable and harmless at the time of trial, "the protection rationale that animates the exception to the states' confidentiality laws no longer applies." *Id.*

179. *Glass*, 133 F.3d 1356.

180. *Id.* at 1357.

and wanted to shoot Bill Clinton and Hilary [sic].”¹⁸¹ Defendant was charged with knowingly and willfully threatening to kill the President in violation of 18 U.S.C. § 871(a).¹⁸²

The defendant moved to exclude Dr. Darbe’s statement on the ground that it was protected from disclosure by the psychotherapist-patient privilege as set forth in *Jaffee*.¹⁸³ Although the court appeared willing to recognize the exception, it applied a case by case balancing test in which it weighed the public good served when communications of this nature are protected from disclosure against the need for the evidence.¹⁸⁴ It refused to allow the exception in the case at hand because it found that the government had not shown a “significant evidentiary need.”¹⁸⁵

This issue was addressed two years later by the Sixth Circuit Court of Appeals in *United States v. Hayes*.¹⁸⁶ The defendant, Roy Lee Hayes, an employee of the U.S. Postal Service, was charged with threatening to murder a federal official, pursuant to 18 U.S.C. § 115,¹⁸⁷ resulting from disclo-

181. *Id.*

182. *Id.* The government argued that the statement was not protected by the privilege but, rather, that it fell within the exception Justice Stevens set forth in footnote nineteen of the opinion, which provides:

Although it would be premature to speculate about most future developments in the federal psychotherapist privilege, we do not doubt that there are situations in which the privilege must give way, for example, if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist.

Id. (citing *Jaffee v. Redmond*, 518 U.S. 1, 18 n.19 (1996)).

183. *Id.*

184. *Glass*, 133 F.3d at 1359.

185. *Id.* The government had argued for the extension of the court’s holding in *United States v. Burtrum* to the present case. *Id.* (citing *United States v. Burtrum*, 17 F.3d 1299 (10th Cir. 1994)). The court distinguished *Burtrum* on the grounds that *Burtrum* was a pre-*Jaffee* case and that it “addressed only the narrow issue [of] whether to recognize the privilege in a criminal child sexual abuse context.” *Id.* The *Burtrum* court held that a balancing test was required in order to protect “this vulnerable segment of society,” concluding “that significant evidentiary need compels the admission of this type of relevant evidence in child sexual abuse prosecutions.” *Id.* at 1356-60 (quoting *United States v. Burtrum*, 17 F.3d 1299, 1302 (10th Cir. 1994)). Finally, the court noted that it had also recognized an exception to the marital communications privilege in cases involving child abuse. *Id.* at 1359. That is, a subset of the public good, the welfare of children, presented the sort of situation *Jaffee* anticipated. *Glass*, 133 F.3d at 1360 (citing *United States v. Bahe*, 128 F.3d 1440 (9th Cir. 1997)). It remanded the case to the district court to determine whether the threat “was serious when it was uttered and whether its disclosure was the only means of averting harm to the President when the disclosure was made.” *Id.*

186. *United States v. Hayes*, 227 F.3d 578 (6th Cir. 2000).

187. 18 U.S.C. § 115(a)(1)(b) (2000) (“Whoever . . . threatens to assault, kidnap, or murder, a United States official . . . with intent to impede, intimidate, or interfere with such official . . . while engaged in the performance of official duties, or with intent to retaliate

tures he made during a therapy session in 1998, which, “outlined in great detail,” his plan to kill his supervisor, Veda Odle.¹⁸⁸ Hayes motioned to suppress the production of his therapist’s records and to exclude his therapist’s testimony on the ground that both were privileged.¹⁸⁹ The district court agreed, and the Sixth Circuit Court affirmed the decision.¹⁹⁰

The Sixth Circuit began its discussion by distinguishing the state law *Tarasoff* duty-to-warn requirement from the psychotherapist-patient privilege.¹⁹¹ It noted the lack of a connection between a therapist’s duty to notify a third person of a patient’s threat to harm him and the psychotherapist-patient privilege, which serves to prohibit a therapist from testifying about the threat in a subsequent prosecution of the patient arising from the act.¹⁹² The court explained that the *Tarasoff* duty serves a more immediate function than the dangerous patient exception and noted that the likelihood of the threat being carried out greatly diminishes, if not evaporates, once court proceedings have begun.¹⁹³ The court held:

[T]he federal psychotherapist/patient privilege does not impede a psychotherapist’s compliance with his professional and ethical duty to protect innocent third parties, a duty which may require, among other things, disclosure to third parties or testimony at an involuntary hospitalization proceeding. Conversely, compliance with the professional duty to protect does not imply a duty to testify against a patient in criminal proceedings or in civil proceedings other

against such official . . . on account of the performance of official duties, shall be punished.”).

188. *Hayes*, 227 F.3d at 580. On the evening of March 31, 1998, Hayes participated in a therapy session with James Edward Van Dyke, a social worker at the Veteran’s Center. *Id.* He described the layout of her home and explained that he knew when she would be at home alone. *Id.*

189. *Id.* at 581.

190. *Id.* at 587. The government argued that the information was admissible under the exception set forth in footnote nineteen of the *Jaffee* opinion. *Id.* at 584. The district court ordered the suppression of Van Dyke’s testimony and Hayes’s medical records and dismissed the case. *Hayes*, 227 F.3d at 581.

191. *Id.* at 583.

192. *Id.*

193. *Id.* at 584. The court noted the paradox involved in cases such as these. *Id.* Although Hayes should be applauded for seeking therapy for his psychotic delusions, he is subject to criminal prosecution because his therapists are required to testify against him. *Id.* Addressing the questions raised by footnote nineteen in the *Jaffee* opinion, the Sixth Circuit believed that this was intended as a means of assuring that the privilege will not operate to impede a therapist’s compliance with the duty to protect third persons from harm and recognized the need for therapists to testify in certain court proceedings, such as those for involuntary commitment of a patient, as part of their duty to protect third persons. *Hayes*, 227 F.3d at 585-86.

than directly related to the patient's involuntary hospitalization, and such testimony is privileged and inadmissible if a patient properly asserts the psychotherapist/patient privilege.¹⁹⁴

B. EXCEPTIONS IN THE STATE COURTS

The trend among the states has been to extend the psychotherapist-patient privilege to a wide variety of mental health professionals while limiting its use through the creation of numerous exceptions.¹⁹⁵ The dangerous patient exception to the psychotherapist-patient privilege has been recognized in Florida and California.¹⁹⁶ California has statutorily recognized this exception and requires therapists to disclose dangerous patients to authorities or intended victims and allows them to testify to threats made during the course of therapy.¹⁹⁷

Twenty jurisdictions recognize the exceptions contained in proposed rule 504 of the Federal Rules of Evidence.¹⁹⁸ In these states, communications between therapists and patients in court proceedings requiring hospitalization, communications during a court-ordered examination of the mental or emotional condition of the patient, or communications when the mental or emotional condition of the patient is an element of a claim or defense

194. *Id.* at 586. The court also addressed the question of whether Hayes had waived the psychotherapist-patient privilege. *Id.* The government argued that Hayes's continued communications made after he was informed by the therapist that he would need to disclose Hayes's threats constituted a waiver of the testimonial privilege—the majority was unconvinced. *Id.* It noted: "It is one thing to inform a patient of the 'duty to protect'; it is quite another to advise a patient that his 'trusted' confidant may one day assist in procuring his conviction and incarceration." *Id.* Since none of his therapists had advised him that they might testify against him, he could not have made a knowing and voluntary waiver of the privilege. *Id.* at 586-87.

195. Glossoff et al., *supra* note 166, at 455.

196. CAL. EVID. CODE § 1024 (West 1995) ("There is no privilege under this article if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger."). Florida also appears to recognize this exception. *See Guerrier v. State*, 811 So. 2d 852, 856 (Fla. Dist. Ct. App. 2002) ("[T]he Legislature intended to allow admission of the psychiatrist's testimony in a subsequent prosecution of the dangerous patient for offenses committed against the victim.").

197. CAL. EVID. CODE § 1024.

198. Karen L. Ross, *Revealing Confidential Secrets: Will It Save Our Children?*, 28 STETSON L. REV. 963, 971 (2000).

are not privileged.¹⁹⁹ Virtually all states have exceptions to the psychotherapist-patient privilege in cases involving child abuse and neglect.²⁰⁰

One study reports that the most frequently cited to the least frequently cited exceptions to the psychotherapist-patient privilege are:

(a) in cases involving a dispute between counselor and client; (b) when a client raises the issue of mental condition in legal proceedings; (c) when a client's condition poses a danger to self or others; (d) in cases involving child abuse or neglect (in addition to mandated reporting laws); (e) when the counselor has knowledge that the client is contemplating the commission of a crime; (f) in cases involving court ordered psychological evaluations; (g) in cases involving involuntary hospitalization proceedings; (h) when the counselor has knowledge that a client has been the victim of a crime; and (i) in cases involving harm to vulnerable adults.²⁰¹

Some states employ very broad and generalized exceptions to the privilege, abrogating the privilege when the confidential information is "essential to the court proceeding"²⁰² or when "disclosure is necessary to a proper administration of justice."²⁰³

C. EXCEPTIONS IN CHILD CUSTODY CASES

The best interest of the child standard is the generally accepted standard applied by courts to resolve child custody disputes resulting from the dissolution of a marriage.²⁰⁴ The Uniform Marriage and Divorce Act has had an important influence on the statutes of many jurisdictions. Section 402 of the Act speaks to the best interest of the child and provides:

The court shall determine custody in accordance with the best interest of the child. The court shall consider all relevant factors including:

199. Rules of Evidence for the United States Courts and Magistrates, 56 F.R.D. 183, 241 (1972).

200. Glossoff et al., *supra* note 166, at 456.

201. *Id.* at 455.

202. *See, e.g.*, N.H. REV. STAT. ANN. § 330-A:19 (LexisNexis 2003).

203. N.C. GEN. STAT. § 8-53.3 (2007).

204. The best interest of the child also comes into play in termination of parental rights cases stemming from allegations of child abuse and neglect. *See* Deborah Paruch, *The Orphaning of Underprivileged Children: America's Failed Child Welfare Law & Policy*, 8 J.L. & FAM. STUD. 119, 148-63 (2006).

- (1) the wishes of the child's parent or parents as to his custody;
- (2) the wishes of the child as to his custodian;
- (3) the interaction and interrelationship of the child with his parent or parents, his siblings, and any other person who may significantly affect the child's best interest;
- (4) the child's adjustment to his home, school and community; and
- (5) the mental and physical health of all individuals involved.

The court shall not consider conduct of a proposed custodian that does not affect his relationship to the child.²⁰⁵

205. UNIF. MARRIAGE AND DIVORCE ACT § 402 (1973). Many other states' statutes include other factors for the courts' consideration, including "the capacity and disposition of the parties involved to give the child love, affection and guidance." *See, e.g.*, MICH. COMP. LAWS ANN. § 722.23 (West 2002). Section 722.23 of the Michigan Code sets out the following factors to be considered:

As used in this act, "best interests of the child" means the sum total of the following factors to be considered, evaluated, and determined by the court:

- (a) The love, affection, and other emotional ties existing between the parties involved and the child.
- (b) The capacity and disposition of the parties involved to give the child love, affection, and guidance and to continue the education and raising of the child in his or her religion or creed, if any.
- (c) The capacity and disposition of the parties involved to provide the child with food, clothing, medical care or other remedial care recognized and permitted under the laws of this state in place of medical care, and other material needs.
- (d) The length of time the child has lived in a stable, satisfactory environment, and the desirability of maintaining continuity.
- (e) The permanence, as a family unit, of the existing or proposed custodial home or homes.
- (f) The moral fitness of the parties involved.
- (g) The mental and physical health of the parties involved.
- (h) The home, school, and community record of the child.
- (i) The reasonable preference of the child, if the court considers the child to be of sufficient age to express preference.
- (j) The willingness and ability of each of the parties to facilitate and encourage a close and continuing parent-child relationship between the child and the other parent, or the child and the parents.
- (k) Domestic violence, regardless of whether the violence was directed against or witnessed by the child.
- (l) Any other factor considered by the court to be relevant to a particular child custody dispute.

