

THE BITTER PILL OF EMPIRICISM: HEALTH MAINTENANCE
ORGANIZATIONS, INFORMED CONSENT AND THE
REASONABLE PSYCHOTHERAPIST STANDARD OF CARE

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I. INTRODUCTION: THE PROBLEM

FOR the first time, those who practice psychotherapy need to show results, and not just to the patient. The therapist-patient relationship has acquired a third member: the Health Maintenance Organization ("HMO"). Thus, patient satisfaction is no longer enough: the insurer must also be satisfied. Because their decisions to pay for treatment are based on predictions about effectiveness, and not on post-treatment actual success, HMOs are only satisfied by (and will only pay for) treatments supported by scientifically generated data.

This need to justify economically the cost of treatment has collided with the philosophical foundation of the profession pursuant to which treatment choices may be based upon philosophy, and not upon a track record of success.¹ The source of this collision lies in managed care, which will reimburse treatment only insofar as it can be proven effective, and only for the fewest sessions that can be justified.² The therapist must not only make the patient happy, but also the patient's insurance company.³ Otherwise, the insurance company will not pay for the treatment, and the patient may not seek it.⁴

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1. With the explosion of managed care in the last fifteen years, behavioral healthcare providers have found themselves lodged between the proverbial rock and a hard place: do they honor their ethical obligation to provide their client with a treatment plan selected solely on the basis of the therapist's professional judgment and the client's interest—thus risking expulsion from the coveted preferred-provider list—or do they breach that obligation by providing compromised treatment dictated by a third party; thereby ensuring a continued source of patient referrals and the success of their practice?

2. See Steven C. Hayes, *What Do We Want from Scientific Standards of Psychological Practice?*, in SCIENTIFIC STANDARDS OF PSYCHOLOGICAL PRACTICE: ISSUES AND RECOMMENDATIONS 63 (Steven C. Hayes et al. eds., 1995) [hereinafter SCIENTIFIC STANDARDS OF PSYCHOLOGICAL PRACTICE] (noting that "[t]he key to the development of scientifically-based practice standards are the changes that are occurring in the health care delivery system in this country").

3. See Jeffrey Barnett & Steven Shearer, *Managed Care Bad for Our Mental Health*, WASH. BUS. J., July 14, 1997, at 1 (noting that powerful managed care companies expected to

This collision between payors and practice has already occurred in the context of medical care; its effects dominate choices of treatment and often create tragic conflict when HMOs deny treatments on the grounds that a treatment is experimental or not empirically justified. The doctors (and their patients) are no longer the sole decision-makers. The HMOs do much of the deciding, and their decisions are rooted in economics and not necessarily in the patients' interests.⁵

The effects of HMO demands for empirically provable treatments are now spreading into the realm of psychotherapy.⁶ Because of the nature of

control every aspect of health-care market including training clinicians to exercise beliefs and skills consistent with theirs), available at <http://www.bizjournals.com/washington/stories/1997/07/14/editorial4.html>. As managed care organizations wage war on mental healthcare costs in an effort to remain profitable, Americans suffering from a mental disorder are often left untreated and, perhaps worse, mistreated. See *Mental Health: Does Therapy Help?*, CONSUMER REP., Nov. 1995, at 734 (discussing recent government study which shows that less than one-third of fifty million Americans who suffer from mental or addictive illness at any given time receive treatment that they need). Despite the fact that over one-half of the states in this country have passed mental health parity laws requiring equality in the provision of mental health benefits, these benefits continue to be doled out at an alarmingly disproportionate rate to those dispensed for general healthcare. See Steven Findlay, *Managed Behavioral Health Care in 1999: An Industry at a Crossroads*, HEALTH AFF., Sept.-Oct. 1999, at 116, 122, available at LEXIS, News Library, Medical and Health Materials Combined File (noting that as of June 1999, twenty-four states had passed mental health parity laws with additional twenty states in process of enacting similar legislation); *Mental Health: A Little Goes a Long Way*, AM. HEALTH LINE, Oct. 1, 1999, available at LEXIS, News Library, Medical and Health Materials Combined File (discussing discrepancies between managed care coverage of mental versus physical health). The average hospital stay dropped 23%, from 6.8 to 5.2 days, between 1990 and 1993, while the average stay in a psychiatric hospital fell by almost 50%, from 20.7 to 10.9 days. See *id.* Additionally, one study reported that when a large behavioral healthcare firm replaced a fee-for-service system with a case-rate system (a.k.a. managed care), psychiatric outpatient treatment fell by twenty-five percent. See *id.*

4. See LINDA SELIGMAN, SELECTING EFFECTIVE TREATMENTS 340 (1990) (noting that managed care organizations emphasize brief treatment of mental disorders, offer little choice of treatment provider and pay little attention to need for extended treatment and prevention, resulting in clients having to pay their own psychotherapy bills or failing to receive needed treatment).

5. See Andy Miller, *Managed Care and Mental Health; A Revolution in Treatment; Patients' Choices Have Narrowed; 'Hassle Factor' Is Much Greater*, ATLANTA J. & CONST., Aug. 30, 1998, at R1 (stating that managed care companies may be focused on "bottom line" instead of patient improvement and noting that only \$3 of every \$100 in health care benefits are spent on behavioral health).

6. See Hayes, *supra* note 2, at 50 (addressing why such standards are not already well established). According to Hayes:

Why do we not already have scientifically-based standards of psychological practice? You might be tempted to say that it has not already been done because the state of the science has not been such that it was possible. It is true that the state of applied psychological science thirty years ago was nothing like what it is today. But there is more to it than that.

The whole *idea* of scientifically-oriented professional disciplines is not very old. Professions have succeeded for centuries in hiding what they do from public view. Special languages were developed, special training barriers were erected. A fair look at the history of guilds shows that these special qualities and processes were developed in part *precisely because they mystified the public*. The rise of psychology as a profession has been marked by the rise of psychology as a guild.

psychotherapy, the problems presented by HMO demands are even more intense than the problems created for medical doctors. In the medical context, there is at least some empirical justification for every treatment offered to a patient.⁷ Those treatments based solely on philosophy ended when the allopaths won control of the medical profession.⁸ This is not true, however, in

Standards of practice that are science-based are *deeply* foreign to the structure and functioning of professional guilds. This is a transition that will not come easily.

What we are witnessing in the standards of care movement is the development of a new view about what professionals should be, not just in psychology but also in society at large. The people and their representatives (government, industry, the media, the courts) no longer genuflect in front of the centuries old mumbo jumbo of guilds. They are refusing to be put off by undocumented claims to special knowledge. As a result we are beginning to see the vague outlines of a day in which practicing psychologists will actually know and will actually follow the scientific literature. At least at first they will do it *not* because they value science but because they will be held accountable—by insurance companies, by the government, by agencies, by funding sources, by consumers, and by the profession.

This change is not just happening in psychology. It is happening in medicine, engineering, industry—in all areas of human functioning. But we have to face facts: if we go down this road, the old way of certifying professionals and of protecting the profession will be threatened. And that is the biggest reason that it has not already happened—intuitively the guild realizes that scientifically based standards of care will be a very real threat to the well understood and successful means they have always used to create a sense of value and specialness about the profession.

Id. at 50-51; *see also* Sam Leigland, *On the Relation Between Clinical Practice and Psychological Science*, in SCIENTIFIC STANDARDS OF PSYCHOLOGICAL PRACTICE, *supra* note 2, at 69 (noting that "clinical psychology faces the problem of attachment to a scientific field that provides very little in the way of basic scientific knowledge regarding clinical phenomena").

7. Faith healing is excepted from this class of treatments.

8. Herbal remedies and the like are not an issue in terms of managed care, because managed care entities do not pay for them anyway. *See* Gregory J. Hayes, *Lessons from Medicine*, in SCIENTIFIC STANDARDS OF PSYCHOLOGICAL PRACTICE, *supra* note 2, at 92-94 (discussing American Medical Association's struggle to improve quality of medical practice in early 1900s). Abraham Flexner, an expert in educational reform and the author of the Flexner Report, is credited with improving medical education in the United States. *See id.* at 92. He felt that there were too many poorly trained physicians practicing and that "society was being denied the fruits of current scientific knowledge . . ." *Id.* at 93. Flexner felt that only the best medical schools should be allowed to operate, and, consequently, medical schools not affiliated with major universities soon faded into extinction. *See id.* On psychology and quality of practice, Hayes notes:

The creation of a scientific base for psychology has lagged behind that of medicine. But it has nonetheless made great strides in the past several decades . . . Psychology has reached a level in its development where it can offer effective diagnosis and treatment in many circumstances. But as was true of medicine 85 years ago, not all psychologists are competent to utilize this knowledge. Many lack the training and skills. It is thus clear that the need for a Flexner-like report on psychological education in the United States . . . is fast approaching. The growing pressures for maximizing quality and minimizing cost in the health and mental health arenas demand that we pursue practical, workable, yet scientific standards of clinical practice in both medicine and psychology without delay.

Id. at 94. For a discussion of the history of medicine, *see* JOHN P. DOLAN & WILLIAM N. ADAMS-SMITH, *HEALTH AND SOCIETY: A DOCUMENTARY HISTORY OF MEDICINE* (1978), which discusses the history of medicine in a societal context, and JACALYN DUFFIN,

the realm of psychotherapy. Choices of treatment depend heavily on the philosophical basis of the particular form of psychotherapy at issue, and empirical justifications may be few and far between. They may also be equivocal, a fact that creates its own dilemmas.

As a result, a patient who approaches a psychotherapist must confront a new choice—whether to proceed with a particular treatment that may well go uncompensated by the patient's insurance provider, or to choose a form of treatment that will be compensated. Certainly, the choice of the average patient will be affected by whether a proposed treatment is covered by his or her health plan. The need for the patient to make this choice means that the patient must be educated to do so. This creates a new obligation—or what may appear to be a new obligation—for the therapist, which is to disclose both the reimbursement status of and alternative treatments to the proposed course of therapy. Because of the nature of psychotherapy, in which the form of treatment will probably depend upon the philosophical beliefs of the therapist, these alternative treatments may well involve therapists other than the one initially consulted, unless the particular therapist has an unusually eclectic approach. Disclosure may also require that the therapist present options with which that therapist disagrees. For those conditions for which medication is at least a possible treatment, disclosure will involve sending the patient to a physician as well.

HMO insistence upon empirical evidence will change psychotherapy in numerous ways. Two of these changes, on which this paper will focus, are the development of a discernable standard of care—what the reasonable therapist should do in the circumstances—and a concomitant change in the content of informed consent, with the therapist obligated to inform the patient about alternative treatments and their success rates. The idea of coupling alternative treatments and success rates arises out of the development of the standard of care, with its implication that some treatments have more empirical support than others. If a particular treatment has strong empirical support, it may be negligent for a therapist to fail to offer that treatment. Moreover, an HMO may refuse to pay for any treatment other than the one with the strongest chance of success. This empirically supported treatment may thus become the standard of care, with the therapist negligent for offering anything else. In a profession in which the choice of treatment may be based on the philosophy of the therapist and not upon empirical data, this change may be cataclysmic.

The focus of this Article will be on the intersection between managed care's demand for empirically proven results and psychotherapy's perception of itself as driven by theory rather than by empiricism. This intersection has created a survival crisis for psychotherapists, who often cannot continue to practice in the absence of reimbursement. The obligation of informed consent and the fact that patient choices of treatment may be reimbursement-driven place a huge burden on the profession, which now must justify its own existence

in a new way. Those driving the reimbursement-based decisions, however, must be careful that what amounts to their supervision of the profession is done with care and knowledge, and not just a concern for the bottom line. The idea of HMOs creating the standard of care through reimbursement decisions is a frightening one. It has had an impact on medical practice. The potential impact on psychotherapy is even greater because the determination of a successful treatment is itself nebulous.

This Article begins with an examination of the profession of psychotherapy, focusing on the tension between the philosophical bases of therapy and the need for empirical justification of those therapies.⁹ The Article then examines informed consent in the medical profession generally.¹⁰ Next, the Article turns to the application of the doctrine of informed consent to psychotherapy, concluding that informed consent, even in the days before managed care, received undeservedly short shrift in the context of talk therapy.¹¹ Finally, the Article examines the impact of managed care on psychotherapy, paying specific attention to the idea of informed consent.¹²

Managed care, with its focus on the bottom line, is forcing psychotherapy into changing its fundamental nature, from a philosophy-based profession into one emphasizing quick and discernible "cures." The informed consent problem poses itself in this context. Therapists have always had an obligation to inform their patients about alternative approaches, although they have largely ignored this obligation. This obligation takes on a new dimension in the managed care context. Managed care's focus on costs compels the profession of psychotherapy to figure out ways to prove its treatments worthy of reimbursement. This proof will consequently impose a more uniform standard of care that will in turn engender the need for therapists to inform their patients of empirically proven treatments.

II. PHILOSOPHY V. EMPIRICISM: THE PROOF OF THE PUDDING

Put simply, the problem is one of philosophy versus science, empiricism versus pure theory, and accountability versus a lack thereof. Much psychotherapy is based on philosophy, the philosophy of the mind and the study of the soul.¹³ This is at least partly due to the mysterious nature of the mind itself. The mind cannot be cured of its problems with a dose of penicillin. On

9. For a discussion of the profession of psychotherapy and the tension between the philosophical basis of therapy and the need for empirical justification of those therapies, see *infra* notes 13-139 and accompanying text.

10. For a discussion of informed consent in the medical profession generally, see *infra* notes 22-26 and accompanying text.

11. For a discussion of the application of the doctrine of informed consent to psychotherapy, see *infra* notes 162-258 and accompanying text.

12. For a discussion of the impact of managed care on psychotherapy, see *infra* notes 259-68 and accompanying text.

13. See ANN F. NEEL, THEORIES OF PSYCHOLOGY: A HANDBOOK 21 (2d ed. 1977) (stating that early psychological theory was "part and parcel of philosophy"); see also *id.* at 33 (noting that psychology incorporated branches of philosophy concerned with mind and behavior).

the other hand, the success of efforts to cure psychological problems can be measured, at least to some extent.

The field of psychology can trace its origins to the philosophical thought of Aristotle, who used simple concepts to explain the relationship between the nature of human experience and mental processes.¹⁴ Dissatisfaction with this purely philosophical model gave rise to psychological schools of thought that stressed observable phenomena.¹⁵ Over time, these two paradigms have vied for dominance. Each paradigm has gained the upper hand before being displaced by a different theory that gained the acceptance of the then-young discipline. The discipline took on the characteristics of a pendulum, swinging slowly and inevitably from one side to the other. As a result, the discipline was unable to produce a unified theory of behavior that comfortably incorporated both of its historical traditions.

The result of this diversity and lack of consensus is a wide range of psychological schools of thought and practices, some driven by observation and others driven by pure theory. It was not until the work of Sigmund Freud in the 1900s, however, that the discipline began to focus on the diagnosis and treatment of the mentally ill.¹⁶ Because it was difficult to define, understand and treat mental illness, treatment models at once took on a strong theoretical approach. This in turn meant that systematic evaluation of success rates was virtually impossible. Thus, empiricism was subsumed in the interest of improving the human condition.

As a result, the recent history of psychology is notable for the variety and number of schools of psychotherapy.¹⁷ These schools are numerous, but few are concerned with empirical underpinnings, preferring instead to focus on patient improvement and theoretical convenience. This theoretical/philosophical model has dominated psychological treatment modalities for approximately the last fifty years. Although this domination of psychological thought is noteworthy, it also appears to be temporary. Recent history suggests that the pendulum is involuntarily swinging in favor of the forces of empiricism.

Ironically, it appears that the lack of empirical support for most modern treatment modalities is itself driving the resurgence of empiricism in the discipline. One of the major goals of managed care is to provide only those services that are needed by eliminating unnecessary treatment.¹⁸ As applied to

14. *See id.* at 21, 23 (noting that psychology arose from philosophical movement of Associationism whose basic principles were conceived by Aristotle); *see also id.* at 33 (noting that psychology incorporated philosophy dating back to Aristotle and Ancients).

15. *See, e.g., id.* at 28-30 (discussing how transformation of Philosophical Associationism into Psychological Associationism was effected by empirical approaches); *see also id.* at 33 (noting that Structuralist school of psychology marked separation of psychology from philosophy as discipline concerned with objective study of human mind and behavior).

16. *See generally id.* at 225-58 (discussing Freud's contributions to psychology).

17. *See generally id.* at 261-627 (discussing various theories of psychology to emerge over last fifty years).

18. *See* G. Terence Wilson, *Empirically Validated Treatments as a Basis for Clinical Practice: Problems and Prospects*, in SCIENTIFIC STANDARDS OF PSYCHOLOGICAL PRACTICE, *supra* note 2, at 163 (discussing goals of managed care).

mental health treatment, this financial goal simply means that managed care does not want to pay for psychotherapy that is ineffective or prolonged. Accordingly, managed care has forced psychology to reconsider its standards of practice, as well as its very future. It is doing so by covering those treatments that have been shown to be effective in producing symptom relief and improvement in patient functioning. In more specific terms, managed care will only cover treatments that have been *empirically validated or supported* and shown to be effective.¹⁹

This emphasis on empirically validated treatments has created a trend towards accommodating managed care and attempting to validate, for HMO reimbursement, a wide variety of different psychotherapies for a wide variety of mental illnesses.²⁰ This is not to say that there is no resistance. Many members of the discipline disfavor a shift to empirically validated treatments for a number of reasons.²¹ One of the most salient reasons is the fear that forcing the profession to validate every treatment will lead to the collapse of kinds of treatment into one compensable form, to the destruction of many individual schools of thought on psychotherapy and to the financial ruin of these practitioners. Many also fear that this will give managed care the power to regulate how psychotherapy is practiced in the future. On the other hand, it is not necessarily the case that such validation is entirely negative: surely generating information on what works and what fails cannot be all bad.

Managed care's insistence on empirically validated treatments also poses other problems for the discipline. In the past, the fact that schools of thought in psychology and psychotherapy were so diverse, not to say nebulous, in itself protected practitioners from legal liability. In terms of treatment and diagnosis, the standard of care for psychological treatment remained vague because there was little agreement on the proper course of action, so it was difficult to sue a therapist for breaching it.²² Thus, in the past, given the lack of consensus in the

19. See *id.* (discussing limitations imposed by managed care).

20. See *id.* at 163-89 (discussing need for empirically validated treatments and progress towards standardized treatment packages).

21. See Jacqueline B. Persons, *Why Practicing Psychologists Are Slow to Adopt Empirically-Validated Treatments*, in SCIENTIFIC STANDARDS OF PSYCHOLOGICAL PRACTICE, *supra* note 2, at 141-54 (discussing various reasons why profession has been reluctant to accept empirically validated treatments). Persons proposes the following six causes: (1) psychologists receive little training in methods that are proven efficient by empirical evidence; (2) psychologists often receive extensive training in methods that are unsupported by empirical evidence of efficacy; (3) many clinicians fail to read the outcome literature; (4) research findings prove difficult for clinicians to utilize; (5) many clinicians feel that all psychotherapies are equally effective; and (6) consumers are uninformed of the research findings. See *id.* at 141-42.

22. See Gerald L. Klerman, *The Psychiatric Patient's Right to Effective Treatment: Implications of Osheroff vs. Chestnut Lodge*, 147 AM. J. PSYCHIATRY 409, 411 (1990) (discussing practitioner orientation, diagnosis and treatment). Professor Klerman notes that in the *Osheroff* case:

Resolution of both the clinical and scientific issues is made difficult by divisions within psychiatry in the United States, where psychiatry is divided theoretically and clinically into different schools—biological, psychoanalytic, and behavioral. . . . There is agreement that the differences in theory and practice involve controversies

field, an exact standard of care has been difficult to determine. The shift to empirically validated treatments may now provide a more scientific and universal standard of care. If there are well validated treatments for depression and anxiety—and there are—should therapists be able to escape liability for malpractice because their therapeutic orientation is not consistent with the validated approach? Would we accept this from the medical profession? Absolutely not.

The existence of empirically supported treatments thus has several effects. One is that a therapist administering a non-empirically supported treatment may be committing malpractice. Another is that the relevant HMO may refuse to reimburse the patient for the care received. A third involves the therapist's obligation to disclose all alternatives and their respective success rates to the patient prior to the initiation of treatment.

This last obligation might require therapists to go outside their own school of thought in order to provide patients with necessary information. In psychology, treatment approaches vary considerably depending on the orientation and knowledge base of the practitioner. A therapist with a specific orientation might not explain or offer referrals for other treatment options outside their school of thought. This might be because they do not accept the validity of other treatments, lack knowledge of other empirically validated treatments or because they have decided that such referrals are bad for business. So when a patient agrees to therapy with such a practitioner (regardless of the practitioner's orientation) without being informed of other, possibly more effective, treatment options, can there really be informed consent? If a patient wants to pursue a possibly less effective therapy for their problems after being told that there might be more effective alternatives, that is the patient's decision. But until a patient is informed of all treatment options, particularly the empirically validated or supported reimbursable ones, that patient cannot give true informed consent. Just as with physicians, the burden should be on psychotherapists to explain a full range of treatment options that include empirically validated ones.

Managed care is forcing psychology and the practice of psychotherapy to become more of a science and less of a philosophy. To meet HMO criteria, psychology is being forced to abandon part of its historical roots and adopt an empirical approach typified by randomized clinical trials and effectiveness outcome studies.²³ Theory alone is no longer adequate; empirical evidence is now required. Although the field of medicine adopted this approach long ago with the discovery of microbes and bacteria, the discipline of psychology has

over the nature of mental illness [and] the appropriateness of different forms of treatment

Id.

