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Robert Jay Braman
Indiana University School of Law

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NOTES

GROUP THERAPY AND PRIVILEGED COMMUNICATION

Introduction

Group psychotherapy has really come into its own since World War II. It is currently used in most, if not all, psychiatric state hospitals in the country; it is used extensively in outpatient clinics, adult and child guidance clinics, correctional institutions, alcoholic treatment centers, and increasingly more in the private practice of psychiatry and psychology. The enhanced practice of group psychotherapy is reflected in the rapidly increasing membership of the American Group Psychotherapy Association and in the rapid growth of the literature in the field.

Many of the difficulties with patients are caused or aggravated by failure of communication, distorted perceptions of other people, or a distorted self-image. Erroneous assumptions are made about what others think and fear which results in inappropriate behavior, often with harmful psychological and social consequences. Moreover, many patients consider themselves unique in their difficulties or fear that their problems, if known by others, would result in ridicule and rejection.

In the group therapy situation, the patient learns to understand, and communicates with, others either similarly or differently afflicted with emotional difficulties. He is more likely to acquire a sense of proportion about his problems when viewed in this kind of therapeutic milieu than he would when he discusses his problems in the privacy of an individual therapist. It is through his interactions with other patients in a group that he learns to communicate more effectively with his peers and that he is made to realize that many of his fears and anxieties are shared by others or may be exaggerated or unfounded. This cannot be so readily achieved in individual therapy. One of the most pronounced effects of group treatment is an increase in self-respect and a corresponding reduction of tension and appre-

hension in the company of other people.[1]

These statements by a current practitioner present a brief insight into the extensive use of the group method in present-day psychotherapy,[2] and they point out the important medical rationale for its existence. Experimentation with group psychotherapy began in the early 1900's,[3] but only since the World War II period has it evolved as a widespread means of treatment. As a result of the war, a prevalence of psychological disabilities arose which necessitated group treatment.[4] The abundance of patients compared with the limited number of therapists had really left little choice in such major institutions as the Veterans Administration Hospitals and others but to turn to the group method. The first prime reason, therefore, for the extensive application of group psychotherapy was simply a reason based in the principle of efficient allocation of medical resources. The shortage of psychotherapists has never cured itself, and the responsibility of therapists for vast numbers of patients is a definite present and future reason for the existence of group therapy on a widespread basis.[5]

The opening interview also indicates that the justification for group psychotherapy lies in its intrinsic merits, *i.e.*, its therapeutic value. Its therapeutic value has caused group psychotherapy to become a discipline per se. Research indicates that the 1906-1955 period produced 1,747 published works on group psychotherapy, and the ten year period subsequent to this has produced works which in number exceed that entire fifty year period.[6]

Group therapy is applied to the whole spectrum of emotional and behavioral problems. It is used for both adults and children, and

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1. Interview with Dr. Hanus J. Grosz, Associate Professor of Psychiatry and Senior Clinical Investigator at the Institute of Psychiatric Research at Indiana University; Chief of Neurology and Psychiatry at the Veterans Administration Hospital, Indianapolis, Indiana, in Indianaplois, Indiana, April 3, 1967.

2. *See also* LUCHINS, GROUP THERAPY ch. 1 (1964) and SCHOFIELD, PSYCHOTHERAPY 167-168 (1964).

3. GARFIELD, INTRODUCTORY CLINICAL PSYCHOLOGY 294 (1957).

4. POWDERMAKER, GROUP PSYCHOTHERAPY 1 (1953).

5. "If all the 15,000 M.D.'s in the U.S. who are psychiatrists, plus all the psychiatric social workers and all the psychologists trained as therapists, spent all their working hours with individual patients, they would still be able to treat only one in ten of the Americans who need help for emotional ills." TIME, Feb. 8, 1963, at 38.

"Given the shortage of psychotherapists, one might foresee a time in the near future when patients may be treated primarily in group situations." Schechter, *The Integration of Group Therapy with Individual Psychoanalysis*, 1 CURRENT PSYCHIATRIC THERAPIES 145 (Masserman ed. 1961). Economic considerations are also important. The group system has been said to lessen individual costs from an average of approximately twenty dollars per session to as little as fifty cents for the needy and four or five dollars for those in middle income brackets. TIME, Feb. 8, 1963, at 38.

