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Tarasoff at Thirty: Victim's Knowledge Shrinks the Psychotherapist's Duty to Warn and Protect

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INTRODUCTION

In 1974, the California Supreme Court made headlines in medical privacy law when it held in Tarasoff v. Regents of the University of California that a psychotherapist has a duty to warn a third party, and therefore breach patient confidentiality, if one of his patients makes a sufficiently strong and serious threat towards the third party. In a very rare occurrence, the court reheard the case two years later and extended this duty from warning to full-fledged protection. This quickly polarized the medical community, as well as a sizeable number of legal commentators, against the judiciary. Many psychotherapists lashed out at the California opinions, arguing that they constituted a large step backward in the evolution of the therapist-patient privilege.

1. The author’s primary research interests include health law generally, and medico-legal ethics in particular, with a focus on privacy issues. He thanks Susan E. Lederer, Associate Professor of History of Medicine at Yale University, for several productive discussions of the history of medical privacy that partly inspired this paper. The author earned both a B.S., cum laude, with departmental distinction in Mathematics, and an M.S. in Mathematics from Yale University in 2004. All correspondence should be sent to bginsb@law.columbia.edu.


4. See Alan A. Stone, The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society, 90 Harv. L. Rev. 358, 378 (1976). Stone tempered his statements eight years later in Alan A. Stone, Law, Psychiatry, and Morality 181 (Am. Psychiatric Press, Inc. 1984), when he wrote that the “duty to warn is not as unmitigated a disaster for the enterprise of psychotherapy as it once seemed to critics like myself.”
But, three decades later, it appears that these controversial decisions might hold more potential for good than once was believed.

In particular, a recent but persistent line of cases has limited the so-called "Tarasoff duty" when the victim had prior knowledge of the patient-attacker's violent tendencies.5 This has quelled some of the controversy stemming from the sweeping breadth of the original 1974 and 1976 decisions. This limitation has also appeased those therapists who viewed the courts as shifting the public protection burden from the realm of law enforcement to the realm of psychotherapy.

Also, psychotherapists have re-examined Tarasoff for themselves, to very interesting ends. To wit, some contemporary psychiatric commentators have presented anecdotal evidence suggesting that the act of issuing a "Tarasoff warning" might be a valuable clinical tool, particularly when done by the patient himself.6

In short, thirty years of reflection and empirical observation have cast Tarasoff in a more optimistic, evolving light.

5. See discussion infra Part VII.
I. **TARASOFF v. REGENTS OF THE UNIVERSITY OF CALIFORNIA:**

**FACTS AND BACKGROUND**

In 1969, two hundred fifty thousand Americans marched on the Capitol to protest United States involvement in the Vietnam War. Droves of rock-and-roll fans flocked to a pasture in Sullivan County, New York, for the first Woodstock Music Festival. Dr. Lawrence Moore, a clinical psychologist at the University of California at Berkeley student health center, began treating a graduate student from India named Prosenjit Poddar. Several weeks into treatment, Dr. Moore diagnosed Poddar as a potentially dangerous paranoid schizophrenic. The chief basis for his diagnosis was Poddar's pathological attachment to Tatiana Tarasoff.

Poddar first met Tarasoff a year earlier in a folk dancing class at the university's International House. They became good friends and, on New Year's Eve of 1968, Tarasoff kissed Poddar. Poddar interpreted the kiss as an indication of a serious relationship, yet Tarasoff rebuffed all of Poddar's subsequent romantic attempts. Poddar grew increasingly distressed with each rejection and sought emotional counseling, eventually ending up in the care of Dr. Moore.

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7. This general heading actually refers to a trio of cases (all of which have the same set of facts): Tarasoff v. Regents of the Univ. of Cal., 108 Cal. Rptr. 878 (Cal. Ct. App. 1973); Tarasoff v. Regents of the Univ. of Cal., 529 P.2d 553 (Cal. 1974); and Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334 (Cal. 1976). The 1976 decision is a rehearing of the 1974 case, and interestingly it makes no mention of why the California Supreme Court decided to permit such a rare occurrence. The 1974 and 1976 California Supreme Court decisions are often called *Tarasoff I* and *Tarasoff II*, respectively, and I will preserve this convention.

The *Tarasoff* fact pattern is nearly identical to the fact pattern in two criminal cases involving Poddar: People v. Poddar, 103 Cal. Rptr. 84 (Cal. Ct. App. 1972), and People v. Poddar, 518 P.2d 342 (Cal. 1974). I shall call these cases *Poddar I* and *Poddar II*, respectively. *Poddar II* reversed *Poddar I* (which itself brought Poddar's conviction down from murder in the second degree to manslaughter), as the supreme court concluded that the appeals court issued poor jury instructions regarding the consideration of Poddar's mental illness. The court uses more vivid detail in the *Poddar* cases than in the *Tarasoff* cases, so I will sometimes reference *Poddar* rather than *Tarasoff* for background information.


During the ninth therapy session, Poddar confided in Dr. Moore that he was going to kill an unnamed female, readily identifiable as Tarasoff, when she returned from a vacation in Brazil. Dr. Moore notified the campus police and told them that he thought Poddar should be civilly committed. The police took Poddar into custody but released him shortly after judging him to be rational and not harmful. They also made Poddar promise to stay away from Tarasoff.\textsuperscript{12}

In the meantime, Dr. Moore's request for civil commitment was denied.\textsuperscript{13} Poddar was never restrained further, and he never returned to therapy. On October 27, 1969, Poddar entered Tarasoff's home and chased her into the backyard, where he shot her with a pellet gun and fatally stabbed her with a kitchen knife. Immediately, Poddar reentered the house and called the police. He told them he had stabbed Tarasoff and wished to be handcuffed.\textsuperscript{14}

Though convicted of second-degree murder, Poddar had his conviction reduced to manslaughter in 1972 when the California Court of Appeals determined that the trial judge failed to issue a proper jury instruction regarding Poddar's mental condition.\textsuperscript{15} In 1974, the California Supreme Court reversed the appeals court decision--on the theory that, given Poddar's mental condition, even a manslaughter charge might be unduly harsh--and remanded Poddar for a new trial.\textsuperscript{16} Several years passed, though, and rather than begin a lengthy retrial, the state deported Poddar to India and barred him from ever returning to the United States.\textsuperscript{17}

Vitaly and Lydia Tarasoff, Tatiana's parents, brought suit against the University of California, the therapists who treated Poddar at the student health center, and the police.\textsuperscript{18} The Tarasoffs argued the therapists and police acted negligently in failing to secure Poddar's commitment. The Tarasoffs said these failed attempts to commit Poddar deterred him from returning to therapy and indirectly made his attack on Tatiana possible. In a 5-2 decision (known as Tarasoff I), the California Supreme Court found that both the police and

\textsuperscript{12} Tarasoff II, 551 P.2d 334, 341 (Cal. 1976).
\textsuperscript{13} Id.
\textsuperscript{14} Poddar II, 518 P.2d at 345.
\textsuperscript{15} Poddar I, 103 Cal. Rptr. 84 (Cal. Ct. App. 1972).
\textsuperscript{16} Poddar II, 518 P.2d 342.
\textsuperscript{17} Vanessa Merton, Confidentiality and the "Dangerous" Patient: Implications of Tarasoff for Psychiatrists and Lawyers, 31 EMORY L.J. 263, 290 (1982). In the same paper, Merton interestingly reports that Poddar (at the time of that article's publication) was happily married to a lawyer. Id.
\textsuperscript{18} Tarasoff I, 529 P.2d 553 (Cal. 1974).
psychotherapists had an affirmative duty to warn Tarasoff of the threat Poddar posed.\textsuperscript{19} However, a dissenting opinion urged that the court not incite violations of the psychotherapist-patient privilege by requiring disclosure of facts learned in the course of therapy.\textsuperscript{20}

Not surprisingly, a large portion of the psychotherapeutic community disagreed with the court's ruling. The American Psychiatric Association, for example, filed an amicus brief emphasizing the sanctity of psychotherapist-patient confidentiality.\textsuperscript{21} Surprisingly, the court agreed to rehear the case.\textsuperscript{22} This time the court released the police from all liability but extended the scope of the psychotherapists' liability.\textsuperscript{23} According to the second decision (known as \textit{Tarasoff II}), therapists must exercise "that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of that professional specialty under similar circumstances" to predict violence in patients.\textsuperscript{24} Moreover, once a therapist predicts violence, he is legally obligated not only to warn but to protect an identifiable potential victim.\textsuperscript{25} Justice Tobriner, who wrote the majority opinion in both cases, concluded with a far-reaching and ominous declaration of when a psychotherapist must breach confidentiality: "The protective privilege ends where the public peril begins."\textsuperscript{26}

Outside criticism came immediately and often tendentiously, but, from a psychotherapeutic point of view, was it warranted? The hardships \textit{Tarasoff} theoretically could have forced on therapists were many, but did the subsequent case law really validate practitioners' greatest fears? Also, aside from possible harm created, was any good generated by these controversial opinions?