23. See Kathleen E. Grady, *Compliance with Standards of Care: Evidence from Medical Research*, in SCIENTIFIC STANDARDS OF PSYCHOLOGICAL PRACTICE, *supra* note 2, at 83-87 (discussing phases of clinical trials).

been reluctant to follow the same path for financial, theoretical and legal reasons.²⁴

The problem is also one of accountability. In the past, it has been difficult for the legal system to hold psychotherapists liable for treatment and diagnostic decisions. As mentioned previously, this is due, in part, to a nebulous and shifting standard of care—a standard of care that was at the mercy of a wide variety of treatment modalities and psychological schools of thought. Currently, it appears that the legal system has not taken into account the importance of empirically supported or validated treatments to the practice of modern psychology and psychotherapy. These new standards of practice are the beginning of a clear standard of care for all therapists regardless of orientation, and also breathe new life into the doctrine of informed consent as applied to psychological interventions.

Informed consent has in the past proved a difficult doctrine in the realm of psychotherapy. This is partly due to the nebulous nature of the standard of care, which caused difficulty in defining exactly what the therapist had to disclose to the patient in order to obtain informed consent. With the advent of empirically validated treatments, some of this nebulousness will dissipate, and it will be easier to prove a standard of care in cases alleging its breach. Beyond this, however, the question of reimbursement may have an effect on informed consent. One of the primary difficulties of informed consent in psychotherapy is the problem of proving damages.²⁵ Where a therapist is being sued for failure to inform a patient of the availability of a treatment that would be reimbursed, however, the damages will be the unreimbursed cost of the treatment provided.

The informed consent issue reaches beyond HMOs and reimbursement into a more fundamental realm. Arguably, informed consent is even more

24. See generally *id.* at 83 (discussing application of Food and Drug Administration review process to psychological treatments). In discussing the application of empirical validation to psychology, Grady notes:

The generalizability from the clinical practice of medicine to the clinical practice of psychology is clearly limited. . . . Medicine is far ahead of psychology in the establishment of its profession. Yet, an accepted method for the promulgation of standards of care has not been developed, and novel approaches are still being tested. Enforcement of standards of care is uneven and, in many cases, ineffective. However, broad-based voluntary compliance and individual commitments to professional standards support the need for continuing efforts. . . .

Id. at 91.

25. Damages in informed consent cases are difficult, even in cases involving medical treatment. In order to prevail, the plaintiff must show that, had the plaintiff been informed of alternative treatments, he or she would have selected one of the alternatives and thereby eliminated the negative side-effects of the treatment that was administered. See *Canterbury v. Spence*, 464 F.2d 772, 790 (D.C. Cir. 1972) ("A causal connection exists when, but only when, disclosure of significant risks incidental to treatment would have resulted in a decision against it."). In cases involving psychotherapy, the difficulty of proving that the patient would have been better off with an alternative about which the patient was uninformed might well be impossible. In reimbursement cases, however, where the patient would have selected a reimbursable treatment if informed of its existence (or if informed that the particular recommended treatment would not be reimbursed), the damages will be the cost of the treatment itself. The patient would have been at least financially better off with the alternative.

important when a patient is paying for psychotherapy out-of-pocket, because the managed care entity is not involved and functioning as a quasi-quality assurance mechanism. Like managed care, the legal system should be applying more pressure on the discipline of psychology and the practice of psychotherapy. Ironically, by pressuring the discipline to develop standards of care, HMOs may accomplish this goal. Increased accountability through "suability" will force the discipline to validate its existence in scientific terms, just as the field of medicine was forced to do years ago. In addition, increased accountability should raise standards of practice, improve treatment and diagnosis, weed out charlatans and incompetents, and raise the respectability of the profession in the eyes of the public.²⁶

III. PSYCHOLOGY, PHILOSOPHY AND THEORY: THE BACKGROUND

The development and history of psychology can best be conceptualized as a battle between two opposing forces—philosophy and empiricism. Fundamentally, psychology is a discipline based on philosophy, and can best be characterized as theory driven.²⁷ Although there are basic concepts and common threads that provide the foundation for most psychological concepts and schools of thought, the rifts between the theoretical orientations and schools of thought remain substantial.²⁸ Indeed, the theoretical commonalities that provide a common language and conceptual viewpoint for the observation-based "hard" sciences (e.g., medicine, chemistry and physics) are not well established or are cast aside in favor of theoretical neatness in psychology.²⁹

26. See Hayes, *supra* note 2, at 49 (noting that scientific standards of practice have potential to change practice of applied psychology). Traditionally, protection of the public has been attempted through a variety of mechanisms such as licensure requirements and ethical codes. See *id.* at 49-52. Some commentators have noted that the licensure requirement has not provided adequate protection from poor psychological practice. See *id.* at 49 (stating that "licensed psychologists have . . . 'taken license' with their clients by providing empirically unproven technologies—as if licensing itself insures the quality of services that are delivered"). The argument continues that specific forms of professional conduct and skills (i.e., the application of empirically validated treatments) should be the standard rather than focusing on a general standard such as the general practice of psychotherapy in an unspecified modality. See *id.* at 50 (asserting that this must be done for good of public and profession); see also Stephen R. Reisman, *Managed Care: Some Implications for Practice and Training*, in SCIENTIFIC STANDARDS OF PSYCHOLOGICAL PRACTICE, *supra* note 2, at 79 (discussing total quality improvement process in context of empirically validated treatments and managed care).

27. See B.R. HERGENHAHN, AN INTRODUCTION TO THE HISTORY OF PSYCHOLOGY 5 (2d ed. 1992) (discussing science, psychology and empiricism and noting argument that psychology is not science because it relies on subjective experience).

28. See NEEL, *supra* note 13, at 3 (noting that theories of psychology are based on various hypotheses and tend to lack common language or theoretical basis).

29. See *id.* (noting that language and concepts of one psychological system is foreign to another). Some have characterized the approach to establish commonality in scientific theory as the "philosophy of science." See *id.* In order to provide a common basis among these theories a common framework for analysis must be established. See *id.* Components of this framework impose order on observable facts and information and include: (1) basic terminology that provides an organizational underpinning and point of reference; (2) the principle focus of the theory; (3) theoretical boundaries and guidelines for studying the principle focus of the theory; and (4) application of

Thus, a large number of psychological theories and treatments flourish despite the complete absence of any empirical support or basis in reality.³⁰ This in turn means that, over time, the discipline of psychology has become fragmented, unscientific and contentious.³¹ Rather than evolving as a science, psychology has remained conceptual, philosophical and theoretically driven.³² The view tends to be that scientific validation cannot prove that any one theory or treatment is better than any other. This approach was evident at the inception of the discipline and continues to flourish and influence the development of psychological theory today despite strong financial pressures to the contrary. The history and development of psychology is the perfect foil for analyzing how the discipline of psychology evolved in this fashion, and also how this evolution has led it into the current theoretical crisis that it now faces.³³

The historical roots of psychology can be traced to the philosophy of Aristotle and Philosophical Associationism.³⁴ Originally, Associationism conceptualized human experience and thinking in the context of philosophical thought and focused on the basic concepts of "ideas," "images" and "sensations."³⁵ Associationists used these simple concepts both individually and in combination to interpret and explain the relationship between the nature of human experience and mental processes.³⁶ As philosophers, Associationists were not interested in consciousness, emotion, motivation, behavior or

the methods of investigation leading to the discovery of causal relationships and principles. *See id.* at 3-4.

30. *See id.* at 7-8 (discussing philosophical and scientific conventions of theory construction). Science is primarily concerned with establishing cause and effect relationships. *See id.* at 7. There are two primary approaches to theory construction. The empiricist view asserts that:

[T]he goals of science can be reached only through collecting facts ungarnished by interpretation [T]he value of a fact may not be immediately apparent, but . . . when enough data has been accumulated, the complex patterns connecting isolated bits of information will be understood Theories or extrapolations [that] anticipate the interpretations of these relationships are unscientific.

Id. Other investigators advocate a theoretical approach to understanding information. Under a theoretical approach

[t]heory gives the scientist an appropriate framework within which to consider new findings. He can then be guided by their implications rather than continuing to record blindly whatever data he comes upon. Theory can add economy and efficiency to research and point up relationships one might not otherwise suspect.

Id. Although these two views appear irreconcilable, both seek to explain observable phenomenon. *See id.* at 10.

31. *See generally id.* at 21-61 (discussing historical foundations of psychology and various theoretical orientations).

32. *See generally id.* (same).

33. *See generally id.* (same).

34. *See id.* at 21 (noting that much of science can attribute its origins to philosophical thought).

35. *See id.* at 22 (noting that Aristotle's Associationism was influential up until Renaissance and was then refined by modern theorists such as Thomas Hobbes, John Locke and James Mill).

36. *See id.* at 22 (discussing how Associationists explained complicated thoughts and experiences by combining basic elements as they related to ideas).

personality per se; did not distinguish between sensation and perception; and used logic, observations and speculation to explore these relationships.³⁷

In an attempt to explain the mental existence of humankind, Associationism began to focus on the natural behavior of man and other organisms.³⁸ As it evolved, Associationism began to take on a psychological perspective by considering the content of the human experience and the acquisition of associations.³⁹ This form of Associationism, known as Psychological Associationism, focused on the importance of perception of meaningful relationships between the organism and the environment for the formation of associations.⁴⁰ Associationism continued to evolve, and one can still see its influence in modern psychological schools of thought such as Behaviorism.⁴¹

In 1846, the psychological school of thought known as Structuralism came into being.⁴² A blend of Associationism and empiricism, Structuralism was the first attempt by psychology to separate from philosophy as a discipline through the *objective* study of the human mind and behavior.⁴³ Like the Associationists, Structuralists attempted to reduce human psychology and behavior into basic components called "mental elements."⁴⁴ The Structuralists hypothesized that the human consciousness was the direct result of components that were similar to chemical elements. These elements were essential to understanding the human experience and mental function and could only be understood by analyzing the structure of mental processes.⁴⁵ Believing that their discipline

37. *See id.* at 23 (noting that these concepts were crude but appropriate for conceptualizing hypotheses of era). The study of these relationships produced three fundamental principles that explained human thought and associations. *See id.* at 23-24 (discussing Aristotle's three primary laws accounting for formation of associations). The first principle hypothesized that similar ideas become associated with one another. *See id.* at 23 (providing example of bread and rolls; shoes and boots). Conversely, the second principle asserted that contrast between concepts produces association. *See id.* (offering examples of black with white; yes with no; up with down). Not surprisingly, the third principle focused on contiguity, and stood for the proposition that objects become associated because of their relationship in time and space. *See id.* (providing example of tables with eating; chairs with sitting; pens with writing; schools with learning; churches with praying). Although these principles were established centuries ago, they are still accepted as psychological tenets today. *See id.* at 27 (critiquing principles of Associationism).

38. *See id.* at 28-30 (discussing evolution of Associationism).

39. *See id.* at 21-22 (noting that this occurred when empirical approaches were applied to Associationism).

40. *See id.* at 28-30 (noting that Lloyd Morgan, for example, not only observed his subjects' behavior, but also their reaction to external forces).

41. *See id.* at 22 (discussing theoretical advances in learning theory as characteristic of final period of Associationism).

42. *See id.* at 33 (noting that Structuralism marked emergence of psychology as science apart from philosophy).

43. *See id.* (stating that Structuralism incorporated philosophy of Aristotle and Ancients).

44. *See id.* at 34 (noting that concept of mental elements was established by Wilhelm Wundt and E.B. Titchener).

45. *See id.* (comparing Structuralist views of consciousness to Periodic Table of chemical elements). The Structuralist's main focus was to:

should be a pure science, the Structuralists were the first to apply observational techniques to the study of psychology.⁴⁶ Given this focus, Structuralists did not see learning, motivation, emotion, personality or behavior as appropriate areas of study for the evolving discipline of psychology.⁴⁷

Often credited with being the founder of modern psychology, William James created a significant paradigm shift in psychology by shifting the focus from the theories of the Structuralists and Associationists to theories that focused not only on observation and introspection, but also on speculation.⁴⁸ James wanted to broaden the scope of psychology, and, as a result, pursued an eclectic approach that delved into areas previously thought unworthy of study by the Structuralists.⁴⁹ James' approach had a significant impact on the then relatively young discipline of psychology, an impact that is still felt today.⁵⁰ James was unwilling to accept the idea that human psychology could be broken down into basic elements or components, as proposed by previous theorists such

analyze the conscious process into elements, determine the manner of connection among these elements, and then discover the laws which govern the connection. This could only be done by studying immediate experience as it was taking place. Since experience could only be reported by the experiencing person, it was imperative that experience be treated as an objective phenomenon, even if it be that of the observer himself.

The Structuralists further insisted that psychology be a pure science. No metaphysical concerns were permitted and no armchair philosophy was tolerated. Everything was to be tested or testable. Likewise, no practical concerns were allowable. Knowledge was to be secured for its own sake, since the search for applications was felt to sully the purity of science.

Id.

46. *See id.* (noting that desire of Structuralists to study psychology as pure science placed restrictions on their research methodology). The two main investigative modalities employed by the Structuralists were psychophysical techniques and classical introspection. *See id.* at 34-35. Three main types of psychophysical techniques, which are primarily concerned with the measurement of sensory thresholds, were identified by the Structuralists: the method of limits, the method of constant stimuli and the method of average error. *See id.* Classical introspection, which is a form of self-reported introspection, requires the subject to report the observable characteristics of a stimuli without interpreting its meaning. *See id.* at 36. Psychologists still use these techniques, in modified forms, in the study of human perception and behavior. *See id.* at 35.

47. *See id.* at 40-46 (noting that Structuralists were not concerned with higher mental processes and focused instead on perception and consciousness).

48. *See id.* at 49 (discussing William James' contributions to development of modern psychology).

49. *See id.* (noting that James did not focus on experimental work but preferred less rigid means of investigating human experience). Unlike the Structuralists,

James did not subscribe to any particular doctrine; his thinking developed side by side with that of other theorists, and he felt free to borrow from them, to include or exclude their concepts, depending upon the scientific appeal a particular suggestion held for him. His flexibility led not only to eclecticism in his own theory, but also to critical evaluation of contemporary theories, and he thereby stimulated the development of other psychological concepts.

Id.

50. *See id.* at 50 (noting that although James' interest in psychology was short-lived, many of his contributions spark debate to this day).

as the Structuralists and Associationists.⁵¹ Instead, he believed that the primary focus of psychology should be the study of the relationship between physical and psychological reality.⁵² The study of this relationship led James to hypothesize that there must be a physiological link to most, if not all, psychological processes.⁵³ To study these hypotheses, James once again broke from the traditions and methods of Structuralism and Associationism.⁵⁴ Rather than focus on pure observation, James applied less purely objective and more theoretical means of data collection and interpretation.⁵⁵

James' greatest contributions to psychology were in the area of behavior and personality and in his conceptualization of the psychological self and self-

51. *See id.* (discussing basic factors constituting James' theory). Diverging from earlier theories, James proposed that psychology must consider certain basic factors. *See id.* James proposed for the first time that psychology must take into account the fact that the individual's perception and interpretation of the world was critical to the understanding of human psychology. *See id.* For a discussion of the Associationist and Structuralist viewpoints, see *supra* notes 33-50 and accompanying text.

52. *See NEEL, supra* note 13, at 50-51 (noting that James not only expanded areas of study but also was first to study children, primitive groups and severely mentally ill). To James, the study of psychology was "the science of mental life, including the fundamental biological and neurological processes and the individual's personal experience." *Id.* at 50. For a discussion of James' conceptualization of emotion and the nature of consciousness, see William James, *A World of Pure Experience*, 1 J. PHIL. PSYCHOL. & SCI. METHODS 533-43 (1904) (discussing philosophical theories of thought); William James, *Does Consciousness Exist?*, 1 J. PHIL. PSYCHOL. & SCI. METHODS 477-91 (1904) (exploring nature of consciousness); William James, *What is an Emotion?*, 9 MIND 188-205 (1884) (discussing physiology of emotions).

53. *See NEEL, supra* note 13, at 51 (discussing James' contribution to modern study of neural transmission). James also hypothesized that psychological experiences actually modified the human nervous system. *See id.* These alterations led to changes in human behavior, which then satisfied biological drives and needs. *See id.* Despite this biological disposition, James was adamant that individuals were still capable of exercising free will. *See id.*

54. *See id.* at 51 (discussing James' methods of investigation).

55. *See id.* (noting that James' technique was more interpretive and less objective than classical introspection of Structuralists). Although James advocated less structured approaches to research and interpretation, he also recognized the importance of using experimental methods when practical. *See id.* James hypothesized that there was a direct relationship between an individual's state of consciousness and brain activity, and suggested that psychology should accept and study this relationship. James refused to accept the Structuralist view that consciousness was composed of separate elements or fragments, preferring instead to conceptualize consciousness as a "continuous, flowing current, characterized by a private, personal, dynamic quality." *Id.* at 53 (noting that this position was consistent with James' concept of free will and rationality). In essence, James was dissatisfied with studying the content of the human mind, and was more concerned with its function. *See HERGENHAHN, supra* note 27, at 300-01 (discussing themes common to Functionalist school of thought). In addition to redefining the concept of consciousness, James was the first theorist to address higher-level mental processes that other earlier theorists did not deem appropriate for study by psychology. *See NEEL, supra* note 13, at 54 (noting that Structuralists thought human cognition was beyond study). For example, James was the first to study cognition, memory, emotion, motivation and the human learning process-areas of human experience previously unexplored by psychologists. *See id.* at 54-57 (discussing James' contributions and noting that James studied these areas from psychobiological perspective).

esteem.⁵⁶ Although incomplete and controversial, James' conceptualization of the psychological self provided the impetus for further research and intellectual discourse. More importantly, the intellectual exchange that succeeded James' theories contributed significantly to the development of modern conceptualizations of the psychological self and fostered the rise of Functionalism in the late 1800s.⁵⁷

Building on James' theories, the Functionalists continued to attack the more traditional schools of thought exemplified by Structuralism.⁵⁸ Like James, the Functionalists theorized that the study of mental processes, as opposed to the contents of the human mind, was the proper direction for the new science of psychology to follow.⁵⁹ More specifically, the Functionalists were interested in studying mental processes as they applied to an entity's ability to adjust and function within its environment.⁶⁰ Integral to this theoretical position was the development of the "stimulus-response" sequence, which was the forerunner of modern behaviorism and focused primarily on the study of mental processes as

56. See NEEL, *supra* note 13, at 57 (introducing James' conceptualization of psychological self). James's conceptualization of the psychological self was a dynamic interaction among three selves: the material self, the social self and the spiritual self. *See id.* at 57-58 (discussing three aspects of psychological self). The material self involved the material wealth of the individual, and the influence of these objects played a significant role in determining one's identity. *See id.* at 57. The social self referred to how an individual was perceived and treated by others. *See id.* Interaction with various social groups affected a person's perception of self-worth, success and failure. *See id.* An inability to function in certain social environments created psychological discomfort or disturbance, which frequently resulted in a change in self-concept. *See id.* The spiritual self represented "the individual's intellectual capacities, his sensibilities, his will—all of the faculties of his mind in combination. The spiritual self was what the individual thought of as his true self, as 'me.'" *Id.* at 58. Discrepancies between the three aspects of self could produce mild to severe emotional discomfort. *See id.* at 58.

57. *See id.* at 58-60 (noting that concept of self has become tremendously important topic of research); *see also* HERGENHAHN, *supra* note 27, at 300 (noting that focus on individual marked rise of Functionalism).

58. *See* NEEL, *supra* note 13, at 63 (noting that discontentment with Structuralist viewpoint helped promote rise of Functionalism); *see also* HERGENHAHN, *supra* note 27, at 300-31 (discussing Functionalist attack on Structuralism). *But see* Mary Whiton Calkins, *A Reconciliation Between Structural and Functional Psychology*, 8 PSYCHOL. REV. 61, 61-81 (1906) (attempting to reconcile diametrically opposed view points of Structuralists and Functionalists).

59. *See* HERGENHAHN, *supra* note 27, at 300-01 (noting that Functionalists were interested in what mind *is for* rather than what it *is*); *see also* NEEL, *supra* note 13, at 64-65 (noting that this mode of thought was considered "radical" at time). James had anticipated the inevitable conflict between his theories and those of the Structuralists. *See id.* at 64. In an attempt to allow both theoretical orientations to coexist, James distinguished between structural psychology, which was concerned only with the content of the mind, and functional psychology, which was concerned with mental processes and their biological correlates. *See id.* Emphasizing this contrast, James asserted that Structuralism could still play an integral part in understanding the human consciousness, but was only a part of a much larger and complex picture. *See id.*

60. *See* NEEL, *supra* note 13, at 64 (noting this was part of general effort to extend studies of mental processes beyond content of mind).

they mediated between the individual and the environment.⁶¹ To study this relationship, the Functionalists de-emphasized empiricism and adopted a flexible research approach to study the conscious experience and devised methodologies to fit the given problem or research question being posed.⁶² In sum, the overall Functionalist approach identified basic stimulus response units and how the units interacted in a coordinated fashion to produce human behavior.⁶³ Although the Functionalist school of thought was criticized as being more of a vague "abstract statement of principles" than a scientific body of knowledge, its unique psycho-physiological orientation promoted research for years to come and was directly responsible for the rise of Behaviorism.⁶⁴

Generally, Behaviorism was founded in direct response to the shortcomings inherent in the theories of both the Structuralists and the

61. *See id.* at 64-65 (noting that Functionalism quickly gained support from both American and European psychologists). Although unconscious autonomic mental activities (i.e., habit) were within the purview of the Functionalists, they continued in the tradition of James and focused on conscious activities and their impact on human adjustment to the environment. *See id.* at 66 (contrasting habitual and conscious activities).

62. *See id.* at 66-67 (noting that in addition to laboratory experimentation, Functionalists used philosophy, literature and art in their research). This flew directly in the face of the Structuralists and opened many new areas of investigation for psychology. *See id.* at 66.