6. LUBIN & LUBIN, GROUP PSYCHOTHERAPY, A BIBLIOGRAPHY PREFACE (1966). *See also* LUCHINS, GROUP THERAPY 9 (1964); Daniels, McFarland, & Solon, *Group Psychotherapy*, 17 PROGRESS IN NEUROLOGY AND PSYCHIATRY 526 (1962).

essentially it can be applied to all patients who are candidates for psychotherapy in general, even though there are many selection procedures that are applied in the formation of a group.[7] The inherent advantages of group therapy are the result of enabling the therapist to work with his patient in a social setting, *i.e.,* an environment characteristic of the patient's everyday life as opposed to the more unusual situation of the patient's associating with the therapist alone. There is a simulation of the patient's outside relationships, and his weaknesses can be discovered and treated accordingly. For the patient, the group can be used to provide a variety of ameliorative changes. These include a lessening of feelings of isolation by providing new identifications, mutual support, and improved self-assertion and self-esteem. The realization that others have similar problems can diminish feelings of guilt, fear, and unrealistic dependency; and the ability to see another person's problem better than one's own can increase both the patient's objectivity and his capacity to approach new points of view. Finally, there is an opportunity for group members to associate their activities in group therapy to their outside relationships, and the successful personality changes achieved in group therapy can be correlated by the patient to apply to his outside role as a member of natural groups.[8]

The intrinsic merits of group psychotherapy, its economic justifications, and its very substantial growth are all symptomatic of its future utilization on an even more widespread basis. Because its expansion has been recent and because there appear to be no reported cases involving group therapy problems, the entire subject matter has been hidden from the legal commentators and very little consideration has been given to the group as a legal entity. Resulting from the relationship of group therapy to the physician-patient situation, the question of privileged communications raises what is probably the dominant legal problem presented by the existence of the group. The subsequent discussion is intended to meet this problem by considering the questions of whether or not the participants in a group psychotherapeutic situation *should have* legally privileged communications and, primarily, whether or not their communications *are* privileged under present law.

RATIONALE FOR THE PRIVILEGE

Ralph Slovenko, one of the foremost authorities in the area of

7. Grosz, *supra* n. 1.

8. *See,* JOHNSON, GROUP THERAPY 2 (1963); WHITHAKER & LIEBERMAN, PSYCHOTHERAPY THROUGH THE GROUP PROCESS ch. 8 (1964); BACH, INTENSIVE GROUP PSYCHOTHERAPY 3, 271-272 (1954); FOULKES, THERAPEUTIC GROUP ANALYSIS 33 (1965).

psychotherapy and privileged communication, gives only summary discussion to the group therapy problem.[9] However, he points out that it does seem necessary "to reformulate the medical privilege in view of group therapy."[10] Slovenko presents what is perhaps the most comprehensive case to date for granting a privileged communication in a "dyadic" psychotherapy relationship. He applies the renowned Wigmore criteria for a privileged communication[11] to the psychotherapist-patient relationship and concludes that each of these criteria are satisfied.[12] Similar findings supporting the psychotherapist-patient privilege have been reached almost unanimously by the legal writers who have dealt with it.[13] Their reasoning for supporting a psychotherapeutic privilege is clear in light of the notion that if therapists are forced to testify as to information received during therapy, patients will hesitate to disclose fully their thoughts and, as a result, they will not adequately benefit from treatment. Any psychotherapeutic situation requires frank self-disclosure, and the general feeling among therapists is that nothing inhibits a patient's frankness as much as the fear that his confidences will be used against him.[14] Therapists must prevent the existence of conditions that would stifle a confidential relationship, for they must be free to insist on very personal data in exploring the nexus between the patient's acts and his basic drives. It has been said that the psychiatric patient confides to a greater extent than anyone else in the world, for the nature of his effective communication is characterized by those thoughts which are the most difficult to expose.[15] This is true for the patient of the psychol-

9. SLOVENKO, PSYCHOTHERAPY, CONFIDENTIALITY, AND PRIVILEGED COMMUNICATION 119 (1966).

10. *Id.* at 119.

11. (1) The communications must originate in a *confidence* that they will not be disclosed.

(2) This element of *confidentiality must be essential* to the full and satisfactory maintenance of the relation between the parties.

(3) The *relation* must be one which in the opinion of the community ought to be sedulously *fostered.*

(4) The *injury* that would inure to the relation by the disclosure of the communications must be *greater than the benefit* thereby gained for the correct disposal of litigation. 8 WIGMORE, EVIDENCE § 2285 (McNaughton rev. 1961).