Id.

This standard, under which a wide array of evidence may be relevant, has led to a tradition of liberal admissibility of evidence in child custody proceedings.²⁰⁶ Accordingly, family court judges presiding over disputed child custody actions frequently order disclosure of confidential information obtained in psychotherapy on the grounds that it is helpful in determining the best interest of the child.²⁰⁷ This evidence comes in through the admission of patient treatment records or the compelled testimony of the treating therapist.²⁰⁸ Additionally, judges will often order psychological evaluations of the parties.²⁰⁹ However, since court-ordered evaluations are not treatment and are performed with the understanding that the results of the evaluation will be provided to the court, they are not subject to the psychotherapist-patient privilege on the grounds that there is no expectation of confidentiality.²¹⁰

Not all courts automatically abrogate the psychotherapist-patient privilege in child custody actions, although the protection of this privilege varies among jurisdictions. In *Kinsella v. Kinsella*,²¹¹ the Supreme Court of New Jersey held that the psychotherapist-patient privilege should be pierced only in the most compelling of circumstances.²¹² It ruled that the proponent of the evidence must demonstrate a legitimate need for the evidence and that the evidence is both relevant and material to the question before the court.²¹³ The proponent must also demonstrate, by a preponderance of the evidence, that the information cannot be obtained from other less-intrusive sources.²¹⁴ In this case, which involved allegations of domestic violence and substance abuse, the trial court found that the husband's admissions to his therapist were relevant and material to the issues before the court.²¹⁵

206. AM. PSYCHIATRIC ASS'N, TASK FORCE REPORT 31: DISCLOSURE OF PSYCHIATRIC TREATMENT RECORDS IN CHILD CUSTODY DISPUTES I (1991), available at http://archive.psych.org/edu/other_res/lib_archives/archives/tfr/TFR31.pdf.

207. *Id.*

208. *Id.*

209. *Id.* at 4.

210. See, e.g., *In re Alethea W.*, 747 A.2d 736, 739 (Md. Ct. Spec. App. 2000) (explaining that since court ordered psychological examinations are performed for the benefit of the court and not the individual and with the understanding that no privilege of confidentiality applies, the purpose of the privilege, which is to aid in providing effective treatment by encouraging free and open communication between the therapist and the patient, is not served and, accordingly, does not apply).

211. *Kinsella v. Kinsella*, 696 A.2d 556 (N.J. 1997); see also *In re Matthew R.*, 688 A.2d 955, 962 (Md. Ct. Spec. App. 1997) ("The benefits to society of having confidential and privileged treatment available to troubled parents far outweighs the limitations placed upon the court by not having such information revealed.").

212. *Kinsella*, 696 A.2d at 584.

213. *Id.* at 572.

214. *Id.*

215. *Id.* at 583-84.

However, the supreme court reversed and remanded the case to the trial court to consider whether other sources of information were available to allow for proper adjudication of the child custody matter without disclosure of the father's therapy records.²¹⁶ It noted:

Made public and taken out of context, the disclosure of notes from therapy sessions could have devastating personal consequences for the patient and his or her family, and the threat of such disclosure could be wielded to unfairly influence settlement negotiations or the course of litigation. Especially in the context of matrimonial litigation, the value of the therapist-patient relationship and of the patient's privacy is intertwined with one of the most important concerns of the courts—the safety and well-being of children and families. Therefore, only in the most compelling circumstances should the courts permit the privilege to be pierced.²¹⁷

Many jurisdictions apply a case by case balancing approach in which the policies in favor of the privilege are weighed against the need for disclosure.²¹⁸ Massachusetts provides for the abrogation of the psychotherapist-patient privilege. The Massachusetts statute provides, in relevant part:

In any case involving child custody . . . in which . . . the judge, in the exercise of his discretion, determines that the psychotherapist has evidence bearing significantly on the patient's ability to provide suitable care or custody, and that it is more important to the welfare of the child that the communication be disclosed than that the relationship between patient and psychotherapist be protected.²¹⁹

Sometimes the decision to abrogate the privilege occurs only after a court's *in camera* review of the evidence for relevancy.²²⁰

216. *Id.* at 584.

217. *Id.*

218. *See* Von Goyt v. State Dept. of Pensions and Sec., 461 So. 2d 821, 823 (Ala. Civ. App. 1984) (“[Where a] proper resolution of a child custody issue requires disclosure of privileged medical records, the psychologist-patient privilege must yield.”); *Cabrera v. Cabrera*, 580 A.2d 1227, 1233 (Conn. App. Ct. 1990) (stating that the party seeking admission of evidence subject to the psychotherapist-patient privilege must demonstrate to the court that justice requires admission of the evidence).

219. MASS. GEN. LAWS ANN. ch. 233, § 20B(e) (West 2000 & Supp. 2009).

220. *See, e.g.,* *Morey v. Peppin*, 353 N.W.2d 179, 183 (Minn. Ct. App. 1984) (noting that before disclosing therapy records, the court is required to review the records *in camera* in order “to prevent disclosures that are irrelevant to the custody question or otherwise an-

Conversely, some jurisdictions offer little protection for the psychotherapist-patient privilege in child custody cases, setting the threshold for piercing the psychotherapist-patient privilege extraordinarily low. These jurisdictions, which include Indiana, Louisiana, and Kentucky, have held that the psychotherapist-patient privilege is waived once a parent petitions for custody of children in a divorce action.²²¹ Other jurisdictions, such as Missouri, abrogate the privilege in child custody actions once allegations of child abuse or neglect are made.²²²

The reliance that family court judges frequently place on psychological evidence in child custody matters is demonstrated by recent studies. One study asked judges to rank the importance of eleven different types of evidence in disputed child custody cases on a scale of one to nine.²²³ The results show that the judges considered testimony or reports from a court-appointed psychologist as one of the most important sources of information, rating it a 6.49, or the fourth most important out of the eleven items.²²⁴ Only the desires of older children, court ordered custody investigation reports, and the testimony of the parties were given higher values.²²⁵ The judges found this psychological evidence to have greater value than the testimony of school personnel, the desires of younger children, or the testimony of

noying, embarrassing, oppressive, or unduly burdensome”), *rev'd on other grounds*, 375 N.W.2d 19 (Minn. 1985).

221. See, e.g., *Owen v. Owen*, 563 N.E.2d 605 (Ind. 1990); *Atwood v. Atwood*, 550 S.W.2d 465 (Ky. 1976); *Kirkley v. Kirkley*, 575 So. 2d 509 (La. Ct. App. 1991). But see *Clark v. Clark*, 371 N.W.2d 749 (Neb. 1985) (stating that since seeking custody “does not result in making relevant the information contained in the file cabinets of every psychiatrist who has ever treated the litigant,” a court must review evidence *in camera* for relevance before disclosure).

222. Gale Humphrey Carpenter, *Overriding the Psychologist-Client Privilege in Child Custody Disputes: Are Anyone's Best Interests Being Served?*, 68 UMKC L. REV. 169, 170 (1999).

223. Thomas J. Reidy, Richard M. Silver & Alan Carlson, *Child Custody Decisions: A Survey of Judges*, 23 FAM. L.Q. 75 (1989). The researchers distributed questionnaires to superior court judges in the State of California. *Id.* at 76. One hundred fifty-six responses were received. *Id.* The questionnaire covered several aspects of a child custody dispute, including sources of evidence. *Id.* at 78. The types of evidence the judges were asked to rank were: (1) the desires of children, age 15; (2) custody investigation reports; (3) testimony of the parties; (4) reports from court-appointed psychologists; (5) testimony of school personnel; (6) the desires of children, age 10; (7) reports from psychologists retained by a party; (8) testimony of extended family members; (9) recommendations of attorneys; (10) testimony of friends; and (11) the desires of children, age 5. *Id.* at 78-79 & tbl.2. In addition to court-appointed psychologists, judges considered the testimony of the parties and the wishes of older children as the most important sources of information. *Id.* at 78. The judges gave the highest rating, 7.33, to the desires of children over the age of 15 and the lowest rating, 4.79, to the desires of children age 5 and under. Reidy, Silver & Carlson, *supra* at 79 tbl.2.

224. *Id.*

225. *Id.*

extended family members or friends.²²⁶ The judges also considered psychological testimony from a therapist employed by one of the parents to have greater value than the recommendations of attorneys or the testimony of extended family members or friends.²²⁷

Shuman and Weiner also reported on the significant reliance that judges place on psychological evidence in family law cases.²²⁸ They reported that the judges responding to their questionnaires indicated that testimony from psychologists was most frequently sought in family law cases.²²⁹ This may be due to the fact that the stakes are high in these types of proceedings. In fact, judges reported that there is no more difficult decision to make than one involving a child custody determination.²³⁰

Responding to the growing trend of the use of psychological evidence by family court judges, the American Psychiatric Association formed a task force to study the practice of judicially compelled disclosure of this type of information in child custody disputes. Its report, entitled *Disclosure of Psychiatric Treatment Records in Child Custody Disputes*, was issued in 1991.²³¹ The association recommends that courts draw a “sharp distinction . . . between the typical divorce custody proceeding and the relatively uncommon divorce case in which a parent’s capacity to care adequately for

226. *Id.*

227. *Id.* The overall ratings of the judges, on a scale of one to nine, with nine meaning “extremely important” and one meaning “not at all important,” were as follows:

- Desires of children, age 15 – 7.33
- Custody investigation reports – 6.87
- Testimony of the parties – 6.60
- Court-appointed psychologists – 6.49
- Testimony of school personnel – 5.45
- Desires of children, age 10 – 4.79
- Psychologists retained by one attorney – 4.50
- Testimony of extended family – 4.37
- Recommendations of attorneys – 3.94
- Testimony of friends – 3.92
- Desires of children, age 5 – 2.82

Id. The authors comment that this difference may be attributable to differing theoretical approaches to child custody determinations. Reidy, Silver & Carlson, *supra* note 223, at 79. They note that mental health professionals who differ in their opinions may be viewed as “hired guns” when their differences are actually the result of “honest theoretical disputes.” *Id.* at 80. The authors suggest that judges be better educated regarding the differing theoretical approaches to child custody determinations along with recent research findings. *Id.*

228. *Privilege Study I, supra* note 107, at 927; *Privilege Study III, supra* note 107, at 409, 411.

229. *Privilege Study I, supra* note 107, at 927; *Privilege Study III, supra* note 107, at 409, 411.

