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Warning Third Parties: The Ripple Effects of Tarasoff

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INTRODUCTION

When, in the name of public safety, the California Supreme Court imposed upon the mental health professional a duty to warn potential victims who have been threatened by the therapist's patient, it touched off a conflict between the requirements of law and those of sound clinical practice. The Court's ruling in *Tarasoff v. Regents of University of California*[1] was met with opposition from psychiatric and psychological associations who claimed that the decision interferes with sound clinical practice.[2] Opponents particularly objected to the decision's standard, which is based on the therapist's ability to predict dangerousness, and to the

1. 13 Cal. 3d 177, 529 P.2d 553, 118 Cal. Rptr. 129 (1974) [*Tarasoff I*], *vacated*, 17 Cal. 3d 425, 440, 551 P.2d 334, 346, 131 Cal. Rptr. 14, 26 (1976) [*Tarasoff II*]. The court's opinion in *Tarasoff I* has been omitted from publication in California Reports. All references to *Tarasoff* in this article will refer to *Tarasoff II* unless otherwise noted.

2. Motion of American Psychiatric Association, Area IV Assembly of the American Psychiatric Association, Northern California Psychiatric Society, California State Psychological Association, San Francisco Psychoanalytic Institute and Society, California Society for Clinical Social Work, National Association of Social Workers, Golden Gate Chapter, and California Hospital Association for Leave to File Brief Amicus Curiae and Brief Amicus Curiae in Support of Petition for Rehearing, Tarasoff v. Regents of Univ. of Cal., 13 Cal. 3d 177, 529 P.2d 553, 118 Cal. Rptr. 129 (1974).

decision's mandate to violate confidentiality under certain circumstances.[3]

In view of the contention that the threat of liability curtails sanctioned conduct, this Article considers whether and how *Tarasoff* has affected psychotherapeutic practice.[4] Specifically, it reports on a survey which focuses upon therapists' familiarity with and understanding of the *Tarasoff* decision, their ability and willingness to comply with its requirements, how they have responded to its prescriptions, and what particular effects the decision has produced upon their practices.

This study is not the first attempt to discern the effects of *Tarasoff* upon psychotherapeutic practice. The national impact[5] of *Tarasoff* prompted three earlier studies: The Beck Study, the Wisconsin Study, and the Stanford Study.[6] All three studies concluded that *Tarasoff* has had widespread effects upon clinical practice.[7] Moreover, they provided additional information regarding the major criticisms of the *Tarasoff* decision--namely, the inability of psychotherapists to predict potential dangerousness and the decision's mandate to breach confidentiality.[8] The Wisconsin study and the Beck study also determined that psychologists and

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3. *Tarasoff I*, 13 Cal. 3d at 177, 529 P.2d at 553, 118 Cal. Rptr. at 129.

4. *See* Daniel J. Givelber et al., Tarasoff, *Myth and Reality: An Empirical Study of Law in Action*, 1984 WIS. L. REV. 443, 486-87 (1984) [hereinafter *The Wisconsin Study*] (discussing evaluation of the practical effects of *Tarasoff* and citing William B. Schwartz & Neil K. Komesar, *Doctors, Damages and Deterrence*, 298 NEW ENG. J. MED. 1282-89 (1978)).

5. Washington, Pennsylvania, Nebraska, and New Jersey courts have acknowledged *Tarasoff* in recognizing a limited duty to protect. Petersen v. Washington, 671 P.2d 230 (Wash. 1983); Leedy v. Hartnett, 510 F. Supp. 1125 (M.D. Pa. 1981); Lipari v. Sears, Roebuck, & Co., 497 F. Supp. 185 (D. Neb. 1980); McIntosh v. Milano, 403 A.2d 500 (N.J. 1979).

6. James C. Beck, *Violent Patients and the* Tarasoff *Duty in Private Psychiatric Practice*, 13 J. PSYCHIATRY & L. 361 (1985) [hereinafter *The Beck Study*]; *The Wisconsin Study*, *supra*, note 4; Toni P. Wise, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of* Tarasoff, 31 STAN. L. REV. 165 (1978) [hereinafter *The Stanford Study*].

7. *The Beck Study*, *supra* note 6, at 375; *The Wisconsin Study*, *supra* note 4, at 447, 485; *The Stanford Study*, *supra* note 6, at 167, 178, 182, 190.

