Standard of Care in Administering Non-Traditional Psychotherapy

> In no specialty of medicine is there more charlatanism than in the field of mental disorder, with the possible exception of those afflicted with cancer.
>
> Dr. Allison Landolt[1]

I. INTRODUCTION

Although the first sensitivity training session was conducted more than twenty years ago,[2] the encounter movement did not begin to mushroom into a significant phenomenon until about 1968. But once it caught hold, growth was rapid. By 1970 one hundred thousand people each year were taking part in some type of sensitivity training.[3] The number of growth centers in the United States (institutions which sponsor encounter groups and related activities[4]) grew from 40 in 1967 to 163 in 1971.[5] Churches, public schools, universities, prisons, and corporations, as well as profit-making growth centers, are now conducting encounter groups.[6]

Many of the techniques and ideas fostered by the encounterists have been adopted by reputable psychiatrists and psychologists for use in group psychotherapy. Most psychotherapists agree that much that is useful and good has been learned from encounter. However, when carelessly applied by those ill-equipped to serve as leaders, non-

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[1] *Hearing on Abuses by Unregulated Therapists in the Mental Health Field*, before Louis J. Lefkowitz, Atty. Gen. of the State of New York (Dec. 15, 1972).

[2] Greene, *Sensitivity Training: Fulfillment or Freakout?*, 219 CATH. WORLD 18 (April 1970).

[3] *Id.* at 19.

[4] The term "encounter group" or "sensitivity group" is used loosely throughout this article to include the many variations which have been created on the first, rather sedate training groups sponsored by National Training Laboratories, a private educational firm. The only factor which all these groups have in common is a goal of "enhancing personal growth." Today there are sensory awareness groups, marathon groups, truth labs, psychological karate groups, human relations groups, personal growth groups, psychodrama groups, human potential groups, Bioenergetic labs, Gestalt training groups and many more. AMERICAN PSYCHIATRIC ASSOCIATION TASK FORCE, REPORT ON ENCOUNTER GROUPS AND PSYCHIATRY 4 (1970).

[5] B. MALIVER, THE ENCOUNTER GAME 49 (1973) [hereinafter cited as ENCOUNTER GAME].

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traditional psychotherapeutic techniques can produce a battery of negative effects, some severe, among group participants.

This article will explore the standard of care applicable to the leader of such a group.[7] Attention will be focused on the distinction between the liability of a licensed or certified practitioner, either psychiatrist or psychologist, and that of a leader who is unregulated by license or certificate.[8]

II. CONTRAST WITH TRADITIONAL PSYCHOTHERAPY

Although the encounter movement is in a constant state of flux, with new schools of practice continuously arising and splintering in an ever-increasing number of approaches to personal growth, certain key themes echo throughout the encounter culture. These generalizations are certainly not universal among encounterists; nevertheless, they are common enough that discussion of them will help to impart a flavor peculiar to many of the new brands of therapy. A contrast is drawn between encounter groups and traditional psychotherapy groups in order to show why certain unprecedented problems can arise in encounter groups.

A. LEADERSHIP TRAINING

Traditional psychotherapists are a highly schooled group. Psychiatrists hold medical degrees. Most clinical psychologists hold doctoral degrees; their postdoctoral training programs require at least four years of intensively supervised training before a therapist is considered competent.[9] The American Group Psychotherapy Association, in outlining its model for a special training program for group psychotherapists, suggests that before entering a program a psychiatrist should have an M.D. degree and a year of approved psychiatric residence, a clinical psychologist should have either a Ph.D. degree in clinical psychology or state certification, and a social worker should

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[6]Maliver, *Encounter Groups: A Dangerous Game?*, 126 CURRENT 3 (Feb. 1971) [hereinafter cited as *Encounter Groups*].

[7]The necessity for limiting the scope of this article made it impossible to include all the issues which an attorney litigating a suit in this area would have to consider. One of the most important of these is the problem of proving causation, when the injury is mental or emotional. Some good law review articles are: McNiece, *Psychic Injury and Tort Liability in New York*, 24 ST. JOHN'S L. REV. 1 (1949); Schwartz, *Civil Liability for Causing Suicide: A Synthesis of Law and Psychiatry*, VAND. L. REV. 24:217 (1971); Smith, *Relation of Emotions to Injury and Disease; Legal Liability for Psychic Stimuli*, 30 VA. L. REV. 193 (1944); Taney, *Psychic Trauma and the Law*, 15 WAYNE L. REV. 1033 (1969). *Also see* Annot., 64 A.L.R.2d 100 and R. COHEN, M.D., TRAUMATIC NEUROSES IN PERSONAL INJURY CASES (1970).

[8]Tarshis, *Liability for Psychotherapy*, 30 FAC. L. REV. 75 (1972); Note, *Regulation of Psychological Counseling and Psychotherapy*, 51 COLUM. L. REV. 474, 493 (1951).

[9]*See Encounter Groups, supra* note 6, at 4.

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have an M.S.W. degree and two years of experience in a psychiatric agency or clinic. All candidates in any category are expected to complete 200 hours of individual psychotherapy under qualified supervision before beginning the group training program, which takes a minimum of two years.[10]

On the other hand, some group leaders (also termed "facilitators" or "paraprofessionals") have no academic credentials in the field of psychotherapy. In some cases, training may last only long enough for the leader to acquire a professional veneer. Some of them are out in practice after only six months' exposure to the encounter scene, three months as a participant, and three months as a co-leader.[11]

This situation led a well-known psychologist to complain, "Some people who are inadequately prepared are suggesting to other people what they feel, how to express their feelings, and interpreting how others respond to them. Recently it has come to my attention that there are inadequately prepared trainers who lead student groups on college campuses without supervision."[12]

This remark reflects the attitude of those professional psychotherapists concerned at the lack of training standards for leaders of encounter groups. Nevertheless, there are others, some of whom possess the academic qualifications which many of the encounter movement lack, who disagree.[13] It has even been stated that academic experience may be detrimental to the leadership role. Esalen's William C. Schutz declares that traditional professional training discourages the qualities of warmth, informality and humanity needed by a good facilitator.[14]

Reputable psychotherapy institutes in the traditional mold also require that the therapist undergo intensive personal therapy as part of his training.[15] This permits therapists to screen new patients to be sure that their own psychological weak points will not be awakened to the detriment of the patient's therapy. No such customary protection exists in the encounter movement.[16]

B. LEADER/CLIENT RELATIONSHIP

Psychiatrists and clinical psychologists are bound by the respective ethical and professional codes of the associations to which they be-

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[10] AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION, GUIDELINES FOR THE TRAINING OF GROUP PSYCHOTHERAPISTS (1970).

[11] *See Encounter Groups, supra* note 6, at 4.

[12] Lakin, *Some Ethical Issues in Sensitivity Training,* in ENCOUNTER GROUPS: BASIC READINGS 303 (G. Egan, 2d ed. 1971) [hereinafter cited as Lakin].

[13] *See Encounter Groups, supra* note 6, at 6.

[14] *Id.*

[15] *Id.*, at 4.

[16] *Id.*

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long.[17] They assume responsibility for the well-being of their patients, at least to the extent of using routine measures for their protection.[18] Some encounter leaders would agree with the principle of responsibility for clients. But others deny that they have such responsibilities and believe they should be thought of as ordinary participants in the group.[19]

Another element affecting the relationship between encounter-group leader and participant is that group members are supposed to be "normals," rather than "clients" with emotional problems as in traditional psychotherapy.[20] Thus, the leader feels justified in being less solicitous for the participant's welfare than the psychotherapist might be toward a patient.

Correspondingly, most group leaders insist that they are not practicing psychotherapy.[21] "We're not practicing medicine," commented a certified psychologist who leads encounter groups. "It's adult education. We're teaching people about emotions in the same way we teach them about mathematics."[22]

Professional psychotherapists consider it unethical to become sexually involved with a patient. Psychoanalysts believe that through transference, a process in which the patient comes to see how he transfers childhood mechanisms to adult experience, the patient tends to relate to the psychotherapist as if he were a parent figure and to idealize him much as the young child does the parent, regardless of the actual characteristics of the therapist.[23] Under such circumstances, most psychotherapists believe that to allow themselves to engage in sexual relations with a patient would be exploitative.[24] In sharp contrast, many encounter group leaders see nothing wrong with sex between leader and group member because they place such a high value on spontaneous interaction.[25]

A minority of leaders take this a step further, as does an even smaller group of academically qualified therapists. They justify various forms of sexual interplay with patients on grounds of offering restitutive emotional experiences or of providing a "learning experience" for naive or innocent group members.[26]

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[17] Relevant aspects of these professional codes are discussed in section IV A.

[18] Paul, *Some Ethical Principles for Facilitators*, 13:1 J. HUM. PSYCHOL. 43 (1973).