63. *See id.* at 67 (noting that conscious behavior could be identified by creativity, problem-solving value or adaptiveness). On the nature of consciousness, the Functionalists once again focused on the individual's responses to the environment, asserting that consciousness "was synonymous with adaptation, [because] it mediated between the environment and the organism's needs." *Id.* at 68 (quoting James R. Angell). Accordingly, and with mixed results, the Functionalists applied this same theoretical construct to other aspects of the human experience such as sensation, cognition, emotion, motivation, behavior and personality. *See id.* at 68-72 (describing contributions of Functionalist theory to understanding human behavior).

64. *See id.* at 73-74 (giving critique of Functionalist movement). The school of Psychological Associationism followed Functionalism and established the basis for early learning theory. *See id.* at 81 (discussing Associationism's influence on discipline of psychology from 1898 to 1938). Driven by the study of animal behavior, Associationist theorists such as E.L. Thorndike and I.P. Pavlov established the basis for modern learning theory. *See id.* at 81-102. The primary focus of the Associationists was cognitive learning and the stimulus-response model made famous by Pavlov's classic work with animals. *See id.* at 96. Pavlov's best-known work involved the salivation response in dogs. *See id.* Pavlov noticed that dogs salivate in the presence of food. *See id.* He referred to the food as an "unconditioned stimulus" and the salivation as an "unconditioned response." *Id.* Put simply, Pavlov used these terms because he hypothesized that the response to food was native to the dog and would have been present without any intervention. *See id.* Pavlov then "conditioned" the dog to salivate in the absence of food by pairing the presentation of food with an unnatural stimulus, in this case, the sound of a ringing bell. *See id.* The presentation of food coincided with the ringing of the bell. *See id.* After a number of these trials, the food was not presented while the bell was rung. *See id.* Even in the absence of food, the ringing caused the dog to salivate—the dog had "learned" to associate the ringing of the bell with the presentation of food. *See id.* Pavlov referred to the ringing as the "conditioned stimulus" and the salivation that occurred after its presentation as the "conditioned response." *Id.* In essence, he had created a learned behavior that was not native to the dog. *See id.* This work required neither introspection nor self-report on the part of the subject and allowed psychology to focus on observable behavior that could be empirically analyzed. *See id.*

Functionalists.⁶⁵ Although both schools of thought relied on introspection as a legitimate research methodology, the Structuralists studied only the content of the mind and were not concerned with practical applications, while the Functionalists were more concerned with application over pure science.⁶⁶ These concerns prompted the Structuralists to take an observational approach while the Functionalists de-emphasized observation in favor of theoretical soundness. Despite this theoretical orientation, latter day Functionalists began to realize the value of studying human behavior without using introspection, and began to reevaluate the use of empiricism and the objective study of behavior.⁶⁷ Although this conceptual shift eventually became known as Behaviorism, the original foundations were clearly set in the Functionalist theoretical framework.⁶⁸

John B. Watson is credited with founding Behaviorism.⁶⁹ Watson's work relied heavily on the efforts of earlier theorists who helped transform Functionalism into modern Behaviorism.⁷⁰ Watson came from a strong

65. See HERGENHAHN, *supra* note 27, at 335-36 (discussing criticism of Structuralist and Functionalist use of introspection).

66. See *id.* at 335 (comparing Structuralism and Functionalism).

67. See *id.* at 336 (describing drift of Functionalism towards Behaviorism).

68. See *id.* (noting that convincing argument can be made that James Cattell established Behaviorism approximately nine years before John B. Watson's "official" founding of school of thought). Cattell's own words are informative:

I am not convinced that psychology should be limited to the study of consciousness as such, insofar as this can be set off from the physical world . . . I admire the products of the Herbartian School and the ever-increasing acuteness of introspective analysis from Locke to Ward. All this forms an important chapter in modern psychology; but the scientific results are small in quantity when compared with the objective experimental work accomplished in the past fifty years. There is no conflict between introspective analysis and objective experiment—on the contrary, they should and do continually cooperate. But the rather wide-spread notion that there is no psychology apart from introspection is refuted by the brute argument of accomplished fact.

It seems to me that most of the research work that has been done by me or in my laboratory is nearly as independent of introspection as work in physics or in zoology. The time of mental processes, the accuracy of perception and movement, the range of consciousness, fatigue and practise, the motor accompaniments of thought, memory, the association of ideas, the perception of space, color-vision, preferences, judgments, individual differences, the behavior of animals and children, these and other topics I have investigated without requiring the slightest introspection on the part of the subject or undertaking such on my own part during the course of the experiments. . . . It is certainly difficult to penetrate by analogy into the consciousness of the lower animals, of savages and of children, but the study of their behavior has already yielded much and promises much more.

Id. at 335.

69. See Diane F. DiClemente & Donald A. Hantula, *John Broadus Watson, I/O Psychologist*, 37 *INDUS.-ORGANIZATIONAL PSYCHOL.* (Apr. 2000) (providing overview of Watson's contributions to psychology), available at <http://www.siop.org/tip/backissues/TipApril00/7Diclemente.htm>; see also NEEL, *supra* note 13, at 107 (noting John Watson's influence on development of Behaviorism).

70. See HERGENHAHN, *supra* note 27, at 324-31 (discussing work of latter day Functionalist Edward L. Thorndike and Russian psychologist Ivan Petrovich Pavlov). Using the stimulus response model, Thorndike established a number of classical psychological

empirical background, and, as a result, he hypothesized that there could be a completely objective formulation of all psychological processes, including consciousness.⁷¹ It is fair to say that the overarching goal of Watson's work was to establish psychology as a science based on observable phenomena and then to free it from non-quantifiable concepts such as consciousness and other mentalist concepts.⁷² Watson believed this so zealously that his theoretical orientation is often referred to as "objective psychology."⁷³ Objective might be too subtle a term for describing Watson's theories, because he also believed that the study of psychology should strive toward the goal of predicting and controlling behavior by understanding environmental influences that effected the behavior of the organism.⁷⁴ Focusing on the organism as a whole, Watson limited his inquiries to observable behavior.⁷⁵ Accordingly, Watson rejected the use of introspection as a methodological approach and also rejected the idea that consciousness was responsible for behavior.⁷⁶ Conversely, Watson proposed that consciousness

principles known as the Law of Effect, the Law of Exercise and the Law of Spread of Effect. *See* NEEL, *supra* note 13, at 90 (summarizing Thorndike's theory of learning). The Law of Effect stands for the proposition that rewarding behavior reinforces it, while punishment diminishes it. *See id.* The Law of Exercise stands for the proposition that the repeated pairing of a stimulus and response aids in learning but does not cause it. *See id.* The Law of Spread of Effect stands for the proposition that responses occurring close together temporally are strengthened through a process known as generalization. *See id.* Although Thorndike was not concerned with consciousness, he contributed significantly to theories of learning and the role of motivation in the learning process. *See id.* at 91 (summarizing Thorndike's theory of learning). Similar to Thorndike, Pavlov hypothesized that all mental events were the products of "reflex units of behavior." *Id.* at 95. His theoretical stance was slightly more extreme than Thorndike's, because Pavlov asserted that all psychological constructs could be reduced to the study of physiological processes. *See id.* at 102. Focusing on the principles of "brain excitation and inhibition," Pavlov hypothesized that "reinforcement was necessary to establish a conditioned response." *Id.* Failure to reinforce a conditioned response produced extinction of the conditioned response, just as a response could be generalized to stimulus that was similar to the original conditioned stimulus. *See id.*

71. *See* NEEL, *supra* note 13, at 107-08 (noting that much of Watson's work was in opposition to continued efforts by Structuralists to impose their theoretical orientation on psychology). Although Watson studied under the renowned British empiricist A.W. Moore, history notes that the greatest influence on his theoretical orientation came from the prominent Functionalist James Angell. *See* HERGENHAHN, *supra* note 27, at 348 (discussing Watson's studies at University of Chicago).

72. *See* NEEL, *supra* note 13, at 109 (noting that Watson defined psychology as study of behavior and interaction with environment).

73. *See* HERGENHAHN, *supra* note 27, at 352 (noting that Watson found support for his theories in Russian objective psychology characterized by work of Pavlov).

74. *See* NEEL, *supra* note 13, at 109 (noting that Watson's goal was "to free psychology from leanings he believed to be unscientific").

75. *See id.* (noting that this approach encompassed neurological and physiological responses of organism). This approach reduced Watson's study of behavior to an organism's sensory receptors, its nervous system and its effectors. *See id.* (explaining variables of interest for studying behavior under Watson's approach).

76. *See* HERGENHAHN, *supra* note 27, at 352 (noting that Watson rejected all conceptualizations of behavior based on mentalism). Watson conceptualized emotion as follows: an organism is exposed to an environmental stimulus, overt behavior occurs in reaction to the stimulus, and then the overt behavior creates a visceral change, which is interpreted as emotion. *See* NEEL, *supra* note 13, at 114 (explaining Watson's theory on

"was merely a phenomenon that accompanied certain physiological reactions caused by stimuli."⁷⁷

This observational approach to the study of psychology provided groundbreaking information that guided the discipline for years.⁷⁸ Despite these contributions, however, Watson did not achieve his overarching goal—the goal of redefining psychology as the study of observable behavior.⁷⁹ Ironically, Watson's own theories were integrated into a new school of thought represented by the Neobehaviorists.⁸⁰ Using Behaviorist theories and logical positivism, the Neobehaviorists reintegrated psychology and philosophy—clearly not a goal Watson would have supported.⁸¹

The unexpected backlash of Watson's purely empirical approach was a growing dissatisfaction with psychology's ability to predict human behavior.⁸² Watson himself acknowledged that, although his research produced valuable data, there were no overarching theoretical constructs that could be used to explain and predict human behavior.⁸³ Enter logical positivism and the Neobehaviorists.

Neobehaviorism has its roots in logical positivism.⁸⁴ Logical positivism is the blending of empirical and theoretical approaches to the study of science, in

origin of emotion). Consistently, Watson interpreted personality as "the sum total of an individual's verbal, visceral, and motor habits." *Id.* at 118.

77. HERGENHAHN, *supra* note 27, at 352 (comparing and contrasting Watson's work with Russian contemporaries). Watson identified and focused on four main types of behavior, into which all human behavior could be classified: explicit (overt) learned behavior, such as talking and writing; implicit (covert) learned behavior, such as increased arousal in stress-provoking situations; explicit unlearned behavior, such as involuntary bodily responses like blinking; and implicit unlearned behavior typified by biological processes. *See id.* at 353 (explaining how Watson defined types of behavior and studied them). Because Watson shunned mentalism, his research methodology was empirically driven and objective. *See id.* Specifically, Watson used the four following methods for studying behavior: observation, the conditioned reflex method, testing of behavioral samples and verbal reports that were treated as a form of behavior and not used as a means of studying consciousness. *See id.*

78. *See id.* at 358-59 (explaining that Watson's work had lasting effects on psychology, such as establishing "prediction and control of behavior" as major goal of psychology).

79. *See id.* at 359 (explaining that few psychologists accepted Watson's view that only "environment events and overt behavior" can explain behavior).

80. *See id.* at 373 (noting that Neobehaviorism dominated psychological thought from 1930 to approximately 1950).

81. *See id.* at 372-92 (discussing theoretical evolution of Neobehaviorist theory). For a discussion of behaviorist theories as applied to the therapeutic process, see Daniel B. Fishman & Cyril M. Franks, *Evolution and Differentiation Within Behavior Therapy: A Theoretical and Epistemological Review*, in *HISTORY OF PSYCHOTHERAPY: A CENTURY OF CHANGE* 159 (Donald K. Freedheim ed., 1992) (explaining "evolution of behavior therapy in terms of epistemology and theory").

82. *See* HERGENHAHN, *supra* note 27, at 370 (discussing how positivism influenced Watson's theoretical orientation). Positivism, when applied to psychology, stands for the proposition that only the products, and not the products of the mind, could be studied. *See id.* To proceed in any other manner would be to enter the "forbidden realm of metaphysical speculation." *Id.*

83. *See id.* (stating that Watson's own research "often generated facts that appeared to have no relationship among themselves").

84. *See id.* at 370-72 (discussing logical positivism, operationism and physicalism and their impact on Neobehaviorism).

this instance, psychology.⁸⁵ This approach to the study of science originated in the early 20th Century and first appeared in the physical sciences, such as chemistry and physics.⁸⁶ Like psychology, the physical sciences were working with theoretical constructs that were not directly observable, such as gravity and the atom.⁸⁷ Scientists needed a way to integrate theoretical speculation into their research while eliminating possible bias and remaining as objective as possible.⁸⁸ Logical positivism provided this framework.⁸⁹

Logical positivism split the scientific world into two realms, the empirical and the theoretical.⁹⁰ Within these realms, empirical terms were observable events, while theoretical terms were the theoretical explanations or underpinnings for explaining the observable events.⁹¹ Empiricism was still important, and theories were only relevant if they explained the observed phenomenon.⁹² In order for psychology to apply this framework, every abstract or theoretical construct had to be *operationally defined*.⁹³ Put simply, an operational definition allows an abstract term or concept to be defined in terms of the procedures used to measure the concept.⁹⁴ For example, the construct of anxiety, not directly observable by psychologists, is usually operationally defined by conformance with accepted diagnostic criteria or a score on a standardized assessment instrument.⁹⁵

Operationism, in conjunction with logical positivism, was the catalyst for a new surge of intellectual growth and curiosity in psychology; in 1930, psychology entered into its "age of theory."⁹⁶ At the forefront of this age of theory were the Neobehaviorists.⁹⁷ Although there were many different schools of thought within Neobehaviorism, in general this was the first theoretical

85. *See id.* at 370-71 (noting that goal of strict empiricism was becoming unrealistic).

86. *See id.* at 371 (noting that theoretical constructs were becoming indispensable).

87. *See id.* (noting that theoretical constructs were becoming essential to understanding physical world).

88. *See id.* (noting that scientists needed to use "theory without encountering the dangers inherent in metaphysical speculation").

89. *See id.* (discussing origins of logical positivism). History suggests that logical positivism came into being in 1924 when philosophers in Vienna created the approach. *See id.* The logical positivists took the empirically based tenets of positivism and combined them with the structure of formal logic. *See id.* This combination allowed for theoretical underpinnings if the terms of such underpinnings could be "logically tied to empirical observations." *Id.*

90. *See id.* (explaining that "[l]ogical positivism divided science").

91. *See id.* (explaining empirical and theoretical components of logical positivism).

92. *See id.* (same).

93. *See id.* (noting that Harvard physicist Percy W. Bridgman proposed concept of operational definition in 1927).

94. *See id.* (noting that psychology must operationalize principles to be considered "a science on par with physics"). Operationism can be seen in the physical sciences such as physics. *See id.* (explaining how physics operationalized concept of force). For example, in physics, force equals mass times acceleration. *See id.* Force can be operationally defined by procedures in determining the amount of force present. *See id.*

95. *See id.* (explaining how to operationalize concepts, such as anxiety, as test scores).

96. *See id.* (describing new age of theory as psychology's first real attempt to study complex forms of behavior while maintaining objectivity and limiting bias).

97. *See id.* at 371, 373 (noting that age of theory lasted from 1930 to 1950 and Neobehaviorism dominated this period).

school since the Functionalists to reintegrate theory back into psychology.⁹⁸ Neobehaviorism demonstrated that theory and empiricism could peacefully coexist in psychology.⁹⁹

At approximately the same time that Structuralism and Functionalism were being questioned by the Behaviorists, Max Wertheimer founded the school of thought known as Gestalt psychology.¹⁰⁰ As with many theories, Gestalt

98. *See id.* at 372 (explaining that Neobehaviorism recaptured theory as integral to explaining behavior).

99. *See id.* (same). Although orientations within the school varied, all Neobehaviorists appeared to accept certain general principles:

1. If theory was used, it must be used in ways demanded by logical positivism.
2. All theoretical terms must be operationally defined.
3. Nonhuman animals should be used as research subjects for two reasons:
 - (a) Relevant variables are easier to control than they are for human subjects.
 - (b) Perceptual and learning processes occurring in nonhuman animals differ only in degree from those processes in humans; therefore, the information gained from nonhuman animals can be generalized to humans.
4. The learning process is of prime importance because it is the primary mechanism by which organisms adjust to changing environments.

Id. at 372-73.

Edward Chace Tolman was one of the most influential Neobehaviorists of his time. *See id.* at 375 (noting that Tolman influenced Neobehaviorism by introducing concepts of purpose and cognition into approach). Tolman introduced the concept of intervening variables as a means of understanding why certain behavior occurred. *See id.* at 376-77. Unlike Watson, Tolman hypothesized that independent variables (environmental events) gave rise to internal unobservable events (intervening variables), which in turn led to behavior (dependent variables). *See id.* at 377. Tolman's work had considerable influence on other prominent theorists such as Albert Bandura, who pioneered the concepts of observational learning and vicarious experience. *See id.* at 379 (explaining impact of Tolman's theoretical stance). Building on Tolman's work, Clark Leonard Hull, expanded the intervening variable concept. *See id.* at 382 (explaining that Hull viewed physiological events intervening between environmental experience and behavior, whereas Tolman viewed cognition as intervening variable). Burrhus Frederic Skinner, although somewhat less concerned with theoretical underpinnings, clarified the nature of the relationship between behavior and environmental stimuli. *See id.* at 387 (explaining Skinner's view of behavior and noting that his theoretical approach viewed behavior as interplay between environment contingencies). Most notably, Skinner established the principle of operant conditioning and established the framework for modern day behavior therapy. *See id.* at 387-90.

100. *See id.* at 397 (discussing origins of Gestalt psychology). Max Wertheimer was a distinguished scholar in the field of psychology. *See id.* at 400 (noting Wertheimer's academic positions). He held numerous prestigious positions at the universities of Prague, Vienna, Frankfurt and Berlin before immigrating to the United States where he taught at the New School for Social Research in New York. *See id.* Originally, Wertheimer pursued the study of law at the University of Prague before shifting his focus to philosophy. *See id.*

History suggests that Max Wertheimer was vacation-bound on a train from Vienna to the Rhineland when he conceptualized the foundations for Gestalt psychology. *See id.* at 399. The main premise was that human perception was not necessarily congruent with the experience of human sensation. *See id.* Wertheimer's initial exploration of this hypothesis took place in a hotel room with a toy stroboscope. *See id.* He used the stroboscope to demonstrate that a human could perceive motion when, in fact, none existed. *See id.* Building on this rudimentary experiment, Wertheimer acquired more sophisticated equipment and discovered what he later called the *phi phenomenon*. *See id.* at 399-400.

Flashing two lights successively, Wertheimer found that if the time between the flashes was long (200 milliseconds or longer), the observer perceived two lights flashing on and off successively—which was, in fact, the case. If the interval

psychology arose, in part, in response to the Structuralist and Behaviorist theories of the time.¹⁰¹ The Gestaltists were strongly opposed to the Structuralist concept of breaking down human behavior into elements, preferring instead to conceptualize the human experience as a whole.¹⁰² The Gestaltists also expressed strong opposition to the stimulus-response model of behavior advocated by the Behaviorists because the model attempted to reduce human consciousness down to elemental components.¹⁰³ Conceptually, the Gestaltists felt that the "whole of anything was more than the sum of its parts," and this conceptual orientation provided the framework for theoretical investigations.¹⁰⁴

Although the original work of Max Wertheimer focused on perceptual experiences, from a theoretical standpoint the Gestaltists quickly turned to developing a general theory of human experience and behavior.¹⁰⁵ The development of this theoretical orientation relied on introspection, and the Gestaltists, although known for using empiricism when it suited them, developed a reputation for creativity in research methodology that at times flew

between flashes was very short (30 milliseconds or less), both lights appeared to be on simultaneously. But if the interval between flashes was about 60 milliseconds, it appeared that *one light* was moving from one position to the other.

Id.

101. *See id.* at 397 (discussing origins of Gestalt psychology).

102. *See id.* (noting that Gestaltists opposed "elementalism in psychology").

103. *See id.* (noting that German term "Gestalt" means "form" or "whole").

104. *See* NEEL, *supra* note 13, at 322-23 (discussing Gestaltist methods of investigating psychological phenomenon); *see also* HERGENHAHN, *supra* note 27, at 398-99 (discussing antecedents of Gestalt psychology). One Gestalt psychologist described his opposition to an elemental approach to psychology as follows:

The perception itself shows a character of totality, a form, a Gestalt, which in the very attempt at analysis is destroyed; and this experience, as directly given, sets the problem for psychology. It is this experience that presents the raw data which psychology must explain, and which it must never be content to explain away. To begin with elements is to begin at the wrong end; for elements are products of reflection and abstraction, remotely derived from the immediate experience they are invoked to explain. *Gestalt* psychology attempts to get back to naive perception, to immediate experience "undebauched by learning"; and it insists that it finds there not assemblages of elements, but unified wholes; not masses of sensations, but trees, clouds, and sky. And this assertion it invites anyone to verify simply by opening his eyes and looking at the world about him in his ordinary everyday way.

HERGENHANH, *supra* note 27, at 397 (quoting EDNA HEIDBREDE, SEVEN PSYCHOLOGIES 331 (1933)).

105. *See* NEEL, *supra* note 13, at 323 (noting that Gestaltists synthesized laws of perception and applied them to human behavior). The basic principles of Gestalt psychology focused on perceptual processes. For example, the principle of proximity states that when stimuli are presented close together, they will be grouped together as one perceptual unit by human perception. *See* HERGENHAHN, *supra* note 27, at 408. Similarly, the principle of inclusiveness asserts that when there is more than one figure in the perceptual field, an individual is more likely to notice the figure that contains the greater number of stimuli. *See id.* For a thorough discussion of Gestaltist principles, *see id.* at 408-14; NEEL, *supra* note 13, at 323-27; Max Wertheimer, *Laws of Organization in Perceptual Forms*, in A SOURCE BOOK OF GESTALT PSYCHOLOGY 74 (Willis D. Ellis ed. & trans., 1938).

in the face of past empirical approaches.¹⁰⁶ Minimizing pure empiricism in favor of empirical flexibility and introspection, the Gestaltists established the framework for the future development of psychology in the United States and Europe—a framework that redirected psychology from empiricism to a more flexible, theoretically and philosophically driven approach that allowed a vast number of schools of thought to flourish.¹⁰⁷

The number of psychological schools of thought that have come into existence over the last hundred years is remarkable, and a complete discussion is well beyond the scope of this Article. Some have gone the way of the dinosaur while others still thrive today. Rarely is such a proliferation of diverse theoretical positions seen in other, more empirically based, disciplines. Although operating under various names and theoretical orientations, all share a common foundation that can be attributed to a drift away from scientific empiricism and a strong reliance on philosophically and theoretically driven approaches.