8. *See supra* notes 4, 6.

psychiatrists interpret the *Tarasoff* duty to protect as a duty to warn the potential victim.[9]

The present study builds on the work of precursors which were published eight, nine, and fifteen years ago, respectively.[10] Section I reviews the history of the *Tarasoff* decisions.[11] Section II examines the legacy of *Tarasoff*: The role of the special relationship that exists between therapists and their patients; the courts' attempts both to narrow and to expand the notion of foreseeability of the victim; the nature and type of threatened harm; as well as those to whom the *Tarasoff* decision applies.[12] Section III then examines the criticisms of the decision, and particularly the capacity of mental health professionals to predict dangerous behavior as well as the implications of the decision for the confidentiality of patient-therapist communications.

Section IV turns to the study itself, in which 872 psychotherapists responded to a mail survey which was distributed during the Spring of 1987. The survey addressed such matters as: The psychotherapist's understanding of the *Tarasoff* decision, including to whom they thought it applied, and what behaviors were required of the therapist; whether and how the decision had impacted upon their practice, including the number of dangerous patients they see, and how many they have turned away; their perception of the decision's effects on confidentiality, and how they handled matters of confidentiality in their practice; whether they felt obligated to warn potential victims of harms other than those arising from violent injury; as well as a variety of standard demographic

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9. *See The Wisconsin Study, supra* note 4, at 483, 486-87 ("*Tarasoff* must be evaluated in terms of its practical impact rather than in terms of the court's assumptions, or critics' predictions of psychiatric armageddon.... The judicially determined rule of *Tarasoff I*, protect through warning, appears to have affected therapist attitudes, knowledge and behavior to a far greater degree than *Tarasoff II*."); *see also* William J. Bowers et al., *How Did* Tarasoff *Affect Clinical Practice?*, 484 ANNALS AAPSS 70 (1986); *accord The Beck Study, supra* note 6, at 374. The findings suggest that *Tarasoff* must be evaluated as if it requires a warning. The authors of this study have used this operational definition of reasonable care within the "*Tarasoff* Survey" document. *See infra* app. A.

10. *The Beck Study, supra* note 6; *The Wisconsin Study, supra* note 4; *The Stanford Study, supra* note 6.

11. *See infra* notes 16-39 and accompanying text.

12. *See infra* notes 40-130 and accompanying text.

issues.[13] Section V assesses and discusses the results of the study,[14] while Section VI examines its implications.[15]

I. THE HISTORY OF THE TARASOFF DECISION

In 1969, Prosenjit Poddar, a graduate student, voluntarily sought psychiatric counseling at Cowell Memorial Hospital at the University of California, Berkeley.[16] Dr. Moore, a psychologist at the university health center, diagnosed Poddar as a potentially dangerous paranoid schizophrenic.[17] His diagnosis was based primarily upon evidence of Poddar's intention to purchase a gun and Poddar's pathological obsession with Tatiana Tarasoff, another Berkeley student who had previously rebuffed Poddar's expressions of affection.[18] Poddar informed Dr. Moore that he planned to kill an unnamed woman, identifiable as Tatiana, when she returned from vacationing in Brazil.[19] After consulting with psychiatric colleagues, Dr. Moore sought to have Poddar committed for observation in a mental hospital. Moore notified the police, orally and in writing, of Poddar's potential dangerousness and requested their assistance in securing Poddar's confinement.[20] The officers took Poddar into custody but, satisfied that he did not pose a danger, released him with a warning to stay away from Tatiana.[21] Subsequently, the director of psychiatry at Cowell Memorial Hospital ordered that all records regarding Poddar's therapy be destroyed and that no further action be taken to detain him.[22]

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13. *See infra* notes 131-185 and accompanying text.
14. *See infra* notes 186-267 and accompanying text.
15. *See infra* notes 268-269 and accompanying text.
16. *Tarasoff II*, 17 Cal. 3d at 429, 551 P.2d at 339, 131 Cal. Rptr. at 19; People v. Poddar, 10 Cal. 3d 750, 518 P.2d 342, 111 Cal. Rptr. 910 (1974) (the criminal action against Poddar). For a comprehensive discussion of the facts and circumstances surrounding the *Tarasoff* case, see Alan A. Stone, *The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358 (1976) [hereinafter *Suing Psychotherapists*].
17. *Poddar*, 10 Cal. 3d at 754, 518 P.2d at 345, 111 Cal. Rptr. at 913.
18. *Suing Psychotherapists*, *supra* note 16, at 359.
19. *Tarasoff II*, 17 Cal. 3d at 432, 551 P.2d at 341, 131 Cal. Rptr. at 21.
20. *Suing Psychotherapists*, *supra* note 16, at 359.
21. *Id.* at 360.
22. *Id.*; *Tarasoff II*, 17 Cal. 3d at 432, 551 P.2d at 341, 131 Cal. Rptr. at 21.

