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Tarasoff and the Psychotherapist's Duty to Warn

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TARASOFF AND THE PSYCHOTHERAPIST'S DUTY TO WARN

INTRODUCTION

The psychiatric profession has reacted with alarm to a recent California Supreme Court decision which it views as threatening the very basis of psychiatry—the psychiatrist-patient relationship.[1] The decision in *Tarasoff v. Regents of the University of California*[2] imposes on psychotherapists[3] who have reason to believe a patient may harm someone a duty to warn the potential victim. A strong dissent by Justice Clark claimed that the ruling will cripple the use of psychotherapy by destroying the confidentiality vital to the psychiatrist-patient relationship.

This Comment will highlight the issues of the therapist's duty to warn potential victims and the duty to confine dangerous patients. A more detailed emphasis is placed on confidentiality and privilege in the therapist-patient relationship and on the predictability of violence. These issues provide a background for an analysis of the potential effects of *Tarasoff* on the psychiatric profession and the practical problems arising from the decision.

Tarasoff v. Regents of the University of California

In 1967, Prosenjit Poddar, a Bengali Hindu of the Harijan (untouchable) caste, entered the University of California at Berkeley.[4] At folk dancing classes he met and fell in love with Tatiana Tarasoff. Poddar's attraction apparently was not shared by Tatiana who so informed him. A severe depression resulted from this re-

1. TIME, Jan. 20, 1975, at 56.

2. 13 Cal. 3d 177, 529 P.2d 553, 118 Cal. Rptr. 129 (1974). This Comment is based on the California Supreme Court decision of Dec. 23, 1974. A rehearing was granted and oral arguments were heard on May 5, 1975.

3. Psychotherapists include psychiatrists, clinical psychologists, clinical social workers, school psychologists, and marriage counselors. CAL. EVID. CODE § 1010 (West Supp. 1974).

4. The criminal action against Poddar is People v. Poddar, 10 Cal. 3d 750, 518 P.2d 342, 111 Cal. Rptr. 910 (1974).

buff manifesting itself in declining health and neglect of studies. After six months of languishing, Poddar sought psychiatric help as a voluntary out-patient at the Cowell Memorial Hospital at the University.

Plaintiffs alleged that during treatment with clinical psychologist Dr. Lawrence Moore, Poddar revealed his intent to kill Tatiana when she returned from a summer in Brazil. It was further alleged that two other doctors at the hospital concurred with Moore that Poddar was "at this point a danger to the welfare of other people and himself."[5] Moore wrote a letter of diagnosis to the campus police[6] requesting that they detain Poddar for a 72-hour emergency psychiatric detention for treatment and evaluation pursuant to Welfare and Institutions Code section 5150.[7] The campus police detained Poddar, but released him when he appeared rational and promised to stay away from Tatiana. Moore's superior, Dr. Powelson, then directed that no further action be taken against Poddar

5. Dr. Gold, who initially examined Poddar, and Dr. Yandell, assistant to the director of the department of psychiatry. *See* Dr. Moore's letter to the Chief of Police, *infra* note 6.

6. Letter from Dr. Moore to William Beall, Chief of Police, Aug. 20, 1969 on file with Clerk of the Supreme Court of California, *cited in* brief for Respondent Moore at 168, Tarasoff v. Regents, 13 Cal. 3d 177, 529 P.2d 553, 118 Cal. Rptr. 129 (1974).

> Mr. Poddar was first seen at Cowell Hospital by Dr. Stuart Gold June 5, 1969, on an emergency basis. After receiving medication he was referred to the outpatient psychiatry clinic for psychotherapy. Since then I have seen him here seven times.
>
> His mental status varies considerably. At times he appears to be quite rational, at other times he appears quite psychotic. It is my impression that currently the appropriate diagnosis for him is paranoid schizophrenia reaction, acute and severe. He is at this point a danger to the welfare of other people and himself. That is, he has been threatening to kill an unnamed girl who he feels has betrayed him and has violated his honor . . . .
>
> I have discussed this matter with Dr. Gold and we concur in the opinion that Mr. Poddar should be committed for observation in a mental hospital. I request the assistance of your department in this matter. *Id.*

7. Pursuant to the provisions of § 5150, a person may be detained for a period not exceeding 72 hours. A person detained for 72 hours under the provisions of § 5150 who has received an evaluation may be certified for not more than 14 days of involuntary intensive treatment under certain conditions. At the end of the 14-day period a person may be confined for an additional period not to exceed 90 days upon petition to the superior court when a person is a danger to himself or to others as a result of a mental disorder. CAL. WELF. & INST'NS CODE §§ 5150, 5250-54, 5300 (West 1972).

and that his records be destroyed. Two months later when Tatiana returned from Brazil, Poddar killed her with a butcher knife. No one had warned the girl or her parents of the threat. Plaintiffs, the victim's parents, brought a wrongful death action against the Regents, the campus police, and the hospital's doctors.

Justice Tobriner, writing for the majority, found that under the facts, plaintiffs could state a cause of action for negligent failure to warn. Addressing the issue of duty, the court stated:

> . . . we bear in mind that legal duties are not discoverable facts of nature, but merely conclusory expressions that, in cases of a particular type, liability should be imposed for damage done.[8]

The court recognized the general rule that there is ordinarily no duty to control the conduct of another or to warn those endangered by such conduct, but stated further that,

> . . . the courts have noted exceptions to this rule. In two classes of cases the courts have imposed a duty of care: (1) cases in which the defendant stands in some special relationship to either the person whose conduct needs to be controlled or in a relationship to the foreseeable victim of that conduct and (2) cases in which the defendant has engaged, or undertaken to engage, in affirmative action to control the anticipated dangerous conduct or protect the prospective victim.[9]

With respect to the first exception, the supreme court, in direct opposition to the appellate court,[10] held that the psychiatrist-patient relationship in itself was sufficient to demonstrate the requisite special relationship between the defendant psychiatrist and Poddar. In addition, the court found the second exception to be applicable. Poddar was picked up as a result of Dr. Moore's letter to campus police. The bungled attempt to confine Poddar was found to have increased the danger to Tatiana. The court reasoned that as a result of the incident, Poddar discontinued the psychiatric treatment which could have prevented the murder.[11]

The defendant therapist's immunity from liability depended on the court's interpretation of what constitutes a "discretionary act" under section 820.2 of the Government Code.[12]

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8. Tarasoff v. Regents, 13 Cal. 3d 177, 185, 529 P.2d 553, 557, 118 Cal. Rptr. 129, 133 (1974).