For example, who has not had at least a nodding acquaintance with the work of Sigmund Freud, psychoanalysis, the Oedipus/Electra complex, and the Id, Ego and Superego?¹⁰⁸ One of the most influential theorists in the history of psychology, Freud did not base his theories on empirically observable phenomena, but rather on a complicated web of unsubstantiated theoretical assumptions about the human conscious and subconscious.¹⁰⁹ Indeed, some

106. See NEEL, *supra* note 13, at 322 (noting "Gestaltists had no vested interest in method . . . and felt free to use or invent procedures as they were needed").

107. See *id.* at 331 (discussing impact of Gestalt psychology on modern schools of psychological thought); see also HERGENHAHN, *supra* note 27, at 421 (same). Although some critics note that Gestalt theories are experimentally untestable and vague, the impact of Gestalt psychology on modern psychological theory is undeniable. See *id.* Michael Wertheimer, son of the venerable Max Wertheimer, describes the influence of Gestalt psychology on modern psychological thought as follows:

The Gestalt movement played a significant role in the revolt against structuralism. Its objections to elementism went beyond its critique of structuralism . . . and were applied to [stimulus-response] behaviorism as well. Gestalt psychology called attention to the usefulness of field concepts and to various problems that might otherwise have been ignored, such as insight in animals and humans, the organized nature of perception and of experience, the richness of genuine thought processes, and to the utility of dealing in larger, molar, organized units, taking full account of their nature and structure

Although the Gestalt school no longer existed as a major self-conscious movement after the middle of the twentieth century, the issues it raised in opposition to the prevalent oversimplified [stimulus-response] psychology typical especially of American associationistic behaviorism continued to be central in psychological thought. The Gestalt school had done its job well, leaving a lasting mark on the discipline

Id. (quoting MICHAEL WERTHEIMER, A BRIEF HISTORY OF PSYCHOLOGY 139-40 (3d ed. 1987)).

108. For a thorough discussion of Freud's work, see HERGENHAHN, *supra* note 27, at 453-81 and NEEL, *supra* note 13, at 225-54.

109. See HERGENHAHN, *supra* note 27, at 479-81 (discussing criticisms of and contributions from Freudian psychoanalysis). See generally SIGMUND FREUD, THE INTERPRETATION OF DREAMS (A.A. Brill trans., 1994) (explaining dreams and use of dreams in therapy); SIGMUND FREUD, THE PSYCHOPATHOLOGY OF EVERYDAY LIFE

would argue that Freud's biggest contribution to the development of psychology was spurring on other psychologists to prove him wrong.¹¹⁰ Freud's method of investigation was called *free association*, where a patient was asked to report everything that came to mind, regardless of its rationality or relevance to the topic at hand.¹¹¹ Freud also relied heavily on dream interpretation.¹¹² In these approaches, a trained analyst listened to observations and interpreted them, producing a series of interrelated associations.¹¹³ Freud hypothesized that these associations were responsible for feelings, impulses, ideas and, eventually, psychopathology.¹¹⁴ Freud conceptualized the human being as hedonistic and sexually motivated, and at the core of these associations was the individual's intent to maximize pleasure and minimize pain.¹¹⁵

Freud was also the first theorist to hypothesize about the presence of an *unconscious mind*.¹¹⁶ The conscious mind was at work when the individual had an awareness of what was taking place, while the subconscious mind could be at work without the individual being aware of it.¹¹⁷ To explain these processes, Freud conceptualized the human psychic process as a theoretical three-part personality structure consisting of the Id, Ego and Superego.¹¹⁸ The Id represented an individual's primitive biological drives, while the Ego was responsible for finding socially appropriate outlets for these impulses.¹¹⁹ The Superego represented the individual's moral values and ethics, and therefore regulated the interaction of the Id and the Ego.¹²⁰ Each of these aspects of

(Alan Tyson trans., James Strachey ed., 1965) (explaining basis for everyday human errors and mistakes); Sigmund Freud, *The Origin and Development of Psychoanalysis*, 21 AM. J. PSYCHOL. 181-218 (1910) (explaining origins of psychoanalysis in series of five lectures).

110. Cf. HERGENHAHN, *supra* note 27, at 481 (explaining that "every personality theory since [Freud's] can be seen as a reaction to his theory or to some aspect of it").

111. See NEEL, *supra* note 13, at 226-27 (discussing evolution of Freud's investigational methodology). Initially, Freud used hypnosis to help patients recall traumatic experiences. See *id.* at 226. Given that hypnosis was marginally effective at best, Freud turned to simply having the patients recount their experiences without the use of hypnosis. See *id.* at 227. This technique, in conjunction with dream analysis, became the basis for free association. See *id.*

112. See *id.* at 234 (noting Freud's use of dream work during therapy to uncover "unconscious forces at the base of personal problems").

113. See *id.* at 228 (discussing process of psychoanalysis).

114. See *id.* (discussing internal conflicts and evolution of psychopathology or maladjustment in Freudian theory).

115. See *id.* at 227 (summarizing basic tenets of Freudian theory and noting Freud's emphasis on sexual conflict). Freud's psychosexual stages of development focused on the human body's erogenous zones as a sexual source of pleasure and consisted of five stages. See HERGENHAHN, *supra* note 27, at 475-77 (noting that Freud theorized that foundations for adult personality was formed by age five).

116. See NEEL, *supra* note 13, at 230-31 (discussing Freud's conceptualization of conscious and unconscious mind).

117. See *id.* (discussing Freud's conceptualization of conscious and unconscious mind).

118. For a comprehensive discussion of the Id, Ego and Superego, see HERGENHAHN, *supra* note 27, at 470-73 and NEEL, *supra* note 13, at 230-31.

119. See HERGENHAHN, *supra* note 27, at 471 (noting that Id represents human instincts and drives, and is part of unconscious mind, whereas Ego satisfies instincts and drives by matching them with real objects in physical environment).

120. See *id.* at 472 (noting that superego is "moral arm of the personality").

personality influenced an individual's experience of consciousness and the individual's ability to interact in the environment.¹²¹

Although these theories have had a significant impact on the development of psychology and have stimulated considerable intellectual debate, most of Freud's concepts were vague and undefined to the point of being nebulous and unverifiable.¹²² His approach flew directly in the face of empiricism, marked the end of Structuralism and sanctioned the use of intuition and unsupported speculation in the development of psychological theory—a trend evident even today.¹²³ From this unempirical foundation sprang a wealth of psychological

121. *See id.* at 471-73 (describing how Id, Ego and Superego influence individual's behavior).

122. *See NEEL, supra* note 13, at 250-51 (noting that Freud did not tolerate questioning of his ideas and that "dogmatic acceptance" of his concepts was required even though such orientation is incompatible with science). The praise and criticisms of Freud's work are numerous. *See id.* at 249-51 (discussing criticisms of Freudian theory); *see also* HERGENHAHN, *supra* note 27, at 479-80 (same). Critics tend to focus on the breadth of Freud's theories and the lack of empirical foundations for their existence. *See id.* at 479-80 (discussing common criticisms). First, critics note that Freud's theories were based on limited observations of his own patients. *See id.* at 479. Accordingly, these patients were probably not representative of the population at large. *See id.* In addition, Freud did not confirm his observations with others, and, as a result, probably biased these observations with his own expectations. *See id.* Second, critics point out that Freud's theories and definitions could not be measured because they could not be operationally defined. *See id.* Third, Freud was intolerant and dogmatic to the point that competing ideas were dismissed out of hand along with the individuals who proposed them. *See id.* at 480. Fourth, Freud's theories relied heavily, and some would say inappropriately, on sexual energy as motivation for human behavior. *See id.*

Despite these criticisms, Freud's work was essential to the growth of modern psychology and psychiatry. *See* HERGENHAHN, *supra* note 27, at 480-81 (explaining Freud's contributions to psychology). First, Freud was the first to theorize about unconscious motivation and formulated the first comprehensive theory of personality formation. *See id.* Second, Freud provided the first basis for understanding both normal and abnormal behavior while laying the foundations for psychoanalytic treatment. *See id.* at 481. Finally, Freud's theories allowed for the application of psychology to a wide variety of human experiences such as religion and interpersonal relations. *See id.* One commentator described Freud's contributions as follows:

Whenever the Freudian theories have been accepted outside the psychoanalytic fold, they have been received not because they carry the credentials of exact, verifiable evidence, but because they aroused conviction as convictions are aroused in everyday life—by the feeling that they represent keen observation and shrewd speculation which, in the main, square with the facts.

It is enlightening to compare psychoanalytic psychology with structuralism, in this respect its antithesis. Structuralism, equipped with a highly developed scientific method, and refusing to deal with materials not amenable to that method, admirably illustrates the demand for exactness and correctness by which science disciplines untutored curiosity. Psychoanalysis, with its seemingly inexhaustible curiosity . . . lacks the means, and apparently . . . the inclination, to check its exuberant speculation by severely critical tests. But what it lacks in correctness, it gains in vitality, in the comprehensiveness of its view, and in the closeness of its problems to the concerns of everyday life.

Id. (quoting HEIDBREder, *supra*, note 104, at 410-11).

123. *See* HERGENHAHN, *supra* note 27, at 481 (explaining that psychoanalysis thrives today, while structuralism has faded from psychology, possibly because psychoanalysis incorporates intuition).

schools of thought.¹²⁴ In the tradition of Freud's work, these schools of thought did not focus on strict observation, emphasizing the importance of theoretical development and concepts.¹²⁵ For example, Carl Jung, once a follower of Freud, developed concepts of psychological archetypes and the "collective unconscious" after breaking with Freud's conceptualization and, more specifically, oversexualization of human personality.¹²⁶ Like Freud's ideas, Jung's concepts and theories were not empirically driven or verifiable. At times, Jung's theories were so theoretical and unverifiable that he has been criticized as being a man less of science than of mysticism and, possibly, occultism.¹²⁷

Jung is also credited with introducing the concept of "self-actualization" into the discipline of psychology, which, in turn, provided the foundation for therapeutic treatment and many humanistically and existentially oriented schools of psychological thought.¹²⁸ In fact, Freud and Jung often are credited with being pioneers in the area of applying psychological theory to the actual treatment of patients.¹²⁹ Because Freud's and Jung's theoretical positions and conceptualizations of personality and its dysfunction were far from empirically driven and verifiable, it is not surprising that the development of evolving therapeutic interventions and psychological thought took on a strong philosophical, unempirical bent.¹³⁰

With Freud, the emphasis in psychology began to encompass the treatment of the mentally ill, and humanistic, existential and individual psychology began to flourish.¹³¹ The collection of these psychologies is sometimes referred to as

124. *See id.* at 481-91 (discussing alternative theories developed in response to psychoanalysis).

125. *See id.* (discussing alternative theories built upon Freudian concepts).

126. *See id.* at 482-85 (discussing Jung's major theoretical concepts). Unlike Freud's conceptualization of sexual motivation, Jung conceptualized the unconscious as a "storage house for all the past experiences and conflicts that man had undergone, all his folk wisdom, his yearnings, his misalliances, his struggles with nature." NEEL, *supra* note 13, at 263. Jung's concept of the *collective unconscious* posited that human beings shared common experiences and emotional responses that were inherited as predispositions called *archetypes*. *See* HERGENHAHN, *supra* note 27, at 483 (noting that "collective unconscious was Jung's most mystical and controversial concept and his most important"). Genetically represented, these *archetypes* were present in the form of symbols and found expression in abstract vehicles such as dreams, philosophy and religion. *See* NEEL, *supra* note 13, at 263-64. Jung was also known for his conceptualization of personality in terms of extroversion and introversion. *See id.* at 271.

127. *See* HERGENHAHN, *supra* note 27, at 485 (noting that Jung's theories have been criticized as being "unclear, incomprehensible, inconsistent, and, in places, contradictory").

128. *See id.* (discussing Jung's contributions to psychology).

129. For a general discussion of psychoanalytic theories of psychotherapy, see Morris N. Eagle & David L. Wolitzky, *Psychoanalytic Theories of Psychotherapy*, in HISTORY OF PSYCHOTHERAPY: A CENTURY OF CHANGE, *supra* note 81, at 109-58.

130. *See* NEEL, *supra* note 13, at 269-70 (explaining criticisms of Jung's theory and noting that, despite its lack of empiricism, Jung's theory thrives possibly because it incorporates facets of psychotherapy deemed "sacred," such as psychoanalysis).

131. For a general discussion of the various forms of humanistic and existential psychologies, see HERGENHAHN, *supra* note 27, at 499-524. Existential psychology has its roots in early Greek philosophy. *See id.* at 502. Martin Heidegger is credited with bridging the gap between existential philosophy and psychology. *See id.* at 503. Heidegger's basic premise was that a person and the world that they exist in are inseparable. *See id.* at 503.

"third-force psychology," but for the purposes of this Article will be referred to as Humanistic psychology.¹³² Humanistic psychology evolved in direct response to dissatisfaction with the theories of Behaviorism and psychoanalysis.¹³³ Humanists asserted that pure science was not an adequate vehicle for understanding human behavior.¹³⁴ Specifically, Humanistic psychology criticized Behaviorism because Behaviorism "likened humans to robots, lower animals, or computers."¹³⁵ Likewise, Humanistic psychology criticized psychoanalysis because it "concentrated mainly on emotionally disturbed people and on developing techniques for making abnormal people normal."¹³⁶ Accordingly, the emphasis of Humanistic psychology was to make already mentally healthy individuals healthier.¹³⁷ More specifically, Humanistic

Accordingly, the human mind is responsible for bringing reality into existence. *See id.* Another important aspect of Heidegger's theory was that human beings were dynamic and exist to change and develop. *See id.*

Abraham Maslow is generally credited with founding Humanistic psychology. *See id.* at 508. Humanistic psychology rejects Behaviorism and the scientific method, and focuses on the following tenets:

1. Little of value can be learned about humans by studying nonhuman animals.
2. Subjective reality is the primary guide for human behavior.
3. Studying individuals is more informative than studying what groups of individuals have in common.
4. A major effort should be made to discover those things that expand and enrich human experience.
5. Research should seek information that will help solve human problems.
6. The goal of psychology should be to formulate a complete description of what it means to be a human being. Such a description would include the importance of language, the valuing process, the full range of human emotions, and the ways humans seek and attain meaning in their lives.

Id. at 510. Because humans are much more complex than physical objects, the humanists felt that the methods of science were inapplicable to the study of human behavior and mental illness. *See id.* at 510 (explaining that Humanistic psychology rejects "goal of predicting and controlling human behavior, while so many scientifically inclined psychologists accept"). Maslow's theories mirrored this approach and established the foundation for his well known concepts of the hierarchy of needs and self-actualization. *See id.* at 511-12. Maslow theorized that human needs could be arranged in a hierarchy. *See id.* at 511. Human needs progressed from primitive physiological needs to higher order esteem, love and belonging needs. *See id.* Only when the more primitive needs were satisfied could an individual address the next higher order need. *See id.* Individuals who satisfied these needs reached self actualization, or "one's full, human potential." *Id.* Maslow's theories laid the groundwork for the development of a number of humanistically based psychotherapies. *See id.* at 513-20 (discussing work of Carl Rogers and George Kelly).

132. *See id.* at 501 (noting that third-force psychology includes Humanistic psychology, which combines romanticism and existentialism).

133. *See id.* at 500 (emphasizing importance of individual human attributes that Behaviorism and psychoanalysis ignored).

134. *See id.* (explaining that psychology must establish a new "human science"). The Humanists believed that this new science "would study humans as aware, choosing, valuing, emotional, and unique beings in the universe. Traditional science does not do this and must therefore be rejected." *Id.*

135. *Id.* (noting that automatic nature of behaviorism was humanistic psychology's major argument against behaviorism).

136. *Id.*

137. *See id.* (explaining that third-force psychology attempted to provide information to healthy persons rather than focus solely on abnormal persons).

psychology rejected science and operated from the theoretical position that the primary focus of any psychological model should be the uniqueness and positive aspects of each individual.¹³⁸ Although Humanistic psychology contributed significantly to the development of many client-centered psychotherapies, it has been criticized for dismissing the contributions of science to psychology and for sending the discipline on a course reminiscent of its "prescientific past."¹³⁹

IV. PSYCHOLOGY TODAY

The historical context set forth above provides the basis for viewing contemporary psychology—a discipline that is still struggling with the philosophy versus science question.¹⁴⁰ This theoretical impasse has allowed contemporary psychology to become an incredibly diverse field, the major

138. *See id.* (explaining Humanistic psychology's focus on helping people "reach their full potential"); *see also* Laura N. Rice & Leslie S. Greenberg, *Humanistic Approaches to Psychotherapy*, in *HISTORY OF PSYCHOTHERAPY: A CENTURY OF CHANGE*, *supra* note 81, at 197-99 (noting that all humanistic therapies share principles that differentiate them from other major orientations and explaining core beliefs of humanistic psychology). For a seminal work in Humanistic psychology, see Carl R. Rogers, *Significant Aspects of Client-Centered Therapy*, 1 *AM. PSYCHOL.* 415, 415-22 (1946).

139. *See* HERGENHAHN, *supra* note 27, at 523 (explaining criticisms of Humanistic psychology). The criticisms of Humanistic psychology are numerous, with most focusing on the lack of scientific underpinnings for its theoretical base. *See id.* at 523. One commentator noted the following specific criticisms:

1. Humanistic psychology equates behaviorism with the work of Watson and Skinner. Both men stressed environmental events as the causes of human behavior and denied or minimized the importance of mental events. Other behaviorists, however, stress both mental events and purpose in their analysis of behavior
2. [Humanistic psychology] overlooks the cumulative nature of science by insisting that scientific psychology does not care about the loftier human attributes. The problem is that we are not yet prepared to study such attributes. One must first learn a language before one can compose poetry. The type of scientific psychology that humanistic psychologists criticize provides the basis for the future study of more complex human characteristics.
3. The description of humans that humanistic psychologists offer is like the more favorable ones found through the centuries in poetry, literature, or religion. It represents a type of wishful thinking that is not supported by the facts that more objective psychology has accumulated. . . .
5. If humanistic psychology rejects scientific method as a means of evaluating propositions about humans, what is to be used in its place? If intuition or reasoning alone is to be used, this enterprise should not be referred to as psychology but would be more accurately labeled philosophy or even religion. The humanistic approach to studying humans is often characterized as a throwback to psychology's prescientific past.
6. By rejecting animal research, humanistic psychologists are turning their backs on an extremely valuable source of knowledge about humans. Not to use the insights of evolutionary theory in studying human behavior is, at best, regressive.
7. Many of the terms and concepts that humanistic psychologists use are so nebulous that they defy clear definition and verification. . . .

Id. at 522-23.

140. *See id.* at 531 (noting that contemporary psychology reflects remnants of almost every school of psychological thought).

theoretical orientation of which might best be described as "eclectic."¹⁴¹ A cynic might note that eclecticism is shorthand for a complete and total lack of consensus or direction. This diversity is evident in the fact that the American Psychological Association lists forty-seven separate divisions of psychology.¹⁴² This diversity also is evident in the education and training of clinical psychologists, the psychologists involved primarily with patient care.¹⁴³ Although psychology has turned to more contemporary approaches for the study of human behavior and the treatment of mental illness such as information processing, cognitive psychology and genetic influences on personality, the status of psychology is still far from that of a science.¹⁴⁴

At this point, psychology is still struggling to find an identity. As a result, the discipline finds itself in limbo between pure philosophy and hard science.¹⁴⁵ Further confounding the problem is the existence of disagreement among and within psychological schools of thought.¹⁴⁶ This can still be attributed directly to the continued existence of the age-old battle between the scientific empiricists and the theoretical philosophers.¹⁴⁷ Although it appears that the battle will never be resolved from within the discipline itself, a new force has appeared in recent years that threatens to settle the issue once and for all.¹⁴⁸

141. *See id.* at 532 (explaining that eclectic view of modern psychology allows diverse views to coexist peacefully without relying on schools of psychological thought and permits psychologist to choose "most effective" approach to handle specific problems).

142. *See id.* at 532-34 (listing divisions of American Psychological Association and explaining its diversity). The diversity and specificity represented by this list is informative in that it reflects the influence of historical antecedents on the development of the discipline. Some relevant division examples include: General Psychology, Teaching of Psychology, Experimental Psychology, Psychology and the Arts, Clinical Psychology, Military Psychology, Theoretical and Philosophical Psychology, History of Psychology, Psychotherapy, Psychological Hypnosis, Psychology of Women, and Exercise and Sports Psychology. *See id.* at 533-34.

143. *See id.* at 534-35 (discussing different training options for clinical psychologists).

144. *See id.* at 535-52 (discussing decline of radical behaviorism and rise of contemporary cognitive psychology and psychology's current status as science).

145. *See id.* at 551-55 (explaining psychology's status as science and how discipline differentiates between "philosophy that emphasizes rationalism" and "philosophy that emphasizes empiricism").

146. *See id.* at 553-54 (noting that different divisions of American Psychological Association, which represent different psychological schools of thought, are more empirically oriented than others).

147. *See id.* at 554 (noting differences in divisions render some more "scientifically oriented" and others more "humanistically oriented").

