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PATIENT THREATS AGAINST THIRD PARTIES: THE PSYCHOTHERAPIST’S DUTY OF REASONABLE CARE

Charles B. McCarty

Violent crime in the United States has reached epidemic proportions. Approximately one in ten Americans will be a victim of violent crime during their lifetime. These frightening statistics are paralleled by the need for mental health care in the United States. An estimated thirty-four million Americans seek professional mental health care each year. Out of these thirty-four million patients, psychotherapists consider 900,000 potentially dangerous. Amazingly, only 31,000 warnings are issued annually by psy-


2. This figure is conservative. It is based upon the Census statistics for the 1975-1979 time period. Those statistics show that 48 people out of 1000 are annual victims of violent crime. Id. at 176. Therefore, 1 in 20 Americans are victims each year.

A lifetime rate can be calculated by multiplying the annual number of victims (48) by the average life span (73 years) (the average lifespan in this formula is being reduced by the Census statistics which begin with victims age 12) divided by the number of victims per 1000. Therefore, 48 x 61 ÷ 1000 = 2.928 violent crimes per person per lifetime. Certainly, this formula does not provide for chronic victims. However, the underlying data refers only to offenses known to police.

Assuming that the lifetime formula is unreliable, the estimate of 1 in 10 victims per lifetime is valid in that the annual rate of 1 in 20 would lead a reasonable person to conclude that a different five percent of the population would be victimized over an average lifespan.


4. Psychotherapist is defined as: “A person, usually a psychiatrist or clinical psychologist, professionally trained and engaged in psychotherapy.” STEDMAN’S MEDICAL DICTIONARY 1167 (5th ed. 1982). Psychotherapy is defined as: “Psychotherapeutics; treatment of emotional, behavioral, personality, and psychiatric disorders based primarily upon verbal or nonverbal communication with the patient, in contrast to treatments utilizing chemicals and physical measures. . . .” Id.

5. This figure was derived by adding the number of psychologists (44,000) and psychiatrists (38,000) together (82,000) and multiplying by .8 (80% is the percentage of psychologists and psychiatrists who reported treating at least 1 potentially dangerous patient a year)(82,000 x .8 = 65,600) and, thereafter, multiplying 65,600 by 13.87 (the mean number of potentially dangerous patients seen each year by the psychiatrists and psychologists who reported treating

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chotherapists regarding these dangerous patients.6

In 1976, the California Supreme Court held that psychotherapists owe a duty of reasonable care to third parties when a patient threatens those parties.7 This holding set off an avalanche of criticism within the medical8 and legal professions.9 The critics argued that confidentiality10 and the inability to predict dangerous behavior placed an unreasonable burden on psychotherapists.11 This Note rejects both these arguments and maintains that the

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6. This figure was computed by adding the total number of psychologists (44,000) and psychiatrists (38,000) together (82,000) and multiplying by .376 (the percentage of psychologists and psychiatrists who reported giving a warning within the last year)(82,000 x .376 = 30,832) to equal 30,832 dangerous patient warnings by psychotherapists each year. Note, Survey, supra note 5, at 179 n.75.

7. For purposes of this Note, confidentiality refers to the psychotherapist's professional obligation to keep his patient's disclosures private.


10. If the definition of psychotherapist were to be expanded to include social workers with master's degrees (approximately 50,000) the number of warnings would increase to 49,632.

11. See supra notes 8 & 9.
majority of psychotherapists do not believe in or practice strict confidentiality and that predicting dangerousness is something psychotherapists do quite often. Moreover, a utilitarian approach would require that psychotherapists protect third parties.

It is asserted that requiring such a duty would provide a greater benefit to society than not imposing such a duty. The benefits would flow to the patient in that he would receive proper treatment and rehabilitation. This

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12. A survey of 1,272 Californian psychotherapists in 1978, conducted by the Stanford Law Review and the California Psychiatric Association, found that 69.7% of the psychotherapists thought a breach of confidentiality could be justified and 49.7% had warned a third party prior to Tarasoff. Note, Survey, supra note 5, at 176 n.65 & 183 n.97. The Survey results compare favorably with two more recent studies. Shuman & Weiner, The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege, 60 N.C.L. REV. 893, 934-38 (1982) [hereinafter Shuman & Weiner] (51% of the 79 therapists had warned a third party and 88% said confidentiality was not absolute); Beck, When the Patient Threatens Violence: An Empirical Study of Clinical Practice after Tarasoff, 10 AM. ACAD. PSYCHIATRY & L. No. 3 (1978) [hereinafter Beck] (16 psychiatrists out of 38 had given warnings and 36 of 38 said they accepted the Tarasoff duty).

In addition, Dr. Alfred Freedman, Past President of The American Psychiatric Association, agrees that a breach of confidentiality is appropriate in a Tarasoff situation. See N.Y. Times, Dec. 25, 1974, at 15, col. 2 quoted in Slovenko, supra note 9, at 393. Freud published case histories asserting he had a duty to science, the profession, and society regarding the study and cure of personality disorders. See S. FREUD, NOTES UPON A CASE OF OBSESSIONAL NEUROSIS cited in 7 J. STRACHEY, STANDARD EDITION OF THE COMPLETE PSYCHOLOGICAL WORKS OF SIGMUND FREUD 7-9 (1964). See also Slovenko, supra note 9, at 382 n.24.

13. The Stanford Survey found that a significant number of psychotherapists had predicted dangerous behavior by a patient prior to Tarasoff and in the one year subsequent to Tarasoff. (573 psychotherapists had warned either the police or a third party prior to Tarasoff and 426 psychotherapists had warned the police or a third party subsequent to Tarasoff). Note, Survey, supra note 5, at 179 n.76.