12. SLOVENKO, *supra* note 9, at 37-52.

13. *See e.g.,* Fisher, *The Psychotherapeutic Professions and the Law of Privileged Communications,* 10 WAYNE L. REV. 609 (1964); Guttmacher and Weihofen, *Privileged Communications between Psychiatrist and Patient,* 28 IND. L.J. 32 (1952); Rappeport, *Psychiatrist-Patient Privilege,* 23 MD. L. REV. 39 (1963); Slovenko, *Psychiatry and a Second Look at the Medical Privilege,* 6 WAYNE L. REV. 175 (1960).

14. SZASZ, THE ETHICS OF PSYCHOANALYSIS 144 (1965).

15. ". . . 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

ogist also as he undergoes the processes of psychotherapy.

With reference to group psychotherapy in particular, confidentiaity is needed for essentially the same reasons. Corsini, a noted author and practitioner in the field of group therapy, refers to "protected" groups in his definition of group psychotherapy, and he later explains his employment of the adjective by the following language:

> An essential concept in psychotherapy is that of *protection.* In psychotherapy there is always an understanding, whether implicit or explicit, that the individual members are freed from some of the usual responsibilities for their behavior. In a therapeutic situation a person can say and do things that the group would not permit under other circumstances. The member of a therapeutic group understands that as a part of the process of self-exploration, he may safely operate in certain ways not generally acceptable in society. He expects that his communications will be regarded as privileged (*i.e.,* confidential), and he understands that he is to respect the secrets of other members.[16]

It should also be noticed that in disclosing information in the dyadic relationship, a patient concerned about confidentiality would certainly feel more assured of its maintenance than he would when first sitting down to a group meeting. He would be less defensive on this point in the one-to-one relationship simply because of the ethicality assumed about most therapists and also because of the lesser mathematical probability of future disclosures by one person being apprised of his secrets rather than more than one. Any resistance based on fear of redisclosure would naturally be less because of these reasons; conversely, inhibitions based on such fear would be stronger in the group situation and would more intensely prevent the frank self-disclosure which is requisite in effective therapy.

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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." GUTTMACHER AND WEIHOFEN, PSYCHIATRY AND THE LAW 272 (1952).

See also GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, CONFIDENTIALITY AND PRIVILEGED COMMUNICATIONS IN THE PRACTICE OF PSYCHIATRY (Report No. 45, 1960); and Taylor v. United States, 222 F.2d 398, 401 (D.C. Cir. 1955).

16. CORSINI, METHODS OF GROUP PSYCHOTHERAPY 132 (1957). *See also,* BACH, INTENSIVE GROUP PSYCHOTHERAPY 30 (1954), in which it is pointed out that participating patients assume the same professional ethics of absolute discretion that bind professional therapists, and in which it is emphasized that only through open communication will the group become a therapeutically effective medium; BRAMMER AND SHOLSTROM, THERAPEUTIC PSYCHOLOGY (1963).

Is the Group Privileged

In speaking of the group therapy privilege, a realization that actually two privileges are involved is imperative. No generally accepted definition of group therapy presently exists,[17] but for purposes of a legal analysis the predominant group situation can be considered to consist of a therapist(s) and multiple numbers of patients.[18] Therapists consist of both psychiatrists and psychologists. As a result there is a relationship between each patient and the therapist (formally, this relationship is either medical or quasi-medical) and a relationship between each of the patients themselves. Therefore, the two privilges are therapist-patient and patient-patient; but in considering whether or not a group privilege can exist, the two will be discussed together for certainly neither would be effective if the other were not also enforced.

Within the present statutory framework of medical and quasi-medical privileged communications, there are essentially four variations of privileges—physician-patient,[19] psychiatrist-patient,[20] psychologist-patient,[21] and psychotherapist- patient.[22] Scattered haphazardly

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17. Luchins, Group Therapy 11 (1964).

18. Although the number of people in a group is subject to variation, most groups consist of one therapist and five to ten patients. Occasionally two therapists will work with the group, thereby lending additional knowledge and experience to the subsequent analyses. Frequently, the number of patients will also vary beneath or beyond the above mentioned average.