9. *Id.* at 186, 529 P.2d at 557, 118 Cal. Rptr. at 133 (citations omitted).

10. Tarasoff v. Regents, 33 Cal. App. 3d 275, 108 Cal. Rptr. 878 (1973).

11. Another issue raised in the opinion is whether the police have a duty to warn. Justice Tobriner wrote in brief and vague terms that the police had a duty to warn because the officer's attempt to control the anticipated dangerous conduct increased the risk of violence. As Justice Clark pointed out in his dissent, such a holding creates a new duty for police which could have broad implications. An adequate discussion of this issue, while significant, is beyond the scope of this Comment.

12. "[A] public employee is not liable for an injury resulting from his

> Noting that virtually every public act admits of some element of discretion, we drew the line of *Johnson v. State*,[13] between discretionary policy decisions which enjoy statutory immunity and ministerial administrative acts which do not.[14]

The court concluded that failure to warn of latent dangers was not a basic policy decision and therefore falls outside the scope of discretionary omissions immunized by the Government Code.[15]

Plaintiff's cause of action for failure of the hospital's psychiatrists to confine Poddar was dismissed under Government Code section 856,[16] which insulates a defendant from liability. Although an exception is provided for "injury proximately caused by . . . negligent act[s] or omission[s] in carrying out or failing to carry out . . . a determination to confine or not to confine a person for mental illness,"[17] such was held not applicable to the circumstances present in *Tarasoff*. Dr. Moore did make a determination to confine Poddar, but countermand of the order by Dr. Powelson, Moore's superior, was deemed by the court to be a constructive decision not to confine.[18] Defendant police were also immune from liability for failure to continue detention of Poddar under section 5154 of the Welfare and Institutions Code which states:

> [t]he professional person in charge of the facility providing 72-hour treatment and evaluation, his designee, and the peace officer responsible for detainment of the person shall not be held civilly or criminally liable for any action by a person released at or before the end of 72 hours. . . .[19]

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act or omission where the act or omission was the result of the exercise of the discretion vested in him, whether or not such discretion was abused." CAL. GOV'T CODE § 820.2 (West 1966).

13. 69 Cal. 2d 782, 447 P.2d 352, 73 Cal. Rptr. 240 (1968).

14. 13 Cal. 3d at 193, 529 P.2d at 562, 118 Cal. Rptr. at 138.

15. *See* Underwood v. United States, 356 F.2d 29 (1966).

16. "Neither a public entity or public employee acting within the scope of his employment is liable for any injury resulting from determining . . . (1) whether to confine a person for mental illness or addiction." CAL. GOV'T CODE § 856a (West 1966).

17. *Id.* § 856c (1).

18. This argument seems weak in that the countermanding order wasn't made till the "negligent act . . . in failing to carry out a determination to confine" was made. A stronger argument would seem to be that there was no direct causation between the failure to confine and the death two months later. This argument is discussed by the appellate court. Tarasoff v. Regents, 33 Cal. App. 3d 275, 279, 108 Cal. Rptr. 878, 884 (1973).

19. CAL. WELF. & INST'NS CODE § 5154 (West 1972).

While *Tarasoff* imposes a new duty to warn upon doctors[20] and psychiatrists, the holding need not necessarily be viewed as a total departure from prior case law. In some respects it is merely an extension of principles expressed in previous cases.

The imposition of a legal duty depends upon policy considerations,[21] which policies are susceptible to influence by changing social mores and sentiments. Courts generally consider the moral blameworthiness of the defendant's conduct, the policy of preventing future harm, the burden on defendant of imposing a duty, and foreseeability of harm to the plaintiff.[22] The nonexistence of the duty to a third party effectively allows acts in careless disregard of that person's safety. The extent to which such an absence of duty offends the social conscience and notions of decency and fairness will determine its bounds.

It was thought[23] that the *Tarasoff* court might take the opportunity to further narrow the rule handed down in *Richards v. Stanley*[24] that, "in the absence of a special relationship between the parties, there is no duty to control the conduct of a third person so as to prevent him from causing harm to another."[25] Subsequent cases have indicated a trend away from the *Richards* principle.[26] *Hergenrether v. East*[27] held that an individual owes a duty of care to plaintiffs who are injured by the foreseeable negligent act of a third person when that individual has created the risk. In *Hergenrether* the act of leaving a truck parked on a skid row street with the keys in the ignition created a sufficiently foreseeable risk that a thief would steal the vehicle and negligently cause an accident. It could be said that *Tarasoff* expands this holding by imposing a duty not to create a risk to a plaintiff who is injured by the foreseeable *intentional* act of a third person. *Hergenrether* uses a test for imposition of a duty of care depending on the foresee-

20. The decision specifically applies to physicians, 13 Cal. 3d at 187, 529 P.2d at 558, 118 Cal. Rptr. at 134.

21. Dillon v. Legg, 68 Cal. 2d 728, 734, 441 P.2d 912, 917, 69 Cal. Rptr. 72, 77 (1968).

22. Rowland v. Christian, 69 Cal. 2d 108, 113, 443 P.2d 561, 564, 70 Cal. Rptr. 97, 100 (1968).

23. Fleming & Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CALIF. L. REV. 1025 (1974).

24. 43 Cal. 2d 60, 271 P.2d 23 (1954).