Thirty years after the first California Supreme Court \textit{Tarasoff} opinion, it is appropriate to take stock of these questions by charting the evolution of \textit{Tarasoff} through three decades of jurisprudence, trying to determine how it has changed psychotherapy and how it can

\begin{thebibliography}{99}
\bibitem{19} Id. at 561.
\bibitem{20} Id. at 565 (Clark, J., dissenting). In \textit{Tarasoff II}, Justice Mosk switched from the majority to the dissent and wrote a separate opinion, dissenting in part and concurring in part.
\bibitem{22} \textit{Tarasoff II}, 551 P.2d 334. The court gave no indication in the record as to why it reheard \textit{Tarasoff I}.
\bibitem{23} Id. at 349.
\bibitem{24} Id. at 345 (quoting Bardessono v. Michels, 478 P.2d 480, 484 (Cal. 1970)).
\bibitem{25} Id. at 340.
\bibitem{26} Id. at 347.
\end{thebibliography}
still change psychotherapy. To do this in context, one has first to look at the very beginnings of the profession that Tarasoff influenced.

II. A BRIEF HISTORY OF AMERICAN PSYCHOTHERAPY

Arguably, American psychotherapy began in the early 1800s with Benjamin Rush, the "first American psychiatrist." Recognizing that the brain is the "seat of the mind," Rush believed that psychopathology stemmed from abnormalities of the cerebral blood vessels. Accordingly, many of the early modes of therapy--swinging a patient, bound by chains, from the ceiling of a room; total immobilization via a confining "tranquilizer chair"; and sudden submersion in water--are not what a contemporary therapist would call "psychoanalytic."

The year 1844 saw the publication of the American Journal of Insanity (which later became the American Journal of Psychiatry), the first journal devoted to "diseases of the mind." One of the articles in the very first issue stressed the link between insanity and genius, claiming to chronicle the madness of such celebrated authors as Alexander Pope and Lord Byron. In fact, it was not until later in the nineteenth century that Sigmund Freud proposed the first well-formed theory explaining mental illness in terms of life experiences as opposed to purely physical imbalances or other spuriously related factors. Freud matured professionally in an era of great progress in the natural sciences, and he made sure that his theory of mental abnormality was no less precise and systematic than contemporary theory in other, more physical branches of medicine.

In 1895, Freud introduced the technique of free association, which involved asking a patient to abandon conscious control over his ideas

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28. MICHAEL H. STONE, HEALING THE MIND: A HISTORY OF PSYCHIATRY FROM ANTIQUITY TO THE PRESENT 121 (1997). The tranquilizer chair, designed by Rush himself, was called "the most complete restraint of a patient ever devised."

29. Id. at 122.

30. Id. An excerpt from this article reads "Insanity is a disease particularly incident to persons remarkable for their talent or genius." Id.

31. ALEXANDER & SELESNICK, supra note 27, at 183.

32. Id.
and say whatever came into his head. Freud discovered that, when performed over a sufficiently long period of time, free association would lead the patient back to forgotten events and the emotions felt when these events originally occurred. The cornerstone of this therapy, termed "psychoanalysis," has always been confidentiality. For any patient, speaking freely is difficult. The necessary factor in overcoming the natural resistance to complete candidness is the belief that anything said in therapy will be kept in the confidence of the therapist. According to Freud, "The whole undertaking becomes lost labor if a single concession is made to secrecy."

Innovative as Freud was, he was not the first to propose confidentiality in medical communication. The great healer Hippocrates of Cos wrote in his eponymous oath: "All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal."

This portion of the oath is an early recognition that safeguarding patient secrets is absolutely necessary for treatment. Thomas Percival of Britain drew on this fundamental tenet when composing his Medical Ethics. The first Code of Medical Ethics of the American Medical Association, drafted in 1847, borrowed extensively from Percival (and therefore from Hippocrates) and championed physician-patient confidence except in certain extenuating circumstances. Although not officially stated, the general consensus among psychotherapists at

33. Id. at 194.
34. Id.
35. KARL A. MENNINGER, A MANUAL FOR PSYCHIATRIC CASE STUDY 5 (2d ed. 1962). Interestingly, Menninger was one of the first psychiatrists to go on record saying that the psychotherapist-patient privilege should not be absolute. Id. at 39.
36. RALPH SLOVENKO, PSYCHOTHERAPY, CONFIDENTIALITY, AND PRIVILEGED COMMUNICATION 41 (1966). Freud's daughter, Anna, a prolific analyst in her own right, wrote that "[C]onfidentiality of the material . . . is a prerequisite for free association. No analysand succeeds in divesting himself of all defenses or controls unless he can be certain that the derivatives of his id will not become known beyond the confines of the analytic situation." 4 ANNA FREUD, THE WRITINGS OF ANNA FREUD 417 (1968).
37. This excerpt appears in the Oath's English translation found in STEDMAN'S MEDICAL DICTIONARY 799 (26th ed. 1995).
38. THOMAS PERCIVAL, MEDICAL ETHICS (Chauncey D. Leake ed., Robert E. Krieger Publ'g 1975) (1803)
the time—then separate from so-called “medical men”—was to incorporate confidentiality into their practices. These codes, however, were merely professional guidelines and established no legal relationship, or privilege, when applied to the communications between psychotherapist and patient.

In fact, there was no legal protection for the communications between regular physicians and patients in America until 1828, when the state of New York enacted a statutory privilege. Confidentiality became a widely discussed topic, and by 1966 two-thirds of the states had laws establishing some sort of a physician-patient privilege. In most of these statutes, though, special attention was not paid to psychiatrist-patient communication. It was not until the early 1950s that the courts began to recognize the difference between the role of confidentiality for the ordinary physician and for the psychiatrist, paving the way for accommodating the needs of psychotherapists without medical degrees as well.

III. ORIGINS OF A LEGAL PRIVILEGE FOR PATIENTS OF PSYCHOTHERAPY

In the landmark 1952 Illinois trial court case of *Binder v. Ruvell*, psychiatrist Dr. Roy Grinker refused to testify when the court sought information about one of his patients. Though Illinois had no physician-patient privilege, the court ruled that the information given by a patient to a psychiatrist in the course of psychotherapy was protected from disclosure. It also commented on the special nature of the psychiatrist-patient relationship:

It doesn’t require any scientific knowledge to understand that there can be no success in the effort to ascertain the true cause of

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40. Ellen W. Grabois, *The Liability for Psychotherapists for Breach of Confidentiality*, 12 J.L. & HEALTH 39, 40 (1997). This article observed that psychotherapists have focused on confidentiality not only since 1847, but from the “earliest beginnings” of the discipline. Id.

41. SLOVENKO, supra note 36, at 15. This privilege was created largely for public health concerns. During this time, many people wanted to conceal embarrassing venereal diseases and feared seeking treatment for them. A legal privilege assured that any diagnosis would remain secret. Id.

42. Id. at 93.

43. Id.

44. *Binder v. Ruvell*, No. 52-C-2535 (Cir. Ct., Cook Cty., Ill. June 24, 1952), reported in 150 JAMA 1241 (1952).

45. Id.
the disturbance or in determining the kind of treatment that should be applied unless there is complete confidence in the mind of the patient, not alone in the capacity and skill of the psychiatrist but in the secrecy of the things transpiring in the doctor's chambers. That relationship in that respect is unique and is not at all similar to the relationship between [ordinary] physician and patient.\(^{46}\)

One test the court used in determining whether a privilege is warranted is the application of the so-called Wigmore criteria: a four-factor checklist created by former Northwestern University Law School Dean John Wigmore outlining necessary (but not sufficient) conditions for the existence of a privilege.\(^{47}\) The court gave the most weight to the fourth factor—a cost-benefit analysis—and determined that the harm caused by compelling Dr. Grinker to disclose the content of his therapy sessions would outweigh the benefits to the present legal case and to society generally.\(^{48}\) The Binder ruling marked the beginning of courts' tendency to distinguish psychiatrists from other physicians and give increased credence to all psychotherapists. In 1960, the Group for the Advancement of Psychiatry issued a report addressing the special need for psychiatric privilege.\(^{49}\) This report was so influential that by 1987 forty-nine states had enacted privileges

\(^{46}\) Id. at 1242.

\(^{47}\) 8 John Henry Wigmore, Evidence in Trials at Common Law § 2285 at 527, revised by John T. McNaughton (1961). Wigmore suggested that a legal privilege should exist with respect to a communication only if: 1) The communications must originate in a confidence that they will not be disclosed; 2) This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties; 3) The relation must be one which in the opinion of the community ought to be sedulously (painsstakingly) fostered; and 4) The injury that would inure to the relation by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation. Id.

Wigmore himself argued that the four-factor test works against the establishment of any physician-patient privilege. He wrote that only husband-wife, priest-penitent, and attorney-client privileges conform to all four factors. Id. at 528.

\(^{48}\) Binder v. Ruvell, No. 52-C-2535 (Cir. Ct., Cook Cty., Ill. June 24, 1952), reported in 150 JAMA 1241, 1242 (1952). Judge Fisher wrote that the question of whether it is more desirable to breach or preserve confidentiality “almost answers itself in a case such as this.” Id.