19. Alaska Rules of Ct. Proc. & Admin., Civ. Rules 43(h)(4) (1963); Ariz. Rev. Stat. Ann. §§ 13-1802(5), 12-2235 (1956); Ark. Stat. Ann. § 28.607 (1962); Cal. Civ. Pro. Code § 1881 (West Supp. 1966); Colo. Rev. Stat. Ann. § 154-1-7(5) (1964); D.C. Code Ann. § 14-307 (1966); Hawaii Rev. Laws § 222-20 (1955); Idaho Code Ann. § 9-203 (Supp. 1967); Ill. Ann. Stat. Ch. 51 § 5.1 (1966); Ind. Ann. Stat. § 2-1714 (Burns repl. 1946); Kan. Gen. Stat. Ann. § 60-427 (Supp. 1965); Ky. Rev. Stat. § 213.200 (1962); La. Rev. Stat. §§ 15.476 (1967); Minn. Stat. Ann. § 595.02(4) (1947); Miss. Code Ann. § 1697 (Supp. 1966); Mo. Ann Stat. § 491.060 (1952); Mont. Rev. Codes Ann. § 93-701-4(4) (1964); Neb. Rev. Stat. § 25-1206 (1965); N.M. Stat. Ann. § 20-1-12 (1954); N.Y. Civ. Prac. § 4504(a) (1963); Nev. Rev. Stat. § 48.080 (1966); N.D. Cent. Code § 31-01-06 (Supp. 1967); Ohio Rev. Code Ann. § 2317.02 (Page 1954); Okla. Stat. Ann. tit. 12 § 385 (1960); Ore. Rev. Stat. § 44.050(d) ,1959-60); Pa. Stat. Ann. tit. 28 § 328 (1958); S.D. Code § 36.0101(3) (1960); Utah Code Ann. § 78-24-8(4) (1953); Va. Code Ann. § 8-289.1 (Supp. 1966); Wash. Rev. Code Ann. § 5.60.060(4) (Supp. 1966); W. Va. Code Ann. § 50-6-10 (1966); Wis. Stat. Ann. § 325.21 (1958); Wyo. Stat. Ann. § 1-139(1) (1959).

20. Conn. Gen. Stat. Rev. § 52-146a (Supp. 1965); Ga. Code Ann. § 38-418 (Supp. 1966); Ark. Stat. Ann. § 72-1516 (1947); Col. Rev. Stat. Ann. § 154-1-7(8) 24-112 (Supp. 1966).

21. Ala. Code tit. 46 § 297(36) (Supp. 1965); Ariz. Rev. Stat. Ann. § 32-2085 (Supp. 1966); Ark. Stat. Ann. § 72-1516 (1947); Col. Rev. Stat. Ann. § 154-1-7(8) (1963); Del Code Ann. tit. 24 § 3534 (Supp. 1966); Ga. Code Ann. § 84-3118 (1955); Idaho Code Ann. § 54-2314 (Supp. 1965); Iowa Code Ann. § 622.10 (1950); Ky. Rev. Stat. § 319.110 (1962); Mich. Stat. Ann. § 14.677(18) (Supp. 1965); Mont Rev. Codes Ann. §93-701-4(6) (1964); Nev. Rev. Stat. § 48.085 (1963); N.H. Rev. Stat. Ann. § 330-A:19 (1966); N.M. Stat. Ann. § 67-30-17 (Supp. 1967); N.Y.

among many states, these statutes total nearly seventy in number, yet only two of them *might possibly* include group therapy and two can be said *partially* to include group therapy. (This language will be explained subsequently.) By their wording, the remainder of the statutes do not provide for a group privilege.

In general, these "non-group" statutes present a stiuation that would provide little opportunity for extension of the privilege to group therapy. Since group therapy is practiced primarily by both psychiatrists and psychologists, *i.e.* by both medical and non-medical practitioners, a specific statute's first effect will usually be to grant the privilege to either one or the other. Secondly, the statutes granting a privileged communication are in derogation of the common law and as a result they frequently receive strict constructions.[23] One of the clearest examples of the inconsistencies caused by this strict construction is *State v. Bednasek.*[24] Here, a psychologist and a psychiatrist had both worked with the defendant, and under the Iowa "physician-patient" statute the psychiatrist (a physician) was not called as a witness yet the psychologist was required to testify. Considering that this type of approach is frequently taken toward the existing privilege statutes, it seems practically impossible even to consider extending their coverage to a group situation. Furthermore, the presence of several people at the scene of the communication, a concept axiomatic to the group process, creates additional problems for the legal maintenance of confidentiality. With reference to the physician-patient privilege there are some cases which require third persons at the scene of the communication to testify even though the physician was privileged from doing so as a result of the statute.[25] In a group therapy situation, this would mean that even if the therapist were covered by the statute, other patients could be compelled to testify as to what a particular