25. *Id.* at 65, 271 P.2d at 27. *See also* Harper & Kime, *The Duty to Control the Conduct of Another*, 43 YALE L.J. 886 (1934).

26. *See* Vesely v. Sager, 5 Cal. 3d 153, 486 P.2d 151, 95 Cal. Rptr. 623 (1971); Brockett v. Kitchen Boyd Motor Co., 24 Cal. App. 3d 87, 100 Cal. Rptr. 752 (1972).

27. 61 Cal. 2d 440, 393 P.2d 164, 39 Cal. Rptr. 4 (1964).

ability of serious injury and the burden of precautions. The same test would seem applicable in *Tarasoff*. In the face of a foreseeable injury and the inconsequential burden of giving warning, a balance would be struck in favor of an imposition of a duty to warn. The court, however, distinguished *Hergenrether* in that it requires the defendant only to take reasonable precautions to safeguard his own property.[28]

Another distinguishing characteristic of the *Hergenrether* line of cases[29] is that in each case there was an affirmative act by the defendant which created a foreseeable risk of harm to the plaintiff. These cases really discuss proximate cause issues. That is, assuming a breach of duty by defendant, is he to be held liable for the full extent of the injuries suffered by a plaintiff even though the injuries were brought about by the conduct (whether intentional, negligent, or innocent) of a third person? *Tarasoff* focuses on the question of duty rather than proximate cause. Simply hearing the patient say he intends to kill the plaintiff involves no conduct on the therapist's part which endangers a potential plaintiff.

In any event the court refused to reverse *Richards* but merely expanded the definition of the "special relationship" necessary to charge the defendant with a duty to control third persons. Whereas previously, a "special relationship" between plaintiff and defendant was necessary to establish a duty, now a "special relationship" between defendant and the third person will suffice. The psychiatrist-patient relationship now qualifies as a "special relationship" for purposes of establishing duty.

The moral question raised in *Tarasoff* is analagous to the highly criticized state of the law concerning the duty to rescue. There is generally no duty to come to the aid of another who is in danger.[30] Several morally revolting decisions have upheld this rule because of the "difficulties of setting any standards of unselfish service to fellow man, and of making any workable rule to cover possible situations where 50 people might fail to rescue one."[31] Rather than attempt to set up a rule with universal application, courts have focused on "special relationships" between people as

28. 13 Cal. 3d at 186, 529 P.2d at 557, 118 Cal. Rptr. at 133.
29. Cases cited note 26 *supra*.
30. *See* W. PROSSER, LAW OF TORTS 340-41 (4th ed. 1971).
31. *Id.* at 341.

a basis for whittling away at the disfavored general rule. Thus, one by one, carriers,[32] innkeepers,[33] shopkeepers,[34] social hosts[35] and jailers[36] have come under an affirmative duty to rescue. Though these situations are clearly distinguishable, *Tarasoff* may be an example of this whittling process and may represent another step toward turning moral duties into legal ones.

As previously noted,[37] a duty to warn may also be imposed when a defendant has voluntarily attempted to control the conduct of a third person. Once an attempt to control is undertaken, the defendant must act with reasonable care. If his conduct has contributed to a dangerous situation the defendant is under a duty to warn those who may be affected.[38] In California, statutory immunity protects state mental hospitals from liability for injury caused by the failure to control patients,[39] the release of patients,[40] or the escape of patients.[41] These immunities protect discretionary acts, but liability has been imposed for negligent execution of ministerial duties.[42] In *Johnson v. State*,[43] a teenaged parolee with homicidal tendencies was placed in a foster home without a warning being given to the foster parents. When the youth assaulted the foster mother, the state was held liable for breach of a duty to warn of the dangerous propensities. In accord is *Merchants National Bank & Trust Co. v. United States*,[44] in which the court found that the hospital had exercised no care in releasing a patient who had threatened to kill his wife and did so on release.[45]

Courts have rarely found open-door clinics liable for failure to control patients for several reasons. First, immunity statutes protect clinics in a number of states.[46] Second, because open-door

32. Yu v. New York, New Haven & Hart. R.R., 145 Conn. 451, 144 A.2d 56 (1958).
33. Dove v. Lowden, 47 F. Supp. 546 (W.D. Mo. 1942).
34. L.S. Ayres & Co. v. Hicks, 220 Ind. 86, 40 N.E.2d 334 (1942).
35. Hutchinson v. Dickie, 162 F.2d 103 (6th Cir. 1947).
36. Farmer v. State, 224 Miss. 96, 79 So. 2d 528 (1955).
37. *See* text accompanying note 9 *supra*. *See also* Morgan v. County of Yuba, 230 Cal. App. 2d 938, 41 Cal. Rptr. 508 (1964).
38. Johnson v. State, 69 Cal. 2d 782, 796-97, 447 P.2d 352, 362, 73 Cal. Rptr. 240, 252 (1968). *See also* United States v. Washington, 351 F.2d 913, 916 (9th Cir. 1965).
39. CAL. GOV'T CODE § 854.8 (West Supp. 1973).
40. *Id.* § 856.
41. *Id.* § 856.2.
42. *See* Greenberg v. Barbour, 322 F. Supp. 745 (D. Pa. 1971).
43. 69 Cal. 2d 782, 447 P.2d 352, 73 Cal. Rptr. 240 (1968).
44. 272 F. Supp. 409 (D.N.D. 1967).
45. *See also* Bullock v. Parkchester Gen. Hosp., 3 App. Div. 2d 254, 160 N.Y.S.2d 117 (1957).
46. In 1968 about 60% of the states still had such statutes. There has

therapy is somewhat experimental, courts have been loathe to stifle innovation by second guessing the decision to release, preferring initially to defer the decision to medical judgment. When therapists failed to predict suicidal,[47] homicidal or escapist tendencies which resulted in death or injuries, courts often found the violence to be unforeseeable.[48] Even if a diagnosis of dangerousness was made, but the patient was nevertheless treated under the open-door, courts have absolved hospitals from liability. In *Zilka v. State*,[49] under such circumstances, the court found no breach of the professional standard of care.