230. Reidy, Silver & Carlson, *supra* note 223, at 75.

231. AM. PSYCHIATRIC ASS’N, *supra* note 206, at 1.

the child because of 'emotional instability' is at issue."²³² The association opposes any judicially compelled disclosure of confidential information obtained in psychotherapy in child custody actions absent a finding that a parent that has received psychotherapy is currently unable to provide adequate care for the child.²³³ This initial finding must be supported by substantial, "reliable independent evidence of [mental or emotional] impairment."²³⁴ The association suggests that courts consider the following criteria in evaluating whether the disclosure of this confidential information will assist the court in rendering a decision as to the parent's ability to adequately care for the child: (1) the gravity of the psychiatric disorder and the type of treatment, (2) the "recency/chronicity" of the treatment, and (3) whether the information can be obtained from other sources, including a court-ordered evaluation by an independent therapist.²³⁵

Other questions arise regarding the use of psychological evidence in child custody determinations independent of the psychotherapist-patient privilege. These concerns principally focus on the reliability of this type of social science evidence. One major concern centers on the use of the best interest of the child standard and the lack of empirical findings in support of it. Some authors contend that empirical findings on the best interest of the child are "nonexistent."²³⁶ Other commentators have criticized the use of various forms of psychological evidence on the grounds that it falls far short of the current requirements for expert evidence set forth in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*²³⁷ and its progeny.²³⁸ Nonetheless,

232. *Id.*

233. *Id.* at 3.

234. *Id.* at 4.

235. *Id.* at 3-4.

236. Sheila Rush Okpaku, *Psychology: Impediment or Aid in Child Custody Cases?*, 29 RUTGERS L. REV. 1117, 1140 (1976). However, as one author put it, the best interest test assumes that mental health professionals have a reliable basis for deciding these questions that judges and attorneys lack. Daniel W. Shuman, *What Should We Permit Mental Health Professionals to Say About "The Best Interests of the Child"?: An Essay on Common Sense, Daubert, and the Rules of Evidence*, 31 FAM. L.Q. 551, 565-66 (1997).

237. *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993). *Daubert* requires courts serve a "gatekeeping role" when determining whether to admit expert evidence. *Id.* at 597. Courts are required to examine the validity or reliability of the evidence, the degree to which the evidence "fits" the facts and issues of the case, and whether the evidence will confuse the issues or mislead the jury. MUELLER & KIRKPATRICK, *supra* note 2, § 7.17, at 652. In determining whether the expert evidence is reliable, the *Daubert* Court instructed lower courts to consider: (1) whether the evidence has been subjected to peer review, (2) whether the technique or theory has been tested, (3) error rates, and (4) the degree of acceptance in the scientific community. *Daubert*, 509 U.S. at 593-94. These are not all-inclusive factors, but they serve as a guideline for the trial courts. MUELLER & KIRKPATRICK, *supra* note 2, § 7.17, at 653.

In *Kunho Tire Co. v. Carmichael*, the Court held that *Daubert* was not limited to scientific evidence but applies to all forms of expert testimony. 526 U.S. 137 (1999). The

judges freely welcome these experts' advice and recommendations and routinely request that mental health professionals render opinions on the ultimate issue in child custody proceedings.²³⁹

D. EXCEPTIONS IN CHILD PROTECTION PROCEEDINGS

All of the concerns addressed above with respect to child custody determinations are present in proceedings involving the termination of parental rights, but to a much greater extent. Mental health professionals are routinely asked to testify in these proceedings and are asked to render an opinion on the ultimate issues in the case—whether the parent is a *fit* parent and whether it would be in the best interest of the child for parental rights to be terminated.²⁴⁰

Court further instructed that lower courts have “broad latitude” not just in determining whether evidence is reliable but also in deciding “how to determine reliability.” *Id.* at 152.

238. Professor Shuman challenges decisions that have held it to be appropriate to apply less-rigorous standards in scrutinizing behavioral or social science evidence because its knowledge base is less exacting. Shuman, *supra* note 236, at 559-64. He notes that the logic is “curious, at best,” and he argues that lowering the bar for admissibility of this type of evidence “demeans the knowledge base of the entirety of behavioral and social sciences and accepts wholesale the criticism that they are soft science.” *Id.* at 563. He further argues that this approach ignores or demeans the rigorous research that is conducted in the fields of psychology or psychiatry. *Id.* For an excellent discussion and analysis of social science research and the family law field, see Sarah H. Ramsey & Robert F. Kelly, *Social Science Knowledge in Family Law Cases: Judicial Gate-Keeping in the Daubert Era*, 59 U. MIAMI L. REV. 1 (2004). An example of what some would refer to as “junk science” in the courtroom is the case where a mother lost custody of her children in a disputed custody action because the court relied upon the testimony of a mental health professional who was allowed to opine that there was a “statistical probability” that her “own emotional trauma and victimization could be projected onto the children.” See *Branson v. Branson*, 411 N.W.2d 395, 400 (N.D. 1987).

239. A survey of Michigan judges demonstrated that eighty-four percent of the judges believed that custody evaluators should give recommendations to the court. James N. Bow & Francella A. Quinnell, *Critique of Child Custody Evaluations by the Legal Profession*, 42 FAM. CT. REV. 115, 121 (2004). This is in contrast to the view of mental health professionals who uniformly believe that they should refrain from rendering opinions on the ultimate issue in a case. GARY B. MELTON ET AL., *PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS & LAWYERS* § 1.04, at 17 (2d ed. 1997).

240. See *infra* notes 284-88 and accompanying text; see also *In re Hamlet*, 571 N.W.2d 750, 754 (Mich. Ct. App. 1997) (recounting the testimony of mental health professionals and their opinions as to the ultimate issue in the case), *rev'd on other grounds*, *In re Trejo*, 612 N.W.2d 407 (Mich. 2000).

All fifty states recognize a psychotherapist-patient privilege,²⁴¹ though it is routinely abrogated in these child protection proceedings. Many states, including New York, Florida, and California, abrogate the privilege completely in child protection proceedings.²⁴² Other states, such as Maryland, appear to draw a distinction between court ordered psychological evaluations and other treatment, abrogating the privilege in the former instance provided the communications are made by the patient after being informed of the absence of a privilege in the course of a court-ordered examination.²⁴³ Alaska follows the Maryland approach and abrogates the privilege in child protection proceedings but only as to court ordered psychological evaluations.²⁴⁴ In *State v. R.H.*,²⁴⁵ the Alaska Court of Appeals explained:

241. Harriet L. Glossoff, Barbara Herlihy & E. Berton Spence, *Privileged Communication in the Counselor-Client Relationship*, 78 J. COUNSELING & DEV. 454, 458 (2000). The authors also provide a chart that identifies the exceptions to the psychotherapist-patient privilege in all fifty states. *Id.*

242. See, e.g., N.Y. SOC. SERV. LAW § 384-b(3)(h) (McKinney 2003 & Supp. 2009) (“In any proceeding brought upon a ground set forth in paragraph (c) of subdivision four, neither the privilege attaching to confidential communications between husband and wife, as set forth in section forty-five hundred two of the civil practice law and rules, nor the physician-patient and related privileges, as set forth in section forty-five hundred four of the civil practice law and rules, nor the psychologist-client privilege, as set forth in section forty-five hundred seven of the civil practice law and rules, nor the social worker-client privilege, as set forth in section forty-five hundred eight of the civil practice law and rules, shall be a ground for excluding evidence which otherwise would be admissible.”); E.H. v. Dep’t of Health & Rehab. Serv., 443 So. 2d 1083 (Fla. Dist. Ct. App. 1984) (interpreting the statute as abrogating the privilege); see also CAL. EVID. CODE § 1012 (West 1995) (permitting disclosure of communications between psychotherapists and patients to “those to whom disclosure is reasonably necessary for . . . the accomplishment of the purpose for which the psychotherapist is consulted”); MO. ANN. STAT. § 211.459.4 (West 2004) (recognizing only the priest-penitent and attorney-client privilege in termination of parental rights proceedings).

243. MD. CODE ANN., CTS. & JUD. PROC. § 9-109 (LexisNexis 2006) (“Unless otherwise provided, in all judicial, legislative, or administrative proceedings, a patient or the patient’s authorized representative has a privilege to refuse to disclose, and to prevent a witness from disclosing . . . [c]ommunications relating to diagnosis or treatment of the patient[’s mental or emotional disorder] There is no privilege if . . . [a] judge finds that the patient, after being informed there will be no privilege, makes communications in the course of an examination ordered by the court and the issue at trial involves his mental or emotional disorder”); see also *In re Alethea W.*, 747 A.2d 736, 739 (Md. Ct. Spec. App. 2000) (explaining that since court ordered psychological services are performed for the benefit of the court and not the individual, the purpose of the privilege, which is to aid in providing effective treatment, is not served).

244. ALASKA R. EVID. 504(d)(5)-(6) (providing exceptions to the physician-patient and psychotherapist-patient privileges). Alaska Rule of Evidence 504(d) states, in relevant part:

(d) Exceptions. There is no privilege under this rule:

....

(5) *Required Report.* As to information that the physician or psychotherapist or the patient is required to report to a public em-

In a court ordered examination, the relationship is likely to be an arm's length one though not necessarily so. In any event, an exception is necessary for the effective utilization of this important and growing procedure. When the psychotherapist is appointed by the court, it is most often for the purpose of having the psychotherapist testify concerning his conclusions as to the patient's condition. . . . The exception, it will be observed, deals with a court ordered examination rather than with a court appointed physician or psychotherapist. Also, the exception is effective only with respect to the particular purpose for which the examination is ordered.²⁴⁶

Wisconsin does not recognize an exception to the psychotherapist-patient privilege in proceedings involving termination of parental rights.²⁴⁷

Some courts have been willing to allow the privilege to stand, acknowledging that the purpose of the psychotherapist-patient privilege is to promote confidentiality, which ultimately enables more successful treatment.²⁴⁸ In a 2000 parental rights termination case, the Supreme Court of

ployee, or as to information required to be recorded in a public office, if such report or record is open to public inspection

(6) *Examination by Order of Judge*. As to communications made in the course of an examination ordered by the court of the physical, mental or emotional condition of the patient, with respect to the particular purpose for which the examination is ordered unless the judge orders otherwise. This exception does not apply where the examination is by order of the court upon the request of the lawyer for the defendant in a criminal proceeding in order to provide the lawyer with information needed so that the lawyer may advise the defendant whether to enter a plea based on insanity or to present a defense based on the defendant's mental or emotional condition.

Id.

245. *State v. R.H.*, 683 P.2d 269 (Alaska Ct. App. 1984) (holding that Alaska's mandatory child abuse reporting law did not abrogate the psychotherapist-patient privilege in criminal proceedings).

246. *Id.* at 275 (quoting ALASKA R. EVID. 504(d) commentary).

247. *See In re Joy P.*, 546 N.W.2d 494, 498 (Wis. Ct. App. 1996).

248. *In re Wieland*, 733 N.E.2d 1127 (Ohio 2000). In this case, a mother, as part of a case service plan, was ordered into substance abuse treatment. *Id.* at 1128-29. The juvenile court ordered her treatment records should be disclosed despite the mother's objection that she had not waived her privilege. *Id.* at 1129. The government argued that the purpose of the privilege was undermined when the mother did not voluntarily enter treatment. *Id.* The court held that the psychotherapist-patient privilege still applied to communications made during treatment ordered as part of a case service plan. *Id.* at 1131.

Ohio refused to abrogate the privilege.²⁴⁹ In refusing to do so, it recognized the concerns that are present in situations involving mandated treatment under court ordered reunification plans, stating, “In other words, if a parent is fearful that any communications with her provider will not be privileged, she may not be open and truthful during treatment, thereby undermining the effectiveness of treatment and ultimately defeating the goal of remedying the reason for removal of the child.”²⁵⁰ Nevertheless, a mere seven months after this decision was handed down, the Ohio legislature amended the privilege statutes, abrogating the privileges for mental health professionals involved in these proceedings.²⁵¹

Michigan has abrogated all privileges in child protection proceedings except for the attorney-client privilege and the clergy privilege. Section 722 of the Michigan Compiled Laws provides:

Any legally recognized privileged communication except that between attorney and client or that made to a member of the clergy in his or her professional character in a confession or similarly confidential communication is abrogated and shall not constitute grounds for excusing a report otherwise required to be made or for excluding evidence in a civil child protective proceeding resulting from a report made pursuant to this act.²⁵²

The Michigan Supreme Court has interpreted this statute broadly, holding that testimony by a respondent mother’s treating psychologist and psychiatrist was admissible in a child protection proceeding even though the testimony was related to treatment she received prior to the filing of a petition alleging child abuse and neglect.²⁵³ It noted, “the purpose of a child protective proceeding is to protect the welfare of the child. It is in the best

249. *Id.*

250. *In re Wieland*, 733 N.E.2d at 1131 (quoting *In re Wieland*, No. 17646, 1999 WL 961154, at *3 (Ohio Ct. App. July 9, 1999)).