[19] Arbuckle, *Koch's Distortions of Encounter Group Theory*, 13:1 J. HUM. PSYCHOL. 47, 51 (1973).

[20] Young and Jacobsen, *Effects of Time Extended Marathon Group Experiences on Personality Characteristics*, 17 J. COUNSEL. PSYCHOL. 247 (1970).

[21] *The Group: Joy on Thursday*, 73:5 NEWSWEEK 104 (May 12, 1969).

[22] *Id.*

[23] Marmor, *The Seductive Psychotherapist*, PSYCHIATRY DIGEST 10, 11 (Oct. 1970).

[24] *Id.* at 14.

[25] *Id.* at 12; *see* ENCOUNTER GAME, *supra* note 5, at 19.

[26] *Id.*

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C. SCREENING OF PARTICIPANTS

The encounter experience can be an intense one. Some participants are not psychologically healthy enough to withstand the stresses of the group. Although the anti-intellectual orientation of the encounter culture has militated against the development of useful screening standards,[27] research has shown that certain types of people are more likely to show pathology during and after an encounter group.[28] Poor candidates for general groups (as opposed to specialized groups) are the paranoid, brain-damaged, hypochondrical, suicidal, psychotic, sociopathic, addicted, alcoholic, hysteric, narcissistic, individual in crisis, and deviant role selector.[29]

Besides the anti-intellectual bias of the group movement, screening is made difficult by controversy among encounterists over the productive value of psychiatric diagnosis, the fact that many leaders do not have the training to recognize pathology, and the fact that at least some encounter leaders are deterred from eliminating participants through screening by the profit motive.[30]

For these reasons, screening of encounter group participants is rarely done.[31] In practical terms, anyone can join just by showing up and paying a fee. In contrast, conventional psychotherapists normally screen group psychotherapy patients.[32] One psychologist comments that "[i]t is reprehensible to expose people unscreened for psychiatric illness or suicidal tendencies to an intense and disruptive psychological process without protecting them with all possible skilled care and observation."[33] Lack of screening is said to be one of the most frequent causes of damage from an encounter group.[34]

D. TECHNIQUES AND GOALS

Traditional psychotherapists focus attention on a patient's life history, with particular emphasis on the pattern of transference, as noted above. Many encounter leaders shy away from such an exploration of a person's past, but rather are interested primarily in strategies and techniques which will direct the participant into rapid behavioral change.[35] Most encounterists ignore transference, con-

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[27] *See Encounter Groups, supra* note 6, at 5.
[28] Reddy, *Screening and Selection of Participants*, in NEW PERSPECTIVES ON ENCOUNTER GROUPS 53, 57 (L. Solomon and B. Berzon, eds. 1972).
[29] *Id.*
[30] *Id.*
[31] Lakin, *supra* note 12.
[32] *See* ENCOUNTER GAME, *supra* note 5, at 97.
[33] *Id.*
[34] Berkwitt, *Behavioral Science: Is The Cure Worth It?*, 95 DUNS 38, 41 (May 1970).
[35] Oden, *Inconsistencies and Miscalculations of the Encounter Culture*, 89 CHRISTIAN CENTURY 85 (1972).

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centrating wholly on the present moment, the "here-and-now."[36] Because of this, the group member may have difficulty translating his experiences in the group into his everyday life pattern, sometimes creating serious emotional problems. The connection between the group experience and life outside the group is unresolved in such cases.[37]

In the traditional psychotherapeutic situation, concern is with developing an understanding of the problems which cause the particular patient's emotional controls to malfunction, as a preface to developing a solution. The encounter leader, however, often operates on the assumption that everyone's emotional workings are similar, and that it is unnecessary to spend time learning to understand the individual patient's problem.[38] Instead, inducement or encouragement of emotional experience is substituted. This approach follows logically from the twin assumptions most common to the encounter culture: first, that emotional expression automatically leads to positive personality changes and second, that emotional expression is good in and of itself.[39] The result is that in many groups highest value is placed on intensity of emotionality and dramatic confrontations,[40] no matter how unsettling it may be to the participants.

Encounterists often equate openness with growth, a premise which is sharply questioned by traditional psychotherapists.[41] Relaxation of all emotional controls coupled with emotional provocation can lead to reactions which most psychotherapists would regard as unhealthy. But some encounterists do not share this concern. One states that a psychotic breakdown during an encounter experience is not necessarily bad. "If the leader doesn't become frightened, these people will often go through the experience and come well out of it."[42]

E. FOLLOW-UP

Follow-up investigation or after-care for encounter group participants is rare.[43] Lay leaders lack the training to help a group-damaged patient, and, as noted above, often feel no ongoing responsibility to the group members. Because of this, little of the self-correction that comes with research and experience has been generated from within the encounter culture.[44] In contrast, traditional psychotherapists believe themselves obligated to follow-up on group participants.

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[36] *See* ENCOUNTER GAME, *supra* note 5, at 135.
[37] *Id.*; Weber, *Book Review*, 95 COMMONWEAL 136 (1971).
[38] *See* ENCOUNTER GAME, *supra* note 4, at 59.
[39] *Id.* at 58.
[40] Lakin, *supra* note 12.
[41] Weber, *Book Review*, 95 COMMONWEAL 136 (1971).
[42] *The Group: Joy on Thursday*, 73:5 NEWSWEEK 104, 106 (May 12, 1969).
[43] *See* Lakin, *supra* note 12.
[44] *Id.*

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F. APPLICABILITY OF LEGAL STANDARDS

The encounter group diverges from the traditional psychotherapy group in many respects. Should it be treated for legal purposes as if it is a form of psychotherapy at all? It is difficult to draw the line, just as it is difficult to distinguish between "counseling" and "psychotherapy."[45] Nevertheless, a line must be drawn somewhere.

There are several reasons which tip the scales in favor of treating the encounter group, for legal purposes, as a form of psychotherapy. One is that many types of encounter groups have goals and employ techniques which overlap heavily with traditional psychotherapy, from whom the encounterists have liberally borrowed.[46] Another is that because of the lack of uniformity in the practices and ideology of the encounter movement, no standard of care uniquely applicable to encounter groups has been agreed upon. Since traditional psychotherapy is the closest accepted professional school, it can be argued that its more settled standard should be applied, in the absence of a specially tailored "encounter" standard.

A third reason is that, often, people who would have turned to psychotherapy with their psychological problems now join encounter groups instead, hoping for a "quick cure." These expectations are encouraged by at least some unscrupulous or over-zealous leaders.[47] The situation is summed up in a statement by the association of group psychotherapists:

> . . . Those who lead such groups do not openly claim a psychotherapeutic purpose, but some other goal more or less explicitly communicated. However, many who attend these sessions do seek a therapeutic result or are drawn into an experience that has deep psychological import they had not anticipated. Some participants are delayed, discouraged or damaged by the discrepancy or lack of clarity of goals in the "non-therapy" group.[48]

III. MANIFEST HAZARDS OF ENCOUNTER GROUPS

Although encounter techniques may be beneficial when skillfully applied, there is now a great deal of evidence to show that participation in a poorly-led group may be hazardous to one's health. The harm may be mental, physical, or both.

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[45] Note, *Regulation of Psychological Counseling and Psychotherapy*, 51 COLUM. L. REV. 474, 491 (1951).

[46] AMERICAN PSYCHIATRIC ASSOCIATION TASK FORCE, REPORT ON ENCOUNTER GROUPS AND PSYCHIATRY 8 (1970).

[47] Reddy, *Screening and Selection of Participants*, in NEW PERSPECTIVES ON ENCOUNTER GROUPS 53 (L. Solomon and B. Berzon, eds. 1972).

[48] AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION, POSITION STATEMENT ON NON-THERAPY AND THERAPY GROUPS (1971).

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A. CLINICAL REPORTS

Clinical psychologists report an increasing number of new patients who incurred severe emotional disturbances in encounter groups. [49] Adverse reactions of this sort range from anxiety and depression to severe neurotic and psychotic reactions.[50] These negative effects often stemmed from groups with leaders who were untrained and had no ongoing sense of responsibility to participants.[51] Because of the dangers in using these explosive techniques, one highly respected psychologist who leads marathon groups[52] will not include any participant who is not under the care of a competent psychotherapist.[53]

Clinicians also report suicides which were committed as a direct result of psychosis induced in encounter groups.[54] Although in many groups physical violence is taboo, some do permit or even encourage fights between participants as a means of expressing rage. As a result, physical injuries have occurred.[55] Group generated emotional breakdowns have resulted in loss of employment for some participants.[56] Divorce is another effect which has been reported as a result of the member's uninhibited expression of negative emotions toward his or her spouse in the home situation or as a side-effect of sexual relations between leader and participant.[57]

B. SOCIOLOGICAL STUDIES

Results of the few sociological studies measuring the effects of encounter groups are mixed. A few studies found encounter experience beneficial to a statistically significant degree, in terms of improvement in "self-actualization" or positive mental health. However, the groups tested were conducted by experienced professional psychotherapists.[58]

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[49] Parloff, *Group Therapy and the Small Group Field: An Encounter*, 20 INTER. J. GROUP PSYCHOTHER. 267, 280 (1970).