\(^{49}\) Committee on Psychiatry and the Law, Group for the Advancement of Psychiatry, Report No. 45: Confidentiality and Privileged Communication in the Practice of Psychiatry (1960).
specifically for psychiatrists or other psychotherapists.\textsuperscript{50} By 1996, all fifty states and the District of Columbia had some type of statutory psychotherapist-patient privilege.\textsuperscript{51}

None of these statutory privileges, however, are absolute. In every case, extenuating circumstances can arise where a psychotherapist can violate the privilege and not be held liable to the patient for doing so.\textsuperscript{52} One such circumstance occurs when a patient threatens violence against an identifiable victim. \textit{Tarasoff} goes a step further. The case upends the concept of privilege by making the psychotherapist liable to the third party if harm does occur.\textsuperscript{53}

Examining \textit{Tarasoff}'s impact on psychotherapy requires a multifaceted analysis. First, I will investigate how the decisions changed the nature of the psychotherapist-patient relationship. Second, I will explain how \textit{Tarasoff} changed the attitudes of prospective patients and their psychotherapists and how these shifts in attitude affected the population of third parties (the general public). Third, prior to examining trends in the resultant case law and in medical attitudes, I will explore the medical problem of predicting violence and the reasonableness of the standard to which \textit{Tarasoff} holds the psychotherapist.

\textsuperscript{50} RALPH SLOVENKO, \textsc{Psychotherapy and Confidentiality: Testimonial Privileged Communication, Breach of Confidentiality, and Reporting Duties} 559-564 (Charles C. Thomas 1998). At this time, Alaska was the only state without such a statutory privilege, although it did recognize such a privilege at state common law.

\textsuperscript{51} Jaffee v. Redmond 51 F.3d 1346, 1356 (7th Cir. 1995). This case and its affirmation by the U.S. Supreme Court in 1996 were chiefly responsible for establishing a federal psychotherapist-patient privilege. Jaffee v. Redmond, 519 U.S. 1 (1996). The Court used the fact that all fifty states had such a privilege to guide its reasoning. \textit{Id.} at 12.

\textsuperscript{52} Some examples of exceptions to the privilege include: CONN. GEN. STAT. § 52-146c(b)(3) (2003), when the psychologist believes there is “risk of imminent personal injury . . . or risk of imminent injury to . . . property” of the patient or others; ILL. ANN. STAT. ch. 740, para. 110/11(vi) (2004), when the patient makes a “specific threat of violence” against an individual; and W. VA. CODE § 27-3-1(b)(4) (2003), “to protect against a clear and substantial danger of imminent injury by a patient or client to himself or another.”

\textsuperscript{53} \textit{Tarasoff II}, 551 P.2d 334, 343 (Cal. 1976).
IV. TARASOFF’S IMPACT ON THE PSYCHOTHERAPIST-PATIENT RELATIONSHIP

Before Tarasoff, the psychotherapist-patient relationship was largely defined in pragmatic rather than legal terms. Benjamin Rush’s contemporaries certainly had no legal precedent to establish the confidentiality central to their practice; they did so because they realized that confidentiality in such a relationship is necessary for proper treatment. More so than in the ordinary physician-patient relationship, confidentiality in the psychotherapist-patient relationship has been the profession’s hallmark since the late nineteenth century.54

One way in which Tarasoff changed this special relationship was by altering the content and direction of a psychotherapy session. Before Tarasoff, the standard therapy session was largely patient-driven in accordance with Freud’s view that the person most qualified to extract information from the patient is the patient himself.55 For this reason, pre-Tarasoff psychiatric manuals advise new psychotherapists to say nothing and listen as long as the patient is talking. He is rarely, if ever, to be interrupted.56 This lets treatment evolve naturally, as the patient controls nearly the entire content of each session.

The Tarasoff decisions, however, add an implicit structure to each session. Since a therapist under Tarasoff can be held liable if he fails to accurately predict violence, in many cases he needs to alter his therapy to focus on the patient’s violent thoughts and tendencies. According to a survey conducted in 1977 shortly after Tarasoff II, and reported in the Stanford Law Review (hereinafter “Stanford Survey”), about twenty-seven percent of responding therapists reported directing therapy sessions more toward the subject of dangerousness.57 A survey conducted in 1987 and published in the Pacific Law Journal (hereinafter “Pacific Survey”), reported that thirty-seven percent of responding therapists said Tarasoff had caused them to devote disproportionately more time focusing on the potential dangerousness of the patient.


55. Fragment of an Analysis of a Case of Hysteria, in 7 THE STANDARD EDITION OF THE COMPLETE PSYCHOLOGICAL WORKS OF SIGMUND FREUD 12 (James Strachey trans., Hogarth Press 1953). Freud did not start out with this belief, but he quickly espoused it and “let the patient himself choose the subject of the day’s work . . . .” Id.

56. MENNINGER, supra note 35, at 23.

57. Toni Pryor Wise, Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff, 31 STAN. L. REV. 165, 180-81 n.82 (1978). The actual statistic is 26.8%.
of their patients. These increasingly significant minorities indicate therapy sessions immediately after and up to ten years after Tarasoff were less patient-driven than were pre-Tarasoff sessions. The literature bears no large-scale Tarasoff-related survey of psychotherapists after the Pacific Survey, but society’s tendency to grow more and more litigious with time suggests that the current value of the aforementioned statistic relating to steering the therapy session towards issues of dangerousness might represent an even larger minority or perhaps the majority of psychotherapists today.

A decision such as Tarasoff reinforces to patients as well as psychotherapists that what patients say during therapy may not remain confidential. Since speaking openly with the psychotherapist is absolutely necessary for any hope of successful treatment, any reluctance on the part of the patient to do so would certainly lessen the value of psychotherapy. The Stanford Survey reported that twenty-five percent of responding therapists noticed patients’ increased reluctance to discuss violent thoughts once the patients knew that there were some cases where the psychotherapist-patient confidence could be broken. The importance of violent thoughts to patient treatment, however, has not changed. They are still considered part of the group of primal urges from which a psychotherapist can uncover the most information about his patients. Unfortunately, a significant reported effect of Tarasoff has been the increased restriction on tapping this reservoir of information.

Conversely, a consequence of similar magnitude arises when therapists to spend too little time asking questions regarding dangerousness in hopes of not discovering threatening information and therefore avoiding a Tarasoff-like legal quandary. The Stanford Survey indicates that a significant minority of responding therapists were reluctant to probe deeply into their patients’ lives because of the potential for violence they might discover. Similarly, it reports that most responding therapists felt more anxious (post-Tarasoff) when the topic of violence arose during a session. Taken together, these

60. Wise, supra note 57, at 177 n.67. The actual figure is 24.5%.
61. Id. at 181 n.86. The Stanford Survey reported that 54% of respondent therapists believed Tarasoff “increased [their] anxiety as an issue relating to dangerousness is broached in the clinical setting.” Id.
tendencies to focus too much and too little on violence reinforce the disproportionality that became part of psychotherapy after Tarasoff.

But what about potential patients not yet in therapy? Surely, if they have the potential for violence, they pose a greater or equal danger to society than those currently seeing a psychotherapist. How does Tarasoff affect their willingness to seek therapy? On a related note, how does Tarasoff affect psychotherapists' decisions to accept or reject new patients?

V. PROSPECTIVE PATIENTS AND THEIR WOULD-BE THERAPISTS

To be sure, the prospective psychotherapy patient is often a delicate individual. He is afflicted not with physical diseases for which there are formulaic cures, but with maladies of the mind that sometimes manifest themselves in less-than-obvious ways. The only route to successful treatment is to find a therapist with whom he can speak openly and candidly. But the content of the therapeutic dialogue is not the only concern of the prospective patient; the mere act of seeking therapy has always carried a social stigma. The patient would therefore be hesitant to reveal that he is in therapy, much less the actual thoughts and urges he discusses with his therapist. Although there are no empirical studies of prospective patients' willingness to seek therapy pre- and post-Tarasoff, it can be logically argued that patients might be less willing to seek treatment if they know that any desire the therapist perceives as significant and violent must be communicated to a potential third party victim. If it persists, this situation will have a perilous effect on both the prospective patient and the public: the prospective patient will seek treatment less frequently, reducing the likelihood that his harmful tendencies will remain safely in check.

62. MENNINGER, supra note 35, at 5.
64. MENNINGER, supra note 35, at 4.
65. But there does exist an excellent survey of Texas patients, in particular, that examines their perceptions of the psychotherapist-patient relationship before and after 1979, the year Texas statutorily recognized psychotherapist-patient privilege. The results, along with results relating to psychotherapist and health care provider surveys, are reported in Daniel W. Shuman & Myron S. Weiner, The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege, 60 N.C. L. REV 893 (1982).
The issue of increased legal liability will consequently make the psychotherapist more discerning in his patient selection. This is counterproductive to the aims of psychiatry— to treat and cure as many individuals as possible and to benefit the greatest number of patients. In fact, the Pacific Survey reported that forty-six percent of responding psychotherapists have in one way or another avoided treating potentially dangerous patients. Frightened by the possibility of learning dangerous desires and the problem of figuring out how to protect the third party, the post-Tarasoff psychotherapist might actually systematically discard those patients in greatest need of psychotherapy. Compounding the problem of a prospective patient’s reluctance to seek treatment, selective treatment by the psychotherapist will endanger both the public and the violent individual in desperate need of counseling.