251. See OHIO REV. CODE ANN. § 2317.02(B)(1)(b), (G)(1)(g) (LexisNexis 2005 & Supp. 2009). The statute creates exceptions to the privilege for licensed independent social workers and licensed psychologists who testify in civil actions concerning court-ordered treatment or services received by a patient if the court-ordered treatment or services were ordered as part of a case service plan in a child protection proceeding. *Id.* The exception also applies when the court-ordered treatment or services are necessary or relevant to dependency, abuse or neglect, or permanent custody proceedings. *Id.*

252. MICH. COMP. LAWS ANN. § 722.631(11) (West Supp. 2008) (“This section does not relieve a member of the clergy from reporting suspected child abuse or child neglect under section 3 [mandatory reporting requirements] if that member of the clergy receives information concerning suspected child abuse or child neglect while acting in any other capacity listed under section 3.”).

253. *In re Brock*, 499 N.W.2d 752 (Mich. 1993).

interests of all parties for the fact finder to be in possession of all relevant information regarding the welfare of the child.”²⁵⁴

E. THE NATURE OF PSYCHOLOGICAL EVIDENCE IN TERMINATION OF PARENTAL RIGHTS PROCEEDINGS

Termination of parental rights proceedings vary slightly by jurisdiction, but they are all governed by state law that is influenced by federal statutes, principally by the Adoption and Safe Families Act.²⁵⁵ Child abuse and neglect proceedings are civil actions that consist of a series of hearings that either conclude in dismissal of the action (and return of the child to the parents’ custody) or termination of parental rights.²⁵⁶ Michigan’s child protection laws are presented in this section for illustration.

Child protection proceedings originate with the filing of a petition by the state child welfare agency in the family division of the circuit court.²⁵⁷

254. *Id.* at 761 (citation omitted). Even though there is no psychotherapist-patient privilege in child protection proceedings, court-appointed therapists or the social service agency monitoring the case will often require respondents in these proceedings to sign waivers of the privilege. This can then turn what would otherwise be privileged information in other proceedings into discoverable and admissible evidence. This is illustrated in *People v. Ackley* where the defendant was referred to therapy by Child Protective Services as part of his case service plan. No. 185904, 1997 WL 33353599, at *1 (Mich. App. Mar. 7, 1997). His psychologist, Laura Nardi, obtained a signed waiver from him at the outset of therapy that stated in part: “Your therapist may be called to testify in court. Under oath, he or she can be ordered by a Judge to answer any questions an attorney asks.” *Id.* The form also indicated, “Your therapist is required by law to report any case of child abuse you tell him or her about.” *Id.* In his criminal trial, the court admitted testimony by Defendant’s therapist that he had admitted to committing acts of sexual abuse. *Id.* As a result, he was convicted of two counts of first degree criminal sexual conduct involving his nine year old daughter. *Id.* He appealed and objected to the admission of the testimony of this therapist on the grounds of privilege. *Id.* The court found that the signed form constituted a clear waiver of his privilege and that he could have expected that any statements he made after signing the form could be the subject of later testimony. *Ackley*, 1997 WL 33353599, at *1. The court also noted that the “[d]efendant was in no way coerced to sign the statements or to attend the counseling sessions, even though he cooperated in the hope of keeping his family together.” *Id.*

255. Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, 111 Stat. 2115 (codified as amended in scattered sections of 42 U.S.C.).

256. *See infra* notes 258-73 and accompanying text.

257. *See, e.g.*, MICH. CT. R. 3.961. This article will use the State of Michigan’s statutory scheme to explain these proceedings. In Michigan, the Department of Human Services is required to submit a petition in certain enumerated situations, including child abandonment, criminal sexual conduct, or “battering, torture, or other severe physical abuse.” MICH. COMP. LAWS ANN. § 722.638 (West 2002). Section 722.638 of the Michigan Compiled Laws provides, in relevant part:

(1) The department shall submit a petition for authorization by the court under section 2(b) of chapter XIA of 1939 PA 288, MCL 712A.2, if 1 or more of the following apply:

State agencies are required by statute to file a petition in cases of physical and sexual abuse, but these agencies will routinely request court intervention for less serious risks.²⁵⁸ Following the filing of a petition, a Michigan court will take jurisdiction over a child if it finds that a child is neglected or is subject to a substantial risk of harm.²⁵⁹ Nationwide, the vast majority of children who are removed from their homes and placed in foster care are done so as a result of parental neglect related to poverty.²⁶⁰

(a) The department determines that a parent, guardian, or custodian, or a person who is 18 years of age or older and who resides for any length of time in the child's home, has abused the child or a sibling of the child and the abuse included 1 or more of the following:

- (i) Abandonment of a young child.
- (ii) Criminal sexual conduct involving penetration, attempted penetration, or assault with intent to penetrate.
- (iii) Battering, torture, or other severe physical abuse.
- (iv) Loss or serious impairment of an organ or limb.
- (v) Life threatening injury.
- (vi) Murder or attempted murder.

(b) The department determines that there is risk of harm to the child and either of the following is true:

- (i) The parent's rights to another child were terminated as a result of proceedings under section 2(b) of chapter XIIA of 1939 PA 288, MCL 712A.2, or a similar law of another state.
- (ii) The parent's rights to another child were voluntarily terminated following the initiation of proceedings under section 2(b) of chapter XIIA of 1939 PA 288, MCL 712A.2, or a similar law of another state.

Id.

258. *Id.*

259. MICH. COMP. LAWS ANN. § 712A.2(b) (West 2002). The following two conditions are the most frequently cited by the courts:

(1) [A child whose] parent or other person legally responsible for the care and maintenance of the juvenile, when able to do so, neglects or refuses to provide proper or necessary support, education, medical, surgical, or other care necessary for his or her health or morals, who is subject to a substantial risk of harm to his or her mental well-being, who is abandoned by his or her parents, guardian, or other custodian, or who is without proper custody or guardianship.

(2) [A child whose] home or environment, by reason of neglect, cruelty, drunkenness, criminality, or depravity on the part of a parent, guardian, nonparent adult, or other custodian, is an unfit place for the juvenile to live in.

Id.

260. DUNCAN LINDSEY, *THE WELFARE OF CHILDREN* 143 (1994); Martin Guggenheim, *Somebody's Children: Sustaining the Family's Place in Child Welfare Policy*, 113 HARV. L. REV. 1716, 1720 & n.83 (2000) (explaining that the children that are currently removed from their homes due to alleged abuse and neglect are disproportionately poor and nonwhite and come from single family households); Dorothy E. Roberts, *Is There Justice in*

On the national level, the Adoption and Safe Families Act requires that a state agency perform “reasonable efforts” to prevent the unnecessary dissolution of families.²⁶¹ The Act lists the following objectives:

(A) protecting and promoting the welfare of . . . neglected children; (B) preventing or remedying, or assisting in the solution of problems which may result in . . . neglect . . . ; (C) preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems, and preventing breakup of the family where the prevention of child removal is desirable and possible; [and] (D) restoring to their families children who have been removed, by the provision of services to the child and the [family] . . .
²⁶²

In conjunction with the requirements of the Act, once a court has taken jurisdiction over a child, the court will conduct a dispositional hearing in which it reviews a case service plan prepared by the child protection agency.²⁶³ This plan sets forth the services to be provided to the families and the conditions that must be met before a child will be returned to the parent’s custody.²⁶⁴ One condition that is routinely included in an agency’s case service plan is the requirement that a parent undergo a psychological evaluation and participate in therapy.²⁶⁵

The dispositional hearing is followed by a series of hearings at which time the court reviews the case service plan and agency reports and may take testimony from the parents, children, foster parents, agency caseworkers, and others.²⁶⁶ The objective of these hearings is to “determine the extent of progress made toward alleviating or mitigating the conditions that caused the child to be placed in foster care.”²⁶⁷ A parent’s compliance with

Children’s Rights? The Critique of Federal Family Preservation Policy, 2 U. PA. J. CONST. L. 112, 119 (1999).

261. Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, 94 Stat. 500.

262. *Id.* The Adoption Assistance and Child Welfare Act of 1980, which adopted these purposes, was the governing federal law dealing with child abuse and neglect until the passage of the Adoption and Safe Families Act of 1997.

263. *Id.*

264. *See, e.g.*, MICH. CT. R. 3.923(b).

265. *Id.*

266. MICH. CT. R. 3.975.

267. *Id.* Michigan law also provides for a Permanency Planning Hearing, which is required to be held within twelve months after a child has been removed from her home. MICH. COMP. LAWS ANN. § 712A.19a(1) (West 2002 & Supp. 2008); *see also* MICH. CT. R. 3.976 (setting forth the required procedures). The purpose of this hearing is to review the child’s situation and the progress that has been made toward the child’s return home. *See*

the agency case service plan is viewed as critical to this determination.²⁶⁸ Consequently, a parent's failure to participate or to make progress in court-ordered therapy required as part of the case service plan will be viewed by the court as evidence of a substantial risk of harm to a child.²⁶⁹

If the court believes that sufficient progress has not been made toward allowing the child to safely return home, it will hold a Termination of Parental Rights Hearing.²⁷⁰ Following the hearing, the court will order the termination of parental rights if it finds by clear and convincing evidence that a statutory ground for termination exists²⁷¹ and that termination of parental rights is in the child's best interest.²⁷²

MICH. COMP. LAWS ANN. § 712A.19a (West 2002 & Supp. 2008). This hearing differs from a review hearing in that following a permanency planning hearing if the court determines that the child is not able to safely return home, it may order the child protection agency to begin proceedings to terminate parental rights. *Id.* § 712A.19a(6).

268. *Id.* § 712A.19a(5) (“[T]he court shall view the failure of the parent to substantially comply with the terms and conditions of the case service plan prepared under . . . this chapter as evidence that the return of the child to his or her parent would cause a substantial risk of harm to the child’s life, physical health, or mental well-being.”).

269. *Id.*

270. This hearing is held following the filing of an original, amended, or supplemental petition by the agency, the child, or the guardian, legal custodian, or representative of the child. MICH. CT. R. 3.977. The petition may also be brought by a “concerned person” (which is a specifically defined term in section 712A.19b of the Michigan Code), the state children’s ombudsman, or the prosecuting attorney. MICH. COMP. LAWS ANN. § 712A.19b (West 2002). The burden of proof is on the party seeking by court order to terminate the rights of the parent over the child. MICH. CT. R. 3.977(A)(3); *see also In re Trejo*, 612 N.W.2d 407, 413 (Mich. 2000). There is no right to a jury trial. MICH. CT. R. 3.977(A)(3).

271. MICH. COMP. LAWS ANN. § 712A.19b(3) (West 2002). Section 712A.19(b) of the Michigan Compiled Laws provides, in part:

The court may terminate a parent’s parental rights to a child if the court finds, by clear and convincing evidence, 1 or more of the following:

(a) The child has been deserted under any of the following circumstances:

(i) The child’s parent is unidentifiable, has deserted the child for 28 or more days, and has not sought custody of the child during that period. For the purposes of this section, a parent is unidentifiable if the parent’s identity cannot be ascertained after reasonable efforts have been made to locate and identify the parent.