If these decisions are interpreted as implying or assuming that defendants owed a duty to plaintiffs, but that defendants were not liable because there was no breach (*Zilka*) or proximate causation[50] (*Bannon*), then *Tarasoff* does not seem to be a great departure from these holdings. However, since no previous case dealt with the specific issue of duty which was raised in *Tarasoff*, an attempt to discern an historical case law basis for imposing the duty may not prove fruitful.

RAMIFICATIONS

Tarasoff was greeted with a great deal of alarm by psychotherapists.[51] Three years earlier, the same court dealt the profession an initial blow by refusing to grant to therapists the absolute privilege of communication enjoyed by the clergy.[52] By upholding the patient-litigant exception[53] in *In re Lifschutz*,[54] the court denied

been a trend away from immunity statutes. Comment, *Liability of Mental Hospitals for Acts of Their Patients Under the Open Door Policy*, 57 VA. L. REV. 156 (1971). *See* Hernandez v. State, 11 Cal. App. 3d 895, 90 Cal. Rptr. 205 (1970); Santa Barbara County v. Superior Ct., 15 Cal. App. 3d 751, 93 Cal. Rptr. 406 (1971).

47. Goff v. County of Los Angeles, 254 Cal. App. 2d 45, 61 Cal. Rptr. 840 (1967).

48. Bannon v. United States, 293 F. Supp. 1050 (D.R.I. 1968).

49. 52 Misc. 2d 891, 277 N.Y.S.2d 312 (Ct. Cl. 1967).

50. *See also* Hicks v. United States, 357 F. Supp. 434 (D.D.C. 1973).

51. TIME, Jan. 20, 1975, at 56.

52. CAL. EVID. CODE §§ 1030-34 (West 1966). The clergyman-penitent privilege has no exceptions.

53. *Id.* § 1016.

> There is no privilege under this article as to a communication relevant to an issue concerning the mental or emotional condition of the patient if such issue has been tendered by: (a) The patient; (b) Any party claiming through or under the patient. . . . *Id.*

54. 2 Cal. 3d 415, 467 P.2d 557, 85 Cal. Rptr. 829 (1970).

the therapist the right to invoke the privilege against the will of the patient. The patient himself had raised the issue by claiming the defense of insanity. This well publicized case incurred a fair amount of criticism in the field of psychiatry, and a number of commentators called for remedial legislation.[55] The present case offers a much more severe threat to the previously favored position[56] of the psychotherapist.

The fear among psychiatrists is that this case marks a trend toward further inroads on the profession's confidential relationship with patients and its statutory privileges.[57] There is a fear that the privilege may become so riddled with exceptions as to be meaningless, as is now the case with the physician-patient privilege.[58]

The dissenting opinion of Justice Clark in *Tarasoff* presents the basic argument of the profession. The opinion contends that the majority erred in basing a duty to warn on the existence of a psychiatrist-patient relationship for policy reasons because the decision destroys the guarantee of confidentiality, which is the basis of psychotherapy. Obviously, public policy favors treatment, but without guaranteed confidentiality fewer people will seek treatment. Those who do will be inhibited from making the full disclosure necessary for effective treatment.[59] The patient's trust in the therapist will be lessened by the possibility of disclosure, which will have a general detrimental effect on the relationship and the possibility for successful treatment.

Justice Clark contends that the inability of the profession to accurately predict violence will result in many more warnings than are necessary, since to avoid liability the therapist will resolve all doubts in favor of warning. Such warnings could have a much more widespread impact on the profession's reputation for secrecy than the majority anticipates.[60]

Must Psychiatrists Accurately Predict Violence?

Predicting violence in the individual is a task often undertaken

55. *See, e.g.*, Note, *Psychiatric Privilege*, 49 TEXAS L. REV. 929 (1971).
56. *See* T. SZASZ, LAW, LIBERTY & PSYCHIATRY 79-80 (1963).
57. There are 11 exceptions to the psychotherapist-patient privilege already. CAL. EVID. CODE §§ 1016-26 (West 1966).
58. CAL. EVID. CODE § 994 (West 1966). There are 12 broad exceptions to the physician-patient privilege. *Id.* §§ 996-1007.
59. Many patients express hostility toward friends, relatives, and employers during therapy. If these hostilities were relayed by the therapist, it could have a severe impact on the patient's relationship with them thus exacerbating his problems.
60. 13 Cal. 3d at 201, 529 P.2d at 568, 118 Cal. Rptr. at 144.

by the psychiatric profession for use in judicial decision-making.[61] At least 17 states include a prediction of dangerousness as part of their civil commitment criteria.[62]

> [A]pproximately 50,000 mentally ill persons per year are predicted to be dangerous and preventively detained . . . . In addition, about 5% of the total mental . . . hospital population of the U.S. . . . are kept in maximum security sections on assessment of their potential dangerousness.[63]

The predictions affect those who have committed no crime as well as those who have committed crimes and are awaiting a judicial decision as to imprisonment, probation, or commitment.[64] Such predictions may also involve the length of detention of the individual. The ultimate deference to the predictive ability of psychiatrists is the indeterminate sentence.[65]

A satisfactory definition of dangerousness has been elusive.[66] Legislatures typically leave the term undefined in statutes[67] or list specific acts which are determined to constitute dangerous behavior.[68] Few cases provide clear meaning regarding interpretation of the term in the commitment process.[69] Many forms of offensive, eccentric, or nonconforming behavior may be considered danger-

61. A great deal of deference is given to psychiatric predictions by the judiciary. *See* Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693, 694-95 (1974).