What exactly constitutes a violent individual? How does a therapist determine if a patient is violent and, further, how does a therapist determine if a patient intends to harm an identifiable third party?

VI. PREDICTING DANGEROUSNESS: WHERE PSYCHOTHERAPISTS FEAR TO TREAD

The issue of predicting dangerousness plagued psychotherapy long before the Tarasoff opinions were handed down. Not only have psychotherapists had difficulty predicting dangerousness, they have had difficulty diagnosing mental illness in general. This means that psychotherapists will miss dangerous behavior in some patients and identify it falsely in others. This is the centerpiece of Justice Mosk’s dissenting opinion in Tarasoff II: he feared that shifting violence prediction from the courts to the psychotherapists “takes us from the world of reality into the wonderland of clairvoyance.”

The next logical question is whether psychotherapists overpredict or underpredict violence, and, if so, what would be the impact of each type of error?

66. Stone, supra note 4, at 183.
67. Rosenhan et al., supra note 58, at 1209.
68. Stone, supra note 4, at 359. Stone wrote that Tarasoff “not only reduces the opportunity of the seriously mentally disturbed to obtain effective treatment, but fails to serve the court’s primary purpose of reducing the danger that such patients pose to the public.” Id.
69. Rosenhan et al., supra note 58, at 1185-1186.
Even before Tarasoff it turns out that psychotherapists had a tendency to overpredict violence in their patients.\textsuperscript{71} Thus, there doubtless exist a number of "false positive" patients who actually do not pose great harm to others.\textsuperscript{72} According to a 1984 study reported in the Wisconsin Law Review (hereinafter "Wisconsin Survey"), forty-five percent of responding psychotherapists have issued Tarasoff warnings when these warnings directly conflicted with the psychotherapists' clinical judgment.\textsuperscript{73} This suggests that the courts have succeeded in substituting their judgment for the psychotherapist's—a substitution that threatens the practice of psychotherapy. An oft-quoted statistical anecdote instructs the reader to assume that one person out of one thousand will kill. If a test with an accuracy of ninety-five percent is devised, for every one hundred thousand people tested, ninety-five out of one hundred killers would be identified. But 4,995 innocent people out of the 99,900 innocents would also be identified as killers.\textsuperscript{74} Even this might not appear to be an obvious problem—at least ninety-five percent of the killers will be able to be stopped—but this does not end the discussion. 

Tarasoff II extended the therapist's duty to warn (established by Tarasoff I) to a duty to protect.\textsuperscript{75} Since the Tarasoff court never supplied substantive content to what "protection" entails, psychotherapists and judges have interpreted this duty in a wide variety of ways. One popular reading of the duty associates protecting third parties with committing dangerous patients to mental hospitals.\textsuperscript{76} The link between commitment and duty to protect was not invented post-Tarasoff. In a 1934 Yale Law Journal article, Harper and Kime suggest that medical professionals, including psychotherapists, have a duty to control the conduct of their patients, discussing commitment as one way to accomplish this.\textsuperscript{77} The previous statistical anecdote suggests that nearly five thousand innocents will be involuntarily

\textsuperscript{72} D.L. Rosenhan, On Being Sane in Insane Places, 179 SCIENCE 250, 258 (1973).
\textsuperscript{74} STONE, supra note 28, at 167.
\textsuperscript{75} Tarasoff II, 551 P.2d at 340.
\textsuperscript{76} STONE, supra note 28, at 183.
\textsuperscript{77} Fowler V. Harper & Posey M. Kime, The Duty to Control the Conduct of Another, 43 YALE L.J. 886, 887, 897 (1932). Harper and Kime wrote that a "duty to control" might exist where there is an "unreasonable risk" to a third party.
committed because the psychotherapist, erring on the side of caution, will overprotect third parties out of concern for his own Tarasoff liability. Therefore, he will infringe on the rights of those five thousand and potentially face legal action for violating patient privilege. This puts the psychotherapist between a rock and a hard place: he must choose between limiting liability and providing proper treatment.

Several of the previous factors—willingness to seek therapy, willingness to treat, and dangerousness—were examined largely theoretically, primarily because there have not been any recent follow up studies on the order of magnitude of those conducted within a decade of Tarasoff. The resultant court cases, however, provide hard data concerning whether (and if so, how) the duty to warn and protect was narrowed or expanded.
VII. TARASOFF'S LEGACY: The Shrinking Duty to Warn and Protect

Tarasoff has had far-reaching effects beyond the realm of psychotherapy, but these applications are beyond the focus of this article. For example, the ongoing HIV epidemic has generated controversy in determining whether a physician has the duty to warn a third party who may be exposed to HIV via the physician’s infected patient. The first court to consider the Tarasoff ruling in deciding such a case was the California Court of Appeals in the 1985 case of Reisner v. Regents of the Univ. of Cal., 37 Cal. Rptr. 2d. 518 (Cal. Ct. App. 1995). In Reisner, twelve-year-old Jennifer Lawson received a blood transfusion while undergoing surgery at the University of California Los Angeles Medical Center in April of 1985. The day after the surgery, her physician, Dr. Eric Fonklesrud discovered that the blood she received was tainted with HIV. However, Dr. Fonklesrud chose not to inform Lawson or her parents.

About three years after the transfusion, Lawson started dating Daniel Reisner. After three months, the relationship became sexually intimate, and, on March 7, 1990, Lawson was diagnosed with AIDS. She immediately informed Reisner and his family of her diagnosis and died a month later. Shortly after Lawson’s death, Reisner learned that he too tested positive for HIV. Reisner and his family sued Dr. Fonklesrud and UCLA, claiming they had a duty to warn “others [who were] likely to apprise [Daniel] of the danger” of contracting HIV. Id. at 520. The defendants argued that this duty to warn did not apply in cases where the third party was “unknown or unidentifiable.” Id.

This court expanded the Tarasoff decisions when it found that the defendant’s liability was predicated on the foreseeability—not the identifiability—of the victim. Holding that Lawson’s likelihood of entering into an intimate relationship at that time was foreseeable, the court granted the defendant’s appeal on the grounds that “[c]ivil liability for a negligent failure to warn under the circumstances of this case may not hasten the day when AIDS can be cured or prevented, but it may, in the meantime, protect one or more persons from unnecessary exposure to this deadly virus.” Id. at 522.

But the courts have also expressed opposite messages regarding the physician’s duty to warn in HIV cases. In 1995, the District of Columbia Court of Appeals in N.O.L. v. District of Columbia held that a physician has no duty to warn a husband of his wife’s HIV status. 674 A.2d 498 (D.C. 1995). On the contrary, the court stated “[T]he hospital staff owed a duty to appellant’s wife to refrain from disclosing that information to anyone.” Id. at 499.

In 1996, the Maryland Special Court of Appeals continued this trend of strengthening confidentiality. In Lemon v. Stewart, the Maryland Special Court of Appeals ruled that physicians attending to Mr. Lemon, an acknowledged intravenous drug addict, had no duty to disclose the results of Lemon’s HIV test to his family. 62 A.2d 1177 (Md. Ct. Spec. App. 1996). The Court said that physicians, hospitals, and laboratories have to warn only the patient—not his family—of his HIV status. Id. at 1183.
A. The Early 1980s: Refining the Notion of Identifiability

In 1980, the California Supreme Court got the chance to clarify what Tarasoff requires of psychotherapists in the case of Thompson v. County of Alameda. James F., a troubled teen in Piedmont, California, and a ward of the county, regularly saw a therapist pursuant to a court order. The therapist noted that James had "latent, extremely dangerous and violent propensities regarding young children and that sexual assaults upon young children and violence connected therewith were a likely result of releasing [him] into the community." During his therapy sessions, James did not threaten any one child in particular; rather, he said he could direct his anger at anyone in the neighborhood. Not having anyone in particular to warn, the therapist warned no one. Within twenty-four hours of his temporary release from county custody, James killed Clifford Thompson's five-year-old son. Thompson argued that the county was liable for failing to warn families in the neighborhood that such a dangerous individual was about to be released. The California Supreme Court, however, disagreed. The court concluded that when James communicated his violent thoughts to his therapist he described a "large amorphous public group of potential targets" rather than a readily identifiable victim. Here, the court noted that even though the potential victim need not have a name, he must still be describable in terms more specific than simply some member of a large, indeterminate group.