14. Utilitarianism is "a doctrine that the useful is the good and that the determining consideration of right conduct should be the usefulness of its consequences . . . ." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 2525 (1981).


16. "North Carolina courts have stated that "[i]n a real sense the [involuntary commitment] proceeding is an important step in [a patient's] medical and psychiatric treatment." Currie v. United States, 644 F. Supp. 1074, 1081 (M.D.N.C. 1986) (quoting In re Farrow, 255 S.E.2d at 777, 780 (N.C. Ct. App. 1979)).
would in turn prevent criminal and civil proceedings resulting from the fruition of the threatened activity. The psychotherapist will benefit his patient by getting him the necessary treatment and saving the patient from civil and criminal proceedings.17 In addition, the psychotherapist's conscience and professional responsibility18 will be satisfied. Moreover, the psychotherapist's duty to society, safeguarding the public from dangerous patients, is covered.19 The innocent third party will benefit in that they will not suffer a threatened attack. Society regains trust in the psychotherapist in that dangerous patients are not endangering third parties.20 Further, the human resources, the patient and the third party, are safeguarded for productive enterprises. The justice system, both civil and criminal, is spared the time and expense of proceedings resulting from the threatened altercations. The negatives, or costs, arising from the Tarasoff duty are the lost liberty of the patient and the psychotherapist's possible loss of the patient. However, the

17. See, e.g., Currie v. United States, 644 F. Supp. at 1077. ("A North Carolina Court of Appeals opinion, In re Farrow, 41 N.C. App. 680, 255 S.E.2d 777 (1979), has cited Tarasoff with seeming approval when discussing a psychotherapist's duty to disclose when necessary to protect his patient. . . ."); See also McIntosh v. Milano, 168 N.J. Super. 466, 491-93, 403 A.2d 500, 512-13 (1979).

18. "[The principle of professional obligation] would require a person who enters an occupation in which he reasonably can expect to have an increased chance of finding a helpless or endangered person to take affirmative steps to protect such a person." Note, Professional Obligation and the Duty to Rescue: When Must a Psychiatrist Protect His Patient's Intended Victim? 91 YALE L.J. 1430, 1431 (1982).


20. In this risk-infested society we can hardly tolerate the further exposure to danger that would result from a concealed knowledge of the therapist that his patient was lethal. . . . [W]e see no sufficient societal interest that would protect and justify concealment. The containment of such risks lies in the public interest.

Tarasoff, 17 Cal. 3d at 442, 551 P.2d at 347-48, 131 Cal. Rptr. at 27-28.

The power and status that psychotherapists enjoy in our society is most evident in their commitment powers. Ennis & Litwack have noted this unique power:

In many states persons who are not considered physically dangerous to themselves or to others can be hospitalized involuntarily even without judicial proceedings, if two psychiatrists certify that the prospective patient is "mentally ill" and in need of treatment. No state authorizes two laymen—a grocer and a clerk for example—to hospitalize a neighbor simply because the laymen believe he or she is mentally ill and in need of treatment. This extraordinary power is given to psychiatrists but not to laymen because legislators and judges assume that psychiatrists are uniquely qualified to determine when an individual requires hospitalization.

Ennis & Litwack, supra note 13, at 695.
benefits outweigh the costs.\textsuperscript{21}

Part I of this Note will review \textit{Tarasoff v. Regents of University of California},\textsuperscript{22} the 1976 California Supreme Court decision which established the psychotherapists' duty of reasonable care to third parties. Special attention will be given to the confidentiality and prediction of dangerousness arguments. This Note will also address subsequent case law and legislative action. In conclusion, this Note will argue that such a duty is correct based upon current practice and utilitarian theory.

I. \textit{Tarasoff v. Regents of University of California: The Duty of Reasonable Care}

On October 27, 1969, Prosenjit Poddar stabbed Tatiana Tarasoff to death.\textsuperscript{23} The murderer's motivation was unrequited love.\textsuperscript{24} Prior to the murder, Poddar had been in therapy at the University of California's Cowell Memorial Hospital.\textsuperscript{25} During therapy Poddar disclosed that he wanted to kill Tarasoff.\textsuperscript{26} The psychologist, Dr. Lawrence Moore, consulted with two psychiatrists, Doctors Gold and Yandell, and jointly agreed that emergency, involuntary commitment was necessary.\textsuperscript{27} The campus police were alerted and instructed to detain Poddar. The police detained Poddar, but subsequently released him based upon their independent evaluation.\textsuperscript{28} The Director of Cowell Memorial Hospital's Psychiatry Department, Dr. Powelson, reviewed and reversed the decision to seek emergency, involuntary commit-
ment proceedings against Poddar. No effort was made to warn Tatiana Tarasoff.

Tarasoff's parents brought suit against the University, the doctors, and the campus police. The trial court granted defendants' demurrer to plaintiffs' complaints without leave to amend. The California Supreme Court reversed.

Judge Tobriner, writing for the court, held that: "When a therapist determines, or pursuant to the standards of his profession should determine that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against danger." This duty of reasonable care was predicated on the foreseeability of Poddar killing Tarasoff and the special relationship between the doctors and Poddar.