62. N. KITTRIE, THE RIGHT TO BE DIFFERENT (1971).

63. Rubin, *Prediction of Dangerousness in Mentally Ill Criminals*, 27 ARCH. GEN. PSYCHIAT. 397 (1972).

64. For arguments attacking this use of psychiatry, *see* T. SZASZ, IDEOLOGY AND INSANITY (1970).

65. Monahan, *The Prevention of Violence*, in COMMUNITY MENTAL HEALTH AND THE CRIMINAL JUSTICE SYSTEM (Monahan ed. in press).

66. *See* Goldstein & Katz, *Dangerousness and Mental Illness: Some Observations on the Decision to Release Persons Acquitted by Reason of Insanity*, 70 YALE L.J. 225, 235 (1960).

67. *See, e.g.*, CAL. WELF. & INST'NS CODE § 5150 (West Supp. 1974). There would seem to be a constitutional argument that such statutes are void for vagueness.

68. If a person has "threatened, attempted or actually inflicted physical harm" on another before or after having been taken into custody and "as a result of a mental disorder, presents an imminent threat of substantial physical harm to others" the court may approve a petition for post-certification treatment for 90 days. CAL. WELF. & INST'NS CODE § 5304 (West Supp. 1974).

69. *See* United States v. Charnizon, 232 A.2d 586 (D.C. Cir. 1967) where the probability that defendant would issue checks drawn or insufficient funds rendered the defendant "dangerous."

ous, not because of threatened physical harm, but because of the unsettling impact of such behavior on the public. When construed so broadly, the concept becomes synonymous with mental illness.[70]

Despite society's heavy reliance on the psychiatric ability to predict dangerousness, it appears that such deference has been unwarranted.[71] Every study conducted to test the accuracy of such predictive ability has concluded that the prediction of dangerousness is difficult at best and largely guesswork.[72]

Three studies were reported by psychiatrists Wenk, Robison, and Smith on predictions of dangerousness undertaken by the California Department of Corrections for use in parole decision-making.[73] In the first study in 1965, 86% of those identified by psychiatrists as potentially violent were not, in fact, charged with the commission of a violent act while on parole. In 1968, a second study revealed that of the group predicted to be dangerous, there were 326 incorrect identifications of violent individuals for every correct one during a one-year follow-up. The third study, using a history of actual violence as the sole predictor of future violence disclosed 19 false predictions out of every 20, based on the number of arrests of parolees during the follow-up period.

Over a longer follow-up period, violence predictions appear to have greater validity according to one study. Psychiatrists Kozol, Boucher, and Garofalo[74] conducted a five-year follow-up of 435 male offenders mostly convicted of violent sex crimes. As a result of intensive observation, analysis and diagnosis, the authors recommended the release of 386 prisoners as non-dangerous. Forty-nine others were released by the court contrary to the authors' recommendations. In a five-year follow-up period only 8% of the 386 predicted to be nondangerous, committed a serious assault. Almost 35% of those predicted to be dangerous committed such assaults. Clearly the psychiatrists demonstrated a much more accurate predictive ability than the court. However, viewed another way, 65% of those identified as dangerous did not, in fact, commit a dangerous act in the five-year follow-up period.[75]

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70. Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75 (1968).

71. *See generally* Roth, Dayley & Lerner, *Into the Abyss, Psychiatric Reliability*, 13 SANTA CLARA L. 400 (1973), *and* Ennis & Litwack, *supra* note 61.

72. Monahan, *supra* note 65.

73. Wenk, Robison & Smith, *Can Violence be Predicted?*, 18 CRIME AND DELINQUENCY 393 (1972).

74. Kozol, Boucher, & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME AND DELINQUENCY 371 (1972).

75. Assume that one person out of a thousand will kill. Assume also

> The difficulty involved in predicting dangerousness is immeasurably increased when the subject has never actually performed an assaultive act. This is particularly relevant to involuntary mental hospitalization and for proposals for preventive detention . . . . *no one can predict dangerous behavior in an individual with no history of dangerous acting out.*[76]

It is not difficult to speculate on the reasons for the overprediction of violence. There is little feedback to the psychiatrist who submits a diagnosis to the court. There is no way to tell if the patient would have been violent had he been out on the streets, nor is the psychiatrist likely to hear about released patients who are not recidivists. He *is* likely to hear about released patients who do commit violent acts as such stories reach the newspapers or the courts, as occurred in *Tarasoff*. The ramifications from the publicity generated by such a misjudgment can be tremendous. For an error of incarcerating harmless people there is likely to be no ill effect on the psychiatrist. It is not surprising, therefore, that the tendency is toward conservatism.

Psychiatry has obtained a favored position of influence through a subtle shift of functions from the judiciary to psychiatry. Society looks to the psychiatric profession to control its potentially disruptive members.[77] The profession has been willing to lend itself to what has evolved into intrusive types of social control[78] in order to extend its own power and influence.[79]

With increasing frequency, nightmarish stories surface in which cursory psychiatric evaluations allow a degree of punishment far beyond what would be appropriate in a criminal case.[80] A man convicted of fondling a six-year-old girl was given the mandatory

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> that an exceptionally accurate test is created which differentiates with 95% effectiveness those who will kill from those who will not. If 100,000 people were tested, out of the 100 who would kill 95 would be isolated. Unfortunately, out of the 99,900 who would not kill, 4,995 people would also be isolated as potential killers. In these circumstances, it is clear that we could not justify incarcerating all 5,090 people. If, in the criminal law, it is better that ten guilty men go free than that one innocent man suffer, how can we say in the civil commitment area that it is better that fifty-four harmless people be incarcerated lest one dangerous man be free? Livermore, *supra* note 70, at 84.