Lipari v. Sears, Roebuck & Co. significantly broadened the Tarasoff duty. In that case, Ulysses Cribbs, a patient of a psychotherapist at a Veterans Affairs hospital, purchased a shotgun from the Sears catalogue, entered a nightclub and opened fire into a crowd. Cribbs killed Dennis Lipari and wounded his wife, Ruth Ann. The court permitted the Lipari family to file suit against the hospital

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For a thorough discussion of Tarasoff's application to HIV/AIDS cases, see Christine E. Stenger, Taking Tarasoff Where No One Has Gone Before: Looking at "Duty to Warn" Under the AIDS Crisis, 15 ST. LOUIS U. PUB. L. REV. 471 (1996), and for a look at Tarasoff applied to genetically heritable diseases in general, see Michelle R. King, Physician Duty to Warn a Patient's Offspring of Hereditary Genetic Defects: Balancing the Patient's Right to Confidentiality Against the Family Member's Right to Know—Can or Should Tarasoff Apply?, 4 QUINNIPIAC HEALTH L.J. 1 (2001).

80. Id. at 730.
81. Id. at 738.
despite the fact that Cribbs never conveyed to his psychotherapist a desire to do harm. The District Court of Nebraska determined that the jury should decide whether the therapist should have known the patient's propensity for violence. Thus, the Tarasoff duty was determined to require protection of all of society from danger caused by a patient whose conduct is reasonably foreseeable to the therapist.\footnote{Ebrahim J. Kermani & Sanford L. Drob, Tarasoff Decision: A Decade Later Dilemma Still Faces Psychotherapists, 41 AM. J. PSYCHOTHERAPY 271, 277 (1987).}

In the 1983 case of Jablonski v. United States,\footnote{Jablonski v. United States, 712 F.2d 391 (9th Cir. 1983).} Phillip Jablonski was brought to a hospital after attempting to rape his girlfriend's mother. While the emergency room psychiatrist concluded that Jablonski was a danger to others, he could not involuntarily commit Jablonski to a mental institution under California law. Less than a week after his release, Jablonski killed his girlfriend. The Ninth Circuit held that the hospital failed to obtain necessary medical records and to warn the potential victim. In addition to extending the psychotherapist's Tarasoff duty, Jablonski comments on the formation of the psychotherapist-patient relationship. The court's ruling implies that the special covenant between psychotherapist and patient may in fact arise from cursory meetings in an emergency room. Thus, the Jablonski court expected the psychotherapist to predict the behavior of an individual about whom the psychotherapist knew little more than he did about a random stranger.\footnote{Kermani & Drob, supra note 83, at 280.}

The cases in this subsection represent just a few of the many early-to mid-1980s cases that elaborated on the Tarasoff decisions in determining psychotherapist liability. The full collection of these cases is too large to treat with any depth here, and several authors have done very thorough jobs of this task elsewhere.\footnote{SLOVENKO, supra note 36, and SLOVENKO, supra note 50 present comprehensive treatments of Tarasoff-influenced opinions throughout the 1980s and 1990s. See also Peter F. Lake, Revisiting Tarasoff, 58 ALB. L. REV 97 (1995).}

\section*{B. The Late 1980s and the 1990s: Limiting the Tarasoff Duty by What the Victim Knew or Should Have Known}

One salient way in which courts restricted the Tarasoff holdings was to absolve psychotherapists of the duty to warn if the victim had or should have had prior knowledge of the patient's dangerousness.\footnote{More general versions of this observation have been made before; see Walcott et al., supra note 6. However, this trend of limiting based on victim's knowledge did not become common until the 1990s.}
Courts using this approach reasoned that psychotherapists should not be required to warn a third party when that third party was, or should have been, aware of the danger.

The first clear example of this trend in the literature appears to be the 1982 Iowa case *In re Estate of Votteler.* Lola Hansen was a psychiatric patient of Dr. Robert Votteler’s who suffered from serious mental illness which often manifested itself in the form of compulsive violent behavior over a two-year period in the mid-1970s. She frequently threatened her husband, friends, and others who tried to outbid her at furniture auctions. It was at one of these auctions where she met Ramona Heltsley. True to form, Ms. Hansen threatened to kill Heltsley on several occasions, and also threatened Heltsley and Mr. Hansen jointly more than once. Ms. Hansen was hospitalized twice over the course of her particularly aggressive phase. Each time Dr. Votteler asked Mr. Hansen to shed more light on his wife’s background, and each time Mr. Hansen did not tell Dr. Votteler about his wife’s violence. Perhaps Dr. Votteler should have been able to judge Ms. Hansen’s tendencies for himself, but nevertheless he issued no warning to Helstley or to anyone else.

In early 1976 Ms. Hansen was hospitalized for a second time. In July of that year her husband left her and she began seeing Heltsley socially. Three months later, Ms. Hansen drove her car over Heltsley in a local park and killed her. A suit was filed on Heltsley’s behalf against Dr. Votteler’s estate (he had since died) relying chiefly on *Tarasoff.* The trial court rejected the plaintiff’s analogy to *Tarasoff,* and the Iowa Supreme Court agreed. In its decision, the court distinguished the *Tarasoff* fact pattern on the basis that Tatiana Tarasoff had no knowledge that Poddar posed any danger to her. The court held that *Tarasoff* and some of its progeny “[support] a

knowledge--in psychotherapy cases in particular--seems stronger, perhaps, than what Walcott et al. communicated by citing three such cases: Jacobs v. Taylor, 379 S.E.2d 563 (Ga. Ct. App. 1989); Moye v. United States, 735 F. Supp. 179 (E.D.N.C. 1990); and Boulanger v. Pol, 900 P.2d 823 (Kan. 1995). For one thing, the trend seems to have started even earlier (1982) than the first case they consider. Also, unlike the present paper, Walcott et al. considered *Tarasoff*’s restriction generally--not just with respect to victim’s knowledge--and did not focus their analysis purely on psychotherapy cases.

88. *In re Estate of Votteler,* 327 N.W.2d 758 (Iowa 1982).
89. Id. at 761.
90. Id.
conclusion that the duty should not be imposed when the foreseeable victim knows of the danger."

Next in this line of cases is *Hinkelman v. Borgess Medical Center*, a 1987 case in Michigan. Virginia Hinkelman’s live-in boyfriend, Daniel Travis, started to become possessive and suspicious of her in the spring of 1978. That June he went to counseling sessions at a nonprofit mental health center. His condition worsened, and he was referred to psychiatrist Dr. Charles Overbey for further evaluation. At the same time, Hinkelman told Travis to leave her parents’ home where they both had been staying. Dr. Overbey diagnosed Travis with a personality disorder, treatable with medication and continued counseling, but he did not commit Travis. In October of that same year, Travis showed up unannounced at Hinkelman’s parents’ home and refused to leave until Hinkelman would speak with him. Hinkelman complied on the condition that they would go together to Borgess Medical Center, where Travis would admit himself for treatment, which he agreed to do.

At Borgess, Travis experienced second thoughts about hospitalization, but Hinkelman begged him to stay. Travis then threatened her and, behind a closed conference room door, tried to choke her. Hinkelman did not press charges until Travis appeared at her home again later in October. Police issued an arrest warrant two days later, but Travis had readmitted himself to Borgess. His admission was approved by Dr. Overbey. Though he was evaluated by a social worker to be unstable and violent, Travis was allowed to leave the hospital later that night. Less than two weeks later, Travis broke into Hinkelman’s home and raped her. He was later apprehended. While in jail, a psychiatrist (not Dr. Overbey) examined Travis and found him to be a definite danger to Hinkelman, despite the fact that he had made no direct threats during the evaluation. One week later, after he was released on bail, Travis kidnapped Hinkelman, and fatally shot her and then himself. Hinkelman’s family argued that Dr. Overbey and Borgess Medical Center failed to warn Hinkelman of the danger Travis posed, but the Michigan Court of Appeals affirmed the lower court’s ruling that discharged Dr. Overbey’s and Borgess’s psychotherapy personnel’s duty to warn because “regardless of whether the hospital knew or should have known of the danger to Hinkelman, the victim herself was aware of the danger. Since

91. *Id.* at 762.
93. *Id.* at 548.
94. *Id.*
Hinkelman already knew of the danger, the duty to warn did not arise.95

This principle was reinforced by the 1989 Georgia case Jacobs v.
Taylor.96 Since 1978, Ronald Murray had been in and out of mental hospitals for threatening to kill his former wife, Marjorie. The record showed that Ms. Murray either received the threats directly or had learned of them through indirect means. During his initial stay at the hospital, Mr. Murray was under the care of Dr. Jacobs, a therapist. In 1980, fresh from his latest release, Mr. Murray was arrested for "terroristic threats" he had made to his wife during an earlier confrontation.97 He was deemed unfit to be jailed and was sent to a secure psychiatric facility where he was again placed under Dr. Jacobs's care. Eventually, Dr. Jacobs judged Mr. Murray fit to enter the general prison population. Shortly thereafter, he was ruled competent to stand trial. Mr. Murray was acquitted in April 1981, and, upon his release, murdered his former wife and two others. Ms. Murray's family argued that Dr. Jacobs breached his duty to warn Ms. Murray, but the court held that Ms. Murray's knowledge of her former husband's threats constituted all the warning to which she was legally entitled. That is, "[T]he doctors were not legally required to warn Marjorie Murray of the precise danger to which she was already fully aware."98