(ii) The child’s parent has deserted the child for 91 or more days and has not sought custody of the child during that period.

.....

(b) The child or a sibling of the child has suffered physical injury or physical or sexual abuse under 1 or more of the following circumstances:

(i) The parent’s act caused the physical injury or physical or sexual abuse and the court finds that there is a reasonable like-

likelihood that the child will suffer from injury or abuse in the foreseeable future if placed in the parent's home.

(ii) The parent who had the opportunity to prevent the physical injury or physical or sexual abuse failed to do so and the court finds that there is a reasonable likelihood that the child will suffer injury or abuse in the foreseeable future if placed in the parent's home.

(iii) A nonparent adult's act caused the physical injury or physical or sexual abuse and the court finds that there is a reasonable likelihood that the child will suffer from injury or abuse by the nonparent adult in the foreseeable future if placed in the parent's home.

(c) The parent was a respondent in a proceeding brought under this chapter, 182 or more days have elapsed since the issuance of an initial dispositional order, and the court, by clear and convincing evidence, finds either of the following:

(i) The conditions that led to the adjudication continue to exist and there is no reasonable likelihood that the conditions will be rectified within a reasonable time considering the child's age.

(ii) Other conditions exist that cause the child to come within the court's jurisdiction, the parent has received recommendations to rectify those conditions, the conditions have not been rectified by the parent after the parent has received notice and a hearing and has been given a reasonable opportunity to rectify the conditions, and there is no reasonable likelihood that the conditions will be rectified within a reasonable time considering the child's age.

....
(g) The parent, without regard to intent, fails to provide proper care or custody for the child and there is no reasonable expectation that the parent will be able to provide proper care and custody within a reasonable time considering the child's age.

....
(i) Parental rights to 1 or more siblings of the child have been terminated due to serious and chronic neglect or physical or sexual abuse, and prior attempts to rehabilitate the parents have been unsuccessful.

(j) There is a reasonable likelihood, based on the conduct or capacity of the child's parent, that the child will be harmed if he or she is returned to the home of the parent.

Id.

272. See Deborah Paruch, *The Orphaning of Underprivileged Children: America's Failed Child Welfare Law & Policy*, 8 J.L. & FAM. STUD. 119 (2006) (discussing the best interest of the child factor in termination of parental rights proceedings). The rules of evidence do not apply at any of these series of hearings, including the Termination of Parental Rights Hearings. MICH. CT. R. 3.973. Instead, the court will admit "all relevant and material evidence," generally in the form of oral and written information from the child care agency worker, parents, and foster parents. *Id.*

The court-ordered condition that a parent participate in therapy raises the important question of whether the abrogation of the psychotherapist-patient privilege in these proceedings is justified, as the Michigan Supreme Court has indicated, on the grounds that “[i]t is in the best interests of all parties for the fact finder to be in possession of all relevant information regarding the welfare of the child.”²⁷³ For this paper, a sample of decisions was retrieved from the Michigan Court of Appeals stemming from appeals of parental rights termination orders in which the appellate court relied upon a therapist’s testimony in reaching its decision. The cases were retrieved by means of an electronic search request.²⁷⁴

Psychological evidence was admitted at the termination hearings in each of the cases reviewed.²⁷⁵ The specific nature of the psychotherapist evidence admitted in the parental rights termination proceedings was examined, along with the weight accorded this evidence by the courts.²⁷⁶ The description of this evidence in the opinions varied from a brief reference to a full description of the testimony presented in the lower court proceedings.²⁷⁷ This testimony included statements or reports from professionals who would fall under the therapist umbrella, such as social workers, psychologists, and psychiatrists.²⁷⁸ Not one case included a reference to the qualifications of these individuals.²⁷⁹

Therapist testimony played an outcome-determinative role in the vast majority of the termination of parental rights cases.²⁸⁰ The nature of the therapist testimony cited by the court of appeals was overwhelmingly nega-

273. *In re Brock*, 499 N.W.2d 752, 761 (Mich. 1993).

274. Thirty six decisions were retrieved on Westlaw when the search string of “parental /3 rights /p thera! /s testimony” was entered in the Michigan Cases database with the search limited to the years after 2000. The court of appeals affirmed the trial courts’ ruling terminating the parental rights in thirty-five of the thirty-six cases. Recognizing that this search retrieved only a small sample of the cases on appeal that involved psychotherapist evidence, there is no reason to believe that the search failed to retrieve a representative sample of these cases.

275. *See supra* note 274.

276. *See supra* note 274.

277. *See supra* note 274.

278. *See, e.g., In re Tuck*, Nos. 268575, 268576, 2006 WL 2787839, at *1 (Mich. Ct. App. Sept. 28, 2006).

279. *See supra* note 274.

280. Therapist testimony was not outcome determinative in all of the cases. *See, e.g., In re A.C.G.*, No. 244302, 244387, 2003 WL 21205386, at *1 (Mich. Ct. App. May 22, 2003); *see also In re Slater*, No. 275621, 2007 WL 2745215, at *2 (Mich. Ct. App. Sept. 20, 2007) (emphasizing the facts that the mother was unemployed and was not able to provide her children with a home).

tive in nature,²⁸¹ and in some cases, positive evidence was overshadowed by the court's focus on the negative nature of a therapist's testimony.²⁸²

Therapist testimony was found to be evidence of the condition for termination under subsections (3)(c)(i)²⁸³ and (3)(j)²⁸⁴ of section 712A.19b of the Michigan Code in sixty-seven percent of the cases reviewed.²⁸⁵ Additionally, therapist testimony was used as a means of proving the conditions contained in section 712A.19b(3)(g)²⁸⁶ in eighty-nine percent of the cases reviewed.²⁸⁷

281. Only two cases out of the thirty-six reviewed contained positive therapist testimony. *In re Mahon* contained mostly positive testimony from the therapists, and the court of appeals affirmed the trial court's decision denying the petition to terminate parental rights. No. 276118, 2007 WL 2429378, at *1-*2 (Mich. Ct. App. Aug. 28, 2007). The case of *In re Buck* also contained mostly positive testimony by the therapist. No. 268073, 2006 WL 2270389, at *1-*2 (Mich. Ct. App. Aug. 8, 2006).

282. Note the case of *In re Hanna* in which the testimony of the mother's therapist, who felt the mother had gained insight and achieved personal growth that would positively affect her children, was overcome by negative testimony of a psychologist hired by the court to perform a psychological evaluation. No. 263791, 2006 WL 141869, *1 (Mich. Ct. App. Jan. 19, 2006).

283. MICH. COMP. LAWS ANN. § 712A.19b(3)(c)(i) (West 2002) ("The conditions that led to the adjudication continue to exist and there is no reasonable likelihood that the conditions will be rectified within a reasonable time considering the child's age.").

284. MICH. COMP. LAWS ANN. § 712A.19b(3)(j) (West 2002) ("There is a reasonable likelihood, based on the conduct or capacity of the child's parent, that the child will be harmed if he or she is returned to the home of the parent.").

285. See *supra* note 274.

286. MICH. COMP. LAWS ANN. § 712A.19b(3)(g) (West 2002) ("The parent, without regard to intent, fails to provide proper care or custody for the child and there is no reasonable expectation that the parent will be able to provide proper care and custody within a reasonable time considering the child's age.").

287. See *supra* note 274. Courts will frequently cite more than one statutory ground as the basis for their order terminating parental rights. See, e.g., *In re McBride*, Nos. 282062, 282243, 2008 WL 2751233, at *1 (Mich. Ct. App. July 15, 2008). The conditions surrounding the termination of parental rights appeared to be conducive to therapeutic treatment of the parents, children, or both, but such conditions were not enough to overcome the "reasonable likelihood" and/or the "reasonable time frame" requirements of section 712A.19b of the Michigan Code. MICH. COMP. LAWS ANN. § 712A.19b (West 2002). Twenty-six of the cases (72%) had situations in which: (1) the parent(s) suffered from drug addiction or mental illness/deficiencies, or (2) the children had mental and/or physical abnormalities that required special care. See *supra* note 274. These types of conditions may be overcome with the assistance of therapeutic treatment or training, but testimony from the therapists concerning the likelihood of recovery and recovery time frames played a determinative role in the courts' decisions to terminate the parental rights because of the requirements of section 712A.19b of the Michigan Code. MICH. COMP. LAWS ANN. § 712A.19b (West 2002). For example, in the case of *In re McBride*, the mother's therapist testified that it would take longer than six months for her to overcome her addiction to prescription medication because the mother was in the middle phase of an eighteen month recovery program. Nos. 282062, 282243, 2008 WL 2751233, at *2-*3 (Mich. Ct. App. July 14, 2008). The court of appeals affirmed the trial court's decision to terminate parental rights because it believed that an

The courts' reliance on the therapists' testimony suggests that this evidence is necessary for a proper adjudication of these cases. Indeed, this is corroborated by judges' own responses to questions directed toward assessing the importance of this information in their decision making.²⁸⁸ However, of the cases reviewed for this paper, not one case was found where the testimony of a parent's treating therapist seemed to be essential to a proper adjudication of the case.²⁸⁹

There were several cases in which the court cited a parent's failure to participate in therapy as grounds for termination of parental rights.²⁹⁰ In *In re Kalman*, the court terminated a mother's parental rights based on the findings that she had taken herself off of her prescribed medications and had stopped attending therapy.²⁹¹ It stated that "[a] parent's failure to comply with the essential requirement of her treatment plan may justify termination of her parental rights based on continuing neglect."²⁹²

In many of the cases reviewed, although the treating therapist's testimony was important to the court's decision to terminate parental rights, the information obtained through this testimony could have been acquired through other means with little or no difficulty.²⁹³ The following cases illustrate this point. In *In re Tuck*, a mother's therapist testified that she "had not yet attained the physical stability or parenting ability necessary to provide a

eighteen month recovery was not a reasonable time considering the child's age. *Id.* at *9-*11.

288. See *supra* notes 223-27 and accompanying text.

289. See *supra* note 274.

290. See *In re Forehand*, No. 280404, 2008 WL 1885818, at *1 (Mich. Ct. App. Apr. 29, 2008); *In re Ostrander*, No. 274901, 2007 WL 2404726, at *1-*2 (Mich. Ct. App. Aug. 23, 2007); *In re C.T.T.T.*, No. 239403, 2003 WL 462371, at *1-*3 (Mich. Ct. App. Feb. 21, 2003).

291. No. 280854, 2008 WL 1886334, at *2 (Mich. Ct. App. Apr. 29, 2008).

292. *Id.* (citing *In re Hall*, 469 N.W.2d 56 (Mich. Ct. App. 1991)).