Poddar did not return for psychological treatment following his release.[23] On October 27, 1969, shortly after Tatiana returned from Brazil, Poddar fatally shot and stabbed her in her home.[24]

Tatiana's parents filed suit against the Regents of the University of California, the psychotherapists who handled Poddar's case, and the campus police.[25] The trial court dismissed the complaint for failure to state a cause of action, and the court of appeals affirmed.[26] The plaintiffs then appealed to the California Supreme Court, arguing (1) defendants had a duty to warn Miss Tarasoff or her family of the danger Poddar posed to her and (2) that defendants failed to use reasonable care to confine Poddar pursuant to the Lanterman-Petris-Short Act, the California civil commitment statute.[27]

In the first of two decisions, the California Supreme Court reversed the lower courts.[28] In *Tarasoff I*, the court held that the defendant psychotherapists had a duty to warn Tatiana of Poddar's threatened violence.[29] This duty was premised on the special relationship that exists between a psychotherapist and his patient.[30] Additionally, the court held that the defendant policemen could be liable for failing to warn Miss Tarasoff on the theory that their "bungled" attempt to detain Poddar inevitably deterred him from continuing psychotherapy and contributed to the danger

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23. *Suing Psychotherapists, supra* note 16, at 360.

24. *Poddar*, 10 Cal. 3d at 754, 518 P.2d at 345, 111 Cal. Rptr. at 913. Poddar was convicted of second degree murder. The original conviction was reversed, however, for failure to instruct the jury adequately regarding the defense of diminished capacity. *Id.* at 760-61, 518 P.2d at 349-50, 111 Cal. Rptr. at 917-18. Subsequently, Poddar was convicted of voluntary manslaughter, confined to the Vacaville prison, released, and has since returned to India. *Suing Psychotherapists, supra* note 16, at 358.

25. *Suing Psychotherapists, supra* note 16, at 360.

26. Tarasoff v. Regents of Univ. of Cal., 33 Cal. App. 3d 275, 276, 108 Cal. Rptr. 878, 880, 887, *vacated and remanded*, 13 Cal. 3d 177, 529 P.2d 553, 118 Cal. Rptr. 129 (1974), *vacated*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

27. Tarasoff v. Regents of Univ. of Cal., 13 Cal. 3d 177, 529 P.2d. 553, 118 Cal. Rptr. 129 (1974) [*Tarasoff I*], *vacated*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976); *see* CAL. WELF. & INST. CODE §§ 5000-5404.1 (West 1984 & Supp. 1993) (civil commitment statutes).

28. *Tarasoff I*, 13 Cal. 3d 177 at ___, 529 P.2d at 556, 118 Cal. Rptr. at 139.

29. *Id.* at ___, 529 P.2d at 555, 118 Cal. Rptr. at 131.

30. *Id.* at ___, 529 P.2d at 558, 118 Cal. Rptr. at 134.

confronting Tatiana.[31] Finally, although the defendants were found to have a duty to warn, the court concluded that the psychotherapists and police were immune from liability for failure to confine Poddar.[32]

The California Supreme Court's imposition of a duty to warn in *Tarasoff I* generated vigorous discussion in legal and psychological literature.[33] Inspired by criticisms raised, defendants and several amici curiae petitioned the court for reconsideration of the decision.[34] In an atypical move, the court granted the defendant's petition for rehearing.[35]

Changing its earlier position, the court found no duty to warn owed by the police.[36] Nevertheless, the court again imposed a duty on psychotherapists.[37] In *Tarasoff II*, however, the psychotherapists' duty was defined more broadly. Specifically, the court held that the special relationship which exists between a therapist and his patient, coupled with the therapist's knowledge that his patient poses a serious threat of violence to another, gives rise to an obligation "to use reasonable care to protect the intended

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31. *Id.* at ___, 529 P.2d at 561, 118 Cal. Rptr. at 137.