76. Kozol, *supra* note 74, at 384 (emphasis added).
77. Fleming & Maximov, *supra* note 23, at 1036.
78. Wenk, *supra* note 73, at 402.
79. SZASZ, *supra* note 56, at 79.
80. Rouse v. Cameron, 387 F.2d 241 (D.C. Cir. 1967).

one-year-to-life sentence. He is now serving his twenty-second year.[81] At his parole hearings which last about 12 minutes, parole is denied on the basis of a psychiatric profile. In a similar case, a prisoner convicted of a second count of indecent exposure was ordered released by the California Supreme Court after having served five years of an indeterminate sentence.[82]

The willingness of the legislatures to allow therapists to detain patients under emergency confinement statutes and the willingness of the judiciary to accept expert testimony of psychiatrists at commitment proceedings often result in violations of constitutional guarantees which would be intolerable in a criminal proceeding.[83] The patient may be incarcerated as a result of disclosures made to a therapist without a Miranda warning or an efficacious waiver. In practice, the burden of proof is subtly shifted so that the patient must often prove himself to be nondangerous.[84] The indeterminate sentence is only now coming to be criticized as resulting in cruel and unusual punishment in violation of the eighth amendment.[85] The right of patients to refuse medication raises a right of privacy issue,[86] which right has been upheld on first amendment religious grounds.[87]

The inequities of the present use of psychiatric predictions of violence raise the question of what appropriate alternatives exist for protecting society from violence of the mentally deranged. There is a widespread belief that the "mentally ill" are more apt to be violent than "normal" members of society. Empirical research however, concludes that

> [a]n individual with a level of mental illness is quite capable of committing any act of violence known to man but probably does not do so with any greater frequency than his neighbor in the general population.[88]

Such findings suggest "that there is no empirical basis to support the preventive detention of those psychologically disturbed persons who have not committed a violent act."[89]

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81. L.A. Times, Feb. 23, 1975, § 1, at 22, col. 1.
82. *In re* Lynch, 8 Cal. 3d 410, 503 P.2d 921, 105 Cal. Rptr. 217 (1972).
83. SZASZ, *supra* note 56, at 186.
84. On the other hand, it would seem unrealistic to require a showing that a person will be violent in the future beyond a reasonable doubt.
85. L.A. Times, *supra* note 81.
86. Ferleger, *Loosing the Chains: In Hospital Civil Liberties of Mental Patients*, 13 SANTA CLARA LAW. 447, 474 n.96 (1973).
87. Winters v. Miller, 446 F.2d 65 (2d Cir. 1971).
88. Gulevich & Bourne, *Mental Illness and Violence*, in VIOLENCE AND THE STRUGGLE FOR EXISTENCE 309 (Daniels, Gilula, & Ochberg eds. 1970).
89. Testimony by John Monahan, before the California Assembly Select Committee on Mentally Disordered Criminal Offenders, Dec. 13, 1973, in

A less onerous alternative to preventive detention of a patient deemed dangerous by a psychiatrist is a requirement that psychiatrists warn potential victims of "dangerous" patients. But here again the tendency of psychiatrists to overpredict violence becomes a problem. Because *Tarasoff* has created a threat of civil liability for failure to diagnose dangerousness, the holding may compound a therapist's tendency to overpredict. Justice Clark argued that because any doubt will be resolved in favor of warning, the increased number of warnings will lead to the virtual disintegration of confidentiality in the psychotherapist-patient relationship.[90] This line of reasoning then leads to the question of what effect limited confidentiality will have on the psychiatrist-patient relationship and on the success of treatment.

Privilege, Confidentiality and Secrecy

> The psychiatric patient confides more utterly than anyone else in the world. He exposes to the therapist not only what his words directly express: he lays bare his entire self, his dreams, his fantasies, his sins and his shames.[91]

This oft-quoted characterization of the psychotherapeutic relationship and the necessity for an assurance of confidentiality is widely accepted by legal writers.[92] As with other professions, confidentiality is usually assumed by the patient when he undertakes treatment. Though not usually requested, it is implicit in the relationship.[93]

Privileges

It is important to establish the point at which a privilege arises. Legal privilege allows the patient to prevent his psychiatrist from testifying or being forced to testify in a legal proceeding[94] as to any confidential communication or diagnosis resulting from the

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COMMUNITY MENTAL HEALTH AND THE CRIMINAL JUSTICE SYSTEM (Monahan ed. in press).

90. Tarasoff v. Regents, 13 Cal. 3d at 201, 529 P.2d at 567, 118 Cal. Rptr. at 143.

91. M. GUTTMACHER & H. WEIHOFEN, PSYCHIATRY AND THE LAW 272 (1952).

92. Comment, *Underprivileged Communications: Extension of the Psychotherapist-Patient Privilege to Patients of Psychiatric Social Workers*, 61 CALIF. L. REV. 1050 (1973).

93. R. SLOVENKO, PSYCHOTHERAPY, CONFIDENTIALITY AND PRIVILEGED COMMUNICATION 3 (1966).

94. The term is defined in CAL. EVID. CODE § 901 (West 1966).

psychiatrist-patient relationship. The holder of the privilege, *i.e.*, the patient, his representative, or the psychiatrist in his behalf,[95] may use the privilege to exclude testimony by the psychiatrist as well as by anyone to whom the psychiatrist disclosed the confidential information.

Since the privilege applies only in "proceedings," it has no effect on disclosures of confidential information made outside the courtroom. The patient is afforded only limited protection from such disclosures.[96] The psychiatrist may have violated his oath[97] and thereby be subject to professional discipline. He may also have violated a statutory requirement of confidentiality warranting suspension or revocation of his license.[98] Such sanctions are weak, ineffective[99] and of little consolation to the patient.