Less than a month after the Jacobs decision, the court in Wagshall v. Wagshall held that a victim's knowledge eliminated a psychotherapist's Tarasoff duty to warn.99 Joshua Wagshall and his wife Marlene saw a therapist for several months in 1985 because of marital problems. During their counseling, they signed an agreement with the counselor to have their firearms stored in a place neither could access. This was done so in part because Mr. Wagshall knew firsthand that his wife was prone to violent behavior. In July 1985, after the marriage counseling ended, Ms. Wagshall used one of the family-owned firearms to shoot and injure her husband. Mr. Wagshall argued that the counselor should have warned him about his wife's potential for violence, but the Appellate Division of the New York Supreme Court said Mr. Wagshall's prior knowledge eliminated the counselor's duty to warn him.100

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95. Id. at 551.
97. Id. at 564.
98. Id. at 568.
100. Id. at 598-99.
The next case on the record that eliminated Tarasoff warnings when the victim had knowledge of the patient’s violent tendencies was the 1990 case of Moye v. United States from the Eastern District of North Carolina.\footnote{Moye v. United States, 735 F. Supp. 179 (E.D.N.C. 1990).} Milton Moye joined the U.S. Navy in June of 1981, but developed paranoia and alcohol dependency and had to be medically discharged just two years later. At that point, Moye checked in voluntarily to a Veterans Affairs treatment facility where he underwent three separate periods of treatment, each lasting a month on average. Between the first and second treatment periods, Moye attended outpatient therapy and participated in family conferences with his parents, who were made aware of, and who apparently independently knew of, his potential for violent behavior.\footnote{Id. at 180. The court noted that Moye’s father did not “inform the police or hospital staff of his son’s violent propensities or bizarre behavior.” Id.} Before he left his third treatment session, Moye was told that he suffered from a personality disorder and that the medication he was prescribed was not helping. Shortly after leaving the Veterans Affairs facility, he entered a private treatment center, but was asked to leave after just one week at the center because he did not comply with its rules and policies. Staff at the private facility asked Moye’s parents if they wanted to medicate him, but they refused. Moye moved into a YMCA near his parents’ home in Raleigh and almost immediately thereafter shot and killed his parents. Relatives of the Moyes sued the Veterans Affairs center for failing to warn Moye’s parents of the danger their son posed, but the appellate court did not entertain this claim since North Carolina does not have a Tarasoff statute. Moreover, the court ruled that even if such a duty did exist, the hospital would not be held liable since “the foreseeable victim knew of the danger associated with the patient . . . .”\footnote{Id. at 181.}

In the 1993 case Leonard v. Latrobe Area Hospital,\footnote{Leonard v. Latrobe Area Hosp., 625 A.2d 1228 (Pa. Super. Ct. 1993).} the Pennsylvania Superior Court affirmed a motion for summary judgment for a psychologist who failed to warn a victim who knew that her husband was violent. James Gault was admitted to the Latrobe Hospital Psychiatric Unit after overdosing on aspirin in September of 1983. A psychiatrist observed him for eight days and allowed him to return home. Less than three months later, he shot and killed his wife. The record states that Gault’s wife was familiar with his previous violent episodes. The lower court granted the hospital’s motion for summary judgment, finding it “a curious lapse in logic on plaintiffs’
part to claim that [the psychiatrist] should have warned them of information they already had, and with which they were familiar."¹⁰⁵

Knowledge negated duty once again in the 1995 Kansas case *Boulanger v. Pol.*¹⁰⁶ Ron Hill had endured brain damage as a child and suffered from physical and mental abnormalities thereafter. In particular, in the late 1980s, he believed his uncle Boulanger was the Devil. Following an incident in late 1989 where he had accosted Boulanger, Hill voluntarily admitted himself for treatment. However, less than six months later Hill was discharged and sent home, where he assaulted his father and attempted to stab himself. He was then sent to another treatment facility where he was supervised by Dr. Albert Pol. Hill exhibited normal, nonviolent behavior and was discharged into his parents' care with Dr. Pol's permission after five months in the facility. Ten days later, Boulanger visited the Hill's home, where Hill shot Boulanger, killing him. Boulanger's family claimed that Dr. Pol had a duty to warn Boulanger upon Hill's release, but the Kansas Supreme Court disagreed, stating that "the uncontroverted facts establish [Boulanger] was fully apprised of the danger posed by Ron. The duty to warn does not arise when the victim already knows of the danger."¹⁰⁷

This reasoning was also followed in *Dunk v. United States*¹⁰⁸ in 1996. Robert Dunk was a corporal in the U.S. Marine Corps and physically abused his wife in November 1985 while he was stationed in Quantico, Virginia. He transferred to Camp Lejeune in North Carolina that December and took his wife and two sons with him. The domestic abuse continued. Ms. Dunk attempted to leave her husband and obtained a protective order against him. Cpl. Dunk's commanding officer had him removed from the family home and placed in the barracks with another marine, but shortly thereafter Cpl. Dunk left the barracks, kidnapped his wife, and threatened to kill her. Ms. Dunk filed a complaint, and Cpl. Dunk was eventually arrested and forced to undergo a psychological evaluation. The hospital pronounced him fit to return to full duty, and Cpl. Dunk was released. On July 17, 1990, Ms. Dunk dropped her complaint. That night, Cpl. Dunk purchased a pistol from a fellow marine, entered the family home, and shot his wife, killing her, and then killing himself in front of his two children. When a suit was filed on behalf of Ms. Dunk, the Fourth Circuit stated that no *Tarasoff* duty existed in North Carolina, and, even if one did,

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¹⁰⁵. *Id.* at 1231.
¹⁰⁷. *Id.* at 835. The court cited *Wagshall* in its opinion.
“there is no duty to warn a potential victim of another’s violent behavior when the victim is already aware of the danger.”\textsuperscript{109} The court reasoned that Ms. Dunk must have been aware of her husband’s violent tendencies since she attempted to leave him and later filed a complaint against him.\textsuperscript{110}

The same year saw another example of this trend in New York’s \textit{Kolt v. United States}.\textsuperscript{111} Vietnam veteran Thomas Kolt was honorably discharged from the military in 1971. He began seeing various psychiatrists and psychotherapists at a Veterans Affairs facility in 1978 and continued to make occasional visits until December 1991. Throughout this period, Kolt displayed instances of depressive and suicidal behavior. During one incident in September of 1991, Kolt hit and kicked his wife. Evaluations performed during his treatment periods concluded that Kolt presented only a minimal danger to others and a minimal to severe danger to himself. On January 1, 1992, Kolt shot and killed his wife and himself. His wife’s family argued that psychotherapy personnel at the Veterans Affairs facility had a duty to warn her, even though Kolt’s danger to others was not described as severe. Apart from addressing the issue concerning Kolt’s psychotherapist’s evaluation, the Western District of New York ruled that no duty to warn exists when, as in this case, the victim is fully aware of the patient’s potential for violence.\textsuperscript{112}

This limitation on psychotherapist liability when the victim knows her attacker’s potential for violence might itself be subject to several restrictions which warrant further investigation. First, does this limitation on \textit{Tarasoff} liability observe a cooling-off period? That is, does it matter whether the victim learns of her attacker’s potential for violence one year before versus one month before harm occurs? Second, does this limitation on \textit{Tarasoff} liability depend on whether the victim has knowledge of her attacker’s general violent propensities versus knowledge of her attacker’s tendency to engage in the precise type of violent behavior that causes harm to the victim?

\textsuperscript{109} Id. at *7.

\textsuperscript{110} Id.


\textsuperscript{112} Id. at *10-11.
C. Bringing Tarasoff Up to Date: A Survey of Recent Cases

The 1997 Texas case Limon v. Gonzaba113 discussed a therapist's duty to warn based on second-hand information that a patient may be violent absent any direct observation. In 1992, Lorenzo Limon was taken to the Gonzaba clinic by his daughter and spoke with a therapist for close to a half-hour. He told the therapist he was depressed about his former marriage and problems at work, but he did not report feeling suicidal or homicidal. However, Limon's daughter told the therapist that her father was "a danger to himself and others."114 The therapist diagnosed Limon with mild depression and referred him to another treatment facility. Two days later, Limon went to his ex-wife's home and shot her. As a result, she became a paraplegic. The court found that despite the combination of the daughter's warning of general violence and Limon's specific comments about his former wife's depressing phone calls, the attack was not foreseeable. The therapist was not held liable.115

The 1999 Wisconsin case State v. Agacki116 is interesting to consider in light of Thompson and Lipari. In May of 1996, Curtis Agacki told his therapist that he set a motorcycle on fire after a fight in a bar and that there might have been witnesses. Agacki said he was not afraid because "[i]f they try anything, I will pull my piece out and blow their . . . heads off. I will kill them. I don't care what happens to me . . . I am not afraid of it, dying."117 The therapist asked Agacki to meet him face-to-face in a nearby tavern, separate from the bar where the fight occurred. Before leaving for the meeting, the therapist called Milwaukee police. He requested assistance in the likely (in his opinion) event that Agacki might have to be involuntarily hospitalized. When the therapist finally met Agacki, Agacki communicated to the therapist both verbally and nonverbally that he was armed. The therapist left the tavern briefly and summoned a nearby police officer. He told the officer Agacki was inside and had a gun. The officer arrested Agacki.