32. *Id.* at ___, 529 P.2d at 563-65, 118 Cal. Rptr. at 129-30. The court explained that the psychotherapists' immunity was based on California Government Code § 856, which provided, in pertinent part, that public entities and their employees were shielded from liability for "any injury resulting from determining in accordance with any applicable enactment . . . whether to confine a person for mental illness. . . ." *Id.* The court predicated the immunity of the police on § 5154 of the California Welfare and Institutions Code, stating "the peace officer responsible for detainment of [a] person shall not be held civilly or criminally liable for any action by a person released at or before the end of 72 hours. . . ." *Id.*; *see* CAL. GOV'T CODE § 856 (West 1980); CAL. WELF. & INST. CODE § 5154 (West 1984 & Supp. 1993).

33. *See, e.g.*, George J. Annas, *Law and Psychiatry: When Must the Doctor Warn Others of the Potential Dangerousness of his Patient's Condition?*, MEDIC-LEGAL NEWS (April 1975); John G. Fleming & Bruce Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CAL. L. REV. 1025 (1974); Robert B. Kaplan, Comment, Tarasoff v. Regents of the University of California: *Psychotherapists, Policemen and the Duty to Warn--An Unreasonable Extension of the Common Law?* 6 GOLDEN GATE U. L. REV. 229 (1975); Dennis W. Daley, Comment, Tarasoff *and the Psychotherapist's Duty to Warn*, 12 SAN DIEGO L. REV. 932, 940 (1975).

34. *See supra* note 2 (citing motion of the American Psychiatric Association et al.).

35. *Tarasoff II*, 17 Cal. 3d. 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

36. Absent explanation, the court concluded that the police lacked a special relation with Poddar or Tatiana sufficient to give rise to a duty to warn. *Id.* at 444, 551 P.2d at 349, 131 Cal. Rptr. at 29.

37. *Id.* at 436-37, 551 P.2d at 343-44, 131 Cal. Rptr. at 23-24.

victim against such danger."[38] Whether the therapist can discharge this obligation by warning the potential victim, notifying the police, or performing some other action was to be determined by the circumstances of the particular case.[39]

II. THE LEGACY OF THE TARASOFF DECISION

Much of the controversy surrounding *Tarasoff* concerned the circumstances under which the courts should establish a duty, and where limits to that duty should be drawn.[40] The vague foreseeability standards in *Tarasoff* and its progeny provided therapists little guidance by which to consider and formulate their own behavior. Additionally, recent court decisions have extended liability beyond the apparent scope of the original *Tarasoff* decision.[41] Thus, it is important to understand the general tort principles upon which the therapist's duty to protect potential victims is founded.[42] Generally, the extent of this duty is measured by the foreseeability of the risk and the size of the danger created.[43] The *Tarasoff* court considered seven major factors in deciding whether to recognize a duty of care.[44]

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38. *Id.* at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

39. *Id.*

40. *See, e.g., Suing Psychotherapists, supra* note 16.

41. *See infra* notes 70-82 and accompanying text (discussing the expansion of *Tarasoff* in subsequent cases).

42. *See generally* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS (5th ed. 1984).

43. Palsgraf v. Long Island R.R. Co., 162 N.E. 99, 101 (N.Y. 1928) (cited in Brady v. Hopper, 570 F. Supp. 1333, 1338 (C.D. Colo. 1983) (applying California law by analogy)); *Tarasoff II*, 17 Cal. 3d at 434-35, 551 P.2d at 342-43, 131 Cal. Rptr. at 22-23.

44. *Tarasoff II*, 17 Cal. 3d at 434, 551 P.2d at 342, 131 Cal. Rptr. at 22. These seven factors are: (1) The foreseeability of harm to the plaintiff; (2) the degree of certainty that the plaintiff suffered injury; (3) the closeness of the connection between the defendant's conduct and the injury suffered; (4) the moral blame attached to the defendant's conduct; (5) the policy preventing future harm; (6) the extent of the burden to the defendant and the consequences to the community of imposing a duty to exercise care with resulting liability for breach; and (7) the availability, cost, and prevalence of insurance for the risk involved. *Id.*

A. The Special Relationship

First, the majority recognized that generally speaking, one person has no duty to control the conduct of another.[45] However, a duty to protect a third party exists when the defendant bears a special relation to the dangerous person or to the third party.[46] Courts have carved out an exception to this rule, and the *Tarasoff* court decided that the relationship between a therapist and patient embodies this special relationship.[47] *Tarasoff* thus imposes upon therapists an obligation to protect certain third parties, in part, by virtue of the special relationship which exists between therapists and their patients.