The court recognized that the common law does not impose a duty on an individual to protect third parties from the actions of another, the reason being nonfeasance by the individual. Morally, this position has been attacked. The exception to the nonfeasance rule is based upon the existence of a special relationship. The court declared that the therapist-patient relationship fell within the exception. This finding of a special relationship is consistent with the psychotherapist-patient evidentiary privilege recognized by California and twelve other states. But for this special relationship,

29. Id.
30. 33 Cal. App. 3d 275, 108 Cal. Rptr. 878 (1973) (Superior Court of Alameda County, No. 405694, Robert L. Bostick, Judge).
31. Tarasoff, 17 Cal. 3d 425, 430.
33. Id, 17 Cal. 3d at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20 (J. Wright, Sullivan & Richardson J.J. joined the opinion).
34. Id. at 434-35, 551 P.2d at 342-43, 131 Cal. Rptr. at 22-23.
35. Id. See generally RESTATEMENT (SECOND) OF TORTS § 314 (1974). The courts have recognized the following relationships that fall within the exception: carrier-passenger; innkeeper-guest; ship-seaman; employer-employee; shopkeeper-business visitor; jailer-prisoner; school-pupil; husband-wife; parent-child; landlord-tenant; tavern keeper-intoxicated patron. W. PROSSER & W. KEETON, THE LAW OF TORTS § 56 at 383-85 (1984); Harper & Kime, The Duty to Control the Conduct of Another, 43 YALE L.J. 886, 886-87 (1934).
36. Bohlen, The Moral Duty to Aid Others as a Basis of Tort Liability, 56 U. PA. L. REV. 217 (1908). But see I. KANT, THE METAPHYSICAL ELEMENTS OF JUSTICE (J. Ladd, trans. 1965) (Kant argues that it would be unjust to require a rescue because an individual's freedom would be curtailed by this duty).
38. Tarasoff, 17 Cal. 3d at 436, 551 P.2d at 343, 131 Cal. Rptr. at 23.
there would not be an evidentiary privilege.

Once the special relationship was found, Judge Tobriner suggested that affirmative duties flow to third parties.\textsuperscript{40} His examples included the negligent release of dangerous mental patients, the failure to diagnose contagious diseases, the failure to warn third parties of a contagious disease, and the duty to warn patients of the danger to themselves or others.\textsuperscript{41} This extension of duty is logical in that "[c]onventional psychotherapy encourages patients to vent previously restrained hostility; many patients will confide a desire to kill. . . ."\textsuperscript{42}

Moreover,

\[ \text{[A therapist's] participation is at times neither neutral nor innocent. Since a frequent goal of treatment is to encourage the patient to discharge suppressed feelings, including aggression and even anger, therapy often involves a period of increased instability immediately preceding a breakthrough . . . The result in some instances is injury, even death, where no such tragedy might have occurred but for the therapy.}\textsuperscript{43}\]

This course of prodding emotional instability leads to a duty to protect the patient from himself and the third party. In addition, the therapist creates a duty to protect the third party from the patient because the therapist provoked the instability. Analogies to dangerous instrumentalties and parent-child (patient's mental state equated to child) situations are quite accurate. Therefore, the psychotherapist, as a provocateur, should have an affirmative duty to third parties.


The research indicates that 40 states and the District of Columbia recognize a psychologist-patient privilege; 9 states recognize a psychiatrist-patient privilege; and 36 states and the District of Columbia recognize a physician-patient privilege. \textit{See} Shuman \& Weiner, \textit{supra} note 12, at 907-11 n.100 for state code citations.

Further support for the assertion that the psychotherapist-patient relationship is special is drawn from Proposed Federal Rule of Evidence 504, \textit{Psychotherapist-Patient Privilege}. That rule rejected a general doctor-patient privilege, yet advocated a psychotherapist-patient privilege. The proposed rule was defeated due to the view that the general doctor-patient privilege was very important and that the psychotherapist-patient privilege was part of that general privilege. 56 F.R.D. 183, 240-44 (1972). \textit{See} Saltzburg, \textit{Privileges and Professionals: Lawyers and Psychiatrists}, 66 VA. L. REV. 597, 620 (1980).

40. 17 Cal. 3d at 435-36, 551 P.2d at 343-44, 131 Cal. Rptr. at 23.
41. \textit{Id.} at 436-37, 551 P.2d at 343-44, 131 Cal. Rptr. at 23-24.
42. Note, \textit{Survey, supra} note 5, at 186 n.111.
A. Predicting Dangerousness

First, the court considered the argument that therapists do not have the ability to predict dangerousness. Judge Tobriner analogized psychotherapists to physicians and held: "Th[e] judgment of the therapist in diagnosing emotional disorders and in predicting whether a patient presents a serious danger of violence is comparable to the judgment which doctors and professionals must regularly render under accepted rules of responsibility." The court clarified the standard by stating: "Obviously we do not require that the therapist, in making that determination render a perfect performance; the therapist need only exercise 'that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [that professional specialty] under similar circumstances.'" Because Dr. Moore had predicted that Poddar would kill Tarasoff, the inability to adequately predict dangerousness argument was dismissed as irrelevant.