148. *See* Michael J. Lambert & Allen E. Bergin, *Achievements and Limitations of Psychotherapy Research*, in *HISTORY OF PSYCHOTHERAPY: A CENTURY OF CHANGE*, *supra* note 81, at 368-70 (discussing "equal outcomes phenomenon" in context of psychotherapy). The equal outcomes phenomenon refers to the fact that there are no significant differences between various forms of therapy and treatment outcome. *See id.* at 368-69. Despite this assertion, there is a growing body of research affirming that behavioral and cognitive methods appear to consistently improve treatment efficacy above and beyond other treatment modalities. *See id.* at 369. Other explanations are offered for the equal outcomes phenomenon: "(a) [d]ifferent therapies can achieve similar goals through different processes; (b) different outcomes do occur but are not detected by past research strategies; and (c) different therapies embody common factors that are curative although not emphasized by the theory of change central to a particular school." *Id.* Another salient factor is the presence of

This force is managed care, and its emphasis on fiscal responsibility and empirically validated treatment approaches strongly favors the forces of empiricism.¹⁴⁹

A. *Psychotherapy and the Evolution of Empirically Validated Treatments*

Clinical psychology, which is concerned primarily with the diagnosis and treatment of mental illness, has followed a course of development similar to that of the field of psychology generally—one marked by differing theoretical approaches, methodological approaches, diagnostic techniques and treatment formulations.¹⁵⁰ Early explanations of mental illness were far from comprehensive and ranged from primitive medical and psychological models to supernatural causes.¹⁵¹ Early treatments for mental illness were just as haphazard and driven by ignorance as they were based on whatever model of mental illness was in vogue at the time.¹⁵² For example, during the Middle Ages, mental illness was attributed to unknown and possibly evil forces entering the body.¹⁵³ Accordingly, the appropriate cure was to remove these forces, usually through the use of exorcism and magical ritual.¹⁵⁴ Primitive psychological approaches focused on purging the mind of primitive disturbing emotions through a variety of methods including reenactment, love and reassurance.¹⁵⁵ Early biological approaches attributed mental illness to organic

sloppy research design and methodology in psychotherapy outcome studies. *See id.* at 370 (citing Alan E. Kazdin & Debra Bass, *Power to Detect Differences Between Alternative Treatments in Comparative Psychotherapy Outcome Research*, 57 J. CONSULTING & CLINICAL PSYCHOL. 138, 138-47 (1989)).

149. *Cf.* Jesse A. Goldner, *Managed Care and Mental Health: Clinical Perspectives and Legal Realities*, 35 HOUS. L. REV. 1437, 1448 (1999) (noting that managed care programs aim "to provide services more effectively and efficiently," suggesting that programs will prefer therapeutic techniques and approaches validated as effective through empirical means).

150. *See* JOHN M. REISMAN, *A HISTORY OF CLINICAL PSYCHOLOGY* 1-2 (1976) (defining clinical psychology as "a branch of psychology devoted to the search for, and the application of, psychological principles and techniques that contribute to the understanding of individuals and that may be used to promote their more effective functioning"). *See generally id.* (discussing development of clinical psychology).

151. *See* HERGENHAHN, *supra* note 27, at 428-35 (discussing witch-hunts, succubi, incubi, chipping of holes in skulls to release demons and bleeding).

152. *See id.* at 429-33 (discussing natural law, magic and four humors as treatment modalities for mental illness).

153. *See id.* at 429 (noting that supernatural explanations for illness existed until work of early Greek physicians such as Hippocrates).

154. *See id.* (noting that supernatural model of mental illness was very popular during Middle Ages).

155. *See id.* at 430-31 (applying natural law to understanding of mental illness). The Eighteenth Century concept of natural law, when applied to psychology, suggests that mental illness was a consequence of an individual's behavior. *See id.* at 430 (describing natural law beliefs whereby treatment required changing of ways). For example, sinful behavior would be punished with mental illness, while good behavior would be rewarded by success and health. *See id.* at 430-31 (citing B.A. Maher & W.B. Maher, *Psychopathology: II. From the Eighteenth Century to Modern Times*, in TOPICS IN THE HISTORY OF PSYCHOLOGY 303 (G.A. Kimble & K. Schlesinger eds., 1985)).

causes such as inherited traits or physiological imbalances, and treatments included bleeding and the ingestion of certain foods.¹⁵⁶

This poor understanding of the etiology of mental illness caused the mentally ill to be vilified and poorly treated until the end of the Nineteenth Century.¹⁵⁷ In 1883, psychologists made the first attempts to categorize all known forms of mental illness, to explain the origins of these mental illnesses and to set forth how these disorders should be treated.¹⁵⁸ Although these attempts were primitive at best, they helped bring the concept of mental illness out of the dark ages and laid the foundation for later theorists who specialized in the diagnosis and treatment of mental illness.¹⁵⁹

Compared to early explanations for and treatment of mental illness, the field of psychology has come a long way. Originally, psychologists were concerned only with studying observable phenomena, as exemplified by the Structuralists. Because early theorists had no understanding of the covert underlying mechanisms of abnormal behavior, treatment was not possible or practical. Similarly, the complete inability to understand the intricacies/workings of the human mind forced early treating psychologists to adopt a philosophical approach to conceptualization and treatment. Early explanations of mental illness reflected this lack of understanding. With the theories of Freud came the expansion of psychology into the treatment realm.

156. See HERGENHAHN, *supra* note 27, at 432-33 (discussing biological approaches dating back to 3000 B.C.).

157. See *id.* at 432 (noting that many believed God inflicted mental illness upon people for impiety). The mentally ill during the Middle Ages and the Renaissance were very poorly treated, and many people during these times believed that what we would now classify as mental illness was conclusive proof of an individual being a witch or the victim of possession. See *id.* at 434. These people also believed that "sinful" individuals were more susceptible than "good" individuals to possession and witchcraft and that women were more susceptible to evil and witchery. See *id.* The lucky mentally ill were locked up in asylums, while the more unfortunate were burned at the stake. See *id.* at 435. Because the mentally ill were treated like animals in these asylums, perhaps burning was the more merciful end. See *id.* (noting that mentally ill were "chained, beaten, fed only enough to remain alive, subjected to bloodletting, and put on public display for visitors"). Many psychologists and humanitarians worked to improve the plight of the mentally ill. See *id.* at 435-48 (noting work of Philippus Paracelsus, Cornelius Agrippa, Johann Weyer, Felix Plater, Philippe Pinel, Joseph Daquin, Benjamin Rush, Dorethea Dix, Emil Kraepelin and Lightner Witmer).

158. See *id.* at 439 (discussing contribution of Emil Kraepelin). Kraepelin's system classified mental disorders based on their causes, involvement of the brain and nervous system, symptoms and treatment. See *id.* His classification system brought structure to diagnosis and treatment in the fledgling and, at times, nebulous, field of clinical psychology. See *id.* (noting impact of system).

159. See *id.* at 435-48 (discussing early approaches to treatment of mental illness). In 1896, Lightner Witmer established the world's first psychological clinic dedicated to treating people with mental illness. See *id.* at 440-42 (noting that Witmer is credited with coining term clinical psychology). In addition to establishing the first true clinical treatment facility, Witmer also developed the first training curriculum for clinical psychologists and the first scholarly journal devoted entirely to the subject. See *id.* at 440-42 (noting that Witmer's establishment of school and journal stemmed from his formal training as experimental psychologist, which made him very critical of unscientific approaches to psychology). For a discussion of Witmer's conceptualization of clinical psychology, see Lightner Witmer, *Clinical Psychology*, 1 PSYCHOL. CLINIC 1 (1907).

Today, the diagnosis and treatment of mental illness is as common as going to a medical doctor for a physical ailment. Although identification, awareness and treatment of mental illness are common today, even the most "advanced" and modern forms of psychotherapy are, at least in part, philosophically and not empirically based.¹⁶⁰ Ironically, many of these non-empirically based theoretical positions provided the basis for many of today's modern psychotherapies.

This theoretical/philosophical orientation has spawned a large number of treatment orientations and approaches, and there is no single agreed-upon method within the discipline for treating a particular disorder.¹⁶¹ This variation is reflected in the fact that there is no generally accepted definition of psychotherapy.¹⁶² Because there is no generally accepted definition, there is also little consensus regarding treatment approaches. Some of the theories and treatment approaches are accepted as effective even when there is no empirical evidence to support them, while others border on taking the discipline back to the Middle Ages when the burning of the mentally ill was in vogue. Some treatment modalities are so bizarre that one might argue that the

160. See generally RAYMOND J. CORSINI & DANNY WEDDING, CURRENT PSYCHOTHERAPIES (3d ed. 1984) (discussing modern psychotherapies). Today, there are over 250 different systems of psychotherapy. See *id.* at 7. The major systems include: Psychoanalysis (derived from the work of Sigmund Freud), Adlerian Psychotherapy (focusing on moving an individual toward fictional goals in a phenomenal field while eliminating feelings of inferiority), Analytical Psychotherapy (creating a dialectical relationship between the conscious and unconscious via a self-regulating system), Person-Centered Psychotherapy (focusing on self-growth and conflict resolution), Rational-Emotive Therapy (focusing on how emotional consequences are created by individual's belief system), Behavior Therapy (applying modern learning theory to treatment of psychopathology), Cognitive Therapy (based on theory of personality which maintains that how one thinks and feels largely determines how one feels and behaves), Gestalt Therapy (phenomenological-existential therapy where perceiving, feeling and acting are distinguished from interpreting and reshuffling preexisting attitudes), Existential Psychotherapy (exploring nature of human existence), Transactional Analysis (focusing on three active, dynamic and observable ego states), Family Therapy (focusing on functioning of whole family unit rather than individual), and Multimodal Therapy (integrated system dealing with sensory, imagery, cognitive and interpersonal factors and their interactive effects). See *id.* at 19-545 (listing and discussing theories).

161. See generally *id.* (discussing various forms of systemic psychotherapy).

162. See *id.* at 1 (noting that "psychotherapy cannot be defined with any precision"). Corsini provides the following general definition:

Psychotherapy is a formal process of interaction between two parties, each party usually consisting of one person but with the possibility that there may be two or more people in each party, for the purpose of amelioration of one of the two parties relative to any of the following areas of disability or malfunction or any combination thereof: cognitive functions (disorders of thinking), affective functions (suffering or emotional discomforts), or behavioral functions (inadequacy of behavior), with the treatment party having some theory of personality's origins, development, maintenance and change and some modality of treatment logically related to the theory, with the treatment party generally having professional and legal approval to act as a therapist.

Id. Similarly, Webster's Collegiate Dictionary defines psychotherapy as the "[t]reatment of mental or emotional disorder or of related bodily ills by psychological means." 943 WEBSTER'S COLLEGIATE DICTIONARY (10th ed. 1993)

psychotherapist is practicing witchcraft.¹⁶³ We laugh at these unorthodox and absurd approaches because, even at a common sense level, it is hard to believe either that they possess any therapeutic value or that anyone would believe that they do. Despite this, many unusual treatments with questionable effectiveness continue to thrive and are still very much a part of the psychological landscape.¹⁶⁴

In fact, it is not only bizarre therapies that survive. Many "mainstream" treatments continue to thrive despite a lack of empirical validation. We accept at face value that the theories underlying them have some basis in reality and are effective at some, perhaps immeasurable, level. Part of the reason that these ideologies and theories continue to exist without being tested is that the discipline has, until recently, been unwilling to become more of a science and less of a theoretically driven philosophy. This is not to say that theory is not an integral part of psychology.¹⁶⁵ Theory has been, and probably always will be, an integral part of better understanding and conceptualizing human behavior. In our modern environment, however, theory alone may no longer be good enough. Financial concerns in the form of managed care have changed the landscape for the foreseeable future.

Only empirically supported interventions will be allowed to survive in the future. To adapt, the discipline must become more scientific and base treatment on empirically supported interventions. Although many in the psychological community will find the last statement appalling, and criticize it

163. See CORSINI & WEDDING, *supra* note 160, at 1 (discussing unusual forms of psychotherapy). Some forms of therapy are truly bizarre. For example, there are systems where no therapist is needed or where the therapist does nothing, which makes one wonder why a therapist is needed at all. See *id.* (citing Ernst Schmidhofer, *Mechanical Group Therapy*, 115 SCI. 120, 120-23 (1952) and J. BION, *THERAPEUTIC SOCIAL CLUBS* (1948)). Other methods symbolically rebirth the patient, while others make fun of the patients, treating them with ridicule and disrespect. See *id.* (citing Paul Bindrim, *Aqua-energetics*, in *HANDBOOK OF INNOVATIVE PSYCHOTHERAPIES* 32 (Raymond J. Corsini ed., 1981) and Frank Farrelly & Jeff Brandsma, *PROVOCATIVE THERAPY* (1974)).

164. See CORSINI & WEDDING, *supra* note 160, at 8 (discussing ideological enclaves). Like many philosophically based disciplines, psychology can be theoretically incestuous. One commentator refers to schools of psychological thought as "ideological enclaves," where "people who believe that they have the right, the final, the complete, and the only answer-and that all other systems [or theories] are incomplete, tentative, weak, or simply mistaken." *Id.* Further,

[p]eople within these enclaves (better known as schools of therapy) tend to communicate mostly with others they meet at conventions; they read each other's writings, and they tend over time to develop specialized vocabularies. They reinforce one another by recounting their successes with the clients of people of different persuasions, . . . "proving" to one another the superiority of their way of thinking and acting.

Id.

165. See generally Henry E. Adams, *The Relevance of Psychological Theories to Standards of Practice*, in *SCIENTIFIC STANDARDS OF PSYCHOLOGICAL PRACTICE*, *supra* note 2, at 251 (discussing advantages and disadvantages of theory driven approaches to psychotherapy); Patrick M. Ghezzi, *Science, Theory, and Practice*, in *SCIENTIFIC STANDARDS OF PSYCHOLOGICAL PRACTICE*, *supra* note 2, at 261 (discussing importance of science in practice of applied psychology).

as being unrealistic, there is a parallel from another discipline supporting the need for this approach. Specifically, the discipline of medicine evolved in a similar fashion, and today has left its philosophical roots in the past in order to pursue the study of medicine on an empirical level. In order to survive in today's financial and legal environment, psychology must do the same or face extinction.

In addition to the ebb and flow of history set forth above, the development of psychology and psychotherapy has also been subject to economic, political and environmental influences.¹⁶⁶ Economic factors such as government involvement and insurance reimbursement are critical to keeping the mental health profession alive and thriving.¹⁶⁷ Similarly, environmental factors—such as the environment where psychotherapy is practiced—have a direct effect on the development of therapeutic models and schools of thought.¹⁶⁸ Political and social advocacy can also have an impact on the evolution of the discipline; by keeping policymakers informed of the latest developments and benefits to the population at large.¹⁶⁹ Of all of these influences, HMOs are having the most significant impact on the practice of psychotherapy.

B. *HMOs & Psychotherapy*

From an economic standpoint, the advent of managed care—and its accompanying financial realities—has been a primary impetus for the evolution of psychology.¹⁷⁰ Managed care, with its goal of limiting expenditure, has had

166. See generally Gary R. Vandenbos et al., *A Century of Psychotherapy: Economic and Environmental Influences*, in HISTORY OF PSYCHOTHERAPY: A CENTURY OF CHANGE, *supra* note 81, at 65 (discussing variety of settings in which psychotherapists have practiced).

167. See *id.* at 97 (noting that government support and insurance reimbursement provided by Medicare, Medicaid and private health insurance plans has played instrumental role in advancing discipline of psychology).

168. See *id.* at 67-96 (discussing impact of therapeutic environments). For example, the mental health clinics of the 1920s were psychoanalytic in orientation. See *id.* at 67 (noting Freud's establishment of psychoanalysis precursor to scientifically oriented psychotherapy). These early clinics were responsible for popularizing psychotherapy in the United States. See *id.* at 69 (stating that psychoanalysis spread from Europe to cities in United States in 1930s and 1940s). World War II stressed the importance of understanding psychological factors of behavior and functioning, and lead to the rise of Veterans Administration Programs. See *id.* at 77. The establishment of Veterans' Administration Programs provided the profession with its first clear training guidelines and defined the psychologists role to encompass individual and group psychotherapy. See *id.* at 77-78. The advent of community mental health centers provided the first model for delivering outpatient care and allowed psychotherapists to migrate to rural areas. See *id.* at 87.

169. See *id.* at 95-96 (discussing policy involvement and advocacy). Until the early 1970s, mental health professionals were not active in advocacy or policy formulation. See *id.* at 95. In the 1970s, economic growth slowed, and psychologists became active in attempting to influence Congress' allocation of funding for mental health services. See *id.*

170. See Mary Jane England, *From Fee-for Service to Accountable Health Plans*, in ALLIES AND ADVERSARIES: THE IMPACT OF MANAGED CARE ON MENTAL HEALTH SERVICES 3-8 (Robert K. Schreter et al. eds., 1994) [hereinafter ALLIES AND ADVERSARIES] (describing mental health reform in context of managed care environment); Goldner, *supra* note 149, at 1438 (noting that managed care dominates health care system and that over 140 million individuals rely on managed care for health services). Managed care is defined by the

an enormous impact upon mental health treatment given that financial concerns were the primary motivation for moving to a managed care model for mental health services in the first place.¹⁷¹ The initial impetus for this shift occurred in the 1980s, when there was a significant growth in for-profit psychiatric hospitals.¹⁷² This shift was further fueled by the perception that the cost of delivering mental health services was increasing at an alarming rate.¹⁷³ In addition, managed care is becoming even more prominent and crucial in the delivery of mental health services in publicly financed mental health systems, such as state psychiatric hospitals.¹⁷⁴ The expansion of Medicaid funding for mental health treatment has been another catalyst for the entrenchment of managed care in the mental health system.¹⁷⁵ As expenditures in Medicare and

Institute of Medicine as "a set of techniques used by or on behalf of purchasers of health benefits to manage health care costs by influencing patient care decisionmaking through case-by-case assessment of the appropriateness of care prior to its provision." John Petrila, *Ethics, Money, and the Problem of Coercion in Managed Behavioral Healthcare*, 40 ST. LOUIS U. L.J. 359, 363-64 (1996) (citing COMMITTEE ON UTILIZATION MANAGEMENT BY THIRD PARTIES, INSTITUTE OF MEDICINE, CONTROLLING COSTS AND CHANGING PATIENT CARE? THE ROLE OF UTILIZATION MANAGEMENT 2-3 (M.J. Field & B.H. Gray eds., 1989)). Currently, there are 175 million Americans enrolled in a managed behavioral healthcare plan, a number that has increased over twenty percent since 1996. See Miller, *supra* note 5, at R1 (noting increase in managed care enrollment since 1996). Prior to the advent of managed care, a fee-for-service scheme dominated mental health treatment. See Goldner, *supra* note 149, at 1445 (describing scheme in which patients chose their doctor and doctors had absolute control of treatment; scheme lasted until mid-1980s). Fee-for-service benefits allow patients to select their own provider and method of treatment, and the mental health professional worked autonomously making treatment decisions based on the best interests of their patient with little consideration for the cost of proposed treatment. See Petrila, *supra*, at 378 (noting that fee-for-service programs presented doctors with few dilemmas between cost and care). The nature of the fee-for-service system led to what has been considered an over-utilization of mental health services and ultimately the demise of fee-for-service in the mental healthcare industry. See Goldner, *supra* note 149, at 1446 (stating that because doctors were paid more for doing more and because fee-for-service plans provided for all-or-nothing mental care, many patients stayed in mental hospitals even though they did not need that treatment).

171. See Laurie M. Flynn, *Managed Care and Mental Illness*, in ALLIES AND ADVERSARIES, *supra* note 170, at 203-10 (noting that managed care considers mentally ill to be bad actuarial risks); see also Petrila, *supra* note 170, at 374-76 (discussing possible negative effects of managed care in mental health arena). The major areas of concern are that managed behavioral health care will have a negative effect on individual psychotherapy and that the seriously mentally ill will be denied long term care. See *id.*

172. See Henry T. Harbin, *Inpatient Services*, in ALLIES AND ADVERSARIES, *supra* note 170, at 11-22 (discussing conflicts between managed care companies and psychiatric hospitals); Petrila, *supra* note 170, at 369-70 (discussing managed behavioral health and patient autonomy). This increase in psychiatric bed capacity was particularly evident in psychiatric facilities that provided assistance for children and adolescents. See *id.* at 369. To fill this capacity, facilities actively marketed for patients and the probable result was inappropriate psychiatric commitments and treatment. See *id.* The shift to managed care was prompted by this phenomenon as a method of containing costs. See *id.*

173. See Petrila, *supra* note 170, at 370 (noting that mental health care costs rose at rate higher than overall inflation rate for health care expenditures).

174. See *id.* at 370-73 (discussing overall decline in state hospital capacity and impact of Medicaid programs).

175. See *id.* at 371-73 (discussing Medicare's impact on expanding financial base for mental health treatment).

other social programs increased, fiscal and political issues forced government entities to move to a managed care model for mental health treatment.¹⁷⁶

1. *Utilization Review & Psychotherapy*

Although managed care's initial and primary focus was the delivery of health services for physical ailments, it was not long after their inception that some HMOs began providing mental health coverage.¹⁷⁷ Given managed care's ability and need to contain costs and today's political and economic realities, it is not surprising that HMOs have made further inroads into the realm of mental health care over the last three decades and now appear to be here to

176. *See id.* (noting states' requests that federal government allow them to switch from fee-for-service public plans to managed care); *see also* Goldner, *supra* note 149, at 1445-51 (discussing replacement of fee-for-service mental health programs with managed mental health care).