Patients may have a remedy in tort for invasion of privacy[100] or defamation, but this remedy has been disappointing in practice. In *Clark v. Geraci*,[101] the plaintiff was fired from his job in the U.S. Air Force as a result of his psychiatrist's disclosure of his alcoholism to the employer. The psychiatrist had previously supplied, at the patient's request, incomplete medical certificates to explain the plaintiff's absences from work. The court held that "having placed the doctor in the position of telling but part of the truth, [the plaintiff] is estopped from preventing his divulging the remainder."[102]

In *Berry v. Moench*,[103] a psychiatrist disclosed to a physician the psychiatric analysis and records of a former patient. The patient was engaged to marry a young girl and her parents had requested the advice of a physician. The psychiatrist's letter came into the possession of the patient who sued for libel. The court said:

> [C]oncern for [the girl's] well-being and happiness was a sufficient interest to protect, and . . . it was within the generally accepted

95. *Id.* § 1013.

96. *See* Broeder, *Silence and Perjury Before Police Officers*, 40 NEB. L. REV. 63 (1960).

97. The Hippocratic Oath states:

> . . . whatever in connection with my professional practice . . . I see or hear in the life of man, which ought not to be spoken of abroad, I will not divulge, thinking that all such should be kept secret. *Reprinted in* SLOVENKO, *supra* note 93, at 198.

98. CAL. BUS. & PROF. CODE § 2379 (West 1974).

99. Note, *Functional Overlap Between the Lawyer and Other Professionals: Its Implications for the Privileged Communication Doctrine*, 71 YALE L.J. 1226, 1256 (1962).

100. *See* Horne v. Patton, 291 Ala. 701, 709, 287 So. 2d 824, 830 (1974).

101. 29 Misc. 2d 791, 208 N.Y.S.2d 564 (Sup. Ct. 1960).

102. *Id.* at 794, 208 N.Y.S.2d at 568. *See also* Simonson v. Swenson, 104 Neb. 224, 177 N.W. 831 (1920).

103. 8 Utah 2d 191, 331 P.2d 814 (1958).

> standards of decent conduct for the doctor to reveal the information which might have an important bearing thereon.[104]

In addition to the scarcity of cases granting damages for wrongful disclosure, patients may also be discouraged from bringing suit because they do not want to open their private lives to public scrutiny. Given the lack of an effective remedy for patients whose therapist has disclosed confidential information in the nonlegal setting, it appears that the public has generally not been deterred from seeking treatment by lack of an absolute legal guarantee of confidentiality. However, since the profession has long fostered its image of secrecy, it may well be that even those patients who consciously thought about it considered the profession's reputation as enough of a guarantee.

The existence of the statutory privilege is based not on the fear that psychiatrists would voluntarily betray their patients' confidences, but on the fear psychiatrists might be forced to testify in court as to confidential communications. Yet there are a number of exceptions to the privilege.[105] Among the most significant is the statutory dangerous patient exception:

> There is no privilege under this article 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.[106]

The comments of the Law Revision Commission concerning the exception indicate that

> [a]lthough the exception might inhibit the relationship between the patient and his psychotherapist to a limited extent, it is essential that appropriate action be taken if the psychotherapist becomes convinced during the course of treatment that the patient is a menace to himself and others and the patient refuses to permit the psychotherapist to make the disclosure necessary to prevent the threatened danger.[107]

The scope of the exception can be easily misconstrued. The language implies that confidential communications are privileged outside the courtroom and that therefore the dangerous patient exception also applies in a nonlegal setting. No doubt the term "appro-

104. *Id.* at 198, 331 P.2d at 818.
105. CAL. EVID. CODE §§ 1016-28 (West Supp. 1974).
106. CAL. EVID. CODE § 1024 (West 1966).
107. *Id.*, Comments of the Law Revision Commission.

priate action" in the comments contemplates commitment proceedings, but the statute is not very clear on this point. The prospective wording of the statute seems to imply that the sole use of the exception is in a courtroom during a commitment proceeding to determine the dangerousness of the patient. The psychiatrist's testimony would be used to determine the patient's threat to society. No duty is imposed by the exception despite the goal expressed in the comment that "it is essential that action be taken." It appears, then, that privileges and exceptions are relevant to a discussion of a tort duty only insofar as they are expressions of legislative policy.[108]

Confidentiality

The degree to which psychiatric disclosures become commonplace will determine the effects of this limited confidentiality. It may be true that people in a violent frame of mind do not read court decisions,[109] but one or two sensational cases of disclosure could destroy the profession's reputation for secrecy.[110]

What are the expectations of patients? Would they expect a psychiatrist to stand idly by after they have promised to kill someone? Would they actually be disappointed or surprised if the psychiatrist made an effort to stop them? Would other patients feel this was a breach of faith and be deterred from further treatment? Would the public be deterred from seeking treatment? One of the more outspoken defenders of the profession's need for confidentiality has opined:

> The general public, prospective patients and patients in therapy will not lose faith in the psychiatrist as a keeper of secrets, when in cases of emergency, he acts contrary to strict and absolute confidentiality. Sooner or later the patient realizes that the psychiatrist has acted in his best interest. . . . However, situations of real emergencies necessitating disclosure are rare.[111]

Most arguments against requiring disclosure do not address themselves to a nonlegal setting.[112] This is probably because it is easier to find that confidentiality outweighs the benefit of having the therapist's testimony *after* a crime has been committed. A great deal more weight is added to arguments for disclosure where there is still a possibility of averting a tragedy.