The analogy between physicians and psychotherapists is appropriate in that diagnosis and predictions of dangerousness are part of their medical training and professional work. Each state provides for emergency commitment based largely on the testimony of a psychotherapist. If the states did not have the confidence in the ability of the psychotherapist to accurately predict dangerousness, states would not allow psychotherapist testimony to commit people. How can society trust psychotherapists to evaluate and treat mental disorders? The profession denies responsibility for dangerousness predictions while assuming the power to commit individuals. Certainly, the therapists' place as an expert testifying in commitment pro-

44. Tarasoff, 17 Cal. 3d at 437-40, 551 P.2d at 344-46, 131 Cal. Rptr. at 24-26.
45. Id. at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25.
46. Id.
47. Tarasoff, 17 Cal. 3d at 438-39, 551 P.2d at 345, 131 Cal. Rptr. at 25.
48. See supra notes 12 & 13. However, Bruce Ennis, a New York Civil Liberties Union staff attorney on the Mental Health Law Project, and Thomas Litwack, an attorney and Assistant Professor of Psychology at the City University of New York, John Jay College of Criminal Justice, have attacked the psychotherapy profession for its claimed "expertise" in diagnosing and predicting dangerousness. The data indicates a high degree of unreliability. Therefore, the psychotherapist's expert testimony regarding dangerousness should not be accorded deference by judges, juries, and lawyers. Ennis & Litwack, supra note 13, at 694-95.
50. Judge Petrella asked the same question in McIntosh v. Milano, 168 N.J. Super. 466, 493-95, 403 A.2d 500, 514 (1979): "If psychiatrists now say, as is argued in the brief of defendant and the articles submitted in support thereof, that therapists are no more accurate than the average layman [in predicting dangerousness], serious questions would arise as to the entire present basis for commitment procedures."
ceedings is entrenched, therefore the ability to predict dangerousness is a complimentary burden.

B. Confidentiality

The court also considered, and rejected, the defendant’s strict confidentiality argument. The key, in the majority’s view, was California Evidence Code section 1024: “There is no privilege... if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger.”

This balancing by the legislature was deemed determinative of the competing confidentiality and public interest in safety issues. Additionally, the majority pointed to the American Medical Association’s Principles of Medical Ethics as allowing the disclosure of confidences.

The rejection of the strict confidentiality argument coincides with the majority of psychotherapists who do not believe in or practice strict confidentiality. In 1978, the Stanford Law Review, in cooperation with the California Psychiatric Association, conducted a survey of Californian psychotherapists. A total of 3,685 questionnaires were sent to psychologists and psychiatrists. 1,272 or thirty-five percent (35%) responded. Nearly seventy percent (70%) of the respondents felt that confidentiality could be breached, and fifty percent (50%) of the respondents had warned a third party prior to Tarasoff. This finding is in accord with other sources.

Furthermore, the rejection of strict confidentiality is beneficial to all par-
ties: patient, psychotherapist, third party, and society. From the patient's point of view he is benefitted by receiving the treatment he needs without the trauma of following through on his threat. Certainly, the patient's involuntary detention or betrayed confidence is less important than committing the murder, and suffering the criminal and civil proceedings, together with the lifelong shame of committing murder. Secondly, the psychotherapist will benefit by protecting his patient, third parties, society, and profession from the murder. This multifaceted affair would scar his patient for life; generate a negative image in society of the profession and patients in general; burden the justice system with criminal and civil proceedings; and unnecessarily sacrifice an innocent party's life. Obviously, the third party would benefit by staying uninjured. Finally, society would benefit from a safer environment. Dangerous patients might be rendered harmless and rehabilitated to contribute to society. Psychotherapists would enjoy a better reputation by fulfilling their obligation to maintain a safe society. Third parties would enjoy a safe environment, prosper and thereby enhance society.

C. Other Opinions

Judge Mosk concurred and dissented. He agreed with the result based upon the fact that the therapist had actually predicted the murder of Tatiana Tarasoff but he dissented from a rule holding therapists negligent for failing to predict violence based upon community standards.


62. Many authorities assert that patient threats are cries for help to the therapist asking for control from the violent urges. J. Lion, Evaluation and Management of the Violent Patient (1972); Slovenko, supra note 9, at 393 (1975); Solzman, Truth, Honesty, and the Therapeutic Process, 130 Am. J. Psychiatry 1280 (1973).

63. A patient in treatment has the right to expect from his therapist a rescue intervention in the face of realistic danger. To be the perpetrator of a homicide is one of the most self destructive actions one can take. The therapist as a human being also has an obligation to an innocent victim and, last but not least, he has a duty to his own human dignity. . . .


64. Tarasoff, 17 Cal. 3d at 442, 551 P.2d at 347-48, 131 Cal. Rptr. at 27-28.

65. Id. at 451, 551 P.2d at 353, 131 Cal. Rptr. at 33.

66. Id. at 451-52, 551 P.2d at 353-54, 131 Cal. Rptr. at 33-34.
The Judge accepted the argument that psychotherapists are unable, to any reliable degree, to predict dangerousness. Implicitly, he would strip psychotherapists of their power regarding emergency involuntary commitment and expert witness status in judicial proceedings. This idea has been endorsed by several commentators.67

In dissent, Judge Clark argued that the Lanterman-Petris-Short Act68 bars disclosure by the psychotherapists. Alternatively, Judge Clark argued that the common law and public policy favor nondisclosure.69 He suggested that warnings would increase violence while diminishing or even negating therapeutic treatments. This result would unjustly impinge on patient rights while taxing society.70

Judge Clark’s theory assumes too much. First, the patient and psychotherapist are given credit for the prevention of dangerousness. No statistics are given regarding the deterrent effect disclosure has on patients seeking treatment, successful treatment, violence, or civil commitment.71 Three subsequent empirical studies indicate Judge Clark is incorrect.72 One commentator summed up the research as:

[C]ontrary to the fears of [Tarasoff psychotherapist] amici and others, the warnings given seldom had an adverse effect on the therapeutic relationship. Only warnings that were not discussed with the patient or one which was given without good reason were judged to be harmful to the therapeutic relationship. . . .