293. See *supra* note 274. Cases were also retrieved through the search where psychological evidence was admitted that resulted from a court-ordered evaluation. See, e.g., *In re Ostrander*, No. 274901, 2007 WL 2404726, at *1 (Mich. Ct. App. 2007). These cases are not discussed since they do not involve the abrogation of the psychotherapist-patient privilege. In these situations, it is generally accepted that there will not be any confidentiality since the sole purpose of the evaluation is to provide information to the court. Further, there were several cases in which the court cited a parent's failure to participate in therapy as grounds for termination of parental rights. See *In re Forehand*, No. 280404, 2008 WL 1885818, at *1 (Mich. Ct. App. Apr. 29, 2008); *In re Ostrander*, No. 274901, 2007 WL 2404726, at *1 (Mich. Ct. App. Aug. 23, 2007); *In re C.T.T.T.*, No. 239403, 2003 WL 462371, at *1 (Mich. Ct. App. Feb. 21, 2003). In *In re Kalman*, the court terminated a mother's parental rights based on findings that she had taken herself off of her prescribed medications and had stopped attending therapy. No. 280854, 2008 WL 1886334, at *1 (Mich. Ct. App. Apr. 29, 2008). It stated, "A parent's failure to comply with the essential requirement of her treatment plan may justify termination of her parental rights based on continuing neglect." *Id.* (citing *In re Hall*, 469 N.W.2d 56 (Mich. Ct. App. 1991)).

suitable environment for the children and that . . . [her relationship with her husband] was unstable.”²⁹⁴ Evidence of the fact that she lacked “physical stability” could easily have been introduced through the caseworker.²⁹⁵ Evidence of her inadequate “parenting ability” could also have been introduced through her caseworker, through an independent psychological evaluation, or from a parenting class instructor.²⁹⁶ Evidence of her unstable marriage could have been introduced through her caseworker, by relatives and friends, or through her or her husband’s admissions.²⁹⁷

A mother’s parental rights were terminated in *In re Buck* due to her history of drug abuse and her inability to maintain suitable housing.²⁹⁸ Her therapist testified at the termination hearing that she had stopped using drugs; however, he admitted that he had not verified this by requiring her to submit to drug screens.²⁹⁹ In this case, her agency caseworker could easily have testified that these tests had not been performed.³⁰⁰ Respondent’s therapist also testified that a person generally “needs to be sober for a year before she would be deemed fairly stable in her sobriety and abstinence.”³⁰¹ This information is readily available in professional journals of which the court could take judicial notice.³⁰²

In *In re Jackson*, the court terminated a mother’s parental rights because she suffered from a serious mental illness and was unable to properly care for her children.³⁰³ The evidence also demonstrated that she refused to recognize her illness or remain compliant with her prescribed medications.³⁰⁴ Although this information was admitted through the testimony of her treating therapists, it could also have been obtained as the result of a court-ordered evaluation and the reports and testimony of the caseworker assigned to this case.³⁰⁵

In another case, *In re Flores*, the court of appeals upheld a family court’s order terminating a mother’s parental rights based on testimony

294. Nos. 268575, 268576, 2006 WL 2787839, at *1 (Mich. Ct. App. Sept. 28, 2006).

295. *Id.*

296. *Id.*

297. *Id.* at *1-2.

298. No. 268073, 2006 WL 2270389, at *1 (Mich. Ct. App. Aug. 8, 2006).

299. *Id.*

300. *Id.*

301. *Id.*

302. See, e.g., The Betty Ford Inst. Consensus Panel, *What is Recovery? A Working Definition from the Betty Ford Institute*, 33 J. SUBSTANCE ABUSE TREATMENT 221, 224 (2007) (recognizing that “sustained sobriety” is sobriety lasting more than one year).

303. *In re Jackson*, No. 228188, 2001 WL 850096, at *2 (Mich. Ct. App. July 27, 2001).

304. *Id.* at *1-2.

305. See, e.g., MICH. CT. R. 3.323(B).

from her treating therapist that “[she] was not ready to avoid violent relationships as of the date of the termination trial.”³⁰⁶ The court’s admission of this evidence raises serious concerns not only because it was unnecessary—there was ample evidence in the record of her unwillingness to end her abusive relationship with her son’s father—but also because it clearly presents an example of the court’s willingness to admit and rely on this type of evidence, which lacks any indicia of scientific reliability.³⁰⁷

There were other cases in which the court relied heavily on a treating therapist’s testimony in reaching its decision to terminate parental rights even though the testimony did not appear necessary for a proper adjudication of the case.³⁰⁸ This testimony was not necessary either because the testimony was a needless presentation of cumulative evidence or because there was ample other evidence on the record to support the court’s decision.³⁰⁹ *In re Perez* is one such case.³¹⁰ That case involved alleged acts of sexual abuse against the respondents’ fifteen-year-old daughter by the paternal grandfather who was residing in the respondents’ home at the time of the alleged acts.³¹¹ The court ordered re-unification plan required the respondents to distance themselves from the grandfather and to prevent any contact between the grandfather and the children.³¹² Evidence presented during the pendency of the case, including the parents’ own admissions, indicated that they continued to have frequent contact with the grandfather.³¹³ The court terminated their parental rights on the grounds that they failed to provide proper care and custody of the children.³¹⁴ The treating therapist’s testimony at the termination hearing that the parent’s “refused to distance themselves from . . . [the grandfather’s] influence and that neither [parent] was willing to prevent contact between . . . [the grandfather] and the children,” was duplicative and unnecessary.³¹⁵

306. No. 266155, 266156, 2006 WL 1195861, at *2 (Mich. Ct. App. May 4, 2006).

307. This type of testimony should also be considered irrelevant because it does not provide any therapeutic information concerning the parents or any rehabilitative efforts made by the therapist on behalf of the parent. Another example of this type of testimony is found in *In re Hanna*, where a psychologist opined “that it was more likely than not that [the parent] would continue in an unstable pattern of short-term relationships.” No. 263791, 2006 WL 141869, at *2 (Mich. Ct. App. Jan. 19, 2006).

308. See, e.g., *In re Perez*, No. 257300, 257529, 2005 WL 1124094, *1 (Mich. Ct. App. May 12, 2005).

309. See, e.g., *id.*

310. *Id.*

311. *Id.* at *1-2.

312. *Id.* at *1.

313. *Id.*

314. *In re Perez*, 2005 WL 1124094, at *2.

315. *Id.*

In *In re Kelly*, a mother's therapist testified that she suffered from a dissociative disorder, which began in childhood, that caused her to "focus[] a great deal of her energy on her romantic partner to the point that she neglected herself and her children's needs," that she "could parent at only forty percent effectiveness," and that she was unable to "provide long-term emotional support" for her children.³¹⁶ However, there was ample other evidence in the record to justify the termination, including: (1) the foster care worker's testimony that the mother failed to provide a suitable home and that the baby often returned from visitations with poor hygiene and dirty diapers; (2) the mother failed to keep a neuropsychological examination appointment or attend rehabilitative therapy; (3) one child's emotional development was seriously disrupted while another child reported that he feared being harmed by his parents; (4) a report of physical abuse of a child by an extended family member in her home; (5) the foster care worker's testimony that respondent's parental rights should be terminated; (6) the mother's statements that, due to cognitive problems, she could only focus on one thing at a time; and, most importantly, (7) the mother's own admission that that she could not raise all four of her children.³¹⁷

In *In re D.R.T.*, a young boy had been in foster care for three years at the time of the termination hearing.³¹⁸ The record demonstrated that the father failed to find appropriate housing, failed to benefit from parenting classes, and only sporadically attended therapy sessions.³¹⁹ The record further indicated that he was incarcerated for a three-month period during the pendency of this case and failed to inform anyone, particularly his case-worker, of his situation.³²⁰ The record also showed that when his young son developed a serious mental illness, which included hallucinations and hearing voices, the father remarked that his child's hallucinations were merely an attempt to get attention.³²¹ The father's therapist testified that he "did not understand the importance of stable housing or why it was important to meet his son's most basic needs."³²² She also testified that the father and son "seemed to behave more like brothers than father and son, discussing video games, cartoons, and the minor child's love life," and opined that the minor child's cognitive problems were caused by a "lack of effort" on the part of the father.³²³

316. No. 233067, 2001 WL 1324684, at *1 (Mich. Ct. App. Oct. 26, 2001).

317. *Id.*

318. No. 235308, 2002 WL 31058353, at *2 (Mich. Ct. App. Sept. 13, 2002).

319. *Id.*

320. *Id.*

321. *Id.*

322. *Id.*

323. *Id.*

In re Turlin is an example of a case where the treating therapist's testimony is a needless presentation of cumulative evidence.³²⁴ The case concerned a mother who spent twenty-two months in federal prison on drug charges.³²⁵ Her children, who were four-years-old and seven-months-old at the time of her arrest, were placed with their paternal grandmother, where they remained throughout the case.³²⁶ Respondent completed an intensive drug treatment plan and parenting classes while in prison and obtained employment and housing following her release.³²⁷ However, she was reincarcerated for fifty-eight days for violating the terms of her parole and married a man with a long criminal history.³²⁸ A psychologist hired by the court to evaluate her testified that he was concerned about the harm to her children if they were taken from their grandmother's custody.³²⁹ Respondent's treating therapist also testified at the termination hearing at which time he recommended that the court terminate her parental rights and expressed his concern over the emotional harm to the children that would result if they were removed from their grandmother's care.³³⁰

Another case in which a therapist's testimony was a needless presentation of cumulative evidence is *In re Service*.³³¹ That case involved the termination of a mother's parental rights to her infant son, Cody, who was removed from her care two days after his birth.³³² The agency removed the infant because the mother's parental rights to a previous child, Taylor, were terminated due to serious physical abuse.³³³ Taylor was found to have broken ribs, a broken clavicle, and fractures of her femur and tibia.³³⁴ She also had a collection of blood in her chest and abdomen, numerous unexplained bruises, and was significantly underweight.³³⁵ Other evidence on the record that supported the termination of the mother's parental rights to Cody included: (1) her failure to admit responsibility for Taylor's injuries, (2) conflicting statements she made regarding Taylor's injuries, (3) her problem with anger, (4) her marginal bonding with Taylor, (5) her reported anxiety in the hospital while caring for the new infant, and (6) her "flat effect" with

324. No. 266599, 266600, 2006 WL 1691159, at *1 (Mich. Ct. App. June 20, 2006).

325. *Id.*

326. *Id.*

327. *Id.*

328. *Id.*

329. *Id.*

330. *In re Turlin*, 2006 WL 1691159, at *1.

331. *In re Service*, No. 256037, 2004 WL 2913640, at *1 (Mich. Ct. App. Dec. 16, 2004).

332. *Id.*

333. *Id.*

334. *Id.*

335. *Id.*

Cody.³³⁶ The mother's therapist testified that she was "very frustrated and ill-equipped to care for a child."³³⁷

V. CRITICISMS AND RECOMMENDATIONS

There is overwhelming agreement among the mental health professions that confidentiality is a *sine qua non* for successful treatment and a critical component of the psychotherapist-patient relationship.³³⁸ Numerous studies confirm that a meaningful therapeutic relationship, described as a "working alliance, founded on trust, openness, genuineness and congruence,"³³⁹ is essential to the successful outcome of therapy.³⁴⁰

The need for confidentiality in the psychotherapist-patient relationship has been confirmed by various empirical studies conducted within the past twenty years.³⁴¹ These studies show that a patient's willingness to self-disclose sensitive information is significantly higher when they are informed that their disclosures will remain confidential.³⁴² Conversely, patient self-disclosures, particularly of sensitive or embarrassing matters, decrease significantly when they are informed that their communications will not remain confidential.³⁴³ Furthermore, a patient's willingness to engage in therapy decreases appreciably when the risk of compelled disclosure is high, as in the case of Maryland's mandated reporting statutes evidenced in the Johns Hopkins study.³⁴⁴ These factors directly impact the likelihood that therapy will be successful.³⁴⁵ Additionally, the United States Supreme Court in *Jaffee v. Redmond* acknowledged that important public and private interests are served when confidential communications between patients and therapists are protected from disclosure.³⁴⁶ The Court also acknowledged that facilitating the provision of mental health services works to im-

336. *Id.*

337. *In re Service*, 2004 WL 2913640, at *1.

338. *See, e.g.*, Honea-Boles & Griffin, *supra* note 99, at 150.