B. The Foreseeability of the Potential Victim

In addition to the existence of a special relationship, *Tarasoff* requires the presence of certain elements of foreseeability in order to impose a duty to protect.[48] Adopting the language of prior cases, the majority wrote that, "the defendant owes a duty of care to all persons who are foreseeably endangered by his conduct . . . ."[49] Under *Tarasoff*, the victim must be foreseeable.[50]

The court further explained that it would be unreasonable to require the psychotherapist to interrogate his patient as to conduct, or carry on an investigation regarding the victim's identity.[51] But

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45. *Id.* at 435, 551 P.2d at 342-43, 131 Cal. Rptr. at 22-23 (citing RESTATEMENT (SECOND) OF TORTS § 315-320 (1965)).

46. RESTATEMENT (SECOND) OF TORTS §§ 321-324(a) (1965).

47. *Tarasoff II*, 17 Cal. 3d at 435-36, 551 P.2d at 343-44, 131 Cal. Rptr. at 23-24. *But see* Robert F. Schopp & Michael R. Quattrocchi, Tarasoff, *The Doctrine of Special Relationships, and the Psychotherapist's Duty to Warn*, 12 J. PSYCHIATRY & L. 13, 27-28 (1984) (challenging the court's determination that the relationship between therapist and patient embodies this special relationship; also suggesting that the relationship may allow psychotherapists better access to threats, placing them in a better position to prevent potential harm).

48. *Tarasoff II*, 17 Cal. 3d at 434-35, 551 P.2d at 342, 131 Cal. Rptr. at 22.

49. *Id.* (citing Rodriguez v. Bethlehem Steel Corp., 12 Cal. 3d 382, 399, 525 P.2d 669, 680, 115 Cal. Rptr. 765, 776 (1974); Dillon v. Legg, 68 Cal. 2d 728, 739, 441 P.2d 912, 919, 69 Cal. Rptr. 72, 79 (1968); Weirum v. R.K.O. General, Inc., 15 Cal. 3d 40, 45, 539 P.2d 36, 39, 123 Cal. Rptr. 468, 471 (1975)).

50. *Tarasoff II*, 17 Cal. 3d at 439, 551 P.2d at 345, 131 Cal. Rptr. at 25.

51. *Id.* at 439 n.11, 551 P.2d at 345 n.11, 131 Cal. Rptr. at 25 n.11.

there are occasions when the therapist is able to identify the victim at a moment's reflection. The court concluded that under such conditions the victim is sufficiently foreseeable to justify imposing a duty to warn.[52] There really are no "hard and fast" rules that go into a foreseeability analysis. Rather, foreseeability is dictated by the circumstances of each case.

In addition to the foreseeable potential victim, it may be necessary to warn others. The court stated that the exercise of reasonable care may require the therapist to warn the potential victim "or those who can reasonably be expected to notify him."[53] The opinion does not, however, provide any standards for these additional warnings.[54]

In subsequent decisions, the courts have reconsidered and reinterpreted the definition of foreseeable victim. In *Thompson v. County of Alameda*,[55] the court determined that the county did not knowingly place the decedent child into a "foreseeably dangerous position" when it released a convicted juvenile offender into the neighborhood.[56]

The majority distinguished the murdered child in *Thompson* from Tatiana in *Tarasoff*. While Tatiana was a known, specifically foreseeable and identifiable potential victim, the Thompson child was not.[57] The psychotherapist in *Tarasoff* could have made one

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52. *Id.*

53. *Id.* at 442, 551 P.2d at 347, 131 Cal. Rptr. at 27.

54. Subsequent decisions have held that there is no duty to warn the family of a potential suicide victim. Bellah v. Greenson, 81 Cal. App. 3d 614, 620-21, 146 Cal. Rptr. 535, 539 (1978). California Evidence Code § 1024 and Welfare and Institutions Code § 5328 allow a therapist to warn if desired. CAL. EVID. CODE § 1024 (West 1966); CAL. WELF. & INST. CODE § 5328 (West 1984 & Supp. 1993). Additionally, there is no duty to warn the police under traditional case law since the police have no duty either to warn or protect the victim. Davidson v. City of Westminster, 32 Cal. 3d 197, 205, 649 P.2d 894, 898, 185 Cal. Rptr. 252, 256 (1982); Thompson v. County of Alameda, 27 Cal. 3d 741, 756, 614 P.2d 728, 736, 167 Cal. Rptr. 70, 78 (1980); *see* CAL. WELF. & INST. CODE § 5154 (West 1984 & Supp. 1993) (providing civil immunity for peace officers); CAL. GOV'T CODE § 856 (West 1980) (providing immunity for public entities and employees who detain persons due to mental illness).