A warning that is discussed strengthens an alliance because the therapist demonstrates to the patient the ability to retain his therapeutic concern even in the face of imminent danger.

67. See, e.g., Ennis & Litwack, supra note 13, at 735-43. See also supra note 42.
68. CAL. WELF. & INST. CODE § 5000, (West 1987).
69. Tarasoff, 17 Cal. 3d at 457-64, 551 P.2d at 358-62, 131 Cal. Rptr. at 38-40.
70. Id. at 460-62, 551 P.2d at 360-61, 131 Cal. Rptr. at 40-41.
71. Id. at 458-73, 551 P.2d at 358-62, 131 Cal. Rptr. at 38-42.
72. Id. See Survey, supra note 5, at 182 n.90 (data indicates little if no decline in the number of patients seeking treatment after Tarasoff). “There has been no credible evidence either that the practice of psychotherapy has suffered or the violence within our society has increased because of the imposition of such a duty.” See also Goodman, 3 BEHAV. SCI. & L. 195, 219 (1985) (quoted in Currie v. United States, 644 F. Supp. 1074, 1082 (M.D.N.C. 1986)).

Shuman & Weiner, supra note 12, at 918-19 (data indicated that patients were not deterred from seeking psychiatric help prior to the evidentiary privilege); Id. at 926-27 (data also indicated no psychological harm upon disclosure); Beck, supra note 12, at 193-94 (in 14 cases when the warning was discussed with the patient prior to informing the third party no adverse effect was seen, whereas four cases of no prior discussion rated a 75% negative effect on therapy); Id. at 193 (in 26 cases warnings of violence occurred three times); Shuman & Weiner, supra note 12, at 936 (only 1 case of violence was reported); Regarding civil commitment, the studies were vague on this point reporting between three and four hospitalizations. Shuman & Weiner, supra note 12, at 936; Beck, supra note 12, at 193.
Finally, this study provides a basis on which to conclude the Tarasoff decision is not inimical to good clinical practice and may actually be beneficial to it.\textsuperscript{73}

Moreover, too little credit and concern is given to the third party and society. It may be asserted that if the shoe was on the other foot, i.e., Judge Clark was substituted for Ms. Tarasoff, the Judge would favor disclosure. Third parties and society deserve the benefit of the doubt when an unstable person admits to plotting a violent act. Therefore, Justice Clark's dissent is skewed against the greater good of society.

\section{Post Tarasoff Developments}

\subsection{Case Law Developments}

In the eleven years since Tarasoff, nine cases and several legislative proposals have considered the issue.\textsuperscript{74} The cases have followed a three-pronged analysis: 1) whether a special relationship existed; 2) whether specific threats were made; and 3) whether the victim was readily identifiable.\textsuperscript{75} If such conditions exist, the therapist owes the Tarasoff duty.

As to the first prong, whether a special relationship exists, the majority of courts have accepted a psychotherapist-patient relationship as a special relationship.\textsuperscript{76} This is logical in that most states recognize the doctor-patient

\footnotesize
\textsuperscript{73} Beck supra note 12, at 199-201.

\textsuperscript{74} For cases considering the issue, see: Brady v. Hopper, 751 F.2d 329 (10th Cir. 1984) (President Reagan's press secretary, James Brady, sued a psychiatrist for injuries resulting from John Hinckley's assassination attempt on the president); Jablonski v. United States, 712 F.2d 391 (9th Cir. 1983) (Federal Tort Claims Act suit for damages due to auto accident with army veteran: no negligence was found); Currie v. United States, 644 F. Supp. 1074 (M.D.N.C. 1986) (wrongful death action against the Veterans' Administration for the negligent release of a psychiatric out patient who subsequently killed a fellow IBM employee); Hasenei v. United States, 541 F. Supp. 999 (D. Md. 1982) (Federal Tort Claim Act suit for damages due to auto accident with army veteran); Doyle v. United States, 530 F. Supp. 1278 (C.D. Cal. 1982) (wrongful death action by the estate of a security guard against the Army for negligently discharging an unstable serviceman who had been under psychiatric care); Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185 (D. Neb. 1980) (wrongful death action against Sears for selling a shotgun to out patient of Veterans' Administration psychiatric ward); Davis v. Lhim, 124 Mich. App. 291, 335 N.W.2d 481 (1983) (jury award upheld in wrongful death action against state hospital because staff psychiatrist negligently released patient who killed his mother); McIntosh v. Milano, 168 N.J. Super. 466, 403 A.2d 500 (1979) (wrongful death action against psychiatrist because teenage patient killed his girlfriend); Peck v. Counseling Service of Addison County, Inc., 146 Vt. 61, 499 A.2d 422 (1985) (parents of mental out patient sued health agency for loss of barn, burned down by patient) [hereinafter cases]. See infra, notes 93-110 and accompanying text regarding legislative proposals.

\textsuperscript{75} See cases supra note 74.

\textsuperscript{76} Id. But see Hasenei v. United States, 541 F. Supp. 999 (D. Md. 1982); Doyle v. United States, 530 F. Supp. 1278 (C.D. Cal. 1982).
evidentiary privilege.77 The psychotherapist-patient evidentiary privilege is either an implicit subset of the doctor-patient privilege or explicitly delineated by statute.78 All evidentiary privileges are based upon special relationships.