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FIUC. § 7611 (McKinney Supp. 1967); OKLA. STAT. ANN. tit. 59 § 1372 (Supp. 1966); TENN. CODE ANN. § 63-1117 (1955); UTAH CODE ANN. § 58-259 (1963); VA. CODE ANN. § 8-289.1 (Supp. 1966); WASH. REV. CODE ANN. § 18.83.110 (1961); WYO. STAT. ANN. § 33-343.6 (Supp. 1965).

22. CAL. EVID. CODE §§ 1010-1026 (West 1966); KAN. GEN. STAT. ANN. § 60-427 (Supp. 1965).

23. *E.g.*, Strizak v. Industrial Comm'n, 159 Ohio St. 475, 112 N.E.2d 537 (1953); Meyers v. State, 192 Ind. 592, 137 N.E. 547 (1922); In Re Golder's Estate 37 S.D. 397, 158 N.W. 734 (1916).

24. Criminal Cause 2694, Johnson County Dist. Ct. (Iowa 1950).

25. *E.g.*, Springer v. Byram, 137 Ind. 15, 36 N.E. 361 (1893); Metropolitan Life Ins. Co. v. Brubaker, 78 Kan. 146, 96 Pac. 62 (1908); Denarco v. Prudential Ins. Co., 554 App. Div. 840, 139 N.Y.S. 758 (1913). Some jurisdictions say both the physician and the third person may testify, *e.g.*, Horowitz v. Sacks, 89 Cal. App. 336, 265 Pac. 281 (1928); State v. Knight, 204 Iowa 819, 216 N.W. 104 (1927). The reasoning here is apparently that the communications were not meant to be confidential and are therefore not privileged.

member said. Clearly, such a result would undermine the purpose of the statute.

Other cases look to the relationship between the third person and the physician, and if the third person (*e.g.*, a nurse, medical assistant, or stenographer) is assisting or acting under the direction of the physician in the treatment of the patient, then by implication the third person is included within the privilege.[26] This brings into focus the question of an agency relationship in determining whether or not the statutes can be extended to those people working under the physician's direction. In trying to extend the existing statutes to cover the group therapy situation, it might be possible to follow an agency approach in those jurisdictions that stretch their statutes to cover the agents of the physician. By so "stretching," of course, these jurisdictions abandon the concept of strict construction and take a liberal approach based on the notion that even though the statutes are in derogation of the common law, they are remedial in nature and should therefore be liberally construed.[27] It is quite possible that in a liberal jurisdiction a convincing argument could be made demonstrating that psychotherapy patients, being studied under group conditions by a therapist who himself is covered by the patient's privilege, are agents of the therapist and are thereby freed from a judicial requirement of disclosure. Under this type of argument, they are agents because just like any other "medical assistant," they are performing a function of working with the therapist toward the correction of the other patients' problems. As was demonstrated earlier, the group is used by the therapist to create certain verbal interactions necessary in the process of treating every group patient. Certainly, an examination of the function performed by the group on any particular patient reveals that it is not unlike the function performed by a nurse or a consulting therapist. Just as a nurse aids the physician in treating a medical patient, so does each patient in group therapy aid the therapist in treating other patients. It seems evident, however, that if the existing statutes are to be extended to this new area, the extension can only come through the application of an agency argument combined with a liberal judicial interpretation of the statutes. This much liberality is only possible in a jurisdiction that approaches its statute as "remedial" rather than as "in derogation of the common law"; and even

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26. *E.g.*, Hogan v. Bateman, 184 Ark. 842, 43 S.W.2d 721 (1931); People v. Wasker, 353 Mich. 447, 91 N.W.2d 866 (1958); Culver v. Union Pac. R.R., 112 Neb. 441, 199 N.W. 794 (1924).

27. *E.g.*, Kramer v Policy Holder's Life Ins. Ass'n., 5 Cal. App. 2d 380, 42 P.2d 665 (1935); New York City Council v. Goldwater, 284 N.Y. 296, 31 N.E.2d 31 (1940).

in such a jurisdiction the statute might be limited in its use simply because it applies to either a psychologist or a psychiatrist, and the therapist in the particular case bears the incorrect title.