[50] *See* ENCOUNTER GAME, *supra* note 5 at 97.

[51] AMERICAN PSYCHIATRIC ASSOCIATION TASK FORCE, REPORT ON ENCOUNTER GROUPS AND PSYCHIATRY 15 (1970).

[52] A marathon group is a group which continues non-stop for 12 hours or longer. The purpose is to break down emotional blocks through fatigue and an unbroken build-up of emotional intensity.

[53] *See Encounter Groups*, *supra* note 6, at 7.

[54] *Id.* at 4; Shostrum, *Group Therapy: Let the Buyer Beware*, PSYCHOL. TODAY 36, 37 (May 1969).

[55] AMERICAN PSYCHIATRIC ASSOCIATION TASK FORCE, REPORT ON ENCOUNTER GROUPS AND PSYCHIATRY 15 (1970).

[56] Shostrom, *Group Therapy: Let the Buyer Beware*, PSYCHOL. TODAY 36, 37 (May 1969).

[57] *Id.*

[58] Young and Jacobsen, *Effects of Time Extended Marathon Group Experiences on Personality Characteristics*, 17 J. COUNSEL. PSYCHOL. 247 (1970); Guinan and Foulds, *Marathon Groups: Facilitator of Personal Growth?*, 17 J. COUNSEL. PSYCHOL. 145, 147 (1970).

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When the group is sponsored by a competent organization, studies show low incidence of pathology.[59] Results of studies of long-term psychotic reactions to encounter group experience vary. A study by well-known encounterist Carl Rogers suggests a rate of 0.3 percent, but can be faulted scientifically in that it had no control group, no basic definitions of psychiatric states and no indication of the length of time the subjects were exposed to encounter.[60] National Training Laboratory studies reveal psychotic reaction in 1 percent of participants in the groups which it sponsors.[61] In a 1966 experiment by Dr. Louis Gottschalk, psychotic reactions were found in 6.5 percent of the members of the groups being studied.[62] A 1970 study by W. Brendan Reddy at the University of Cincinnati compared sensitivity groups led by NTL trained leaders (generally recognized as among the most highly schooled encounter leaders) to a control group and to a psychotherapy group led by a clinical psychologist. Testing indicated that the control group remained the same. The psychotherapy group showed a marked decrease in emotional disturbance, while the encounter group members showed a significant increase in disturbance.[63]

The most comprehensive study which has been conducted regarding psychological effects of encounter groups on participants was conducted at Stanford University in 1970, by a team of sociologists.[64] Two hundred and nine undergraduates and sixty-nine controls participated in 18 groups. Leaders were foremost representatives of ten of the most popular West Coast approaches to personal growth. The leaders had an average of ten year's experience.

The results were sobering. By conservative estimate, 9.4 percent of the participants were classified as casualties. (A casualty was defined as an individual who suffered enduring psychological harm evident six to eight months after the end of the group, as a result of the group experience.) One casualty had a psychotic episode during the group session; another suffered severe depression with a forty pound weight loss. Others lost self-esteem, felt less trust in others, expressed a fear of harm from others, or despaired of solving their problems.

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[59] Reddy, *Screening and Selection of Participants*, in NEW PERSPECTIVES ON ENCOUNTER GROUPS 53, 57 (L. Solomon and B. Berzon, eds. 1972).
[60] *See* ENCOUNTER GAME, *supra* note 5, at 99-107.
[61] *Id.*
[62] *Id.*
[63] *Id.*, at 134.
[64] Lieberman, Yalom and Miles, *Impact on Participants*, in NEW PERSPECTIVES ON ENCOUNTER GROUPS 119 (L. Solomon and B. Berzon, eds. 1972).
[65] One important finding of this study was that the variable which determined whether a group would produce a high or a low incidence of casualties was not the brand of therapy, but rather the personal style of the leader. Low-key leaders led relatively safe groups while dramatic, confrontive leaders generated more casualties.

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C. LAWSUITS

Lawsuits might also illustrate the hazards of encounter, but there are no reported cases involving group psychotherapy, traditional or unorthodox, in which liability is based on therapist malpractice. [66] Historically, there has been virtually no litigation in the area of psychotherapy.[67] Most cases involving psychiatric malpractice relate to shock therapy, improper commitment, or liability for the suicide of a hospitalized, mentally-ill patient.[68]

One probable reason why there have been so few psychotherapeutic cases is that in so nebulous a process it is hard to fix causation, to tie the psychotherapist's negligence to the unpleasant consequences in the patient's life. Furthermore, the patient, who has bared his soul to the psychotherapist, is often unwilling to reveal his emotional problems to the court.[69]

The expansion of the use of group therapy is fairly recent, occurring largely because of the shortage of therapists after World War II.[70] The growth of the encounter movement, with its enhanced potential for damage to participants, is even more recent. This too helps explain the dearth of cases.

However, there is reason to believe that suits of this nature are simmering in various parts of the country, ready to boil up into appellate decisions at an early date. For example, although a study of insured American Psychological Association members revealed that not a single case had gone to trial by 1971, it also showed that an average of about ten malpractice cases a year, since 1961, have warranted intercession by the insurance carrier. Recently, there has been a spate of cases in which physical injuries were received in encounter groups of various types. There were four of them in 1971.[71] Rather than accept the higher insurance rates which continued coverage of innovative procedures would have necessitated, an APA advisory group recommended that physical injuries sustained by clients in the course of professional practice be excluded from liability coverage. [72]

Two California cases are relevant. One is an administrative action in which the state sought to rescind the license of a psychologist who made advances to a female patient which ended in sexual intercourse.

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[66] Morse, *The Tort Liability of the Psychiatrist*, 16 BUFFALO L. REV. 649 (1967). Post-1967 research fails to reveal any reported cases.
[67] Tarshis, *Liability for Psychotherapy*, 30 FAC. L. REV. 75, 77 (1972).
[68] Bellamy, *Malpractice Risks Confronting the Psychiatrist: A Nationwide Fifteen-Year Study of Appellate Court Cases, 1946 to 1961*, 118 J. PSYCHIATRY 769 (1961).
[69] Tarshis, *Liability for Psychotherapy*, 30 FAC. L. REV. 75, 96 (1972).
[70] Note, *Group Therapy and Privileged Communication*, 43 IND. L.J. 93, 94 (1967).
[71] Brownfain, *The APA Professional Liability Insurance Program*, 26 AM. PSYCHOL. 648, 650-651 (1971).
[72] *Id.*

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Thereafter, she became very distressed and contacted a suicide prevention facility, which reported the psychologist to the Psychology Examining Committee of the State Board of Medical Examiners. Two women, serving as undercover agents, began to see him as patients. He also made sexual advances to them in his office, couching his seductive urgings in psychotherapeutic terms.[73]

At the administrative hearing, the psychologist was represented by his counsel as a practitioner of "group therapy, Gestalt, body awareness and similar techniques." Rather than denying that the acts in question took place, defendant's opening statement took this approach:

> Dr. Cooper is a firm believer in the fact that the body has a tremendous significance and influence on our actions; and the awareness of one's body is one of the keys to personal health; mental health; and his techniques may be considered new, revolutionary, and even bizarre perhaps to some people. But none of us knows the potential of the human body in relation to the human mind, and to explore that and make a person whole is Dr. Cooper's dedicated professional goal.[74]

The Psychology Examining Committee rejected this reasoning and revoked the license. Dr. Cooper's petition for writ of administrative mandamus to the Superior Court was denied.[75] Notice of appeal has been filed.

The second California fact pattern resulted in the filing of two actions, one by the state for revocation of license[76] and the second a civil suit by the injured patient.[77] Defendant, a certified psychologist, had devised a new form of therapy, termed "Rage Reduction" therapy or "Z-Therapy." This procedure, originally devised by Dr. Robert Zaslow for use with autistic children, can be roughly described as follows: Dr. Zaslow and a number of volunteers from among the client's friends and relatives restrain the client in a prone position, while he or she is questioned by the therapist. If the answer is satisfactory, the therapist goes on to the next question. If it is not, the therapist instructs the volunteer assistants to tickle and poke the patient until the therapist believes that he has answered honestly and openly.