177. *See* Goldner, *supra* note 149, at 1439 (noting inception of mental health coverage and behavioral health care by HMOs); *see also* Michael S. Pallak, *Managed Care and Outcome-Based Standards in the Health Care Revolution*, in SCIENTIFIC STANDARDS OF PSYCHOLOGICAL PRACTICE, *supra* note 2, at 73 (discussing shift from fee-for-service health care to managed care). With mental health care costs continuing to rise annually, managed behavioral healthcare organizations, or "carve outs" have become prevalent. *See* Goldner, *supra* note 149, at 1448 (discussing inception of Managed Behavioral Health Organizations as significant development in provision of psychiatric and other mental health care services); *see also* Kyle L. Grazier, *Managing Behavioral Health*, 43 J. HEALTHCARE MGMT. 393, 395 (1998) (pointing out that over sixty percent of Americans are enrolled in managed behavioral health plan and most states have carved out their mental health benefits from regular benefits under their Medicaid programs). Managed behavioral healthcare organizations ("MBHO") administer mental health benefits separately from general health care benefits and typically cover only the cost of outpatient visits and inpatient facilities, while the original managed care company continues to cover the cost of prescription drugs. *See* Rebecca A. Clay, *Psychotherapy Is Cost Effective*, 31 MONITOR ON PSYCHOL. (2000) available at <http://www.apa.org/monitor/jan00/pr2.html> (describing dealings with managed care companies). Specializing in behavioral healthcare, the MBHO evaluates and pools the risk associated with all recipients of mental health benefits and establishes a payment rate indicative of the anticipated costs of services. *See* Goldner, *supra* note 149, at 1449-50. In exchange for assuming all of the financial risk and responsibility associated with the provision of mental health benefits, the MBHO becomes the ultimate decision-maker asserting full control over the administration of behavioral healthcare services. *See id.* at 1450. Cost containment is achieved by utilizing three different approaches: "(1) reduced reliance on inpatient care, especially for substance abuse; (2) reduced prices paid to providers; and (3) shorter outpatient episodes of care." Richard G. Frank et al., *The Politics and Economics of Mental Health Parity Laws*, HEALTH AFF., July-Aug. 1997. The impact has been significant. A 1999 Hay Group study of 1043 employers found that behavioral healthcare spending in the private sector accounted for 3.2% of all healthcare costs in 1998, down from 6.1% in 1988. *See* Findlay, *supra* note 3, at 121 (citing study). Nationally, behavioral healthcare spending fell to 8% of all healthcare expenditures, down from 9% in 1986. *See id.* (citing T. MARK ET AL., NATIONAL EXPENDITURES FOR MENTAL HEALTH, ALCOHOL, AND OTHER DRUG ABUSE TREATMENT (1996)). There are those who champion the advent of the MBHO, but industry critics and many behavioral healthcare professionals maintain that cost savings have been realized at the expense of the quality and quantity of care received, therapeutic ethics, and most importantly, the patient's recovery. *See* Goldner, *supra* note 149, at 1468 (arguing that MBHO practices leave patients untreated and under-treated, resulting in overall compromise of patient health and medical ethics).

stay.¹⁷⁸ In addition to having a financial impact on the delivery of mental health services, managed care has also had a significant impact on the providers of mental health services.¹⁷⁹ In the eyes of many in the mental health professions, the impact has been a negative one.¹⁸⁰

Many of the criticisms aimed at HMOs and their delivery of mental health services parallel the criticisms of general health care practitioners.¹⁸¹ Some of these criticisms include decreased quality of care, breaches of confidentiality, the provision of fewer services, destruction of the professional therapeutic relationship and inappropriate decision-making by utilization review administrators.¹⁸² Of these criticisms, the utilization review process appears to

178. See Findlay, *supra* note 3, at 116 (discussing managed care's rapid movement into mental health care). Goldner notes that:

The development of managed care has brought with it needed rationalization into a health care system and its finances that was rapidly spinning out of control. The annual growth in national health expenditures in 1980 was 12.9% and in 1990 it was 11.0%. By 1993 it had decreased to 8.6%. Between 1993 and 1996, the figures had further declined to 5.6%, 4.8% and 4.4% respectively, an average of 5%, compared to an average annual growth increase of 11.7% between 1966 and 1993. The 1996 figure was the slowest growth rate since 1960. Total general costs for providing outpatient care are cut approximately in half in instances when a patient sees a primary care physician ("PCP") first due to lower fees for their services, PCPs providing a less resource-intensive style of practice than specialists, and lower reimbursement for established, as opposed to new, patients.

Goldner, *supra* note 149, at 1442-43.

179. See Goldner, *supra* note 149, at 1439-40 (noting impact of managed care on provider autonomy and decision-making).

180. See *id.* (noting that insurers decide which providers will be authorized to render services).

181. See *id.* at 1440 (stating that many problems caused by managed care in health care affect mental health care even "more poignantly"); see also Petril, *supra* note 170, at 364 (noting that all forms of managed care attempt to contain health care costs and alter the traditional doctor patient relationship).

182. See Ellen Wertheimer, *Ockham's Scalpel: A Return to a Reasonableness Standard*, 43 VILL. L. REV. 321, 325-30 (1998) (discussing rationing by HMOs); Council on Ethical and Judicial Affairs, American Medical Association, *Ethical Issues in Managed Care*, 273 J. AM. MED. ASS'N 330, 331 (1995) (discussing compromised quality of patient care); Jack Olender, *Doctors Agree Managed Care Cost-Cutting Is Hazardous*, WASH. INFORMER, Sept. 18, 1996, at 12 (discussing negative impact of cost cutting in managed care). But see Barry R. Furrow, *Incentivizing Medical Practice: What (If Anything) Happens to Professionalism?*, 1 WIDENER L. SYMP. J. 1, 3 (1996) (discussing HMOs' assertions that quality of care is unaffected by managed care).

Designed to eliminate unnecessary care, utilization review is an integral part of managed care's cost containment program. It is also the foremost reason behind the therapist's loss of control in the therapeutic decision making process. See Goldner, *supra* note 149, at 1455 (discussing negative reaction of therapists to utilization review). Utilization review involves the healthcare providers' attempt to convince a reviewer that a patient is in need of mental healthcare. See *id.* There are three types of utilization review: prospective, concurrent, and retrospective. Prospective utilization review, similar to "gate keeping," takes place before treatment is administered and determines whether treatment is even necessary. See Tom J. Manos, *Take Half an Aspirin and Call Your HMO in the Morning—Medical Malpractice in Managed Care: Are HMOs Practicing Medicine Without a License?*, 53 U. MIAMI L. REV. 195, 216 (defining prospective utilization review as decision whether proposed treatment is medically necessary). Concurrent utilization review occurs while the patient is in the midst of treatment and assesses whether continued treatment is warranted. See *id.* Finally,

retrospective utilization review occurs upon the completion of treatment and dictates whether the cost of services rendered will be reimbursed. *See id.* at 217. If the treatment is deemed unnecessary, reimbursement is denied. *See id.* Typically, utilization review is performed by an independent organization and, unlike the gatekeeper, the reviewer is a mental health professional. *See Goldner, supra* note 149, at 1458.

As a result of managed care, patients must contend with restricted access to treatment, limited provider options, caps on the number of hospital days or outpatient visits and annual or lifetime dollar limits on mental health benefits that are almost non-existent in general medicine. *See Philip Boyle, Managed Care in Mental Health: A Cure, or a Cure Worse Than the Disease?*, 40 ST. LOUIS U. L.J. 437, 439 (1996) (noting deficiencies in access to treatment and continued inferior services for mental health as compared to those for physical health); *see also* Heather Fields, *Managed Mental Health Care: Changing the Future of Mental Health Treatment*, 28 J. HEALTH L. 344, 346 (1995) (noting that coverage for physical illness is based on medical necessity as opposed to mental illness, which is covered based on the duration of illness, resulting in a lack of coverage for chronic mental illnesses that do not respond to brief forms of psychotherapy). In addition, patients are frequently denied treatment or, in the alternative, are subjected to the least expensive remedy, which is tantamount to remaining untreated. *See Goldner, supra* note 149, at 1452 (discussing financial incentives used by managed care to influence doctors not to refer patients to specialists, to order fewer diagnostic tests and to prescribe less expensive treatments); Manos, *supra*, at 203 (reporting effects of HMOs on behavioral health care). Perhaps most daunting to the individual seeking mental health treatment is the "gatekeeper." A managed care phenomenon, it is the gatekeeper who makes the initial assessment as to whether treatment is necessary. *See Fields, supra*, at 349 (describing typical managed care "gatekeeper" system). Until recently, most of these decision-makers were non-psychiatric or even worse, non-medical employees severely deficient in their knowledge of the workings of the human mind. *See Goldner, supra* note 149, at 1472-73 (citing various commentators concerned about training of gatekeepers). Under a traditional HMO plan, a patient selects a PCP who provides for the patient's routine medical needs and assumes the role of gatekeeper, assessing whether the individual needs specialized treatment including mental health services. *See Fields, supra*, at 349. The primary care physician as gatekeeper presents several problems including, but not limited to, the lack of time spent with each patient, and the PCP's lack of psychiatric training. *See id.*

Because increased patient volume is the key element of the cost cutting equation, primary care physicians are forced to spend a limited amount of time with each patient; the average consultation is six to seven minutes. *See Goldner, supra* note 149, at 1452. This is unfortunate as one of the most critical phases of psychotherapy is the evaluation phase when a patient relates to a therapist his or her reasons for seeking help. *See ROBERT J. URSANO ET AL., CONCISE GUIDE TO PSYCHODYNAMIC PSYCHOTHERAPY: PRINCIPLES AND TECHNIQUES IN THE ERA OF MANAGED CARE* 24-27 (2d ed. 1998). Another difficulty with the PCP as gatekeeper is the PCP's lack of mental health training. *See Boyle, supra*, at 446 (noting frequent criticism of non-psychiatric gatekeepers to mental health). Studies show that fifty-seven percent of those seeking mental health treatment turn first to their primary care physician. *See Fields, supra*, at 345 (citing Federic G. Reamer, *The Contemporary Mental Health System: Facilities, Services, Personnel, and Finances*, in *HANDBOOK ON MENTAL HEALTH POLICY IN THE UNITED STATES* 21, 23 (David A. Rochefort ed., 1989)). That seems illogical when one considers that the majority of medical schools in this country provide only one month of psychiatric training as part of the clinical education program. *See Goldner, supra* note 149, at 1454 n.100 (citing Leon Eisenberg, *Treating Depression and Anxiety in the Primary Care Setting*, *HEALTH AFF.*, Fall 1997, at 149-51). In fact, it spells a recipe for disaster as evidenced by research showing that the PCP's rate of failure in detecting psychiatric disorders ranges from forty five to ninety percent. *See id.* Criticized for inadequate mental health training, gatekeepers are credited as one of the leading causes behind the diminished quality of care in the managed care setting.

The gatekeeper is a formidable barrier to treatment, and even if a patient makes it across the threshold, the managed care industry has set up many additional roadblocks to keep treatment costs contained. A limited choice of providers has forced many patients to sever long-term therapeutic relationships with their therapists because he or she is not a preferred

receive the most criticism from the mental health profession.¹⁸³ The main criticism is that the patient's quality of care suffers, especially in outpatient settings.¹⁸⁴ Managed care has made utilization review and cost-cutting in the outpatient area a priority, despite the fact that the outpatient population

provider and therefore the sessions are not covered. See Miller, *supra* note 5, at R1. In fact, forty-two percent of mental health patients covered by managed care altered their treatment plans for financial reasons as opposed to twenty-nine percent of mental health patients covered by a traditional insurance plan. See generally *Mental Health: A Little Goes a Long Way*, *supra* note 3. Although insurance industry experts have applauded carve-outs for increasing the number of people receiving outpatient mental health services, such increases have resulted in a reduced number of authorized visits per user. See Grazier, *supra* note 177, at 395.

Managed care presents its fair share of difficulties for the clinician as well as the patient. Tools such as utilization review, economic credentialing and symptom checklists are just a few of the mechanisms by which the managed care industry has taken the wheel from the clinician and placed themselves in the driver's seat. Once managed care administrators have decided that specialized treatment is needed, a provider is chosen from a select list of clinicians known as "preferred providers." The preferred provider, in exchange for a steady flow of clients, agrees to accept limited treatment goals and a restricted number of sessions at a predetermined amount, which is often less than what the clinician could receive outside of the managed care plan. See Goldner, *supra* note 149, at 1453. In addition, most preferred providers have undergone a qualifying process known as economic credentialing. This grade-making process allows managed care administrators to select only those providers with a demonstrated ability to minimize referrals to expensive specialists and curtail the use of supplementary services. See *id.* at 1448. Limited treatment duration and restrictions on covered diagnoses have impeded the clinician's ability to evaluate and treat patients in the manner they deem necessary. For instance, the evaluation phase typically requires several hours in order to establish an accurate diagnosis. See KENNETH S. POPE & MELBA J.T. VASQUEZ, *ETHICS IN PSYCHOTHERAPY AND COUNSELING: A PRACTICAL GUIDE* 151 (2d ed. 1998) (noting that full evaluation often requires several hours of testing and report preparation). Most managed care plans, however, will only reimburse the clinician for the first hour of client assessment. See *id.* This leaves the therapist no choice but to rush the assessment or provide the additional sessions free of charge. To ensure that treatment is not rendered needlessly, managed care companies have introduced symptom checklists into the therapeutic relationship. Used by both clinicians and gatekeepers, symptom checklists serve as a script for each diagnosis, dictating both the diagnosis to be found and the type of treatment to be employed regardless of the specific needs of a particular client. See Miller, *supra* note 5, at R1. Such checklists are frequently criticized as being too vague, making an accurate patient assessment difficult. See Goldner, *supra* note 149, at 1452. Checklists also make it abundantly clear which diagnosis will be covered and which will not. This has spawned the temptation to misdiagnose a patient with a covered disorder rather than report the actual diagnosis, which is not covered. See POPE & VASQUEZ, *supra*, at 151.

183. See Goldner, *supra* note 149, at 1455-59 (discussing various forms of utilization review in managed mental health care). Utilization review is "the system put in place by payers and their surrogates to 'monitor the level, length and intensity of covered treatment,' thus containing costs by limiting demand." *Id.* at 1456 (quoting BARRY R. FURROW ET AL., *HEALTH LAW* 795 (3d ed. 1997)). Generally, utilization review is used to control costs by assuring treatment is a medical necessity given an existing standard of practice. See *id.*

184. See *id.* at 1455 (noting that between 1985 and 1991 percentage of individuals subject to some form of utilization review increased by approximately forty percent). Many criticisms suggest that utilization review inappropriately limits sessions, making it difficult to properly diagnose and treat even the most common and easily identifiable forms of mental illness. See *id.* at 1454-55 (asserting that reimbursement strategies of managed behavioral health care undervalue "cognitive services" and overemphasize medication in attempt to limit length of doctors' visits).

accounts for only approximately twenty percent of mental health care expenditures.¹⁸⁵

From the managed care standpoint, utilization review in the mental health setting involves four elements: (1) *an independent and scientific determination that the proposed treatment is effective*; (2) an independent and scientific determination that the treatment is the appropriate response to the presenting problem; (3) the ability to evaluate the presence of symptoms and the need for treatment through a short questionnaire or phone interview; and (4) the ability to refuse authorization for treatment when there is inadequate justification for it.¹⁸⁶ In short, treatment plans for mental illness under managed care should "include clear, measurable, and realistic goals to address the presenting problem, with the focus on alleviating the patient's impairments and increasing [the patient's] level of functioning."¹⁸⁷ Although this approach has led to significant cost savings for managed health care, it has been criticized by the mental health profession as being a limited approach that focuses only on short-term resolution of acute episodes of distress.¹⁸⁸

The delivery of mental health services under managed care is further complicated by certain difficulties not encountered by the typical general health care practitioner.¹⁸⁹ Many of these difficulties are a direct result of attempts by the mental health profession to diagnose and treat a wide variety of mental illnesses with a wide variety of treatment options, many of which are of questionable effectiveness.¹⁹⁰ Although treatments for most medical conditions are well established, the treatment of many mental illnesses is subject to a wide variety of interventions—interventions that are frequently tied to the mental health practitioner's theoretical orientation.¹⁹¹ For example, a cognitive-behavioral therapist might choose a brief, structured problem-solving approach to the treatment of depression, while a psychodynamically oriented practitioner might opt for a less structured and more long-term approach focusing on object relations, transference, and their relationship to depression. Some would argue

185. *See id.* at 1462-63 (discussing managed care's "aggressive" efforts to cut costs in outpatient mental health care); *see also* Daniel Y. Patterson, *Outpatient Services*, in ALLIES AND ADVERSARIES, *supra* note 170, at 51-60 (discussing managed care strategies toward outpatient mental health care and clinical implications).

186. *See* Goldner, *supra* note 149, at 1463 (noting that utilization review in mental health arena focuses on assessment of patient's presenting problems and not on reasons for development of disorder). Generally, managed care organizations require the presence of a diagnosable mental disorder as specified by the criteria established by the American Psychiatric Association's Diagnostic and Statistical Manual (4th ed.) ("DSM-IV"). *See id.* at 1464 (noting that managed care is not interested in providing treatment for self-improvement, but only for present disorders).

187. *Id.*

188. *See id.* at 1465 (noting that short-term intervention may be inadequate for between twenty and thirty percent of patients and does not resolve underlying causal factors, making relapse likely).

189. *See id.* at 1440-41 (noting aspects of mental health care that make it difficult to practice: difficult diagnosis, uncertain treatments and people without problems seeking help).

190. *See id.* at 1441 (discussing lack of effectiveness of many treatments).

191. *See id.* at 1441-42 (discussing connection between interventions and practitioner's theoretical orientation).

that both types of therapy—indeed that all types of therapy—are beneficial.¹⁹² Although certain factions of the mental health industry have supported this statement, managed care clearly does not agree, and refuses to pay for what it deems to be ineffective treatments.¹⁹³

Despite this disagreement, the mental health industry is being forced to accommodate to the cost cutting and "effective" treatment mandates of managed care.¹⁹⁴ Although the disciplines of psychology and psychiatry can now claim approximately four-hundred different treatment modalities and schools of thought, a variety of economic, political, legal, ethical and social forces are driving the profession towards identifying which of these treatments is effective and, therefore, towards the use of *empirically validated treatments*.¹⁹⁵

2. *The American Psychological Association's Response and Randomized Clinical Trials*

Initially, political, economic and social pressure forced the discipline of psychology to consider the current state of knowledge and treatment modalities in the delivery/field of psychotherapy.¹⁹⁶ Political pressure was the direct result of the United States' consideration of a nationwide health care policy.¹⁹⁷ At the time, psychotherapy was not covered in any of the proposed plans.¹⁹⁸ Without

192. See SELIGMAN, *supra* note 4, at 9-10 (discussing impact of client characteristics on treatment effectiveness). Seligman discusses the critical role of client characteristics and treatment outcome. These characteristics are often difficult to operationalize, and frequently confound the results of empirical effectiveness studies. These factors include: genetic, developmental, or other predisposing factors; demographics (age, marital status, family constellation); source of referral and apparent motivation for treatment; treatment history (what has and has not worked in the past); personality profile (interpersonal and intrapsychic dynamics of a client including cognitions, affect, behavior, defenses and lifestyle); relevant developmental history; and client mental status (assessment of client's orientation to reality, level of functioning, and impairment). See *id.*

193. See Nicholas A. Cummings, *The Role of the Psychologist*, in ALLIES AND ADVERSARIES, *supra* note 170, at 117-23 (discussing importance of treatment outcome research in managed care setting).

194. See Anthony F. Panzetta, *The Role of the Psychiatrist: The Managed Care View*, in ALLIES AND ADVERSARIES, *supra* note 170, at 103-16 (noting that standards for therapy outcomes will be standardized under managed care).

195. See Larry E. Beutler, *Identifying Empirically Supported Treatments: What If We Didn't?*, 66 J. CONSULTING & CLINICAL PSYCHOL. 113, 113-20 (1998) (noting that American Psychological Association established Division 12 Task Force on Promotion and Dissemination of Psychological Procedures to determine which of over 400 psychotherapies were effective). For a discussion of the impact of empirically validated treatments on the practice of psychotherapy, see SCIENTIFIC STANDARDS OF PSYCHOLOGICAL PRACTICE, *supra* note 2.

196. For a brief history of and the major issues in psychotherapy outcome research, see Hans H. Strupp & Kenneth I. Howard, *A Brief History of Psychotherapy Research*, in HISTORY OF PSYCHOTHERAPY: A CENTURY OF CHANGE, *supra* note 81, at 309-34; Sol L. Garfield, *Major Issues in Psychotherapy Research*, in HISTORY OF PSYCHOTHERAPY: A CENTURY OF CHANGE, *supra* note 81, at 335-59.

197. See Beutler, *supra* note 195, at 113 (discussing political and social forces at work when APA Task Force was commissioned).

198. See *id.* at 114 (noting that psychotherapy was in danger of being excluded from plans).

the foundation of insurance reimbursement, the discipline was faced with the very real possibility of financial extinction. In response to these pressures, the American Psychological Association ("APA") established the Division 12 Task Force on Promotion and Dissemination of Psychological Procedures ("APA Task Force").¹⁹⁹ The mandate of the APA Task Force was to determine which of the myriad of psychotherapies being offered to the general public were effective.²⁰⁰ Without these data, managed health care and the legal system would begin to force a distinction between different types of psychotherapy without input or guidance from the discipline.²⁰¹ After reviewing the relevant literature and noting that the list was far from complete, the APA Task Force identified a small number of effective empirically validated psychotherapies.²⁰²

199. *See id.* at 113 (detailing origins of APA Division 12 Task Force).

200. *See id.* (stating that APA Task Force's purpose was to determine which treatments were efficacious). To determine which treatments were effective, the APA Task Force used criteria adapted from guidelines established by the Food and Drug Administration ("FDA") and focused on countless research studies. *See id.*

201. *See id.* at 114 (noting that field of psychology was "faced with the possibility that the courts and legislative bodies would define, non-empirically, what types of psychotherapy could and could not be practiced and reimbursed in a system of managed competition"). In the late 1970s, the courts and the legislatures had already established non-empirically based distinctions between psychotherapies in the context of malpractice litigation. *See id.* These standards were typified by the principle of the community standard and the doctrine of the respectable minority. *See id.* One commentator noted:

The first of these principles reduced the task of selecting effective treatments to matters of popularity and common use. Treatments that are frequently practiced within a given community are held . . . to be valid and true, regardless of their clinical effectiveness or their potential for harm. Reliance on this principle obviates the need for scientific research at all, subserving it to the whims of popular appeal to professionals within a given region.