55. 27 Cal. 3d at 753, 614 P.2d at 734, 167 Cal. Rptr. at 76 (holding that the County had no duty to warn the plaintiff, whose child had been murdered by a recently released juvenile offender, where the releasee made nonspecific threats against nonspecific victims).

56. *Id.* at 752-53, 614 P.2d at 733, 167 Cal. Rptr. at 75.

57. *Id.* at 752, 614 P.2d at 734, 167 Cal. Rptr. at 76.

simple, effective warning to protect Tatiana, but because the offender in *Thompson* did not name a specific victim, the county psychiatrist could not have made a single warning. Rather, the county would have had to warn the general public. The court felt that so broad a warning would not only have been ineffective, but also prejudicial to the releasee and detrimental to the county rehabilitation program.[58]

In view of these serious consequences, the *Thompson* court declined to impose a duty upon the county psychiatrist except where the benefits of warning outweigh the costs to the released offender.[59] The court decided that such benefits accrue only when a narrow group of people are involved; that is when a "named or *readily identifiable victim or group of victims* who can be effectively warned of the danger . . ." are the subject of the patient's threats.[60]

Echoing the words of the majority in *Tarasoff*, the California Court of Appeals held in *Mavroudis v. Superior Court of San Mateo County*,[61] that a therapist has a duty to protect a potential victim who can be identified at a moment's reflection.[62] The *Mavroudis* court concluded that the duty to protect arises when a patient threatens a "readily identifiable victim."[63]

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58. *Id.* at 755, 757, 614 P.2d at 736, 737, 167 Cal. Rptr. at 78, 79.

59. *Id.* at 754, 614 P.2d at 735, 167 Cal. Rptr. at 77.

60. *Id.* at 758, 614 P.2d at 738, 167 Cal. Rptr. at 80 (emphasis added); *see* Bill v. Superior Court, 137 Cal. App. 3d 1002, 1012-13, 187 Cal. Rptr. 625, 631-33 (1982) (holding producers of a violent movie have no obligation to protect members of the general public against the anticipated behaviors of violent patrons). *But see Thompson*, 27 Cal. 3d at 760, 614 P.2d at 739, 167 Cal. Rptr. at 81 (Tobriner, J., dissenting) (explicitly arguing that the existence of a readily identifiable victim is not essential in order to establish a duty of care). It should be noted that the dissent in *Thompson* suggested that the defendant owes a duty of care to all foreseeable victims. *Id.* Duty is not, according to Justice Tobriner, founded upon specific foreseeability; rather, it rests on the basic tenet of tort law that a defendant "owes a duty of care to all persons who are foreseeably endangered by his conduct." *Id.* As a result, the victim need not be foreseeable in order to establish a duty. *Id.* Instead, the reasonableness of the therapist's behavior is judged by whether a victim was foreseeable to the therapist at the time the threat was made. *Id.*

61. 102 Cal. App. 3d 594, 162 Cal. Rptr. 724 (1980) (upholding a duty of care in an action wherein petitioners claim that a psychiatrist should have warned them about his patient's potential dangerousness).

62. *Id.* at 600, 162 Cal. Rptr. at 729 (citing *Tarasoff II*, 17 Cal. 3d at 439 n.11, 551 P.2d at 345 n.11, 131 Cal. Rptr. at 25 n.11).

63. *Id.* at 601, 162 Cal. Rptr. at 730.