Paula Abraham, a 22-year-old graduate student, agreed to undergo Z-therapy. She was familiar with the basic ideas of Zaslow's method, having seen a film of his work with autistic children while a student

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[73] Cooper v. State Board of Medical Examiners, D-1329, Jan. 24, 1972 before the Psychology Examining Committee, decision Dec. 15, 1972.
[74] *Id.*
[75] Cooper v. State Board of Medical Examiners, M-6038, Sup. Ct. Monterey County, Dec. 20, 1973.
[76] Zaslow v. State Board of Medical Examiners, D-1330, Sup. Ct. San Francisco County, Sept. 24, 1971.
[77] Abraham v. Zaslow, 245862, Sup. Ct. Santa Clara County, Oct. 26, 1970.

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in one of his classes. She also obtained a statement from her doctor saying that she was in good health. However, the actual experience was considerably at odds with her expectations. While she was held down by ten or twelve unlicensed assistants, recruited for the occasion, Dr. Zaslow administered ten to twelve hours of continuous therapy. She was tickled, poked, jabbed and choked by the psychologist and his assistants. Water was poured down her throat and fingers stuck in her mouth. Dr. Zaslow would not discontinue the treatment even when she begged him to do so.

The result was extensive bruising over the patient's torso and acute renal failure which, according to expert medical testimony, would have caused death if she had not received prompt medical attention. In the civil suit, a jury awarded Ms. Abraham $170,000 damages. [78] In the administrative action the state was successful.[79] The petition for writ of mandamus was dismissed when Zaslow failed to appear.[80] Zaslow is still practicing and training other psychotherapists in New York, Massachusetts, Colorado and New Jersey. His appeal of the civil suit is pending.[81]

Zaslow's administrative appeal brief argued in part that since the psychologist who served as expert witness for the state and for the plaintiff was not familiar with "rage reduction" therapy, he was not qualified to testify. Only Dr. Zaslow and his disciples, it was claimed, could be proper witnesses. This theory is discussed in detail *infra.*[82]

An interesting point in connection with the administrative hearing is that the Psychology Examining Committee found that Ms. Abraham's consent was not an "informed consent." The decision, however, was not based on this fact but rather on defendant's manner of conducting the therapy, coupled with his use of unlicensed assistants.

IV. LEGAL STANDARDS APPLICABLE TO LICENSED AND CERTIFIED PSYCHOTHERAPISTS

All states make provision for licensing of psychiatrists as included in medical licensing acts; most states have passed laws applicable to qualified psychologists.[83] In this section, those who have met the requirements necessary to practice, as set forth in one of these statutes, are discussed as a group, as opposed to those practitioners

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[78] *Id.*
[79] Zaslow v. State Board of Medical Examiners, D-1330, Sup. Ct. San Francisco County, Sept. 24, 1971.
[80] Zaslow v. State Board of Medical Examiners, 655-667, Sup. Ct. San Francisco County, Dec. 4, 1971.
[81] Abraham v. Zaslow, 1 Civil 33219, Cal. Ct. of App., Dist. 1, Div. 3, May 17, 1973.
[82] *See* section IV B.
[83] *See* section V A.

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who operate unregulated by a state's laws.[84] This seems to be the basic distinction in determining liability, although many other factors play a part.

A. GROUNDS FOR NEGLIGENCE LIABILITY

This subsection catalogues the various acts and omissions undertaken by a psychiatrist or psychologist which might become the basis for a negligence action. Commentators' suggestions as well as case law will be discussed.

Psychiatrists and psychologists are usually held to their respective medical standards of care, as determined by expert witnesses rather than precedent. Psychiatrists are held to the provision of the skill and care of a professionally qualified psychiatrist;[85] the psychologist to the skill and care of a professionally qualified psychologist. In *Anclote Manor Foundation v. Wilkinson*,[86] a contract action in which plaintiff sought recovery of fees paid to a psychiatrist who had seduced his wife, resulting in divorce, during the course of his treatment of her, this standard was applied. All the expert witnesses testified that the psychiatrist's behavior in telling plaintiff's wife that he would divorce his wife and marry her was below acceptable psychiatric standards. The court noted that the expert testimony established that the psychiatrist was guilty of malpractice as a matter of law. Since the treatment given could not possibly have benefited appellee, he was entitled to full reimbursement of monies paid under a breach of contract theory.

The concept of "transference," in which the patient comes to look up to the therapist as a parent figure, has a prominent position in psychoanalytic theory. As a by-product of transference, the patient often believes herself in love with the psychotherapist.[87] At least one case, *Zipkin v. Freeman*,[88] has dealt specifically with the psychotherapist's duty of care in handling the transference, although the issue upon which the holding was based concerned the insurance carrier's liability for the therapist's malpractice. A psychiatrist's happily married patient fell in love with him, presumably as a result of the transference. At his instigation, she left her husband and became his mistress. She filed suits against other members of her family, which defendant told her would help release her hostility. She was also persuaded to invest in the psychiatrist's farm, turn over

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[84] Section V is devoted to a discussion of the latter.

[85] Dawidoff, *The Malpractice of Psychiatrists*, 1966 DUKE L.J. 696, 700 (Summer 1966).

[86] Anclote Manor Foundation v. Wilkinson, 263 So. 2d 256 (Fla. 1972).

[87] Marmor, *The Seductive Psychotherapist*, PSYCHIATRY DIGEST 10, 11 (Oct. 1970).

[88] Zipkin v. Freeman, 436 S.W.2d 753 (Mo. 1968).

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her child support money to him, and take trips with him and his wife.

The court awarded the plaintiff-patient $17,000 damages for "remorse, humiliation, mental anguish, loss of respect of friends and family, nervousness, insomnia, headaches, irritability and financial loss." In rendering its decision the court referred to defendant's behavior as "negligence in mishandling the transference phenomena."

Besides his responsibility not to take advantage of the patient's vulnerability, the psychotherapist is expected to have firm control over his own feelings so that he does not respond inappropriately to the patient's reliance on him. He must also have control of his own anxiety or hostile feelings toward the patient.[89] "In analyzing psychoanalytical malpractice litigation, the degree of skill exercised by the psychiatrist in controlling and understanding the countertransference should be a measuring stick for a malpractice defense."[90] Failure to handle the countertransference appropriately is a breach of duty to the patient.

Malpractice liability may be grounded on a failure to obtain the participant's informed consent. In this area many psychotherapists, but encounterists in particular, are notably remiss. Many therapists believe that surprise or unexpected and unrehearsed emotional experience is most conducive to growth.[91] For this reason a group leader is often reluctant to inform a participant in advance of the intentions of the leader, the processes of the group, or their consequences for him.[92] The group member enters "blind." In this regard, a psychologist writes:

> It will be argued that participants willingly agree to these practices . . . it should be remembered that 'the contract' is not between persons who have an equal understanding of the processes involved. It cannot be assumed that the participant really knows what he is letting himself in for.[93]

A common complaint is that the participant in the group will act unwillingly when subjected to heavy psychological pressure by the leader or other members. In those groups in which the leader does not curtail such behavior, the group may ridicule a member who finds some group practices distasteful, such as those involving personal intimacy and invasion of privacy.[94] When a participant crumbles and complies with the group's expectations under such

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[89]Dawidoff, *The Malpractice of Psychiatrists*, 1966 DUKE L.J. 696, 711 (Summer 1966).
[90]Saxe, *Psychotherapeutic Treatment and Malpractice*, 58 KENTUCKY L.J. 467, 476 (1970).
[91]*See* Lakin, *supra* note 12 at 301.
[92]*Id.*
[93]*Id.*, at 306.
[94]Parloff, *Group Therapy and the Small Group Field: An Encounter*, 20 INT. J. GROUP PSYCHOTHER. 267, 286 (1970).

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circumstances, has he truly "consented?"

There are no reported cases specifically applying the doctrine of informed consent to the psychotherapeutic situation. But it is universally held to be a duty of healer to patient;[95] it has been applied, for example, to such areas of the psychiatrist's practice as the administration of shock therapy.[96] It has been held that the psychiatrist must disclose the possible serious collateral hazards of treatment to his patient in such instances.[97] A failure to disclose, or the giving of an untrue answer as to the probable consequences of a treatment constitutes malpractice.[98]

The majority rule has been that the practitioner has a duty to disclose only those risks which a reasonable practitioner of his healing art would reveal under similar circumstances.[99] This must be established by expert witnesses. The medical standard would therefore be most favorable to a psychotherapist who could establish that it is not customary among a large number of professionals to inform the participant in advance of the possible risks of the encounter group experience. However, a recent group of cases reversing this rule may indicate a trend away from the medical standard.[100] In these cases the courts have held that the patient has an absolute right to be informed of important risks involved in treatment which he undergoes. The standard of care in informed consent does not depend on expert testimony as to what the reasonable medical practitioner would have done. Instead, it is based on an objective standard: the practitioner must reveal all risks which the reasonable patient would have considered material to his decision to undergo therapy or not. Although these cases concern medical rather than psychotherapeutic situations, the rationale should apply by analogy. Such a standard would be much more helpful to a plaintiff in a group psychotherapy case than would the older standard.