Of the four group statutes, the two which *might possibly* include group therapy in the above inclusive definition are the California[28] and Kansas[29] statutes. By "inclusive definition," reference is made to the fact that groups are utilized by both psychiatrists and psychologists as opposed to either one in particular. Since both types of therapists practice under this method, an effective group statute would need to provide for both, and the California statute does make this provision. Under section 1010, the statute defines "psychotherapist" to include both a psychiatrist and a psychologist. Under section 1012, the statute defines "confidential communication between patient and psychotherapist" as

> [i]nformation, including information obtained by an examination of the patient, transmitted between a patient and his psychotherapist in the course of that relationship and in confidence by a means which, so far as the patient is aware, discloses the information to no third persons other than those who are present to further the interests of the patient in the consultation or examination or those to whom disclosure is reasonably necessary for the transmission of the information or the accomplishment of the purpose of the consultation or examination. . . .

This definition would seem to mean that in the psychotherapeutic setting, the receiving of communications by necessary participants other than the psychotherapist would still enable the communications to remain confidential. In group therapy, disclosure is "reasonably necessary" for the accomplishment of the purpose when such disclosure is made in the presence of other group patients. The very rationale for the use of group therapy confirms this. However, although the California statute can be described as inclusive with regard to its reaching group sessions under both psychiatrists and psychologists, it was earlier described as a statute which only *might possibly* be applicable to group therapy. The reason for this skepticism is the statutory language in section 1012 which speaks of information "transmitted *between* a patient and his psychotherapist" and further statutory language in section 1014 (the privilege-granting section) which makes privileged "a confidential communication *between* patient and psycho-

28. CAL. EVID. CODE §§ 1010-1026 (West 1966).
29. KAN. GEN. STAT. ANN § 60-427 (Supp. 1965).

therapist." (emphasis added). Both of these sections hint that for the communication to be privileged, it must be directed from the patient *to* the therapist. Group therapy, of course, involves communications between the patients themselves as well as those directed to the therapist and merely overheard by other patients. For a group privilege to exist, the former communications must definitely be privileged also and, should the California courts choose to interpret the statute contra, the statute would fail to present a group privilege. However, to advocate a position favoring a group privilege under this statutory language would not be unfeasible. Certainly, a very rational argument could be made on the basis of presenting those patients spoken to by the one claiming the privilege as mere conduits for communications which, in the end result, are really directed to the therapist in his role as the ultimate producer of ameliorative changes in the patient. Accepting such an argument would lead to the result that the information *was* "transmitted between a patient and his psychotherapist," and the California statute could then be considered a "group privilege" statute.

The Kansas statute is titled as one granting a "physician-patient" privilege. It obviously was designed to apply to some forms of psychotherapy because its definitional section, section 60-427(a), defines "patient" in terms of one with a "physical or mental condition." But since only psychiatrists (as opposed to psychologists) are technically physicians, the statute would not seem to meet the "inclusive" test of applying to both psychiatrists and psychologists. However, section 60-427(a) defines "physician" as "a person licensed or reasonably believed by the patient to be licensed to practice medicine or one of the healing arts as defined in K.S.A. 65-2802. . . ." Section 65-2802 then defines the "healing arts" as

> . . . any system, treatment, operation, diagnosis, prescription, or practice for the ascertainment, cure, relief, palliation, adjustment, or correction of any human disease, ailment, deformity, or injury, and includes specifically but not by way of limitation the practice of medicine and surgery; the practice of osteopathy; and the practice of chiropractic.

In light of this very broad definition of the "healing arts," it could be said that "physician" was meant to include "psychologist," and if such an interpretation were to be reached by the Kansas courts, this statute would be as "inclusive" as the California psychotherapist statute. Since the language is so broad, and since the definition of "patient" does show an obvious intention to include patients with mental conditions, a strong argument could be made demonstrating

that the statute does include both psychiatrists and psychologists; for in essence, when the psychologist is practicing psychotherapy his goal of bringing about ameliorative changes in a patient's mental condition is the same goal as that pursued by the psychiatrist.

But even assuming that this statute were to be interpreted in the "inclusive" sense, it is grouped with the California statute mainly because it too only *might possibly* be applicable to group therapy. The Kansas statute in section 60-427(b) talks in terms of information transmitted *between* physician and patient, and even though this statute also maintains the privilege in the presence of third persons, the semantics of utilizing the preposition "between" creates the same problem discussed with regard to the California statute. Once again, the "conduit theory" would be most applicable.