Similarly, in *Doyle v. United States*,[64] the district court declined to uphold a duty to protect because the victim was not foreseeable and identifiable.[65] The court followed *Tarasoff* and *Thompson*, stating that the duty to warn exists only when the victim is known and foreseeable.[66]

The Ninth Circuit also narrowly defined foreseeability in *Vu v. Singer*.[67] The *Vu* court concluded that under California law, the victim must be "foreseeable and specifically identifiable."[68] According to *Vu*, a therapist must be able to identify the victim specifically or no duty arises.[69]

In two subsequent decisions, the courts reversed course, broadening the definition of foreseeable victim. In *Jablonski by Pahls v. United States*,[70] the potential victim's daughter brought an action against a psychiatrist alleging that the therapist should have obtained his patient's past psychiatric records.[71] The plaintiff claimed that, based upon these records, the therapist should have warned the plaintiff's mother of the patient's homicidal ideations.[72]

The court noted that the patient had not made any threats against any specific individuals.[73] Nonetheless, the court held that the unsecured past psychiatric records indicated that the patient might attack his girlfriend.[74] In other words, the victim was

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64. 530 F. Supp. 1278 (C.D. Cal. 1982) (suit under the Federal Tort Claims Act where petitioner claimed that an Army psychiatrist should have warned decedent about a recently discharged Army serviceman).

65. *Id.* at 1288; *accord* Brady v. Hopper, 570 F. Supp. 1333, 1338 (D. Colo. 1983) (noting that the harm becomes more foreseeable the better known the intended victim becomes).

66. *Doyle*, 530 F. Supp. at 1288.

67. 706 F.2d 1027 (9th Cir. 1983) (declining to impose a duty of care upon a corporation in favor of neighborhood residents where company-related job corps members attacked the plaintiff's decedent at home).

68. *Id.* at 1029.

69. The concurrence in *Vu* argues that the existence of a foreseeable victim is not necessary to impose a duty of care. *Id.* at 1031-33 (Rothstein, J., concurring); *see supra* note 60 (providing J. Tobriner's argument for a duty to care towards *all* potential victims, even if unnamed).

70. 712 F.2d 391 (9th Cir. 1983).

71. *Jablonski*, 712 F.2d at 393.

72. *Id.* at 398. The patient's past history of violence, of which the therapist was unaware, was described in the records. *Id.*

73. *Id.* at 398.

74. *Id.* at 398.

sufficiently foreseeable. The court both recognized that a duty to protect existed and that the psychiatrist was in breach of duty because he had failed to act.[75] *Jablonski* thus expanded the definition of foreseeable victim to include those people who can be identified through a patient's past psychiatric records.

The California Supreme Court further expanded the duty of care in *Hedlund v. Superior Court of Orange County.*[76] In *Hedlund,* a woman who had been shot by a mental patient claimed that the attacker's psychiatrist owed a duty of care to her and to her child who witnessed the shooting.[77] At issue was whether a therapist owes a duty of care to *all* those who *may* be injured if the patient carries out his threat.[78] Specifically, is the potential victim's child a foreseeable victim even though he had not been threatened by the patient?

The *Hedlund* court adopted the rationale of the court in *Dillon v. Legg,*[79] and held that it is not unreasonable to recognize a duty to foreseeable persons closely related to the subject of a patient's threat.[80] This duty of care does not require the psychotherapist to protect anyone other than the threatened victim; still, the psychotherapist is liable to the other foreseeable parties based on his duty to protect the threatened victim.[81] Broadly speaking, by holding that the therapist becomes liable to all foreseeable persons who may be injured as a result of the patient's threat, *Hedlund* stretched the definition of the foreseeable victim far beyond the limits originally set by *Tarasoff* and *Thompson.*[82]

In sum, both *Tarasoff* and *Thompson* held that a potential victim must be foreseeable and readily identifiable.[83] The *Mavroudis* decision added that the victim must be identifiable upon

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75. *Id.*

76. 34 Cal. 3d 695, 669 P.2d 41, 194 Cal. Rptr. 805 (1983).

77. *Hedlund,* 34 Cal. 3d at 700, 669 P.2d at 42-43, 194 Cal. Rptr. at 807.

78. *Id.* at 705, 669 P.2d at 46, 194 Cal. Rptr. at 810.

79. 68 Cal. 2d 728, 441 P.2d 912, 69 Cal. Rptr. 72 (1968) (holding that a mother may recover damages for trauma sustained when she watched her son run over by a car).

80. *Hedlund,* 34 Cal. 3d at 706, 669 P.2d at 47, 194 Cal. Rptr. at 811.

81. *Id.* at 705 n.7, 669 P.2d at 46 n.7, 194 Cal. Rptr. at 810 n.7.

82. *See supra* notes 48-60 and accompanying text.

83. *See supra* notes 48-60 and accompanying text.

a moment's reflection.[84] *Doyle* and *Brady* further held that the victim should be known and foreseeable.[85] Finally, *Vu* stated that the victim should be known and specifically identifiable.[86] These decisions narrowed the scope of foreseeability.