Using the group for responsible research regarding innovative and unusual techniques is a legitimate activity. But if the experience is experimental, the leader owes a stringent duty to make full disclosure to the participant of techniques to be used. He should delineate the respective responsibilities of the leader and group members during a discussion held before the session begins.[101] Under experimental

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[95] W. PROSSER, HANDBOOK OF THE LAW OF TORTS 162, § 32 (4th ed. 1972).
[96] Canterbury v. Spence, 464 F.2d 772, 781 (D.C. Cir. 1972).
[97] *Id.* at 782.
[98] Woods v. Brumlop, 71 N.M. 221, 377 P.2d 520 (1962).
[99] Morse, *The Tort Liability of the Psychiatrist*, 16 BUFFALO L. REV. 649, 651 (1967).
[100] Canterbury v. Spence, 464 F.2d 772, 783 (D.C. Cir. 1972); Cooper v. Roberts, 286 A.2d 647, 650-1, 220 Pa. Super. 260 (1971); Wilkinson v. Vesey, 295 A.2d 676 (R.I. Sup. Ct. 1972).
[101] BOARD OF PROFESSIONAL AFFAIRS, AMERICAN PSYCHOLOGICAL ASSOCIA-

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conditions, it is especially important that the prospective participant has a true appreciation of the nature and extent of the risk; mere knowledge of facts which create the risk will not avoid the leader's liability.[102]

Liability for failure to obtain informed consent is also generally applied when the scope of the treatment has been expanded beyond that to which the client specifically agreed.[103] Thus, when the participant/plaintiff undergoes emotional or physical experiences in an encounter group which go beyond that which it is reasonable to believe he could have foreseen, the therapist may be liable for resulting injuries. This may also be so when the facilitator negligently creates a risk which is different from the one to which the plaintiff assented.[104]

The psychotherapist might also breach a duty of care to the group participant if his provision of improper treatment deprived the group member of the opportunity to obtain more suitable care. This might be evidenced by a deterioration in the participant's condition.[105] A situation of this sort may arise when the group leader permits a person with a serious emotional problem to enter and remain in the group.

Finally, the psychotherapist might be liable for failure to provide for follow-up care for participants who may have been severely disturbed by the group, or for failure to make a proper evaluation of a participant's mental condition before terminating the therapy.[106]

While specific acts of negligence are usually proven through expert testimony, malpractice may also be founded on a showing that objective standards were not met. For example, liability might be predicated on a psychotherapist's failure to adhere to the ethical code set forth by his professional association.[107] Standards espoused by the various organizations are similar. Some of them which have particular significance for the psychotherapist who is utilizing encounter techniques are: No one should be coerced into participation in a group, as when a company or school decrees that all employees must take part in a workshop;[108] a screening interview or if unfeasible, other

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TION, GUIDELINES FOR PSYCHOLOGISTS CONDUCTING GROWTH GROUPS (1972).

[102] Note, *Legal Implications of Psychological Research with Human Subjects*, DUKE L.J. 265, 271 (1960).

[103] Annot. 56 A.L.R.2d 695, 697 (1957).

[104] Note, *Legal Implications of Psychological Research with Human Subjects*, DUKE L.J. 265, 271 (1960).

[105] Beresford, *Professional Liability of Psychiatrists*, 21 DEFENSE L.J. 123, 148 (1972).

[106] Christy v. Saliterman, 288 Minn. 144, 179 N.W.2d 288 (1970).

[107] Stone v. Proctor, 259 N.C. 693, 131 S.E.2d 297 (1963).

[108] BOARD OF PROFESSIONAL AFFAIRS, AMERICAN PSYCHOLOGICAL ASSOCIATION, GUIDELINES FOR PSYCHOLOGISTS CONDUCTING GROWTH GROUPS (1972).

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screening measures, should be used in all instances;[109] the psychotherapist should present the prospective group participant with a written contract, in which the group's goals, techniques to be used, and the respective responsibilities of leader and group member are clearly expressed;[110] the participant should be made aware of the education, training and experience of the leader;[111] the psychotherapist should not offer services nor use techniques which fall beyond the bounds of his competence;[112] the group therapist should maintain interest in evaluation and follow-up of his group members as well as of the practices he uses.[113]

Psychologists also owe their patients the duty to comply with the various minor provisions which are subsidiary to the main regulatory laws in their states.[114] For example, several states adopt the American Psychological Association's Ethical Standards of Psychologists as a criterion for retention of license or certificate,[115] thus strengthening the proposition that breach of the code is evidence of lack of due care. One state lays down strict education and experience requirements for any psychological assistants whom the psychotherapist may employ to aid him in his work;[116] another specifically forbids such assistants to administer psychotherapy, even under supervision.[117] A common provision of the regulatory acts is a requirement that a psychologist who administers psychotherapy may do so only under the direct supervision or in genuine collaboration with a licensed physician or psychiatrist.[118] California bars a psychologist from operating outside his field of competence.[119] Practitioners

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[109] AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION, POSITION STATEMENT ON NON-THERAPY AND THERAPY GROUPS (Jan. 1971); BOARD OF PROFESSIONAL AFFAIRS, AMERICAN PSYCHOLOGICAL ASSOCIATION, GUIDELINES FOR PSYCHOLOGISTS CONDUCTING GROWTH GROUPS (1972).

[110] *Id.;* Paul, *Some Ethical Principles for Facilitators,* 13:1 J. HUM. PSYCHOL. 43 (1973).

[111] BOARD OF PROFESSIONAL AFFAIRS, AMERICAN PSYCHOLOGICAL ASSOCIATION, GUIDELINES FOR PSYCHOLOGISTS CONDUCTING GROWTH GROUPS (1972); Paul, *Some Ethical Principles for Facilitators,* 13:1 J. HUM. PSYCHOL. 43 (1973).

[112] AMERICAN PSYCHOLOGICAL ASSOCIATION, ETHICAL STANDARDS OF PSYCHOLOGISTS 2 (Jan. 1963).

[113] AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION, POSITION STATEMENT ON NON-THERAPY AND THERAPY GROUPS (Jan. 1971); BOARD OF PROFESSIONAL AFFAIRS, AMERICAN PSYCHOLOGICAL ASSOCIATION, GUIDELINES FOR PSYCHOLOGISTS CONDUCTING GROWTH GROUPS (1972).

[114] A discussion of the central provisions of these regulatory acts is found in section V.

[115] CODE OF ALA. tit. 46 § 297(37) (Supp. 1971); MICH. STATS. ANN. § 14.677 (1)(b) (Supp. 1972); UTAH CODE ANN. § 58-25-11 (1963).

[116] 16 CAL. ADM. CODE § 1380.5-.15 (1973).

[117] D.C. CODE § 2-484 (D) (1973).

[118] NEV. REV. STATS. § 641.430 (1973); OHIO REV. CODE ANN. § 4732.20 (Supp. 1972); OR. REV. STATS. § 675.060 (1971).

[119] 16 CAL. ADM. CODE § 1397.3 (1973).

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of the healing arts have been held liable for the use of experimental techniques when the result is negative. This rule has been variously termed an application of *res ipsa loquitur*, because lack of due care can be inferred from the knowledge and experience of the jurors;[120] or a species of strict liability, because negligence need not be proved. The rule has been much criticized.[121] Nevertheless, a shading of this doctrine is evident in two leading psychotherapeutic opinions which one legal writer calls "unfortunate decisions" on the basis that both courts refused to comprehend the treatments given in the light of innovative techniques in psychotherapy.[122]

In *Landau v. Werner*,[123] a British case, the psychiatrist defendant had introduced some platonic social contact into his treatment of a woman patient who was in love with him. The evidence indicated that the visits were honestly intended to help the patient, but her condition deteriorated markedly. The court absolved Dr. Werner of any imputation of sexual misconduct, but found him negligent in departing from the customary standard of practice. In affirming this decision, the appellate court stated that use of an unorthodox treatment is not necessarily wrong, but that it must be justified to the court. If a novel or exceptional treatment fails, this can be called negligence; success is the best justification for an unusual and unestablished treatment.[124]

In *Hammer v. Rosen*,[125] the psychiatrist's method in treating schizophrenics had been described in a medical journal as a "unique aggressive psychoanalytic technique," which apparently involved some physical contact.[126] The plaintiff, a schizophrenic patient, offered evidence that he had beaten her on several occasions as part of a course of treatment which had lasted several years. The court held that she was not required to introduce an expert witness on her behalf, because the mere fact of the beatings, if uncontradicted and unexplained by the defendant, would establish a *prima facie* case of malpractice. The burden of proof that the beatings were justified was placed on the defendant, an unusual requirement because therapeutic techniques are normally presumed legitimate unless proven otherwise.[127]

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[120] Samore and Tyman, *Torts*, 24 SYRACUSE L. REV. 551, 562 (1972).