The Connecticut[30] and Illinois[31] statutes are the two which only *partially* include group therapy. Both of these statutes are clearly worded to include only therapy under a psychiatrist. Neither statute is "inclusvie."[32] However, even with this limitation, there is little doubt that these two statutes do create a "group privilege," *i.e.*, a privilege that extends to those communications directly between patients as well as to those between patient and therapist. It therefore eliminates the "questionable" aspects of the California and Kansas statutes. Since the Connecticut and Illinois statutes are almost identical in the wordings of their respective privilege-granting subsections, either can be used to demonstrate this last point. The Connecticut statute grants the basic privilege in the following terms:

> . . . In civil and criminal cases, in proceedings preliminary thereto, and in legislative and administrative proceedings, a patient, or his authorized representative, has a privilege to refuse to disclose, and to prevent a witness from disclosing, communications relating to diagnosis or treatment of the patient's mental condition between patient and psychiatrist, or between members of the patient's family and the psychiatrist, or between any of the foregoing and such persons who participate, under the supervision of the psychiatrist, in the

30. CONN. GEN. STAT. REV. § 52-146(a) (Supp. 1965).
31. ILL. ANN. STAT. ch. 51 § 5.2 (Smith-Hurd 1966).
32. Goldstein and Katz, members of the drafting committee for the Connecticut statute, point out that the failure to extend the privilege to psychologists is a result of some members of the drafting committee believing that the bill would go too far and of other members believing that legislative support for the bill would be too difficult to obtain. Goldstein and Katz, *Psychiatrist-Patient Privilege: The GAP Proposal and the Connecticut Statute*, 36 CONN. B.J. 185 n. 19 (1962).

accomplishment of the objectives of diagnosis or treatment.[33]

Clearly, the clause "or between any of the foregoing . . . treatment" does provide for an extension of the privilege to those communications between patients and, as a result, one can understand why such a statute is more easily supportable as applicable to group therapy than are the statutes of California and Kansas.

Conclusion

The overall discussion has been in the nature of examining the growing utilization of group therapy, its need for a privilege, and the legal framework within which a privilege might be found. The need for a privilege is obvious. In group treatment, the atmosphere must be one which fosters effective verbal interactions, and only if the patients are willing to disclose their most confidential and embarrassing secrets will the result of their group experience be truly therapeutic. No argument by a group therapist on the need for maintaining strict confidence could be as persuaisve as a mere introspection. Few people could deny their own hesitancy to disclose to others that which is most embarrassing to them. So too, such disclosures are frequently the ones with the most legal ramifications, and if a person knew that the disclosures could one day be compelled from his confidants in a courtroom, his hesistancy so to confide would be increased immeasurably.

When this requirement for a privilege is viewed not in the light of the limited application of group therapy in the early 1940's but instead in the perspective of its extensive application in the 1960's, it should be apparent that the present legal system of granting medical and quasi-medical privileges is somewhat obsolete. The application of an agency argument to the dyadic privilege statutes was shown to have definite shortcomings as a result of the nature of the judicial system. The four "group statutes" were demonstrated as very possibly being effective privilege-granting statutes, yet they were shown to contain questionable language in their respective provisions. Perhaps their most valuable aspects with relation to group therapy are not only that they could be interpreted to grant it a privilege under their present terms, but also that they have shown a susceptibility of multiple-person privileges to legislative approval. The basic approach of these statutes is progressive, and it would require only slight adjustments of their terminology to create an excellent prototype for a decisive group

33. The comparable clause in the Illinois Statute reads:" . . . or between any of the foregoing and such persons under the supervision of a psychiatrist in the accomplishment of the objectives of diagnosis or treatment."

privilege statute. By combining the "psychotherapist" approach of the California statute with the privilege-granting language of the Connecticut and Illinois statutes, the benefits of each could be utilized. The questionable language in the present statutes which seemingly creates problems of psychologist groups not being covered or of communications between patients being unprivileged would be clarified, and the statute created would adequately equip the courts to acknowledge a privilege for any group therapy patient claiming it.

The needs of group therapy for this kind of statutory protection are justifiable. No litigation has yet arisen over the problem of a group privilege, but it should be realized that for every compelled judicial disclosure that may arise, there could be many people rendered reluctant to respond to group therapy as a result of their knowing that the response might be used against them. Quite possibly, such reluctance has already occurred.

Robert Jay Braman