However, one court maintained that an outpatient-psychotherapist situation did not satisfy the special relationship standard.79 This holding was based upon the lack of control or authority by the psychotherapist. This position has been explicitly rejected by two other courts.80 In addition, several commentators have rejected the outpatient distinction.81 Moreover, the psychotherapist-patient evidentiary privilege does not make a distinction between inpatients and outpatients. Appreciating the fact that Tarasoff involved an outpatient, the outpatient distinction is unwise in that the duty is owed to a third party to whom the distinction is meaningless.

The second prong, whether specific threats were made, has created a split in the courts. Some courts follow a narrow construction, while others adhere to an expansive construction.82 The majority of courts have adopted the strict construction of specific threats in an effort to limit the scope of the psychotherapist's duty.83 The narrowing of this prong is appealing in that specificity lends credibility to the patients' intentions. Moreover, the speci-

81. See, e.g., Slovenko, supra note 9, at 395 ("In principle, there is no rationale in law for making a distinction between outpatients and inpatients, though in the latter case there is a degree of physical control."); Fleming & Maximov state: The rationale behind these [custodial control] cases, however, does not support a distinction between inpatients and outpatients. Admittedly, the degree of control over the latter may well be much less than over the former, and this would certainly be relevant in determining what protective measures could reasonably be expected, but it would not justify a complete negation of duty.
ficity of the threat allows the therapist to evaluate whether the patient would carry it out.\textsuperscript{84}

The final prong, a readily identifiable victim, has attracted a distinct majority in favor of narrow construction.\textsuperscript{85} The majority argues that unless the victim is readily identifiable, general public warnings would be necessary. These warnings would not be beneficial in that the public would not take defensive measures, the warnings would reduce limited government resources, and patients would be stigmatized and their rehabilitation hampered.\textsuperscript{86} The limiting of a readily identifiable victim is logical because thousands of paroled criminals and mental patients are released into the general population each year. The cost, both financial and psychological, to the public and patients for such a warning system would be unacceptable.

Regarding the subject of strict confidentiality, the courts that have considered the question were unanimous in their rejection of the argument.\textsuperscript{87} This
is logical in that psychotherapists do not practice strict confidentiality and all parties would benefit from disclosure. The patient would be rendered harmless. The therapist would make society safer and encourage greater societal trust in therapy as a social benefit. The third party would defend the patient, continue to be a productive member of society, and appreciate therapy as a beneficial and protective tool. Finally, society would benefit from fewer Tarasoff type murders, fewer court cases, fewer prisoners, and an increased trust in therapists.

Similarly, the courts have resoundingly denied the argument that therapists are unable to predict a patient's potential dangerousness. The courts only hold the therapist to a reasonableness standard which is measured by the community's professionals. The analogies are to medical doctors who diagnose and prescribe treatment for contagious diseases. In McIntosh v. Milano, Judge Petrella pointed to the inconsistency of the psychotherapists' position:

Defendant also claims that the imposition of a Tarasoff type duty may deter therapists from treating potentially violent patients in light of possible malpractice claims by third parties. . . . If the psychiatrist claims inability to predict dangerousness or detect a dangerous person, how will he make the determination to weed out 'potentially violent patients'?

. . .

If psychiatrists now say . . . that therapists are no more accurate than the average layman, serious questions would arise as to the entire present basis for commitment procedures.

Therefore, psychotherapists must accept the duty or abdicate from their claimed position of expertise.

ski v. United States, 712 F.2d 391 (9th Cir. 1983) (implicit because duty to use reasonable care was found applicable).

88. Patient confidences are breached during consultations with other doctors, research, and published case histories. Slovenko, supra note 9, at 380-84. Dangerous patient disclosures were treated in the preceding section.


91. 168 N.J. Super. at 466, 403 A.2d at 500.

92. Id. at 493-95, 403 A.2d at 514.
B. Legislative Proposals

The negative response that greeted the Tarasoff decision spurred several legislative proposals. These proposals acknowledge the legitimacy of the Tarasoff duty. Their import is to limit liability to the narrow strictures of Thompson v. County of Alameda,93 by requiring specific threats to a readily identifiable victim.

1. The California Amendment

In 1985, the California legislature amended its Civil Code § 43.92 to read:

(a) There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist as defined in Section 1010 of the Evidence Code in failing to warn of and protect from a patient's threatened violent behavior or failing to predict and warn of and protect from a patient's violent behavior except where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.

(b) If there is a duty to warn and protect under the limited circumstances specified above, the duty shall be discharged by the psychotherapist making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.94

The legislative history of this provision explains that the amendment limits the psychotherapists' liability to situations "where the patient has communicated to the psychotherapist a serious threat of violence against a reasonably identifiable victim."95 Implicitly this language limits Tarasoff.96 Unfortu-
nately the effect of this language has yet to be construed by California courts.97

2. APA's Model Bill

Also in 1985, the American Psychological Association circulated a model bill:

(1) No monetary liability and no cause of action may arise against any [psychologist or psychiatrist/psychotherapist/service provider licensed under Chapter ——] for failing to predict, warn of or take precautions to provide protection from a patient's violent behavior unless the patient has communicated to the [psychologist or psychiatrist/psychotherapist/service provider licensed under Chapter ——] an actual threat of physical violence against a clearly identified or reasonably identifiable victim.

(2) The duty to warn of or to take reasonable precautions to provide protection from violent behavior arises only under the limited circumstances specified in subsection (1) of this section. The duty shall be discharged by the [psychologist or psychiatrist/psychotherapist/service provider licensed under Chapter ——] if reasonable efforts are made [to communicate the threat to the victim or victims] or [to seek civil commitment of the patient under Chapter ——] or [to notify the police department closest to the patient's (or the victim's ) residence of the threat of violence].