339. *Id.*

340. *Id.* at 149 (discussing numerous studies that address the importance of the therapeutic relationship and the positive effect of what the authors term a "working alliance" on positive therapeutic outcomes).

341. *See supra* Part III.

342. *See supra* Part III.

343. *See supra* Part III.

344. Fred S. Berlin, H. Martin Malin & Sharon Dean, *Effects of Statutes Requiring Psychiatrists to Report Suspected Sexual Abuse of Children*, 4 AM. J. PSYCHIATRY 449 (1991).

345. *See supra* Part III.

346. *Jaffee v. Redmond*, 518 U.S. 1, 2 (1996).

prove the mental health of the community, which it noted is a “public good of transcendent importance.”³⁴⁷

Unfortunately, the legal protection afforded to these important communications evaporates when legal proceedings arise that involve the welfare of children. Legislators, acting upon the need to protect children, have statutorily abrogated the privilege in cases involving child custody determinations and child abuse and neglect.³⁴⁸ Judges, likewise, readily admit therapist testimony in these proceedings based on the belief that the need for evidence in these cases far outweighs the value in psychotherapist-patient confidentiality.³⁴⁹ However, the abrogation of this vital privilege is simply not justified on these grounds, and the private and public harm resulting from its rejection far outweighs the meager value of the evidence that is often obtained.

The harm that results from the compelled disclosure of confidential communications between patients and their therapists takes many forms. First, the abrogation of the psychotherapist-patient privilege raises what should be seen as insurmountable ethical dilemmas for therapists, particularly when their patients are ordered into therapy by a court. One author has declared that “‘enforced therapeutic relationships are a sham’ . . . dehumanizing and dishonest.”³⁵⁰ As such, these relationships have drawn sharp criticism from professionals in the mental health field.³⁵¹ Another author has opined that “[p]sychotherapists and counselors who enter a therapeutic relationship with a court-ordered client are entering an ethical minefield containing serious threats to professional psychotherapy.”³⁵² This occurs because this form of mandated treatment creates the “traditional anathema for most counselors of a dual relationship” where they are at the command of two masters—the ethical responsibilities of the profession and the legal directives of the court.³⁵³

Robert Shearer contends that mandated therapy violates the code of ethics of several professional organizations since mandated therapy is not supported by informed consent.³⁵⁴ He notes that written consent is not effective because if patients can be ordered to participate in counseling, they can be ordered to sign waiver forms that indicate that there will be no con-

347. *Id.* at 11.

348. *See, e.g.*, MASS. GEN. LAWS ANN. ch. 233, § 20B(e) (West 2000 & Supp. 2009).

349. *See supra* Part IV.C.

350. Honea-Boles & Griffin, *supra* note 99, at 152 (quoting Judith Cingolami, *Social Conflict Perspective on Work with Involuntary Clients*, 29 SOC. WORK 442, 446 (1984)).

351. *Id.* at 152-54.

352. Robert A. Shearer, *Court Ordered Counseling, An Ethical Minefield for Psychotherapists*, ANNALS OF AM. PSYCHOTHERAPY ASS'N, Fall 2003, at 8, 9.

353. *Id.* at 11.

354. *Id.* at 10-11.

fidentiality in the relationship.³⁵⁵ He also questions how a therapist can develop a trusting relationship when the patient is aware that the counselor is paid by the court or a state agency and that the therapist may be subpoenaed to testify against him.³⁵⁶ Most importantly, the mental health professional is precluded from functioning as a therapist in these situations and is asked to assume the role of state investigator.³⁵⁷ This change in role from healer to adversary occurs when the decision to terminate parental rights is based on the findings of therapy.³⁵⁸

Moreover, patients involved in mandated therapy suffer harm when the therapist is obligated to report back to the court or state agency. These patients are caught in the proverbial "Catch 22" situation. If they resist treatment, they are viewed as noncooperative,³⁵⁹ and the failure to participate in therapy when the therapy is a component of the agency service plan is grounds for termination of parental rights.³⁶⁰ On the other hand, any negative thoughts, actions, or feelings that are self-disclosed in therapy can be used against them in termination proceedings.³⁶¹ This appalling situation becomes even more appalling as oftentimes the parents embroiled in these proceedings have a tremendous need for therapy.³⁶² One author has commented:

This is a difficult situation. On the one hand, these parents are often among the most unempowered people in our society. They tend to be poor, often on some kind of welfare (usually AFDC), relatively socially isolated, and often with no support system. It is important for them to know, at this critical time when it may appear to them that they are being victimized by the system, that there is someone who is "on their side," listening to them and there to help them.³⁶³

The practice of mandated therapy coupled with the abrogation of the psychotherapist-patient privilege is in direct conflict with the federally recognized policy goal of preserving families. This practice violates the "reasonable efforts" requirement set forth in the Adoption and Safe Families Act, which requires that state social service agencies make reasonable ef-

355. *Id.* at 10.

356. *Id.* at 11.

357. *See id.* at 10-11.

358. Honea-Boles & Griffin, *supra* note 99, at 153.

359. *Id.*

360. *Id.*

361. *See In re Brock*, 499 N.W.2d 752, 761 (Mich. 1993).

362. *See Janet Weinstein, And Never the Twain Shall Meet: The Best Interests of Children and the Adversary System*, 52 U. MIAMI L. REV. 79, 169 (1997).

363. *Id.* at 130.

forts to assist families in solving the problems that can result in neglect.³⁶⁴ The practice of requiring parents to engage in “mock” therapy devoid of the essential components that would allow for successful treatment coupled with the fact that the therapist is asked to assume the role of state investigator and witness results in a process where the deck is stacked against the parents and, accordingly, where they are likely to fail. This is not a service designed to assist the parents in alleviating the conditions that prevent their children from returning home. While arranging and paying for this mandated therapy may qualify as an effort on the part of the state agency, it certainly is not reasonable.

Similar criticisms of the practice of judicially compelled disclosure of confidential information by a treating therapist apply when parents are engaged in a disputed child custody battle. Although many of the serious ethical dilemmas encountered in the case of mandated therapy are not present in these situations, there is a serious risk of substantial harm to the therapeutic relationship. In jurisdictions that hold that the psychotherapist-patient privilege is waived once a parent petitions for custody of a child, there is a serious risk that any communications between the therapist and the patient will be subject to judicially compelled disclosure.³⁶⁵ The empirical studies have shown that patient self-disclosures decrease dramatically with an increased risk of litigation in which a therapist could be compelled to disclose confidential patient information.³⁶⁶ Under these circumstances, some therapists have taken to limiting the types of issues discussed in therapy even though they acknowledge that “limitations of this sort may not be the optimal therapeutic strategy.”³⁶⁷

The *Jaffee* Court noted that compared to the important public and private interests supporting the acceptance of the psychotherapist-patient privilege, the expected evidentiary benefit to be gained from the rejection of the privilege “is modest.”³⁶⁸ However, it is not simply the amount of evidence that should be considered; the reliability of any evidence garnered under these circumstances must also be seriously questioned. When there is no assurance of confidentiality in the therapeutic relationship it is highly unlikely that a meaningful relationship can be established and there is a low probability that the treatment will be successful.³⁶⁹ Any information ob-

364. Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, 111 Stat. 2115 (codified as amended in scattered sections of 42 U.S.C.).

365. See cases cited *supra* note 221.

366. See *supra* Part III.

367. Shuman & Foote, *supra* note 130, at 485.

368. *Jaffee v. Redmond*, 518 U.S. 1, 11 (1996).

369. See *supra* Part III.

tained as a result of this flawed therapeutic process can have little meaningful value.³⁷⁰

It is remarkable that many of the jurisdictions that abrogate the psychotherapist-patient privilege on the ground that it is necessary for the protection of children continue to recognize the clergy privilege and the attorney-client privilege.³⁷¹ The rationales provided in support of the clergy privilege include the need to foster the clergy-confider relationship and the individual right to privacy.³⁷² It has been suggested that the clergy privilege is also justified by the First Amendment's Free Exercise Clause because it accommodates the religious practice of confiders and the clergy's objections to compelled disclosure.³⁷³ However, absent the interest in spiritual rehabilitation, the justifications for the clergy privilege are the same as those put forth for the psychotherapist-patient privilege.³⁷⁴ This raises the question of whether a person's interest in spiritual rehabilitation or solace is so far superior to the interest of a patient who is struggling to sustain his mental and emotional health such that it validates the abrogation of the psychotherapist privilege while the clergy privilege is preserved.

There are numerous justifications put forth in support of the attorney-client privilege. It is universally believed that the privilege is necessary in order to encourage open communication between attorneys and clients, which, in turn, facilitates the rendering of legal advice.³⁷⁵ It is thought that compelling disclosure of a "client's secrets would force an act of betrayal that would undermine the heart of professionalism."³⁷⁶ Some predict that in the absence of a privilege, "lawyers would be cast in the beginning as po-

370. See *supra* Part III.

371. It has been reported that six states expressly abrogate the clergy privilege whereas approximately half of the states appear to include the clergy privilege in statutes abrogating other professional privileges. Mary Harter Mitchell, *Must Clergy Tell? Child Abuse Reporting Requirements Versus the Clergy Privilege and Free Exercise of Religion*, 71 MINN. L. REV. 723 (1987); see also N.D. CENT. CODE § 50-25.1-10 (2007) ("Any privilege of communication between husband and wife or between any professional person and his patient or client, except the attorney and client, is abrogated and does not constitute grounds for preventing a report to be made or for excluding evidence in any proceeding regarding child abuse or neglect resulting from a report made under this chapter.").

372. Mitchell, *supra* note 371, at 762-69.

373. *Id.* at 791.

374. Compare Mitchell, *supra* note 371, at 762-69 (noting the rationales behind the clergy privilege as protecting the individual's right to privacy and the need to foster the clergy-confider relationship), with REISNER ET AL., *supra* note 24, at 297 (recognizing that a psychotherapist-patient privilege protects the right of individuals to control the disclosure of personal medical information, which is closely tied to the individual's right to privacy), and *Jaffee v. Redmond*, 518 U.S. 1, 10-11 (1996) (finding that a psychotherapist-patient privilege creates a level of confidence required for effective treatment).

375. MUELLER & KIRKPATRICK, *supra* note 2, § 5.8, at 309-10.

376. *Id.* § 5.8, at 308 (citing Geoffrey C. Hazard, Jr., *An Historical Perspective on the Attorney-Client Privilege*, 66 CAL. L. REV. 1061 (1978)).

tential adversaries to their own clients.”³⁷⁷ Indeed, it has been said that “[e]very feeling of justice, honour and humanity would be shocked’ by an attorney’s breach of a client’s confidences.”³⁷⁸

As with the clergy privilege, each of these rationales apply with equal force to the psychotherapist-patient privilege. Compelled disclosure of these private communications forces “an act of betrayal” that undermines the heart of the mental health profession.³⁷⁹ Compelled disclosure by therapists, particularly in the case of mandated treatment, casts them as “potential adversaries” to their patients.³⁸⁰ Indeed, “‘justice, honor and humanity’” should be “‘shocked’” by the compelled disclosure of these confidential communications in judicial proceedings.³⁸¹ Simply put, there is no rational reason for the inconsistent treatment of these two privileges in cases involving the welfare of children.