[121] Note on Recent Decisions, 40 CAL. L. REV. 159, 164 (1952).

[122] Saxe, *Psychotherapeutic Treatment and Malpractice*, 58 KENTUCKY L. J. 467, 479 (1970).

[123] Landau v. Werner, (Q.B. March 7, 1961) in the Times (London), March 8, 1961, p. 5, col. 3.

[124] Landau v. Werner, *aff'd.* (C.A. Nov. 22, 1961) in the Times (London), Nov. 23, 1961, p. 5, col. 1.

[125] Hammer v. Rosen, 7 App. Div. 2d 216, 181 N.Y.S.2d 805 (1959), *modified* 7 N.Y.2d 376, 165 N.E.2d 756, 198 N.Y.S.2d 65 (1960).

[126] M. GUTTMACHER AND H. WEIHOFEN, PSYCHIATRY AND THE LAW 75 (1952).

[127] Dawidoff, *The Malpractice of Psychiatrists*, 1966 DUKE L. J. 696, 715 (1966);

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The rationale behind the rule regarding experimentation, which creates a rebuttable presumption of defendant's negligence, seems to be that there would otherwise be great difficulty in proving negligence in such a situation. In such instances, accepted norms, against which the defendant's conduct might be measured, have not yet been developed. Those who use encounter techniques are particularly vulnerable to the rule; their techniques are new, unproven, and often controverted by those within the encounter culture, as well as by opponents from without.

B. THE LEGAL IMPACT OF DIFFERING STANDARDS WITHIN THE PSYCHOTHERAPEUTIC PROFESSIONS

The encounter leader who is also a qualified psychiatrist or psychologist might argue that he should be held to the standard of some subgroup of practice within the encounter movement rather than to the traditional standard of care for psychotherapists. It is the general rule that a practitioner of a healing art is held to the standard of the particular school to which he belongs, as long as he operates within the scope of his school. Thus a chiropodist, charged with malpractice, could not be held to the standard of care applicable to the general practitioner, but only to the standards laid down by his own profession, which might be less stringent.[128] Similarly, a Christian Science practitioner, who unsuccessfully attempted to treat a woman for appendicitis, was held only to the standard of care and skill which is ordinarily possessed by professors of the same art or science, not to the standard of care of a medical doctor.[129] Generally, a practitioner of one school of medicine is not legally competent to testify in a malpractice action against a practitioner of another school of medicine.[130]

There are, however, exceptions to this expert testimony rule. One of them arises when the healer or practitioner is engaged in a type of practice which has no recognized school or system.[131] In *Nelson v. Harrington*[132] the court refused to judge a clairvoyant physician according to the "ordinary skill and knowledge of the clairvoyant system," saying that a school of medicine must have rules and principles of practice to which all members adhere. There being no such uniformity among clairvoyant physicians, defendant's practice could

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Morse, *The Tort Liability of the Psychiatrist*, 16 BUFFALO L. REV. 649, 664 (1967).

[128] Benz v. Levin, 64 Montg. Co. L.R. 216, 62 York Leg. Rec. 149 (Pa. 1948).

[129] Spead v. Tomlinson, 73 N.H. 46, 59 A. 376, 377, 68 L.R.A. 432 (1904).

[130] Annot., 85 A.L.R.2d 1022 (1962); Annot., 19 A.L.R.2d 1188, 1201 (1951); Nelson v. Harrington, 72 Wis. 591, 40 N.W. 228, 1 L.R.A. 719, 7 Am. St. Rep. 900 (1888).

[131] Annot., 19 A.L.R.2d 1188, 1201 (1951).

[132] 72 Wis. 591, 40 N.W. 228, 1 L.R.A. 719, 7 Am. St. Rep. 900 (1888).

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not be classified within an "accepted school." The holding is analogous in *Hansen v. Pock*,[133] in which the court would not permit a Chinese herb doctor to be evaluated by the standard of the "generation school" in which he professed membership, because there were no uniform principles and standards which characterized the school. In both *Hansen* and *Nelson* the standard that was substituted was that of a physician in good standing.

This line of legal reasoning presents difficulties for the psychiatrist or psychologist turned encounter leader who wishes to be held to a special standard. The encounter movement has no mechanism for policing itself, as do most professions, and there are no universally held internal standards.[134] It is not an "accepted school." By analogy, then, the practitioner should not be permitted the shelter of a special standard. Within the encounter culture there are so many tiny splinter groups that it would be hard for a defendant to muster expert testimony to support any position which is at odds with that of conventional psychotherapy, still the greatest common denominator.

The psychiatrist- or psychologist-encounterist might argue that because the particular techniques he uses are novel and unique, only those familiar with the techniques should be permitted to testify as expert witnesses. This contention would eliminate all witnesses save the defendant and possibly a few others who have learned the technique with or from him. Two California cases have discussed the impracticability of this line of thought. In the first, *Kershaw v. Tilbury*,[135] the defendant, charged with malpractice, represented himself as able to cure serious ailments with a "black box" which he had invented. He claimed to be the only valid expert available to testify. The court stated:

> Simply because a person claims or pretends to have invented a machine for diagnostic and curative purposes which is not known or recognized by any school of medical science, which machine possesses certain powers of healing peculiarly within the knowledge of the inventor, is no reason why other persons who know nothing of the working of such machines but who have knowledge acquired from education, experience and practice, are not competent to judge whether the treatment administered is negligently or carelessly done. Otherwise, as we have heretofore indicated, any nonprofessional person might undertake to treat certain disorders, and if appellants position be correct in law, it matters not how carelessly or negligently his acts were performed, because no one could be obtained of the same pretensions to testify with respect to such treatment, and the

[133] Hansen v. Pock, 57 Mont. 51, 187 P. 282, 285 (1920).
[134] Oden, *Inconsistencies and Miscalculations of the Encounter Culture*, 89 CHRISTIAN CENTURY 85 (1972).
[135] Kershaw v. Tilbury, 214 Cal. 679, 8 P.2d 109 (1932).

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> injured person would be without remedy. This contention, we think untenable and has been held so by other jurisdictions.

In *Valdez v. Percy*,[136] the defendant, a medical doctor, had used an operative method in treating cancer which he had invented. The court held that a pathologist who was not familiar with the technique could serve as an expert witness, because otherwise a physician who used innovative techniques would be immune to suit.

Further complicating the discovery of appropriate standards for reviewing the conduct of a psychiatrist- or psychologist-encounterist is the fact that principles of the practice of psychotherapy are even less clear-cut than those developed by those branches of medical science[137] concerned primarily with physical health. However, there could be instances in which a leader obviously exceeds the bounds of encounter practice. An example would be harm ensuing when the leader permits a person whom he knows or should know is suffering from severe emotional illness to take part in the stressful situation imposed by an encounter group.

It is therefore unlikely that a psychiatrist or psychologist who uses encounter techniques or leads a "non-therapy" group can escape the strict legal standards applicable to psychiatrists or psychologists. Such a person retains his professional responsibility for the well-being of the group members. The psychotherapist "retains his 'mental health expert' designation even when leading a group which is not specifically labelled as therapy but which may be a potent influence, both positively and negatively, upon the mental health of the participants."[138] This is particularly true when group members have been made aware that the leader possesses professional credentials. The leader should not be permitted to ignore the expectations which the participants will naturally hold regarding his conduct.

V. LEGAL STANDARDS APPLICABLE TO NON-PROFESSIONAL GROUP LEADERS

While actionable injuries may arise through use of encounter methods by professional psychotherapists, use of the techniques by those who are untutored in the mental health field offers a much greater potential for harm. A large proportion of encounter group leaders hold no academic credentials in psychology or psychiatry;

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[136] Valdez v. Percy, 35 Cal. App. 2d 485, 96 P.2d 142 (1939), *aff'd.* 35 Cal. 2d 338, 217 P.2d 422 (1950).

[137] Precedent indicates that although a drugless healer, such as a chiropractor, naturopath or sanipractor, is not required to be an insurer of results within his limited field, nevertheless if he attempts to treat a disorder for which medical science has a generally recognized treatment, he will be held to the medical standard. Annot., 19 A.L.R.2d 1188, 1203 (1951).

[138] AMERICAN PSYCHIATRIC ASSOCIATION TASK FORCE, REPORT ON ENCOUNTER GROUPS AND PSYCHIATRY 23 (1970).