(3) No monetary liability and no cause of action may arise under Chapter —— [patient privacy and confidentiality act] against any [psychologist or psychiatrist/psychotherapist/service provider licensed under Chapter ——] for confidences disclosed to third parties in an effort to discharge a duty arising under subsection (1) of this section according to the provisions of subsection (2) of this section.98

This proposal is very similar to the California legislation. Obviously, it attempts to limit the psychotherapist's liability and delineates how he might discharge his Tarasoff duty. This approach adopts the Thompson standard which narrowly construes the specific threats against a readily identifiable

96. Id.
97. This author's research does not indicate any cases construing this language.
98. LEGAL ISSUES, NAT'L ASS'N OF STATE MENTAL HEALTH PROGRAM DIRECTORS (Oct. 1985).
victim. This legislative proposal, much like the California legislation, is desirable in that psychologists should have general guidelines to follow. The California legislation has not yet been construed by the courts and the desired narrowing is speculative at best.

3. Dr. Salter's Proposal

Dianne S. Salter, Ph.D., has proposed a model statute. This statute,


Section 1. DEFINITIONS

As used in this article, the following words and phrases shall have the meanings given them in this section.

(1) Mental health professional. Persons with professional training, experience and demonstrated competence in the treatment of mental illness, or a trainee working under the direct supervision of a person with such training and performing the duties usually performed by such a person. Such persons shall include, but not be limited to, physicians, psychologists, social workers, nurses, or other qualified persons designated by statute to practice psychotherapy or counseling.

(2) Patient. A person who has entered into a contractual or quasi-contractual agreement with a mental health professional to receive psychotherapy or counseling for the amelioration of emotional or mental health concerns. The following persons SHALL NOT be considered a patient under this article: (a) a person who merely initiates a telephone contact with a mental health professional; (b) a person who is merely seen for an initial consultation; (c) a person who is being seen only for evaluative purposes.

(3) Outpatient setting. An office, facility or clinic, or part thereof, which offers mental health services in a nonrestrictive environment. Such a setting does not offer restrictive confinement or involuntary treatment.

(4) Readily identifiable individual. A person whose identity can be ascertained from the information given by the patient, either by use of a name, an accurate description of the person, or a location at which the person can be found.

Section 2. MANDATED DUTY

A mental health professional, performing services in an outpatient setting, has an affirmative duty to take reasonable steps to report the threats of a patient that the mental health professional has determined presents a foreseeable danger to a readily identifiable individual or group of individuals.

Section 3. IMPLEMENTATION

(1) The mental health professional shall discharge his duty by taking the following steps: (a) FIRST, if reasonable, secure the patient's permission to immediately contact the person whose life is in danger and hold a joint consultation to attempt to resolve the conflict that is precipitating the patient's action.

If that course of action is not reasonable or successful, then (b) SECOND, attempt to persuade the patient to voluntarily commit himself or herself for evaluation and inpatient treatment.

If that course of action is not reasonable or successful, then (c) THIRD, institute
much like the California and APA offerings, attempts to narrow and clarify the psychotherapist's duty. For example, in defining "patient", the proposal specifically excludes initial consultations and evaluative contacts. Implicitly, these exclusions are based on the lack of an established relationship. The argument would be made that the therapist did not have sufficient time to evaluate the dangerousness of the patient. This limitation is initially appealing. However, a hypothetical can be derived which demonstrates such blanket exclusions to be unwise. Imagine Charles Manson dropping in at the local therapist's for a free initial consultation. Certainly Mr. Manson's tattoo, a Nazi swastika, positioned proudly between his eyes, his claim to being Jesus Christ, and his assertions that the deaths of particular people would benefit the community, should impose a duty on that therapist. Unfortunately, the definition would immunize the therapist.

Similarly, Dr. Salter's definition of "readily identifiable individual" is too narrow. The language limits the information to that generated by the patient. This provision could be construed that the therapist need not attempt to collect information about the patient from other sources, such as proceedings to have the patient involuntarily committed for evaluation and inpatient treatment.

If that course of action is not reasonable or successful, then (d) FOURTH, notify the local police, making them aware of the patient's name, his or her description, his or her last known whereabouts, the name and any available information about the individual who is in danger of harm because of the patient's threats.

(2) The mental health professional will fully cooperate with the police authorities when that course of action is necessary.

Section 4. CONFIDENTIALITY

Any information disclosed as a result of the mental health professional's discharging of the duty mandated by this article, shall not be considered a breach of their ethical and/or statutory duty to keep confidential all information communicated by the patient.

The duty is based on the public policy consideration that when the state grants to certain professionals a license, certificate or right to practice psychotherapy, that grant includes an obligation to the public. Included in that obligation is a duty to initiate protective measures for identifiable persons who are in foreseeable danger from a patient of that mental health professional. Since our society has designated agents whose specific duty is the protection of its citizens, the mental health professional should contact these agents, fully appraising them of the nature of the situation (persons involved, the kind of harm likely to be involved, etc.). If the patient can be deterred by changing the therapeutic parameters or validly detained through involuntary commitment, those measures may be taken in lieu of notifying the police.

101. Id. (Section 1. DEFINITIONS (2) Patient).

102. Consider the case of a person telling the therapist that he had just placed a time bomb in a children's day care clinic across the street. In such a situation would the therapist have a duty under the proposal?

103. Salter, supra note 100, at 162. (Section 1. DEFINITIONS (4) Readily identifiable individual).
hospitals, clinics, and the government. However, many courts have recognized the therapist's duty to acquire information from outside sources when necessary. Therefore, such a limitation goes against the therapists' duty of reasonable care.