Yet, the court[s] also attempted to address the fact that profound splits in the mental health field frequently prevented the emergence of a clear community standard. They developed the doctrine of respectable minority to address the fact that none of the professionally initiated efforts to establish diagnostic and treatment standards have enjoyed widespread acceptance within the mental health professions. This doctrine assumes the necessary task of defining effective treatments when the professions fail to develop such guidelines.

This respectable minority doctrine holds that where there are disputes based on theoretical differences and methods of practice, the clinician is entitled to be judged according to the school he or she professes to follow. This school must be one of definite principles, and it must be the line of thought of a respectable minority of the profession.

Id.

202. *See id.* at 113 (noting that many critics of APA Task Force think that underlying assumptions of selection process were unnecessarily narrow). The APA Task Force also noted that the list did not substitute for a practitioner's own decisions about what constituted the proper treatment approach for any given client. *See* Dianne L. Chambless et al., *An Update on Empirically Validated Therapies*, *The Clinical Psychologist*, ¶ 6, available at <http://www.apa.org/divisions/div12/est/newrpt.html> (qualifying APA Task Force list). The latest information available from the APA lists what it considers to be empirically validated treatments: cognitive-behavioral therapy for panic disorder with and without agoraphobia, cognitive behavioral therapy for generalized anxiety disorder, group cognitive behavioral therapy for social phobia, exposure treatment for social phobia, exposure and response prevention for obsessive-compulsive disorder, stress inoculation training for coping with stressors, systematic desensitization for simple phobia, cognitive therapy for depression,

Generally, empirically validated treatments are defined as therapies that have been found to be successful in treating psychological disorders in controlled research studies with delineated populations.²⁰³ The use of controlled research allows the investigator to conclude that any observable beneficial effects are attributable to the therapy itself and not to some uncontrolled-for confounding variable.²⁰⁴ In other words, the use of controlled

interpersonal therapy for depression, behavioral therapy for headache, cognitive behavioral therapy for irritable bowel syndrome, cognitive behavioral therapy for chronic pain, cognitive behavioral therapy for bulimia, interpersonal therapy for bulimia, behavior modification for enuresis, parent training programs for children with oppositional behavior, behavioral marital therapy, behavior therapy for female orgasmic dysfunction and male erectile dysfunction, family education programs for schizophrenia, behavior modification for developmentally disabled individuals, token economy programs. See Beutler, *supra* note 195, at 126-27. The APA also lists treatments that are "probably efficacious," meaning preliminary research has been conducted but replication of the results is still pending: applied relaxation for panic disorder, applied relaxation for generalized anxiety disorder, exposure treatment for PTSD, group exposure and response prevention for obsessive-compulsive disorder, relapse prevention program for obsessive-compulsive disorder, behavior therapy for cocaine abuse, brief dynamic therapy for opiate dependence, cognitive therapy for opiate dependence, cognitive behavioral therapy for benzodiazepine withdrawal in panic disorder patients, brief dynamic therapy for depression, cognitive therapy for depression for geriatric patients, psychoeducational treatment of depression, reminiscence therapy for depression for geriatric patients, self-control therapy for depression, behavior therapy for childhood obesity, group cognitive behavioral therapy for bulimia, emotionally focused couples therapy, insight oriented marital therapy, behavior modification of encopresis, family anxiety management training for anxiety disorders, behavior modification for sex offenders, dialectical behavior therapy for borderline personality disorder, habit reversal and control techniques. See *id.* (listing treatments that are "probably efficacious").

203. See Dianne L. Chambless & Steven D. Hollon, *Defining Empirically Supported Therapies*, 66 J. CONSULTING & CLINICAL PSYCHOL. 7, 7 (1998) (proposing method for determining when psychological treatment for specific disorder is established in efficacy or is efficacious); Philip Kendall, *Empirically Supported Psychological Therapies*, 66 J. CONSULTING & CLINICAL PSYCHOL. 3, 3 (1998) (defining empirically validated treatment as psychological treatments that have been exposed to evaluation using accepted methods of psychological science and treatment outcome). Empirically supported treatments are validated by relying on external criteria and statistical estimates of probability in an attempt to eliminate or minimize potential human biases on the evaluation procedure. See Larry E. Beutler & Eve H. Davison, *What Standards Should We Use?*, in SCIENTIFIC STANDARDS OF PRACTICE, *supra* note 2, at 18 (discussing empirical approaches to validation).

204. See Chambless & Hollon, *supra* note 203, at 7 (noting that some of these confounding variables can include large number of factors such as passage of time, effects of psychological assessment and patient/therapist traits). Some commentators also note that the nature of empirical approaches is not set in stone, and the use of different empirical criteria can produce remarkably different results regarding which treatments are the most clinically effective. See Beutler & Davison, *supra* note 203, at 15-21 (discussing empirical and non-empirical approaches to validation). Different approaches to empirical validity include theoretical validity, replicability and incremental validity. See *id.* at 18-21. Theoretical validity stands for the proposition that if a theory is valid, then the method it employs must also be, and vice versa. See *id.* at 18 (noting that theoretical validity is common approach to selection of therapeutic approaches). Replicability posits that when a phenomenon can be objectively observed or measured on at least two separate occasions, then it must be valid. See *id.* at 19 (noting that this position has been adopted by APA Task Force on Promotion and dissemination of Psychological Procedures). Incremental validity asserts that "unless a procedure is better than a minimal intervention or assessment condition, it cannot be justified." *Id.* In contrast are non-empirical approaches to validity, approaches that have

research is an attempt to demonstrate a cause and effect relationship between therapy and improvement.²⁰⁵

Currently, the gold medal standard for controlled efficacy research in the field of psychology is the randomized clinical trial ("RCT"), in which patients are randomly assigned to the treatment of interest or, one or more comparison groups.²⁰⁶ The general purpose of the RCT model is to provide the necessary scientific objectivity and control for demonstrating a cause and effect relationship between the treatment intervention and treatment outcome.²⁰⁷ The RCT design accomplishes this by controlling for and eliminating as many extraneous variables as possible, leaving the treatment intervention as the most reasonable explanation for patient improvement.²⁰⁸ Once a treatment has been through the RCT process and shown to be successful in treating a particular

typified the practice of psychology today and in the past. *See id.* at 15-16 (noting that non-empirical criteria are common in graduate level training). Non-empirical approaches to validity include face validity and consensual validity. *See id.* Face validity stands for the proposition that the proof of validity is a logical fit between the explanation and one's own personal experiences. *See id.* at 15 (describing face validity as "it looks good and is logical" validity). Similarly, consensual validity stands for the proposition that proof of validity is established when it receives public support or the support of authorities in the field of specialty. *See id.* at 17 (describing consensual validity as "everyone knows it true" validity).

205. *See* T.D. Borkovec & Louis G. Castonguay, *What Is the Scientific Meaning of Empirically Supported Therapy?*, 66 J. CONSULTING & CLINICAL PSYCHOL. 136, 136 (1998) (discussing nature of experimental therapy outcome research). This cause and effect relationship is demonstrated by eliminating competing causes. *See id.* These competing causes are controlled for by holding as many variables as possible constant across comparison groups except for the variable of interest—in this case, the therapy in question. *See id.*

206. *See id.* (detailing experimental therapy outcome research); *see also* Jacqueline B. Persons & George Silberschatz, *Are Results of Randomized Controlled Trials Useful to Psychotherapists?*, 66 J. CONSULTING & CLINICAL PSYCHOL. 126, 126 (1998) (discussing use of RCTs and quality of patient care).

207. *See* Chambless & Hollon, *supra* note 203, at 8 (discussing overall research design in therapy outcome research); *see generally* ALAN E. KAZDIN, *RESEARCH DESIGN IN CLINICAL PSYCHOLOGY* (2d ed. 1992) (discussing various uses of research design in clinical psychology).

208. *See* Chambless & Hollon, *supra* note 203, at 8 (discussing basic issues researchers should consider in outcome research). Some of the basic issues in outcome research involve sample selection, outcome assessment, treatment implementation and data analysis. *See id.* at 9-12. Each of these elements is critical to, and can effect the results of, outcome research. The selection of a clearly defined population for which the treatment was designed and implemented is critical to the later application of the therapy. For example, if an RCT study finds that a new treatment for depression is efficacious for adolescents ages eight through sixteen, then the population in question is adolescents ages eight through sixteen. The results of the study support the proposition that the treatment is an effective one for treating depression in this age group. The results do not support the use of the treatment with adults or any other population outside of the delineated age range. In other words, a treatment must be efficacious for a specific population. *See id.* at 9. Outcome assessment is another critical aspect of the RCT design, and specific tools have to be developed that are reliable and valid in measuring treatment outcome. *See id.* at 9-11. Treatment implementation is accomplished through the use of treatment manuals that standardize each step of the therapeutic process. *See id.* at 11-12. Finally, errors in data analyses can cause a researcher to accept a treatment as efficacious, when in reality it is not. *See id.* at 12.

disorder, independent research must replicate the results before the treatment can be identified as efficacious.²⁰⁹

The fact that the APA Task Force only identified a handful of empirically validated treatments led to a firestorm of criticism because it left the impression that most therapies were ineffective.²¹⁰ To address this misunderstanding, the APA Task Force issued an update to their original report.²¹¹ In this update, the APA Task Force cautioned members about the use of the list of treatments by noting that the list was far from complete, pending further research; and that the list should not be a substitute for a mental health professional's decisions about the most appropriate form of intervention for a given client.²¹² The APA Task Force also specifically addressed another issue on the minds of many members—managed care and reimbursement.²¹³ Specifically, the APA Task Force stated:

This list is intended to facilitate education by identifying treatments with a scientific basis [It] is far from complete and should not be employed as the basis for decisions concerning reimbursable treatments by third party payers That a treatment is not on our list in no way means that it has been shown to be ineffective.²¹⁴

Despite this attempt at reconciliation, the genie had already been let out of the bottle, and now the mental health profession was forced to grapple with issues such as "what is the future of psychology" and "what, if any, is the importance of empirically validated treatments in that future."

The original conclusions of the APA Task Force sparked considerable debate in the discipline, a debate that continues to rage today. The debate focuses on how exactly "empirically validated treatment" should be defined and whether a shift toward empirically validated treatments is the proper course of evolution for the discipline generally, and therapy specifically. The two main camps take diametrically opposite positions.²¹⁵ The first point of view is in favor of empirically based treatments, and, accordingly, asserts that they are critical to clinicians and the ethical practice of psychotherapy.²¹⁶ More specifically, proponents of empirically supported treatments assert that practitioners must use them for clinical, ethical and legal reasons.²¹⁷ From a clinical standpoint, the results of RCTs allow clinicians to make informed

209. *See id.* at 8 (noting that efficacy usually requires at least two independent studies reaching same conclusion).

210. *See generally* Persons & Silberschatz, *supra* note 206 (discussing pros and cons of empirically validated treatments).

211. *See* Chambless et al., *supra* note 202, ¶¶1-2 (updating original report).

212. *See id.* ¶ 6 (clarifying limitations of list).

213. *See id.* (addressing managed care and reimbursement).

214. *Id.* ¶ 4.

215. *See generally* Persons & Silberschatz, *supra* note 206 (setting forth various positions in mental health discipline regarding empirically validated treatments).

216. *See id.* at 126 (noting that question of whether randomized clinical trials are useful to practicing clinicians is controversial in field of psychotherapy).

217. *See id.* (discussing relevance of RCTs to practice of psychotherapy).

choices regarding treatment efficacy and other possible treatment alternatives.²¹⁸ From an ethical standpoint, proponents cite numerous authorities supporting the proposition that empirically based treatments are essential to the ethical practice of psychotherapy. Proponents also note that, in certain circumstances, failure to use empirically supported treatments can have legal consequences.²¹⁹

On the other side of the controversy, adversaries assert that the results of the RCTs that support the use of empirically supported treatments are useless to clinicians and have a minimal impact on the practice of psychotherapy.²²⁰ The major criticism from this camp is that the method employed by RCTs does not adequately address the day-to-day realities and intricacies of practicing psychotherapy.²²¹ Specific criticisms of the RCT approach focus on a lack of basic knowledge in the area of mechanisms that produce therapeutic change, unstudied confounding variables such as level of empathy and therapeutic alliance and a lack of internal and external validity.²²² One prominent past-president of the APA has gone as far as to state that although RCTs are an integral part of scientific study, the scientific strengths of the RCT approach make it "the wrong method for empirically validating psychotherapy as it is actually done, because it omits too many crucial elements of what is done in the field."²²³

218. *See id.* (asserting that results of RCTs are essential to improving quality of care).

219. *See id.* (noting legal consequences of ignoring RCTs in practice).

220. *See id.* at 128 (disputing significance of RCTs). *See generally* Gerald C. Davison & Arnold A. Lazarus, *The Dialectics of Science and Practice*, in SCIENTIFIC STANDARDS OF PSYCHOLOGICAL PRACTICE, *supra* note 2, at 95 (discussing theory, clinical practice and need for innovation); Linda J. Hayes, *Achieving Synthesis*, in SCIENTIFIC STANDARDS OF PSYCHOLOGICAL PRACTICE, *supra* note 2, at 121 (noting that therapy setting and process is critical to treatment of patient).

221. *See* Persons & Silberschatz, *supra* note 206, at 128 (stating that RCTs do not address issues and concerns of practicing physicians). One commentator notes that RCT does not help a therapist answer certain basic questions endemic to the therapy process:

When a patient seeks therapy, the therapist must try to answer several basic questions: What is bothering the patient? What does the patient hope to accomplish in treatment? What has impeded the patient from achieving his or her goals? How can the therapist best help the patient?

I believe that certain kinds of research studies are capable of providing useful data to answer these fundamental clinical questions. However, RCT's do not provide any meaningful help in addressing these questions and, consequently, they have had very little impact on clinicians and on the practice of psychotherapy.

Id. (citations omitted).

222. *See generally* William C. Follette, *Correcting Methodological Weaknesses in the Knowledge Base Used to Derive Practice Standards*, in SCIENTIFIC STANDARDS OF PSYCHOLOGICAL PRACTICE, *supra* note 2, at 229 (asserting that current body of research does not provide necessary data to make informed treatment choices and proposing alternative methods for determining treatment efficacy); Logan Wright, *Attending to Findings*, in SCIENTIFIC STANDARDS OF PSYCHOLOGICAL PRACTICE, *supra* note 2, at 248 (noting that even best data available of treatment effectiveness is primitive at best).

223. Persons & Silberschatz, *supra* note 206, at 129 (quoting past APA president Martin Seligman). Seligman identified five specific characteristics that are not factored into RCTs. First, psychotherapy is not of fixed duration; it continues until there is improvement or the patient terminates treatment. *See id.* Second, therapy is self-correcting, with therapists modifying current treatments or adopting new lines of treatment depending on the needs of the client. *See id.* Third, actual psychotherapy patients choose a therapist and are not

3. *The Ethics of RCTs*

Although the debate among mental health care providers continues to rage, the APA and the managed care industry have made their position clear—empirically validated treatments are a critical component of establishing appropriate standards of practice and for the ethical practice of psychotherapy.²²⁴ The APA Task Force has gone as far as to state, and other commentators agree that:

[C]linical psychologists bring information about empirically supported treatments to bear when addressing their patients' legal and ethical rights to informed consent to treatment and informed refusal of treatment. As part of the consent process, clinicians should make sure that clients understand what the treatment can be reasonably expected to accomplish and in what period of time, what any negative effects of the treatment might be, what other treatments might be considered, and whether these would be expected to be more or less helpful and more or less costly. Clinicians who remain uninformed about the research literature are ill-equipped to discuss these issues with clients and thus to discharge their ethical obligation.²²⁵

Clearly, the ethical practice of psychotherapy mandates both the use of empirically based interventions and the wisdom of full disclosure about them.

Although informed consent is required for psychological treatments involving physical touching, courts have not directly addressed the issue of whether informed consent must be obtained before other psychological services are rendered.²²⁶ Because the courts have not addressed this issue directly, mental health professionals are encouraged to look to their professional code of ethics for guidance.²²⁷ The Ethical Guidelines and Code of Conduct for the American Psychological Association ("APA Ethical Guidelines")²²⁸ clearly support the use of empirically based treatments as the current standard of

randomly assigned to one. *See id.* Fourth, unlike RCT trials, actual psychotherapy patients frequently present with multiple, comorbid problems. *See id.* Finally, psychotherapies overall goal is to improve overall functioning and not just to produce symptomatic improvement. *See id.*

224. *See* John Bartlett, *Practice Guidelines: The Managed Care View*, in ALLIES AND ADVERSARIES, *supra* note 170, at 153–62 (discussing managed care's use of practice guidelines as cost containment mechanism); Chambless et al., *supra* note 202, at ¶¶ 32–35 (discussing ethics, science and clinical interventions).

225. Chambless et al., *supra* note 202, at ¶ 35. *See generally* POPE & VASQUEZ, *supra* note 182 (discussing ethical considerations in practice of psychotherapy).

226. *See* DONALD N. BERSOFF ET AL., LAW & MENTAL HEALTH PROFESSIONALS 73 (1999) (noting that law does not require informed consent for psychological services that do not involve physical touching).

227. *See id.* at 73–74 (advising mental health professionals where to look for guidance).

228. AMERICAN PSYCHOLOGICAL ASSOCIATION, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT, app. J at 331 (1992), *available at* <http://www.apa.org/ethics/code.html> (effective date Dec. 1, 1992).

practice.²²⁹ The APA Ethical Guidelines apply to psychologists' scientific and professional roles, and can be applied and enforced by the APA and other sources of authority that choose to adopt them.²³⁰ The Preamble of the APA Ethical Guidelines states that "[p]sychologists work to develop a valid and reliable body of scientific knowledge based on research."²³¹ Similarly, the APA Ethical Guidelines note that psychologists "maintain knowledge of relevant scientific and professional information related to the services they render . . . [and] make appropriate use of scientific . . . resources."²³² Furthermore, and more specifically, the General Standards of the APA Ethical Guidelines note that awareness of current scientific knowledge is critical to psychological expertise and professional judgment.²³³

Although the violation of the ethical standards does not, in and of itself, establish legal liability or consequences, compliance or non-compliance may be admissible in certain legal proceedings or disciplinary causes of action.²³⁴ Although admissible in certain legal proceedings, violations of ethical standards alone do not create a free-standing legal cause of action; however, in the case of informed consent and empirically supported treatments, perhaps they should.²³⁵ Empirically supported treatments appear to play a critical role in the process of informed consent as well. This Article asserts that failure to provide clients with appropriate information in the informed consent process regarding empirically based treatments should create a free-standing legal cause of action for failure to provide informed consent based on both the failure to provide information about the empirically supported treatment and any increased treatment cost that results from that failure.²³⁶

V. MENTAL HEALTH MALPRACTICE, STANDARDS OF CARE, INFORMED CONSENT AND TORT LIABILITY

Although there are alternative theories, negligence is the primary doctrine for holding mental health professionals liable in tort. To establish the tort of negligence, a patient must prove: (1) the existence of a therapist/patient relationship; (2) a breach of the applicable standard of care (i.e., the therapist

229. *See id.* at 332 (noting that ethical standards set forth enforceable rules for conduct of psychologists).

230. *See id.* (noting actions APA may pursue such as reprimand, censure, termination of membership and referral to other administrative bodies).

231. *Id.* at 333 (noting that overall goal of profession is to broaden knowledge of human behavior).

232. *Id.* at 333-34.

233. *See id.* at 335 (establishing code of conduct relevant to maintaining expertise and basis for scientific and professional judgments); *see also* Robyn M. Dawes, *Standards of Practice*, in *SCIENTIFIC STANDARDS OF PSYCHOLOGICAL PRACTICE*, *supra* note 2, at 31, 31-35 (asserting that standards of practice must guide how professionals practice and not how they are trained).

234. *See generally* AMERICAN PSYCHOLOGICAL ASSOCIATION, *supra* note 228 (discussing other administrative remedies).

235. *See* Dawes, *supra* note 233, at 35 (stating that "practitioners should first understand science and secondly be bound by it").

236. For further discussion, see *supra* note 25 and accompanying text.

has failed to act as a reasonable therapist in the circumstances); (3) causation of injury to the patient by the breach; and (4) damages.²³⁷ Because of the number of schools of thought and the paucity of empirical data, part two—the standard of care—poses the greatest difficulty when applied to psychotherapy. Yet it is precisely this aspect of the profession on which HMOs, with their goal of quick cures and uniform approaches, have their greatest impact.

Few cases directly address the negligence of mental health professionals in making diagnostic and treatment decisions. This is likely to change. HMOs, and the need for reimbursement, are pushing psychotherapy into a greater dependence upon RCTs and empirically validated treatments. If a therapist recommends a treatment not supported by an RCT, and hence not reimbursable, the patient may be able to sue on that basis. Of greater importance, however, is the fact that RCTs may themselves create a standard of care by demonstrating what works in a given context. A therapist who recommends a different treatment may find him or herself in violation of what has become, through HMO intervention, an identifiable standard of care, where previously there was none.

The law in this area, as it applies to mental health professionals, must for the time being, be analogized from its application to the field of medicine.²³⁸ Put simply, a mental health professional, like all professionals, must conform to a professional standard of care, skill and technical proficiency normally exercised by professionals practicing in the same field.²³⁹ Although the standard of care can vary from jurisdiction to jurisdiction, generally courts will look to the "nationally accepted or customary standards of the practitioner's particular school of practice."²⁴⁰ Like other professions, mental health professionals holding themselves out as specialists are held to a specialist's standard of care.²⁴¹

237. See WILLIAM PROSSER & PAGE KEETON, ON THE LAW OF TORTS § 30 (5th ed. 1984) (laying out elements for negligence). To establish a claim in negligence, the plaintiff must prove four elements:

[A]ll duty, or obligation, recognized by the law, requiring the person to conform to a certain standard of conduct, for the protection of others against unreasonable risks; [a breach of this duty]; [a] reasonably close causal connection between the conduct and the resulting injury; [and] [a]ctual loss or damage to the interests of another.