The legislatures’ and courts’ willingness to abrogate the psychotherapist-patient privilege while allowing these other privileges to remain intact must be based either on their failure to recognize the value of confidentiality to the therapeutic relationship or because they place little value on psychotherapy per se. This is evidenced by Justice Scalia’s dissenting comments in *Jaffee v. Redmond* in which he equates the role of a psychotherapist with that of a bartender.³⁸²

When is it, one must wonder, that *the psychotherapist* came to play such an indispensable role in the maintenance of the citizenry’s mental health? For most of history, men and women have worked out their difficulties by talking to, *inter alia*, parents, siblings, best friends, and bartenders—none of whom was awarded a privilege against testifying in court.³⁸³

This unwillingness to recognize the value of therapy is wholly inconsistent with the heavy reliance that family courts place on the testimony and

377. *Id.* § 5.8, at 309.

378. *Id.* § 5.8, at 309 n.7 (quoting 1 EDWARD LIVINGSTON, THE COMPLETE WORKS OF EDWARD LIVINGSTON ON CRIMINAL JURISPRUDENCE 461 (1873)).

379. *Id.* § 5.8, at 308-09.

380. *Cf. id.* § 5.8, at 308.

381. MUELLER & KIRKPATRICK, *supra* note 2, § 5.8, at 309 n.7 (quoting 1 EDWARD LIVINGSTON, THE COMPLETE WORKS OF EDWARD LIVINGSTON ON CRIMINAL JURISPRUDENCE 461 (1873)).

382. *See Jaffee v. Redmond*, 518 U.S. 1, 22 (1996) (Scalia, J., dissenting).

383. *Id.*

opinions of mental health expert witnesses.³⁸⁴ As such, it presents an interesting quagmire for courts in that if the practice of psychotherapy has genuine value, as the Supreme Court has indicated,³⁸⁵ then confidentiality in the therapeutic relationship is worthy of protection. On the other hand, if psychotherapy has limited value, then the evidence that is produced through this process is not reliable and should be excluded on these grounds.

The compelled testimony of a treating therapist is a convenient means of obtaining evidence in proceedings involving the welfare of children; however, there are ample other means of obtaining similar evidence. This is demonstrated in the sample of Michigan cases reviewed in the previous section of this article.³⁸⁶ In contested child custody cases and in child protection proceedings, courts may obtain relevant information regarding the parents and the children through court ordered psychological evaluations.³⁸⁷ If the court orders a parent into therapy and is concerned with whether the parent is making progress, an independent follow-up evaluation can be obtained.³⁸⁸ Guardian ad litem are also routinely employed in both of these proceedings and can provide valuable information regarding what is in a child's best interest.³⁸⁹ Court Appointed Special Advocates, or CASA workers, are also frequently used in child protection proceedings and can give helpful information to the court.³⁹⁰ Finally, in child protection proceedings, the agency caseworker is the principal investigator for the state and has a wealth of information about the family.³⁹¹

The mandated reporting requirements that are in effect in each of the fifty states require designated persons to report suspected cases of child

384. Compare *id.* (analogizing a therapist to a bartender), with *supra* Part IV.C (discussing various studies recognizing the importance that family court judges place on the testimony of mental health expert witnesses).

385. See *Jaffee*, 518 U.S. 1.

386. See *supra* notes 274-337 and accompanying text.

387. Courts have the authority to order a variety of services for the parents and children in child protection proceedings. See, e.g., MICH. COMP. LAWS ANN. § 712A.19a (West 2002 & Supp. 2008); MICH. CT. R. 3.973.

388. See, e.g., MICH. COMP. LAWS ANN. § 712A.19a (West 2002 & Supp. 2008); MICH. CT. R. 3.973.

389. See, e.g., MICH. CT. R. 3916. For a discussion of the role of the guardian ad litem in these proceedings, see Donald N. Duquette, *Legal Representation of Children: Two Distinct Lawyer Roles are Required*, 34 FAM. L.Q. 441 (2000).

390. CASA workers are volunteers appointed by a court to advocate for the interests of children involved in child abuse and neglect proceedings. For a detailed description of the program, see CASA: Court Appointed Special Advocates for Children, <http://www.nationalcasa.org> (last visited Apr. 30, 2009).

391. See Michigan Department of Human Services: Children's Protective Services Investigation Process, http://www.michigan.gov/dhs/0,1607,7-124-5452_7119_7194-159484--,00.html (last visited Apr. 30, 2009).

abuse and neglect to the state child protection agency.³⁹² Recognition of the psychotherapist-patient privilege has no effect on a therapist's duty under these statutes. If a treating therapist reasonably believes that a child is being harmed or is at a significant risk of being harmed, he must report his suspicions to the child protection agency.³⁹³ However, a therapist's compliance with these statutory duties should not also imply a duty to testify against his patient in subsequent civil or criminal proceedings.

The rationale applied by the Sixth Circuit in *United States v. Hayes*, in which the court refused to graft a dangerous patient exception to the psychotherapist-patient privilege,³⁹⁴ is equally applicable to cases involving mandated reporting of suspected child abuse and neglect. The *Hayes* court drew a distinction between warning a third party about threats made against them by a patient and subsequent judicially compelled testimony.³⁹⁵ It noted that although these warnings may have a "marginal" effect on the therapeutic relationship, it would not produce the devastating effect that compelled testimony would.³⁹⁶

In the case of mandated reporting statutes, the public interest in the protection of children is served when a report of suspected abuse or neglect is made by a therapist to the state agency. However, this breach of confidentiality does carry a cost. It has been shown to have a negative effect on the psychotherapist-patient relationship, as demonstrated by the Johns Hopkins study.³⁹⁷ That being said, the damage to the therapist-patient relationship is far less severe than the deleterious effect caused by the abrogation of the privilege.

392. For a discussion of mandated reporting requirements, see Mitchell, *supra* note 371, at 725-34, and also see Murray Levine, *A Therapeutic Jurisprudence Analysis of Mandated Reporting of Child Maltreatment by Psychotherapists*, 10 N.Y.L. SCH. J. HUM. RTS. 711 (1993).

393. See Levine, *supra* note 163, at 716.

394. 227 F.3d 578 (6th Cir. 2000).

395. *Id.* at 586.

396. *Id.* at 585.

397. See Fred S. Berlin et al., *Effects of Statutes Requiring Psychiatrists to Report Suspected Sexual Abuse of Children*, 148 AM. J. PSYCHIATRY 449 (1991). Some therapists criticize the mandatory reporting laws because of the harm that they cause to the therapist-patient relationship. See Steven R. Smith & Robert G. Meyer, *Child Abuse Reporting Laws and Psychotherapy: A Time for Reconsideration*, 7 INT'L J.L. & PSYCHIATRY 351 (1984). The authors argue that the requirement to report suspected cases of child abuse or neglect may have an antitherapeutic effect in that it may limit the topics that are brought out for discussion and, therefore, fail to protect children from further episodes. *Id.* at 351, 358-60. They advocate for changes to the mandatory reporting laws eliminating the reporting requirement when a therapist receives information about child abuse from the abuser-patient unless there is a threat of serious, permanent harm to a child, the therapy is not progressing satisfactorily, or the threat of abuse continues. *Id.* at 362-63.

An absolute abrogation of the psychotherapist-patient privilege in cases involving the welfare of children serves no one's best interest. When parents who are experiencing emotional problems as a result of a divorce are hesitant to seek help, their children will suffer. When a child abuser refuses to participate in treatment, children will suffer. It is time for legislators and judges to engage in a re-evaluation of the practice of abrogating the privilege in family law proceedings. Some therapists argue that the psychotherapist-patient privilege should be "inviolable to breach by external authority," including investigations by governmental agencies and court subpoenas.³⁹⁸ However, when young children are involved, a delicate balancing act is required since there is no more compelling interest than the protection of innocent children.

Some courts have adopted a case by case balancing approach when faced with having to decide whether to require a therapist to disclose confidential patient information.³⁹⁹ This approach, which was specifically rejected by the *Jaffee* Court on the grounds that it "would eviscerate the effectiveness of the privilege,"⁴⁰⁰ requires a court to balance the patient's interest in confidentiality against the need for the evidence.⁴⁰¹ However, a simple balancing test can easily fail to afford the protection that the psychotherapist-patient privilege deserves. The subjective value that the court places on the evidence can easily tip the scales in favor of compelling disclosure of the confidential information—a situation not unlike the present state of the law.

The guidelines established by the American Psychiatric Association that were originally drafted to be used in contested custody cases seem to best achieve the goal of protecting children while preserving the confidential nature of the therapeutic relationship.⁴⁰² The association recommends that courts only consider therapist testimony in cases where a parent's capacity to adequately care for a child because of emotional instability is at issue.⁴⁰³ Before a court may consider therapist testimony, it must make a preliminary judicial finding that a parent is currently unable to provide ade-

398. Louis Everstein, Diana Sullivan Everstein, Gary Heyman, Reiko Homma True, David H. Frey, Harold G. Johnson & Richard H. Seiden, *Privacy and Confidentiality in Psychotherapy*, 35 AM. PSYCHOLOGIST 828 (1980).

399. See cases cited *supra* note 218.

400. *Jaffee v. Redmond*, 518 U.S. 1, 17-18 (1996). The Court also noted that "[a]n uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all." *Id.* at 18.

401. See, e.g., *Cabrera v. Cabrera*, 580 A.2d 1227, 1233 (Conn. App. Ct. 1990) (stating that the party seeking admission of evidence subject to the psychotherapist-patient privilege must demonstrate to the court that justice requires admission of the evidence).

402. AM. PSYCHIATRIC ASS'N, *supra* note 206, at 2-4.

403. *Id.* at 2-3.

quate care for the child.⁴⁰⁴ This initial finding must be supported by substantial, reliable independent evidence of mental or emotional impairment.⁴⁰⁵

Following such a finding, the court will need to determine whether the disclosure of confidential therapist-patient information will assist the court in rendering a decision as to the parent's ability to adequately care for the child.⁴⁰⁶ In doing so, the courts should consider the following criteria: (1) the gravity of the psychiatric disorder and the type of the treatment; (2) the "recency/chronicity" of the treatment; and (3) whether the information can be obtained from other sources, including a court-ordered evaluation by an independent therapist.⁴⁰⁷ Courts should be required to make specific findings on the record for each of the criteria.⁴⁰⁸ This approach acknowledges that there will be circumstances where it is necessary to compel disclosure of some patient confidences; however, this approach assures that patient confidences are disclosed only in exceptional circumstances. Finally, this approach eliminates the distasteful but all too common practice of using mental health professionals as state investigators in cases involving the wellbeing of children.

VI. CONCLUSION

Social policy aims, professional ethical requirements, and legal constraints should be harmonious; however, they are at odds with each other in cases involving the welfare of children. The mental health profession recognizes the importance of confidentiality in the psychotherapeutic relationship and the impact that this has on treatment. As such, professional ethical standards require that therapists protect the confidentiality of patient disclosures. These standards are supported by empirical data.

Even though the importance of protecting the confidentiality of the therapeutic relationship is clear, the psychotherapist-patient testimonial privilege, which prohibits the compulsory disclosure of confidential psychotherapist information in legal actions, is freely abrogated in cases involving the wellbeing of children. This article has challenged the assumptions underlying the abrogation of the privilege and the practice of routinely admitting treating therapist testimony in these types of cases.

The wholesale abrogation of this privilege carries a significant cost both for individuals and for society as a whole in that it drastically reduces

404. *Id.* at 3.

405. *Id.* at 3-4.

406. *Id.*

407. *Id.*

408. AM. PSYCHIATRIC ASS'N, *supra* note 206, at 4.

the likelihood of successful therapy. Additionally, the protection of children is not significantly furthered by the abrogation of the privilege since the resulting evidentiary benefit is minor. An alternative approach to the present state of the law should be adopted in which this vital privilege is preserved in all but the most exceptional circumstances and that more fully synchronizes the need to protect our children with the need to guard the confidentiality of the therapeutic relationship.