Significantly, the proposal has a four-step implementation section. The therapist is given a flexible approach to the duty depending upon the situation. This flexible approach is in accord with Tarasoff. Step one, "if rea-

104. Three examples follow: Jablonski v. United States, 712 F.2d 391, 398 (9th Cir. 1983): unlike the killer in Tarasoff, Jablonski made no specific threats concerning any specific individuals. Nevertheless, Jablonski's previous history indicated that he would likely direct his violence against Kimbal. He had raped and committed other acts of violence against his wife. His psychological profile indicated that his violence was likely to be directed against women very close to him. This, in turn, was borne out by his attack on Pahls. Thus, Kimbal was specifically identified or "targeted" to a much greater extent than were the neighborhood children in Thompson.

The finding that Kimbal was a foreseeable victim was dependent on the district judge's finding that the doctors had been negligent in failing to obtain Jablonski's prior medical history.


The trial court nonetheless found that the therapist was negligent, and did not act as a reasonably prudent counselor, because her good faith belief was based on inadequate information and consultation.... The evidence also revealed that at the time of John's treatment the therapist was not in possession of John's most recent medical history. The Counseling Service did not have a cross-reference system between its therapists and outside physicians its therapists and outside physicians who were treating the medical problems of its patients. Nor did the Counseling Service have any written policy concerning formal intra-staff consultation procedures when a patient presented a serious risk of harm to another. The defendant's own expert testified that a therapist cannot make a reasonable determination of a patient's propensity for carrying out a threatened act of violence, without knowledge of the patient's complete medical history.


As to the threat posed to Mollie Barnes in particular, the evidence consisted primarily of one entry in a hospital record. [An aunt had reported that the patient kept threatening the deceased]. We note first that these threats were directed to a specific person, not to the general public. Thus, Mollie Barnes was a readily identifiable potential victim. Second, the defendant was apparently aware of these threats, but found them too remote to have any significance. Nevertheless, a jury could have found that defendant should have realized these threats would recur after Patterson's discharge.

105. Salter, supra note 100, at 162. Section 3. IMPLEMENTATION (1).

106. Tarasoff, 17 Cal. 3d at 439, 551 P.2d at 345, 131 Ca. Rptr. at 25 (footnote omitted).

In our view, however, once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger. While the discharge of this duty of due care will necessarily vary with the facts of each case.... (emphasis added).
Patient Threats Against Third Parties

reasonable, secure the patient's permission to immediately contact the person whose life is in danger and hold a joint consultation to attempt to resolve the conflict that is precipitating the patient's action" is a good approach to the problem but it dodges the informed consent issue. Should the therapist tell the patient that unless he cooperates, his confidences will be breached? The issue of informed consent and waiver by the patient is clouded.

The remaining three steps provide for the therapist to first attempt to persuade the patient to seek voluntary commitment, then involuntary commitment, and finally notifying the police. This progression is logical in that the least restrictive means and patient dignity are accorded priority. However, that priority is not sacred and the final two steps focus more upon the interests of society and the third party than the interests of the patient.

Interestingly, warnings to the threatened third party are not mentioned in the final three steps. Implicitly, the therapist cannot warn the third party without the patient's consent. This goes against Tarasoff but is laudatory in that warning a third party would be of little use. Under the proposal, the police would be contacted, but there is no requirement that they contact the third party. The question is: What would you do if a therapist or the police called and said a dangerous patient might be on the way to kill you? Probably, you would move to have the person detained/committed, and leave the area for a time. Certainly paranoia would be an acceptable reaction.

Effectively, once a patient is determined to be dangerous, he should be committed. Otherwise, a warning to the third party would cause a paranoia which is patently unfair. Third party's paranoia could produce a preemptive strike against the patient. Therefore, the psychotherapist should safeguard the patient and the third party by committing the patient.

III. CONCLUSION

In sum, the psychotherapist owes a duty of reasonable care when evaluating patient threats against third parties. The exercise of this duty does conflict with the confidentiality of patient communications. However, a balancing of interests weighs in favor of disclosure. This affirmative duty of

107. Note, supra note 5, at 176-77 and accompanying notes. The survey indicates that the majority of psychotherapists do not inform their patients that their confidences will be breached under the appropriate circumstances. Twenty-five percent of the respondents indicated that the breach of confidentiality potentially cost them a patient. See also Shuman & Weiner, supra note 12 and Beck, supra note 12. One Commentator has suggested that a Miranda-type warning would ruin the therapeutic situation. Stone, supra note 8, at 369-70.

108. Stone, supra note 8, at 369-70. But see Fleming & Maximov, supra note 21, at 1059-60.

109. Salter, supra note 100, at 162-63. (Section 3. IMPLEMENTATION (1) (b-d)).

110. Stone, supra note 8, at 374. But see Beck, supra note 12.
disclosure is warranted because of the provocative nature of therapy which encourages the discussion of aggression and resulting emotional instability. Historically, psychotherapists have accepted this duty to disclose.

Regardless of the fact that they are inaccurate when predicting dangerousness, psychotherapists have assumed the experts position in our legal system and society. The experts mantle carries with it the burden of liability. This result will benefit the patient, psychotherapist, third party, and society. The patient will be protected from himself and reoriented as a productive member of society. The psychotherapist will fulfill his professional responsibility of keeping his patient, third party, and society safe. The third party will remain a productive member of society. Society will benefit from the three preceding beneficiaries and the savings of court costs, police power, and growing trust among the community.