At trial, Agacki claimed his statements about being armed and killing any bar fight witnesses were privileged.118 The Wisconsin Appeals Court disagreed and held that his statements were not

114. Id. at 237.
115. Id. at 241.
117. Id. at 33.
118. Id. at 33--34.
privileged since the therapist had “reasonable cause to believe his patient was dangerous.”¹¹⁹ The court allowed the therapist to protect the tavern patrons and the public generally even though Agacki specifically threatened the witnesses of a fight at another establishment.¹²⁰ The holding in this case represents one example of a sharp turn in the Tarasoff legacy: allowing a psychotherapist to protect a larger group (the public) based upon an inference drawn from threats made to a smaller group (witnesses to the fight).

The 2000 New Jersey case Runyon v. Smith¹²¹ presents an interesting example of a therapist being punished for having done too much rather than too little. In January of 1995, Diane Runyon obtained a temporary restraining order prohibiting her husband, Guy, from seeing their children. Because he believed it was Mrs. Runyon who posed a threat to the children, Mr. Runyon immediately contested the order. During the hearing, Mr. Runyon called Dr. Maureen Smith, who had treated Ms. Runyon over a five-year period, as an expert witness. Dr. Smith testified that Ms. Runyon had been physically and verbally abusive with one of the children and that she was involved in a cult. She concluded that it was in the children’s best interest that they be placed with Mr. Runyon. The family court judge agreed and granted him temporary custody, but Ms. Runyon filed a complaint against Dr. Smith for breaching psychologist-patient privilege. Dr. Smith then filed a motion for summary judgment, which the court granted. However, the appellate court reversed in favor of Ms. Runyon in large part because Dr. Smith failed to secure a court order granting her permission to disclose information drawn from her therapy sessions with Ms. Runyon. The New Jersey Supreme Court stated, without qualification, that

[If] a psychologist fails to raise the patient’s privilege and discloses confidential information without a court determination that disclosure is required, the psychologist has breached the duty owed to the patient and the patient has a cause of action against the psychologist for the unauthorized disclosure of information obtained in the course of treatment.¹²²

The court did not clarify whether a court order is needed for any type of disclosure of confidential information or only for such disclosure in legal proceedings. The Runyan case simplifies the job of a New Jersey psychotherapist, although the result is perhaps more

¹¹⁹. Id. at 38.
¹²⁰. Id. at 33, 38.
¹²². Id. at 852-53.
frustrating: obtain the court's permission prior to disclosure or do nothing. Only three subsequent cases—all in New Jersey—have appeared to rely on Runyon, and all three seem to have preserved nearly inviolate the need for a court order to disclose confidential contents of psychotherapy sessions. It will be interesting to see whether jurisdictions begin to require psychotherapists to obtain the permission of a court before they intervene on the potential victim's behalf in a Tarasoff-type situation.

United States v. Hayes, a 2000 case before the Sixth Circuit, demystifies Runyon in the sense that it sharply distinguishes between a psychotherapist's disclosure to a third party in dire need of protection and disclosure in a court of law where the third party's safety has presumably stabilized. Roy Hayes had worked for the United States Postal Service for nearly his entire adult life. In 1997, he became depressed and sought treatment at a Veterans Affairs facility in Tennessee, where he informed his treating psychiatrist of his strong desire to kill his supervisor at work. No warning was given to the supervisor. Hayes was released shortly thereafter and told to contact a different treatment center. Just four days later, he returned to the same facility as an inpatient and reiterated his murderous desires. He was treated again, released, and this time given a psychotropic drug prescription. In March of 1998, nearly one year later, Hayes visited another Tennessee mental health facility, this one in Johnson City. He spoke with a social worker at the facility about his desire to kill his supervisor and described in meticulous detail how he was going pull it off. The social worker, however, thought Hayes was not a serious threat and released him the next night on Hayes's promise to return in two weeks for more therapy sessions. Hayes began to feel unpleasant side effects from his medication, and the psychiatrist he saw at the first facility ordered him to stop taking it. This, combined with some unfortunate family events, caused Hayes to become increasingly depressed. Hayes returned to the Johnson City facility for more therapy with the social worker. Again, Hayes outlined a very detailed plan as to how he would murder his supervisor, and again he was released. The next day, the social worker warned the supervisor, and

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the supervisor arranged to file a criminal complaint against Hayes for threatening to murder a federal official.\textsuperscript{125}

The lower court suppressed the threats as privileged, and the Sixth Circuit agreed in the sense that those statements relayed by the social worker were not admissible in any prosecution of Hayes.\textsuperscript{126} However, the court noted that the social worker did act properly when he issued the Tarasoff warning to the postal supervisor.\textsuperscript{127} This case, perhaps more than any of Tarasoff's other progeny, sharply distinguished the public protection aspect of Tarasoff warnings from the legal ramifications behind them by considering third party safety entirely independent from subsequent disclosure in a court of law.

A few other recent cases deserve at least a brief mention. In the 2001 case \textit{Swan v. United States},\textsuperscript{128} the District Court for the Northern District of California held that Tarasoff does not compel a psychotherapist to disclose confidential information to prevent harm \textit{from} a third party. In this case, an inmate told a prison psychologist that he feared attacks from other men in his cellblock. The psychologist neither divulged this information to the prison board nor asked that the fearful prisoner be transferred or protected in any way. The prisoner was later attacked and sustained injuries which required the surgical removal of his left eye. He unsuccessfully sued the government, which controlled the prison in which he was incarcerated, for failure to protect. The court ruled that the prison psychologist did not need to divulge the content of her sessions with the prisoner, even though it might have been the surest way to preserve his safety.\textsuperscript{129}

\textit{Mason v. IHS Treatment Center of Desoto, Texas}\textsuperscript{130} in 2001 offered another chance for a court to close the gap between what constitutes a readily identifiable set of third parties and what is only, as the Thompson court stated, an "amorphous" group.\textsuperscript{131} Mason, Thomas, and Cleveland were patients in a mental health facility. Mason and

\begin{footnotes}
\begin{enumerate}
\item Id. at 580-81.
\item Id. at 586.
\item Id.
\item Id. at 1183.
\item Mason v. IHS Treatment Ctr. of Desoto Tex., No. 05-98-00832-CV, 2001 Tex. App. LEXIS 5494 (Tex. App. Aug. 15, 2001). This case was reversed in part as to defendants other than the therapist considered in this paper in 143 S.W.3d 794 (Tex. 2004).
\item Thompson v. County of Alameda 614 P.2d 728, 738 (Cal. 1980).
\end{enumerate}
\end{footnotes}
Thomas were released, and shortly thereafter, Cleveland, who remained in the hospital, asked his doctor for permission to go for a ride with Thomas and "another former patient" of the facility. Permission was denied, but Cleveland later left the facility on his own accord. Less than a month later, he was killed in a car accident while riding with Mason and Thomas, who was driving. Among the litigation which emerged from this event was the suit against Thomas's therapist brought by Mason's family for failing to protect Mason from the risk created by Thomas's discharge. The Masons claimed the therapist should have identified Mason as a "former patient" and warned him that Thomas might have been planning a dangerous activity. A Texas appeals court disagreed and said that the group of "former patient[s]" of the treatment facility was not sufficiently specific to induce a duty to warn. This stands in stark contrast to cases such as Lipari and Agacki where those courts expected therapists to protect the public at large.

Finally, the North Carolina Court of Appeals dealt with Tarasoff very simply in the 2002 case of Gregory v. Kilbride: It reiterated that "North Carolina does not recognize a psychiatrist's duty to warn third persons.'