Id.; see also RALPH REISNER & CHRISTOPHER SLOBOGIN, LAW AND THE MENTAL HEALTH SYSTEM 64 (2d ed. 1990) (providing doctrinal overview). Alternative theories that have been recognized by the courts include intentional torts, breach of contract and claims based on federal civil rights laws. See *id.* at 153-54.

238. See generally R. Kirkland Gable, *Malpractice Liability of Psychologists*, in THE PROFESSIONAL PSYCHOLOGIST'S HANDBOOK (Bruce D. Sales ed., 1983) (discussing malpractice liability of mental health professionals in terms of medical profession).

239. See REISNER & SLOBOGIN, *supra* note 237, at 64 (describing mental health profession as science and art); Gable, *supra* note 238, at 459 (noting standard is still evolving); Steven R. Smith, *Mental Health Malpractice in the 1990s*, 28 HOUS. L. REV. 209, 211 (1991) (noting malpractice claims would be more frequent with clearly defined standard of care).

240. Gable, *supra* note 238, at 460 (noting varying standards of care for practitioners). A minority of jurisdictions recognize the professional judgment rule, which "shields a physician from liability for mere errors of judgment provided he does what he thinks best after careful examination." See REISNER & SLOBOGIN, *supra* note 237, at 73 (discussing recognition of professional judgment rule). Before the advent of nationally accepted or customary standards, the "locality rule" was used in many jurisdictions. See Gable, *supra* note 238, at 460. Under

Although the standard of care for a mental health professional can be established, in part, by statute, codes of ethics and membership in a professional organization, these are only factors that can be considered and are not in and of themselves determinative.²⁴² Further compounding this problem is that despite these guidelines, mental health professionals have traditionally been afforded a significant amount of leeway in treatment and diagnostic decisions, depending on the particular characteristics of the patient, the circumstances of the case and the practitioner's theoretical orientation.²⁴³ This flexibility in treatment decisions is also borne out in the respectable minority doctrine, where a defense to negligence can be established by showing that a particular intervention is supported by a "respectable minority" of those practicing in the field.²⁴⁴ Needless to say, given the plethora of schools of psychotherapy and treatment interventions, each as unempirically supported as the next, the respectable minority doctrine can be a strong defense against liability in the mental health arena.²⁴⁵

this rule, mental health practitioners were required to meet the standards of practice within their own or similar localities. *See id.* The rule was established to take into account a disparity of resources in some localities. *See id.*

241. *See Gable, supra* note 238, at 460 (noting that mental health professionals holding themselves out as specialists will then be held to higher standard regardless of specialized training in treatment of disorder).

242. *See id.* at 461 (discussing factors that can be used in establishing appropriate standard of care).

243. *See id.* at 462 (noting that experts in psychology rarely agree on best course of treatment). A claim in negligence can be brought against a mental health professional for not utilizing a more appropriate intervention. *See REISNER & SLOBOGIN, supra* note 237, at 75 (introducing respectable minority doctrine). A claim of this type brought against a mental health professional will generally be evaluated under the standard of what members of the profession would customarily do under the circumstances. *See id.* (noting that under respectable minority doctrine finding that therapeutic approach was not customary does not necessarily lead to liability). Under the respectable minority doctrine, a psychological procedure or intervention can be customary even if it is not used by a majority of practitioners. *See id.* In describing the respectable minority doctrine as it applies to the medical profession, one commentator noted:

[W]here two or more schools of thought exist among competent members of the medical profession concerning proper medical treatment for a given ailment, each of which is supported by responsible medical authority, it is not malpractice to be among the minority . . . [of those following] one of the accepted schools.

Id. (citing *Chumbler v. McClure*, 505 F.2d 489, 492 (6th Cir. 1974)).

244. *See REISNER & SLOBOGIN, supra* note 237, at 75 (citing *McHugh v. Audet*, 72 F. Supp. 394 (M.D. Pa. 1947)).

245. *See id.* (noting that doctrine could be used to sanction use of less effective treatments); Smith, *supra* note 239, at 212-17 (noting increase in malpractice premiums and size of claims in psychiatric cases). On the nebulous standard of care for mental health professionals, Smith noted that:

[N]egligence requires a standard of professional care against which the actions of the defendant-professional can be measured. Liability exists only if the professional has failed to provide the same care as would a reasonably prudent professional. The standard of practice for mental health professionals is not as clearly or precisely defined as it is in many areas of medicine. For instance, the standard of practice for treatment of acute appendicitis is fairly uniform and clear; the standard of practice for treatment of schizophrenia is not. The large number of "schools of thought" in psychotherapy complicates efforts to define a clear standard of care. The absence of

Although an exact standard of care for treatment and diagnostic decisions is difficult to determine, there are a number of actions taken by a mental health professional that are generally recognized by the courts as constituting a breach of the standard of care. These include, but are not limited to, physical contact and sexual relations with patients, preventable suicide and homicide by patients, prescription drug cases and breaches of confidentiality.²⁴⁶

The aspect of negligence of particular concern here involves the doctrine of informed consent. At least in theory, and in reality as far as the courts are concerned, the decision-maker in any treatment context is the patient.²⁴⁷ A physician and, by analogy, a therapist, thus has the obligation to list and explain all possible treatments to the patient. The therapist must provide sufficient information to allow the patient to make an informed choice.²⁴⁸ In the field of

a clear "correct" treatment makes it difficult to assess the reasonableness of the therapist.

Id. at 214 (footnotes omitted).

246. See Gable, *supra* note 238, at 464-76 (discussing dereliction of duty by mental health professionals); Smith, *supra* note 239, at 221-42 (discussing areas of established malpractice liability). Mental health professionals have a duty to recognize and treat suicidal behavior and must act reasonably in trying to prevent a patient from committing suicide, even if restraint and hospitalization are necessary. See *id.* at 222. Malpractice liability may result from inadequate diagnosis leading to injury due to unnecessary or incorrect prescription of medication. See *id.* at 225. Sexual misconduct with patients is not only a violation of the ethical code of conduct, but is also one of the biggest sources of malpractice litigation against the mental health profession. See *id.* at 228. The protection of third parties is also a potential source of significant liability for the mental health profession. See *id.* at 242-50 (discussing Tarasoff duty to protect (or warn)). In *Tarasoff v. Regents of the University of California*, the Supreme Court of California imposed on therapists the duty to take steps to warn a clearly identifiable victim at the expense of the therapist-client relationship and its accompanying confidentiality. 551 P.2d 334, 343 (Cal. 1976).

247. See POPE & VASQUEZ, *supra* note 182, at 134-35 (proposing ideal conceptualization of informed consent in psychotherapy). The informed consent process involves more than an explanation of the therapist's proposed treatment plan, and the efficacy of any informed consent process can be determined by how well the following questions are addressed: (1) Does the client understand who is providing the service and the clinician's qualifications?; (2) Does the client understand the reason for the first session?; (3) Does the client understand the nature, extent, and possible consequences of the services offered?; (4) Does the client understand that there may be alternatives to the proposed plan?; (5) Does the client understand actual or potential treatment limitations (i.e., managed care session limits or a therapist who may not be available after the first six months)?; (6) Does the client understand the fees to be charged and policies regarding missed or canceled appointments?; (7) Does the client understand policies regarding access to the therapist, to those providing coverage for the therapist, and to emergency services?; and (8) Does the client understand exceptions to confidentiality of privilege? See *id.* at 132-34. Informed consent fulfills not only a legal obligation to provide the client with relevant information to make an informed decision, but can serve a beneficial therapeutic purpose as well. Research suggests that the informed consent process increases the probability that a client will "become less anxious, follow the treatment plan, recover more quickly and be more alert to unintended negative consequences of treatment." *Id.* at 136.

248. See *id.* at 155-56 (discussing realities of informed consent, psychotherapy and managed care). Ideally, upon completion of the diagnostic phase, the therapist conducts a feedback session with the client in which the therapist explains the diagnosis, the proposed treatment plan and any relevant treatment alternatives. See *id.* at 155-57. In reality, the constraints placed on the therapist's time by managed care organizations often prevent the

psychotherapy, this obligation is not taken seriously. One reason is that informed consent cases are rarely pursued despite the fact that mental health professionals either completely ignore the requirement or give it only superficial treatment.²⁴⁹ Where, however, reimbursement hinges on a specific treatment choice, a patient denied the right to make that choice may well pursue legal relief.

In the medical context, the origins of the doctrine of informed consent can be traced back to 1914 and Judge Cardozo's opinion in *Schloendorff v. Society of New York Hospital*.²⁵⁰ The original doctrine required nothing more than a patient's general agreement to treatment—such a showing immunized the

therapist from conducting a feedback session at all. *See id.* at 155-56. Cost considerations, previously out of place in the treatment decision-making process, now play a greater role in the choices clinicians make. The integrity of the therapeutic relationship has been compromised with the introduction of financial rewards in exchange for providing cost-effective treatment. *See* Manos, *supra* note 182, at 217-19 (discussing financial incentives offered to preferred providers). In addition to financial incentives, clinicians are well aware of the reimbursement limitations on long-term or other expensive modes of therapy, and, as a result, most psychotherapy patients undergo brief psychotherapy never having been informed of the more costly alternatives. *See* POPE & VASQUEZ, *supra* note 182, at 53-54. And if money is an insufficient motivator, gag clauses ensure that patients are not informed of more expensive treatment options. Gag clauses are contractual obligations that prevent the provider from disclosing to the patient treatment alternatives that are not covered by the plan. *See* Manos, *supra* note 182, at 219. Although the National Academies of Practice and sixteen state legislatures have condemned the use of such gag rules, threats of dismissal or blacklisting for disclosure of restricted information have kept gag clauses alive and well. *See id.* at 219.

249. *See* Smith, *supra* note 239, at 239-41 (discussing reasons why mental health professionals fail to take doctrine of informed consent seriously). One commentator noted:

In practice, mental health professionals frequently ignore the doctrine of informed consent. Many factors may interfere with the consent process: the limited mental competency of some patients, the failure to provide sufficient information in an understandable form, a feeling of paternalism toward patients, and the patient's young age. There is evidence that in mental health treatment, informed consent is often not very effective, either because professionals do not believe that patients are capable of participating in the decision or because of a concern that patients will not make decisions that are in their best interests. In other instances, professionals go through the process in a very formal way that does not convey much information to the patient, or the information is presented in sophisticated . . . jargon that the patient cannot understand. Written consent is desirable because it provides a record of the transaction, for the therapist and the patient may take the process more seriously if there is a document to be signed. The ultimate purpose, however, is to provide the patient sufficient information for making an informed treatment decision.

Id. at 239-40.

250. 105 N.E. 92, 93 (N.Y. 1914) (stating that surgeon who performs operation without patient's consent is liable); *see* REISNER & SLOBOGIN, *supra* note 237, at 166 (noting doctrine of informed consent has "deep-seated roots in [American] jurisprudence"); Susan M. Wolf, *Toward a Systemic Theory of Informed Consent in Managed Care*, 35 HOUS. L. REV. 1631, 1631-32 (1999) (noting that opinion came in response to physician abuses). *See generally* JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984) (discussing evolution of informed consent doctrine). In *Schloendorff*, Judge Cardozo characterized the right as:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.

REISNER & SLOBOGIN, *supra* note 237, at 166 (citing *Schloendorff* 105 N.E. at 93).

physician from liability.²⁵¹ Although Judge Cardozo's opinion in *Schloendorff* was instrumental in establishing the right of a patient to informed consent, the doctrine itself did not receive substantial judicial attention until the early 1960s, when state courts began to expand the doctrine to include a patient's right to know of the risks involved in treatment and possible treatment alternatives.²⁵² The doctrine of informed consent continued to evolve, and reached its zenith in the early 1970s in the decision of *Canterbury v. Spence*.²⁵³

Today, the doctrine of informed consent incorporates both consent to treatment and disclosure of all relevant information to the patient necessary to make an informed treatment decision.²⁵⁴ Although the doctrine is well established and active in the medical field, it has yet to be applied to the field of psychology and psychiatry.²⁵⁵ Again, this is directly attributable to the lack of a standard of care that can be applied to psychotherapists and the nebulous nature of the discipline itself.

Extrapolating to the mental health context, informed consent requires that the patient be fully informed about treatment options and any material risks involved.²⁵⁶ Before RCTs and HMOs, and given the variability in mental health interventions and the inability of the discipline to define associated risks of psychotherapy beyond basic emotional discomfort, it was difficult to

251. See REISNER & SLOBOGIN, *supra* note 237, at 166 (noting limited consent necessary to immunize physician).

252. See *id.* (noting that after *Schloendorff* case doctrine of informed consent was honored "more in the abstract than in reality"). Prior to the doctrine of informed consent, the legal system conceptualized unconsented to touching in the medical context as battery. See *id.* At the time, consent was simply the patient's general consent to treatment and the treating physician did not have to inform the patient of potential risks or treatment alternatives. See *id.* In the early 1960s, a trend began to evolve at the state level, and a number of state courts expanded on the doctrine by holding that a patient had a right to information regarding risks and treatment alternatives. See *id.*; see also Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 264 (1999) (noting that cost containment strategies have negative impact on doctrine of informed consent).

253. 464 F.2d 772 (D.C. Cir. 1972) (finding that physician has duty of reasonable disclosure of choices relative to proposed therapy and any inherent and possible dangers); see Wolf, *supra* note 250, at 1632-33 (discussing *Canterbury's* expansion of doctrine of informed consent and noting that by mid-1970s informed consent was firmly established).

254. See REISNER & SLOBOGIN, *supra* note 237, at 166-67 (noting disagreement on source and scope of doctrine). Commentators have noted that the doctrine of informed consent serves a number of goals that can be categorized as ethical, decision-making, regulatory and compensatory. See Jon F. Merz, *On a Decision-Making Paradigm of Medical Informed Consent*, 14 J. LEGAL MED. 231, 237-43 (1993) (reviewing commentary on goals of informed consent doctrine). The ethical goal revolves around promoting the autonomy interests of the patient. See *id.* at 238-39. The decision-making goal advocates for giving the patient all necessary information to make a knowing and rational decision regarding treatment options. See *id.* at 239-40. The regulatory goal places an affirmative duty on physicians to disclose information and establishes appropriate standards of care. See *id.* at 240-42. The compensatory goal is to provide monetary damages to patients that are injured as a result of the physician's negligence. See *id.* at 242-43.

255. See REISNER & SLOBOGIN, *supra* note 237, at 167 (noting only limited application to physically intrusive treatments such as electro-convulsive and pharmacological treatments for depression).

256. See Gable, *supra* note 238, at 464-68 (noting that informed consent is usually inferred when patient voluntarily goes to see therapist).

conceptualize what the exact risks of mental health treatment are in terms of informed consent.²⁵⁷ With the advent of empirically validated treatments and the involvement of managed care, however, it is now possible to point to more concrete risks associated with mental health treatment. For example, one possible risk is spending more time in therapy than necessary. Many of the empirically validated treatments that are reimbursed by managed care are standardized, outcome driven and time focused—most patients should experience symptom reduction within a specified number of sessions. Many non-empirically validated therapies are not time focused, and a person can be in therapy for an indeterminate period of time without clear treatment goals and specified outcomes. As there is, in the HMO view, no reason to keep a person in therapy any longer than needed for resolution of the presenting problem, it is difficult to justify wasting that person's time in extended and possibly ineffective therapy.

Another possible risk associated with not providing information regarding empirically supported treatments revolves around reimbursement. HMOs will only reimburse for therapy that has been empirically supported as being effective. This excludes a large number of treatments, not to mention a significant number of psychological schools of thought. A relatively uninformed consumer, unaware of these circumstances and convinced by a therapist that a non-empirically supported therapy is best for them, might enter into therapy that is not reimbursable, thereby incurring out-of-pocket costs.

Another risk associated with HMOs is the threat to patient privacy. This is especially relevant where patients are paying for psychotherapy out-of-pocket because he or she does not want the fact of seeking therapy to be part of an HMO's database or because the relevant HMO does not have mental health coverage. In this context, knowledge of empirically supported treatments in the context of informed consent is crucial, because it allows the consumer to pick the best treatment while incurring the least amount of temporal and economic expenses. Reimbursement is not the issue here, so HMOs have no control over the treatment decision. Brevity of treatment, however, attains an even greater importance, and the patient will need to know what treatment can be the most effective in the shortest time.

Even with these difficulties, informed consent for psychological treatment should include the following elements: "(1) the diagnosis or purpose of the treatment, (2) the nature and duration of the treatment, (3) the risks involved, (4) the prospects of success or benefit, (5) possible disadvantages if the treatment is not undertaken, and (6) *alternative methods of treatment*."²⁵⁸ Empirically validated treatments offer the solution to providing scientifically based alternatives to otherwise theoretical treatments with questionable effectiveness. They may also mandate that such treatment be offered to the exclusion of others. Accordingly, it is no longer the case that a mental health

257. *See id.* at 466-67 (discussing informed consent, material risk and psychotherapy).

258. *See id.* at 466-67 (emphasis added) (discussing informed consent and treatment goals).

professional should be immune from liability because it cannot be demonstrated that one treatment is better than another.

VI. CONCLUSION

Although adequate for holding most professionals to certain levels of conduct, the doctrine of negligence has traditionally been difficult to apply to the mental health arena.²⁵⁹ The reasons offered for this difficulty all appear to revolve around the fact that psychology is still very much a philosophy and not a science, making it difficult to establish a clear standard of care. Other, less philosophical, reasons have also been offered for the difficulties of applying traditional principles of negligence to mental health practitioners.²⁶⁰ One such reason is the difficulty in proving compensable damages.²⁶¹

Although many jurisdictions recognize damages for emotional distress, generally, in order to recover damages, a plaintiff must demonstrate a physical injury.²⁶² Needless to say, in the realm of psychotherapy, where the damage is most likely to be emotional pain and suffering, physical injury is difficult to demonstrate.²⁶³

The other major and related reason offered for the inability to apply the doctrine of informed consent to mental health treatment is that the patient's injury must be a direct and proximate result of the treatment itself.²⁶⁴ In addition, the plaintiff must demonstrate that the physician did not provide the information necessary to make an informed decision that a reasonable physician would have provided, and that the patient would have made a different treatment choice if the information had been supplied. As with the damages element, these elements of the plaintiff's case can be very difficult to prove in the mental health context because it is almost impossible to demonstrate that the treatment itself was the proximate cause of the resulting injury.²⁶⁵

The difficulty of using the doctrine of informed consent against a mental health practitioner severely limits a plaintiff's options for bringing a cause of action for poor treatment decisions.²⁶⁶ Although there was a time when this might have been justifiable because of the chaotic and undifferentiated state of psychological theories of treatment, empirically validated treatments have

259. *See id.* at 457 (noting that claims of malpractice against mental health professionals are few in number).

260. *See* REISNER & SLOBOGIN, *supra* note 237, at 167 (discussing reasons why doctrine of informed consent has seen application predominantly in bio-medical field).

261. *See id.* (noting that recovery of monetary damages under some tort theories requires demonstration of physical injury).

262. *See id.* (acknowledging that "a patient who has been deprived of the right to give informed consent to psychiatric or psychological treatment may have no compensable damages").

263. *See id.* (noting trend of increased emotional distress liability).

264. *See id.* (explaining second difficulty of extending doctrine).

265. *See id.* (asserting that doctrine of informed consent will eventually be applied to mental health treatment).

266. *See id.* (noting formidable difficulties of bringing such actions).

changed the landscape of liability for the mental health profession.²⁶⁷ In the past, the mechanism for holding mental health professionals liable for lack of informed consent was missing. Treatment was simply a philosophical and/or theoretical choice because the discipline could not—or did not want to—demonstrate that one treatment alternative was more effective than another.²⁶⁸ How could courts hold a humanistically oriented therapist liable for not informing a patient of the possible effectiveness of cognitive behavioral and pharmacological interventions? You could not.

The advent of empirically validated treatments can provide the long-missing mechanism for holding mental health professionals liable under the doctrine of informed consent. If there are empirically validated treatments available and the patient is not informed of this, then liability should be close to automatic. The outcome of the treatment is irrelevant. The theoretical orientation of the therapist is irrelevant. The purpose of the doctrine of informed consent is to provide the individual with the information necessary to make an informed treatment choice. Although still developing, there are ample data suggesting that certain treatments for certain disorders are more effective than others. In terms of psychotherapy, there can be no informed consent if the patient is not given this information.

As an added bonus, application of empirically validated treatments to the doctrine of informed consent could eliminate the need for questionable defenses such as the respectable minority doctrine—a doctrine that clearly, and perhaps inappropriately, limits the malpractice liability of mental health professionals. Rather than allowing liability to be determined by the theoretical orientation of any given practitioner, which produces as many standards of care as there are psychological schools of thought, empirically validated treatments will allow science to decide what the standard should be. Similarly, the use of empirically validated treatments is consistent with the ethical, decision-making, regulatory and compensatory policy goals of the informed consent doctrine. Ethically, knowledge of empirically validated treatments gives legal recognition to the individual's right to make informed treatment decisions. Similarly, decision-making is improved because the consumer has the most scientifically supported information available to make informed treatment decisions. Moreover, it will be easier to regulate the profession, because empirically validated treatments establish a clear and unequivocal standard of care. Finally, rather than having to fight the ever-changing and nebulous standards of care characteristic of psychology, a plaintiff will be able to point to a single standard of care, making it much easier to demonstrate that the standard was breached and allowing for the recovery of monetary damages.

267. For a discussion of the history of psychological treatment, see *supra* notes 149-69 and accompanying text.

268. For a discussion of the philosophical and theoretical origins of psychology, see *supra* notes 27-139 and accompanying text.