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108. *See* Fleming & Maximov, *supra* note 23, at 1063.
109. TIME, Jan. 20, 1975, at 56.
110. Goldstein & Katz, *Psychiatrist-Patient Privilege: The GAP Proposal and the Connecticut Statute*, 36 CONN. B.J. 175, 183 (1962).
111. Slovenko, *supra* note 93, at 56.
112. An exception is Fleming & Maximov, *supra* note 23.

There are numerous situations in other fields in which a duty to disclose is imposed by statute. "Battered Child Statutes"[113] require a doctor to report to police any evidence of child abuse. Doctors must report cases of venereal diseases which have been treated.[114] Prison psychiatrists must report knowledge of plans to commit crimes.[115] Apparently legislatures have decided that the public welfare outweighs any detriment to the confidential relationships in such circumstances.

It has been argued that when a therapist feels his patient is in such an emotional turmoil as to be likely to commit a dangerous act in the immediate future, the psychotherapist is in a unique position to treat the patient and eliminate the threat.[116] Many doubts have been raised concerning psychiatry's ability to prevent violence. Sedatives may temporarily reduce a patient's danger to society but no form of psychiatric treatment has yet been empirically demonstrated to have an enduring effect on reducing violent behavior.[117] In balancing the public's interest in effective therapy against its interest in being warned of potential danger, it is important to ascertain what degree of success psychotherapy has enjoyed. It is clear that psychotherapeutic "treatment is of no proven value in some types of emotional illness,"[118] for example, schizophrenia. More generally, the most authoritative research on the question[119] has shown that much of the success of consulting room type therapy is due to the passage of time rather than the therapy itself. This finding would seem to give more weight to the argument that a duty to warn will better serve the interest of the public safety than total deference to therapist-patient confidentiality.

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113. For a listing of each statute *see* Paulsen, *Child Abuse Reporting Laws: The Shape of the Legislation*, 67 COLUM. L. REV. 1 (1967); *see also* Brown, *Controlling Child Abuse: Reporting Laws*, 80 CASE & COM. 10 (1975).

114. 53 Op. Cal. Att'y Gen. 10 (1970).

115. SLOVENKO, *supra* note 93, at 129.

116. *The GAP Proposal*, *supra* note 110, at 186-87.

117. Monahan, *Abolish the Insanity Defense?—Not Yet*, 26 RUTGERS L. REV. 719, 734 (1973).

118. Gunderson, *Controversies About the Psychotherapy of Schizophrenia*, 130 AM. J. PSYCIAT. 670, 677 (1973).

119. Bergin, *Some Implications of Psychotherapy Research for the Therapeutic Practice*, 71 J. ABNORM. PSYCHOL. 235 (1966). *But see* Malan, *The Outcome Problem of Psychotherapy Research: A Historical Review*, 29 ARCH. GEN. PSYCHIAT. 719 (1973).

Psychiatrists fear that *Tarasoff* may require them to disclose to potential victims all the innocuous threats made by the patient while under treatment. Certainly *Tarasoff* will require a judgment of some expertise. However, the standard of care required is that of the average, reasonable therapist under similar circumstances.[120] As the *Tarasoff* majority pointed out:

> The judgment of the therapist . . . is no more delicate or demanding than the judgment which doctors and professionals must regularly render under accepted rules of responsibility.[121]

A major unresolved problem with the *Tarasoff* decision is that the psychotherapist-patient privilege interferes with the ability of the plaintiff to offer proof at trial. For example, usually only two people know that the patient made a threat on someone's life during treatment, the patient himself and the therapist. The therapist is unlikely to simply admit the pivotal issue in his opponent's case, and even if he were so benign, the privilege may preclude such testimony unless the patient waives it.[122] The result may be that the patient decides whether or not his victim will be able to present evidence on the crucial issue of his case. In cases such as *Tarasoff*, where two psychotherapists and the police knew of the threats and corroborating office records and letters were available, the privilege may still prevent introduction of such evidence. The privilege extends to anyone who derived information on the confidential communication from any source other than the patient.[123] Therefore, in *Tarasoff*, unless the patient, Poddar, fails to invoke the privilege, any testimony derived from the therapist's statements concerning his consultation with Poddar must be excluded.

Conclusion

Duty is a matter of public policy subject to the influences of public sentiment. *Tarasoff* presented a compelling fact situation with an abuse of what heretofore was the discretion of the psychiatrist which so outraged the sensibilities of the court as to lead to the imposition of a new duty to warn potential victims of a dangerous patient.

For years society has deferred to psychiatric predictions of violence in determining the fate of numerous citizens charged with

120. Bardessono v. Michels, 3 Cal. 3d 780, 788, 478 P.2d 480, 484, 91 Cal. Rptr. 760, 764 (1970).
121. 13 Cal. 3d at 190, 529 P.2d at 560, 118 Cal. Rptr. at 136.
122. Cal. Evid. Code § 1014 (West 1966).
123. *Id.*

crimes or with mental illness. Psychiatrists failed to object to this use of their profession and, in fact, helped perpetuate the belief that their predictions had value. Psychiatrists probably possess no greater ability to predict violence in the individual than the layman.[124] But the psychiatrist's reputation for predictive ability may now be turned against him as a result of *Tarasoff*. Because of the reputation, juries may hold therapists to a higher degree of expertise than they actually possess.

It remains to be seen if the new duty to warn will result in an increase in warnings. A dramatic increase is unlikely simply because it is doubtful that the threat of financial liability adds a significantly greater incentive for action than saving a life, especially in a profession dedicated to humanitarian goals.

Lack of absolute confidentiality probably will not deter prospective patients to any great extent because of the unique nature of the therapist-patient relationship. "[T]he popularity of psychotherapy is perhaps not attributable to any notorious success but for the need in our society for a certain type of friendship."[125]

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124. Ennis & Litwack, *supra* note 61, at 696.
125. Tarshis, *Liability for Psychotherapy*, 30 FAC. L. REV. 75, 96 (1972).