D. Continuing the Knowledge As Negator Trend

The tendency for courts to negate the duty to warn a third party who has knowledge of the patient-assailant's violent tendencies has persisted since the late 1980s. The 2000 New Mexico case Weitz v. Lovelace Health Systems presents one of the first such examples. Eddie Gutierrez was a U.S. Air Force Staff Sergeant stationed at Kirtland Air Force Base in Albuquerque, New Mexico. He and his wife Arlene were having marital problems and, in December of 1991, went to see several psychotherapists employed by Lovelace Health

133. Id. at *1.
134. Id.
136. Id. at 692.
137. While its published facts are too sparse to merit a lengthy narrative review, Von Ohlen v. Piskacek might present another example of this trend. 717 N.Y.S.2d 221 (N.Y. App. Div. 2000). Here, the court held that two doctors--perhaps psychotherapists, perhaps not--"had no duty to warn the plaintiff of her husband's vicious tendencies. The plaintiff was well aware of those tendencies, because her husband had stabbed her on a previous occasion." Id. at 222.
138. Weitz v. Lovelace Health Sys., 214 F.3d 1175 (10th Cir. 2000).
Systems, a company providing mental health facilities to Air Force personnel. Both of the Gutierrezes also had individual sessions with these therapists. During one of Ms. Gutierrez’s individual sessions, she expressed fear of her husband’s violent potential.\footnote{139}

On December 29th, she went to her husband’s home to discuss their marriage.\footnote{140} When she told her husband she was leaving, he drew a handgun which she was able to wrestle away. Ms. Gutierrez left safely and reported the incident to her husband’s commanding officer, who made an appointment for Mr. Gutierrez to undergo a mental health evaluation. Mr. Gutierrez met with a therapist to whom he confided that he was unsure whether he would be able to handle his emotions if he and his wife divorced. After his second appointment the next day, the therapist pronounced Mr. Gutierrez “improved” and encouraged him to seek outside counseling.\footnote{141} Mr. Gutierrez never obtained this additional help, but in the interim surrendered his weapons to an Air Force sergeant at the request of his commanding officer. Two weeks later Mr. Gutierrez asked for the weapons back on the excuse that he just wanted to take some target practice on tin cans. The sergeant returned the guns. One month later, Mr. Gutierrez shot and killed his wife, daughter, and finally himself after his wife came to his house to pick up their daughter.\footnote{142}

Suit was filed on behalf of Ms. Gutierrez and her daughter against the Lovelace psychotherapy personnel who saw Mr. Gutierrez but did not warn Ms. Gutierrez of the danger he posed.\footnote{143} Rather than extensively discussing Tarasoff (New Mexico had not decided whether to adopt such a duty) the Tenth Circuit reasoned that New Mexico would not impose a duty to warn where the victim was already “subjectively aware” of the patient’s violent behavior.\footnote{144}

The Tarasoff duty was refined once again in 2003 in Howard v. Parsons’ Child & Family Center.\footnote{145} In this case, the Parsons’ Child and Family Center placed a violent special needs child with a foster parent in the Germantown Central School District in the fall of 1994.
Educational personnel for the school district first assigned the child to the second grade. This proved unsuccessful and the child was reassigned to a first grade class taught by Ms. Alayne Howard. Between the two placements, the Parsons' Center personnel directly observed the child's violent behavior but did not inform Ms. Howard or the school district generally. The child's private full-time aide, however, did say that he observed numerous incidents of the child's aggressive behavior, all of which he reported to school officials (though not necessarily Ms. Howard). Indeed, on February 9, 1995, the aide wrote a letter to a school district official expressing his concern that the child might turn violent in certain situations. Less than a month later, the child grabbed Ms. Howard's hair in class one day and slammed her head against a metal doorstop.\textsuperscript{146}

Ms. Howard survived the attack and sued the Parsons' Center, claiming that its psychotherapy personnel had a duty to warn the school district of the violent tendencies they observed between the child's first and second academic placements and that they failed to do so.\textsuperscript{147} The Appellate Division of the New York Supreme Court affirmed the lower court's dismissal, noting that the child's behavior was brought to the school district's attention by its own psychologist (apparently during an earlier examination) and by the letter from the child's full-time aide. According to the court, the school district had knowledge and did not need to be warned further.\textsuperscript{148}

\section*{VIII. CURRENT PSYCHOTHERAPEUTIC ATTITUDES}

The preceding cases represent the most current examples of judicial attitudes towards \textit{Tarasoff} and its progeny. Psychotherapeutic attitudes towards \textit{Tarasoff} are more difficult to come by, but some recent commentaries do display a rather enlightened and optimistic view of \textit{Tarasoff}'s impact.

While noting that clinicians do not enjoy having regulations forced upon them and that they do not relish having to keep legal--in addition to medical--issues in mind, psychiatrist Dr. Damon Muir Walcott and his colleagues report that some therapists see \textit{Tarasoff} as having had a largely positive impact, particularly when it comes time to issue warnings.\textsuperscript{149} Communicating candidly with the patient about the need

\textsuperscript{146} \textit{Id.} at 382.
\textsuperscript{147} \textit{Id.} at 384.
\textsuperscript{148} \textit{Id.}
\textsuperscript{149} Walcott et al., \textit{supra} note 6, at 340.
for and purpose of the duty to warn is helpful for the clinician. Dr. Walcott reports that this discussion process might actually strengthen the sense of trust between the psychotherapist and the patient. Moreover, several medical commentators have suggested that warning a third party in the presence of the patient might be the best route to take. This way the patient is not surprised and a sense of trust can be enhanced in the therapy session.\(^{150}\)

In fact, one group of psychotherapists argued that having the patient himself issue the Tarasoff warning is the best option.\(^{151}\) Under this scenario, not only is the patient not taken by surprise, but having the patient give the warning is perhaps the most direct way to put him on notice of any potential legal consequences.\(^{152}\) This method lets the psychotherapist escape ethical dilemmas by having someone outside the profession—the patient—break the privilege of confidential conversations. After all, the privilege is for the patient’s protection. Thus, having the patient breach it is perhaps one of the least controversial ways to go about this type of disclosure.

A recent question-and-answer column in the American Medical News’s “Ethics Forum” also sheds some light on this area.\(^{153}\) In outlining some general principles for physicians to consider when contemplating breaching patient confidence, psychiatrist Dr. Paul Browde uses Tarasoff as a starting point for thinking critically about when disclosure is appropriate. Rather than laying out a blanket philosophy, Dr. Browde argues in favor of case-by-case analysis of when it is appropriate to breach confidentiality, and advances a six-point test for evaluating the issue. Dr. Browde formulates his six-step inquiry for physicians in general, but on the whole it is applicable to psychotherapists as well.\(^{154}\)

First, the physician should ask where the secret that might be disclosed is located. For example, is it within an individual or among members of a family?\(^{155}\) Second, what is the content of the secret? It could be something that is innocent, such as a secret a teenager might keep from his parents, or it could be dangerous like Poddar’s

\(^{150}\) Id.

\(^{151}\) See Wulsin et al., Unexpected Clinical Benefits of the Tarasoff Decision: The Therapeutic Alliance and the Duty to Warn, 140 AM. J. PSYCHIATRY 601 (1983).

\(^{152}\) Id. at 602.


\(^{154}\) Id.

\(^{155}\) Id.
statements of his murderous intent. Third, what are the consequences of the secret itself? For example, Dr. Browde notes that the secret of testing positive for HIV meant near-certain death twenty years ago but might be less dramatic and sensational today. Next, what are the consequences of revealing this secret? This point operates like a cost-benefit analysis similar to the fourth Wigmore test for privilege which measures the good versus the harm of keeping a given item confidential. Dr. Browde puts the penultimate question as "Which biases influence the physician's decision?" Finally, if the physician chooses to disclose the secret, how should she proceed? This last point is a nontrivial, practical issue, and Dr. Walcott's report about the therapeutic benefits of warning with the patient present might very well provide the beginnings of an answer to this important question.

CONCLUSION

In some sense, the California Supreme Court intervened in a field that needed no legal intervention because the Pacific Survey found that therapists would disseminate warnings to third parties based upon personal and professional ethics rather than legal mandate. Psychotherapists have reported that Tarasoff's goal was achieved long before the case was ever adjudicated, yet there still lacks a large-scale patient study asking questions analogous to those posed to therapists by the Pacific, Stanford, and Wisconsin surveys.

Other dichotomies have yet to be empirically resolved. When Tarasoff was initially decided there came a great deal of judicial baggage which weighed heavily upon the psychotherapeutic profession. However, the visible trend of limiting the Tarasoff duty when the victim had knowledge of his assailant's violent tendencies has shifted the courts' role from hector to helper. Early post-Tarasoff studies, surveying psychotherapists, reported that patients are less likely than before the Tarasoff decisions to reveal their true feelings in therapy. Nevertheless, future research involving psychotherapists and patients might show that this problem is becoming less severe.

156. WIGMORE, supra note 47.
158. Walcott et al., supra note 6.
159. Rosenhan et al., supra note 58, at 1219. A reported 97.5% of responding psychotherapists said they would warn a potential victim regardless of Tarasoff liability.
160. Id. at 1191.
And while earlier surveys concluded that psychotherapists have become so anxiety-ridden since \textit{Tarasoff} when dealing with the question of violence that they let the issue dominate the therapy session, disregard the issue, or avoid potentially violent patients altogether,\textsuperscript{161} some of the most recent medical commentaries note \textit{Tarasoff}'s potential value as a clinical tool and springboard for thinking critically about medical privacy issues.\textsuperscript{162}

\textit{Tarasoff} has been both nexus and naysayer for American psychotherapy, but it appears that it has the potential to make the field of psychotherapy better through the holding's steady and reasoned limitation in the courts and emergence as a decision with tangible clinical benefits. Obviously, more patient data are needed, and other ethical considerations, such as potential damage done to innocent patients whose confidences are violated, cannot be ignored. On the balance, however, there seems to be enough of an upside to feel cautiously optimistic about \textit{Tarasoff}'s ability to positively impact psychotherapy.

\textsuperscript{161} See Wise, \textit{supra} note 57; Rosenhan et al., \textit{supra} note 58.

\textsuperscript{162} See Walcott et al., \textit{supra} note 6; Browde, \textit{supra} note 153.