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their only training consists of a type of clinical apprenticeship which may be intensive, but is too often scanty.[139] If such a person represents himself to be a psychiatrist or psychologist, it is clear that he will be held to the professional standard of care.[140] But the encounterist is not as a rule dishonest. If he lacks professional qualifications, he will probably refer to himself as a "facilitator," "therapist," "psychotherapist" (permissible in many states) or simply "leader." To what standard should these lay leaders be held? The clearest guides which are arguably applicable are the state psychology regulatory acts.

A. STATE PSYCHOLOGY REGULATORY LAWS IN GENERAL

In 1958, only fourteen states had statutes specifically regulating psychologists.[141] The number had increased by only two states by 1967.[142] But since 1967, thirty more states enacted regulatory laws, so that today only four states, Iowa, Missouri, South Dakota and Vermont, are lacking legislation pertaining strictly to the practice of psychology. It is reasonable to assume that the states responded to the concern of the professional psychological and psychiatric associations regarding the large numbers of non-professionals who are, in effect, practicing psychology.

The statutes establish academic as well as other types of requirements for those who are to be qualified as clinical psychologists by the state. They all require a doctoral degree; in some states an exam and/or postdoctoral clinical experience are additional requisites.[143] The laws may give the administering board the implied discretion to screen out applicants whose own mental and emotional disturbances would interfere with their professional services to clients.[144]

1. LICENSING ACTS

Regulatory statutes may be roughly divided into two categories. The first type is the true licensing statute, which bans the unauthorized practice of psychology.[145] Typically, these include a comprehensive definition of the proscribed activity. For example:

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[139] *See* Lakin, *supra* note 12.
[140] Brown v. Shyne, 242 N.Y. 176, 181, 151 N.E. 197, 199 (1926).
[141] Kayton, *Statutory Regulation of Psychologists: Its Scope and Constitutionality*, 33 ST. JOHN'S L. REV. 249 (1958).
[142] Meltreger, *Legal Limitations of the Practice of Psychology*, 5 ILL. C.L.E. 85, 91 (April 1967).
[143] *E.g.* ALASKA STATS. § 8.86.120 (1973); ARIZ. REV. STATS. § 32-2071 (1)(C), (2) (Supp. 1972); HAWAII REV. STATS. § 465-7-(2) (Supp. 1972); ANN. IND. STATS. § 63-3605-6 (Supp. 1973).
[144] Bloom v. Texas State Board of Examiners of Psychologists, 475 S.W.2d 374, 377 (Tex. Civ. App. 1972).
[145] Kayton, *Statutory Regulation of Psychologists: Its Scope and Constitutionality*, 33 ST. JOHN'S L. REV. 249 (1958).

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> 'Practice of psychology' means the rendering or offering to render for a fee, salary or other compensation, monetary or otherwise, any psychological service involving: (i) The application of the principles, methods and procedures of understanding, predicting and influencing behavior; (ii) the application of the principles pertaining to learning, perception, motivation, thinking, emotions and interpersonal relationships; (iii) the application of the methods and procedures of interviewing and counseling; (iv) the application of the methods and procedures of psychotherapy, meaning the use of learning, conditioning methods and emotional reactions, in a professional relationship, to assist a person or persons to modify feelings, attitudes and behavior, which are intellectually, socially or emotionally maladjustive or ineffectual; . . . (vi) the psychological evaluation, prevention and improvement of adjustment problems of individuals and groups; and (vii) the resolution of interpersonal and social conflicts.[146]

A statute this broad will surely encompass the techniques used by an encounter group leader. By practicing psychology without a license, the encounterist commits a misdemeanor,[147] although these provisions are rarely enforced. Twenty states and the District of Columbia currently have licensing statutes.[148]

Courts vary slightly in their opinions as to the effect of illegal unlicensed practice on civil liability. In the leading case of *Brown v. Shyne*,[149] the court ruled that by offering to treat the plaintiff, the defendant held himself out as qualified to practice medicine, although he was not licensed to do so. He was therefore to be held to the standard of skill and care of those who offer treatment lawfully (practicing medicine without a license was a misdemeanor). The plaintiff was still required to prove that the defendant did not exercise the skill and care which would have been exercised by a qualified practitioner, and further, that the lack of skill and care actually caused the injury.

Other courts have been less kind to the defendant in such cases.

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[146] W. VA. CODE chap. 30 § 21-2(e) (1971).
[147] *E.g.* OKL. STATS. ANN. tit. 59 § 1374 (1971).
[148] CODE OF ALA. tit. 46 §§ 297 (24-27) (Supp. 1971); ALASKA STATS. 8.86.180, .230 (1973); ARK. STATS. §§ 72-1502, -1507 (1957); CAL. BUS. AND PROF. CODE § 2903 (West Supp. 1974); COL. REV. STATS. § 108-1-2(3), -12 (1) (b) (Supp. 1967); D.C.C. §§ 2-482 (D), (E)-484 (1973); FLA. STATS. ANN. §§ 490.14, .17 (Supp. 1973); HAWAII REV. STATS. §§ 465-1(4), (5), -2 (Supp. 1972); IDAHO CODE § 54-2302(e), (f), (g), -2303 (Supp. 1973); KEN. REV. STATS. ANN. §§ 319.005, .010 (1970); ME. REV. STATS. ANN. tit. 32 §§ 3811, 3814 (Supp. 1973); REV. CODES MONT. §§ 66-3202 (4), 3203, 3213, 3214 (Supp. 1971); REV. STATS. NEB. §§ 71-3801 (2), -3802, -3829 (1971); N.J. STATS. ANN. tit. 45 §§ 14B-2(b), -5 (Supp. 1973); GEN. STATS. N.C. §§ 90-270.2(d), (e), -270.16(b) (Supp. 1973); OHIO REV. CODE ANN. §§ 4732.01(b), (c), 4732.21 (Supp. 1972); OKL. STATS. ANN. tit. 59 §§ 1352(c), 1353 (1971); TENN. CODE ANN. §§ 63-1107 (1955), § 1110 (Supp. 1972); TEX. CIV. STAT. tit. 71 art. 4512c §§ 2(b), (c), 20, 25 (Supp. 1974); CODE VA. §§ 54-102.1, 102.9 (1972); W. VA. CODE §§ 30-21-2(e), 3 (1971).
[149] Brown v. Shyne, 242 N.Y. 176, 181, 151 N.E. 197, 199 (1926).

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An unlicensed chiropractor's offer to prove that he had exercised the skill and care ordinarily possessed by chiropractors in the community was refused in *Whipple v. Grandchamp.*[150] Although plaintiff had the burden of proving that the treatments caused his injuries, he was not required to prove that the treatments were negligent. Negligence *per se* (a presumption of negligence based solely on violation of a statute) was established by the fact of the unlicensed practice.[151] A similar result was arrived at in *Harris v. Graham;*[152] an unlicensed physician was liable to his patient "by reason of his having violated an express statute."

The "negligence *per se*" argument gains support from the Restatement of Torts which states that an unlicensed beginner who has not yet attained a minimum of competence is to be treated as if he were negligent in engaging in the activity at all, "particularly where the dangers of incompetence in the activity are so well recognized that licensing statutes have been enacted requiring minimum standards of competence for anyone to engage in the activity."[153] The beginner bears the risk of loss, as against an innocent third party, while he is learning.

The situation of a lay leader who is being sued in a licensing statute state is serious. He will either be held accountable to the standard of a licensed psychologist, or else his leadership of the group without a license will be considered negligence *per se.*

2. *CERTIFICATION ACTS*[154]

The other major type of statute is the certification act. These statutes proscribe only the use of certain titles or words to describe services by uncertified persons. The forbidden titles are usually several variations of the word "psychology"; thus one who refers to himself as "therapist," "counselor," and in some states "psychotherapist" is not in violation of the statute, even though he is in actuality practicing psychology.[155] Twenty-six states have certification statutes.[156]

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[150] Whipple v. Grandchamp, 261 Mass. 40, 158 N.E. 270 (1927).
[151] RESTATEMENT (SECOND) OF TORTS § 286 (1965).
[152] Harris v. Graham, 124 Okl. 196, 255 P. 710, 713 (1927).
[153] RESTATEMENT (SECOND) OF TORTS § 299 Comment d (1965).
[154] The law as developed in this section is also applicable in large measure to those classes of persons who are exempted from licensing act requirements. They include students, interns and professionals such as doctors, teachers, lawyers and clergymen who do counseling in the course of practice.
[155] Kayton, *Statutory Regulation of Psychologists: Its Scope and Constitutionality,* 33 ST. JOHN'S L. REV. 249 (1958).
[156] ARIZ. REV. STATS. § 32-2601(2), (3) (Supp. 1972); CONN. GEN. STATS. ANN. § 20-187a (Supp. 1973); DEL. CODE ANN. tit. 24 § 3501 (Supp. 1970); GA. CODE ANN. § 84-3101, 3106 (Supp. 1972); ILL. STATS. ANN. chap. 91 1/2 §§ 402(5), (6), 403 (1966); ANN. IND. STATS. 63-3602 (Supp. 1973); KAN.

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Certification statutes offer no criminal sanctions against the unqualified encounterist. Such laws are ineffective in regulating the kinds of unauthorized practitioners who are common at this time.[157]

As legislators become aware of the need for more useful regulation in this area, it is probable that they will move to replace certification statutes with licensing acts which offer some measure of protection to the public. In California and New York, the two states in which the encounter phenomenon has made the deepest inroads, bills were introduced in 1973 to accomplish such a change. The California bill passed easily, with no known opposition.[158] The New York bill,[159] on the other hand, was defeated on the floor of the Legislature. The assemblyman who sponsored it attributes its failure to opposition from clergy, drug rehabilitation groups, and school psychologists (who although exempt from the major provisions of the bill, resented any restrictions on their right to give counseling) and from the "$30,000,000 encounter industry."[160] He states that although the bill was supported by the Attorney General, the Department of Education and the professional associations of psychiatrists, psychologists, nurses and social workers, lobbying mail against the bill outnumbered that in favor of it twenty to one.[161]

STATS. ANN. §§74-5302, 5340 (1972); LA. REV. STATS. 37:2352 (4), 37:2361 (1964); ANN. CODE OF MARYLAND art. 43 §§619 (c), 620 (1971); MASS. GEN. LAWS ANN. §§118, 122 (Supp. 1973); MICH. STATS. ANN. §14.677 (11) (1969); MINN. STATS. ANN. §§148.96 (Supp. 1973); MISS. CODE ANN. §73-31-3, -23 (1973); NEV. REV. STATS. §§641.020, .390-.420 (1973); OR. REV. STATS. §§675.010, .020, .990 (Supp. 1971); N.H. REV. STATS. ANN. 330-A § 1, 2, 21 (Supp. 1973); N.M. STATS. ANN. §§67-30-3 (c), -13 (Supp. 1973); NEW YORK EDUCATION LAW §7601 (McKinney 1972); N.D. CENT. CODE §43-32-01 (2), -17 (Supp. 1973); PENN. STATS. ANN. tit 63 §§1202, 1203 (Supp. 1973); GEN. LAWS R.I. 5-44-2, -14, -21 (Supp. 1972); CODE LAWS S.C. §§56-1543.105, -.106, -.107 (Supp. 1973); UTAH CODE ANN. tit. 58-25-4-5 (1963); REV. CODE WASH. ANN. §18.83.010, -.020, -.210 (Supp. 1973); WIS. STATS. ANN. §§ 455.01(4), (5), (6)(a), 455.02 (1)(a) (Supp. 1972); WYO. STATS. 33-343.3, 343.11 (Supp. 1973).

[157] Today in New York anyone — including incompetents, charlatans, criminals and mentally ill persons — can and do hold themselves out as being able to minister to those seeking help for mental, emotional or behavioral disorders, or personality disturbances or maladjustments. These 'practitioners' use a variety of high sounding titles such as 'psychotherapists,' 'hypnotherapists,' 'family counselors.' They hold themselves out as 'Doctor' solely on the basis of a mail order degree or an honorary award from an unaccredited institution. Yet, they are within the law, or more accurately the non-law, so long as they do not use the legally protected titles of 'psychiatrist,' 'psychologist,' or 'certified social worker.'

Hearing on Abuses by Unregulated Therapists in the Mental Health Field, before Louis J. Lefkowitz, Atty. Gen. of the State of New York (Dec. 15, 1972) (introductory remarks by Atty. Gen. Lefkowitz).

[158] CAL. BUS. & PROF. CODE § 2903 (West Supp. 1974).

[159] A.B. (New York) 3902a-c (Feb. 6, 1973).

[160] Telephone interview with New York Assemblyman P. Richard Biondo, Sept. 4, 1973.

[161] *Id.*

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In light of these sharply contrasting experiences, it is impossible to predict the results of future reform efforts. However, it is a misconception to believe that there is no civil liability for negligent administration of psychotherapy by unqualified persons in a certification statute state simply because there are no criminal sanctions to serve as yardsticks. There remains the general standard of care.[162]

D. GENERAL STANDARD OF CARE (ORDINARY NEGLIGENCE)

There is only one reported case dealing with the liability of a non-psychiatrist or non-psychologist who offers counseling. In *Bogust v. Iverson*,[163] the director of a university counseling center, who held a doctorate in education, terminated the counseling interviews which he had held with a student over a five-month period. She committed suicide shortly thereafter. Her parents sued the director for wrongful death on grounds that he failed to secure psychiatric treatment for her when he should have known she was unable to care for her own safety, did not notify her parents of her mental and emotional state, and failed to provide proper guidance by terminating the interviews. The court held that the director had no duty of care to the student, because he could not be held to the same standard as a person trained in medicine or psychiatry.

At first glance, this unfortunately worded decision would seem to absolve the unqualified practitioner of psychology of all responsibility to those whom he injures. But further examination of the opinion indicates that the true basis for the result is that the pleadings were defective. They lacked allegations of facts by which the defendant could have known of the student's emotional state.[164] Also, the difficult causation problems associated with all suicide cases were not well handled by plaintiff.[165]

Actually, a general negligence standard usually offers the layman less protection than the standard applicable to medical practitioners.[166] In cases of medical malpractice, the standard of care is that of other healers of the same school, even though the standard adhered to might be deserving of criticism. But in ordinary negligence cases, the custom in an industry is evidence of, but not absolute

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[162] Persons exempted from compliance with licensing laws, such as doctors, lawyers and clergymen who offer counseling in the course of practice, may be held to the standards of their particular professions. But when a separate fee is charged for counseling, this should not be considered to be counseling "in the course of practice."

[163] Bogust v. Iverson, 10 Wis. 2d 129, 102 N.W.2d 228 (1960).

[164] 10 Wis. 2d at 133, 102 N.W.2d at 232 (1960).

[165] 10 Wis. 2d at 131, 102 N.W.2d at 231 (1960).

[166] McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549 (1959).

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proof of, due care. The court may find that an entire industry or profession follows a negligent custom.[167] Thus, the encounter leader who could produce other leaders to testify that it is highly unusual for encounterists to screen prospective participants may still be liable for injuries flowing from his failure to screen if the ordinary negligence standard is applied.

Liability may also be predicated on any representation of competence, even if the defendant has held himself out only as a "leader" or "therapist." According to the Restatement of Torts:

> An act may be negligent if it is done without the competence which the reasonable man in the actor's position would realize is necessary to prevent causing unreasonable risk of harm to another...[168] This is true . . . where the actor, by professing competence, induces another to accept his services or otherwise subject himself to the acts . . .[169]

The reasonable man is required to know everything with respect to the risk of harm which is a matter of common knowledge in the community in which his conduct occurs.[170] This is really just a common-sense requirement. Nevertheless, the standard is workable in some cases. It does not take an expert to tell that if an obviously mentally ill person is subjected to severe stress, he may develop a psychosis or that if people are encouraged to fight to express aggression, bones may be broken. Of course, the situation is not always so clear-cut.

VI. CONCLUSION

The encounter group leader and the techniques he employs have not as yet been exposed to the scrutiny of the courts. He claims to be neither fish nor fowl; this non-categorization has quite possibly kept him out of the stew. Nevertheless, it is doubtful that a court will permit one person to injure another with impunity simply because it is difficult to decide what to call the tortfeasor.

Because there are presently no universals in the encounter culture, it is impossible to measure liability by the standard of the "reasonable encounter group leader." Factors such as the leader's professional qualifications, the stated purpose of the group, and the laws of the state where the group is conducted help to mold an individual yardstick for negligence in each fact situation. Many guidelines are available. In this article, an attempt was made to delineate some important ones currently in existence.

A civil remedy for those who have been harmed, emotionally or physically, by the encounter experience is feasible. It may be the just

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[167] W. PROSSER, HANDBOOK OF THE LAW OF TORTS 167-8, § 33 (4th ed. 1972).
[168] RESTATEMENT (SECOND) OF TORTS § 299 (1965).
[169] RESTATEMENT (SECOND) OF TORTS § 299 Comment c (1965).
[170] RESTATEMENT (SECOND) OF TORTS § 290 Comment e (1965).

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solution in particular cases. Nevertheless, tort law is wholly inadequate to protect the public against the manifold abuses which can and do occur under the encounter banner. Many professions are self-regulating, especially in the area of the healing arts. Owing to the diversity of viewpoints within the encounter movement, however, members impose no internal controls upon one another. Legislative action is clearly called for: first, in devising workable methods for enforcement of those regulatory laws which already exist; second, in enacting comprehensive licensing statutes in those states which lack them. Civil litigation is at best a stopgap remedy in terms of the overall problem.

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