Meanwhile, *Jablonski* and *Hedlund* reversed the trend towards narrowly defining foreseeable victim. The *Jablonski* decision created uncertainty regarding how far courts may reach in order to determine that the victim is foreseeable. *Jablonski* held that the psychiatrist has a duty to protect those individuals who can be identified from past records, in addition to those who can be identified in a personal interview with the patient.[87] The *Jablonski* court found that the psychiatrist should have located and examined prior records of violent behavior and hospitalization. After *Jablonski*, it was difficult for the psychotherapist to tell who or what she must consult in order to make her determination.

Next, the court in *Hedlund* expanded the duty of care to encompass a group of individuals entirely separate from the threatened victim: Those who are likely to be in the care and presence of the victim.[88] The identifiability of this new class of persons to whom a duty is owed depends upon the foreseeability of the original potential victim and upon whether this second class is foreseeable.[89] Again, because the definition of foreseeability is vague, it is difficult to determine to whom the therapist may be liable under *Hedlund.*

Relevant case law thus provides that in order to impose a duty of care upon psychotherapists, the potential victim must be somewhat identifiable. In view of the various standards discussed above, it is difficult to determine just how identifiable a potential

84. *See supra* notes 61-63 and accompanying text.

85. *See supra* notes 64-66 and accompanying text.

86. *See supra* notes 67-69 and accompanying text.

87. Jablonski by Pahls v. United States, 712 F.2d 391, 393 (9th Cir. 1983); *see supra* notes 70-75 and accompanying text (discussing the *Jablonski* decision).

88. Hedlund v. Superior Court, 34 Cal. 3d 695, 706, 669 P.2d 41, 47, 194 Cal. Rptr. 805, 811 (1983).

89. *Id.*

victim must be, since the courts have refused to furnish a workable definition of "readily" or "specifically identifiable."

C. A Serious Threat

In addition to the existence of a special relationship and a foreseeable victim, *Tarasoff* held that the patient must direct a serious threat of harm against the potential victim for a duty to protect to arise.[90] Specifically, the majority opinion required that the patient pose a "serious danger of violence" to others.[91] Other courts have generally followed this decision; however, they still struggle to define what constitutes a "serious threat of harm." The courts reason that a therapist's duty of care arises when there is a foreseeable risk of danger to a foreseeable victim.[92] The threats made against a potential victim must be serious enough to constitute this foreseeable danger.[93]

Recognizing that patients often make meaningless threats during therapy, the California Supreme Court in *Thompson* commented that a therapist is duty-bound only when a patient poses a "serious danger of violence to others."[94] A casual or nonspecific threat of harm, directed at a nonspecific victim, is not enough to impose a duty upon public entities.[95] Nor do group statistics indicating that a released inmate may kill again constitute a threat of violence from a member of that group.[96] Instead, the *Thompson* court held that a releasing agent is liable for failure to protect only when a released person makes a predictable threat of harm to a named or readily identifiable victim.[97]

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90. *Tarasoff II*, 17 Cal. 3d at 439, 551 P.2d at 345, 131 Cal. Rptr. at 25.

91. *Id.*

92. Molsbergen v. United States, 757 F.2d 1016, 1022-23 (9th Cir. 1985).

93. Palsgraf v. Long Island R.R. Co., 162 N.E. 99, 101 (N.Y. 1928); Doyle v. United States, 530 F. Supp. 1278, 1287 (C.D. Cal. 1982).

94. Thompson v. County of Alameda, 27 Cal. 3d 741, 752, 614 P.2d 728, 734, 167 Cal. Rptr. 70, 76 (1980) (citing *Tarasoff II*, 17 Cal.3d at 439, 551 P.2d at 345, 131 Cal. Rptr. at 25).

95. *Thompson*, 27 Cal. 3d at 754, 614 P.2d at 735, 167 Cal. Rptr. at 77.

96. *Id.*

97. *Id.* at 758, 614 P.2d at 738, 167 Cal. Rptr. at 80.

The court in *Mavroudis* added that the threat must be intended to be carried out in the immediate future.[98] The court held that a duty arises when a "patient presents a serious and imminent danger of violence. . . ."[99] The court in *Brady v. Hopper* additionally noted that the threat must be verbalized and directed at an identifiable victim.[100]

The Ninth Circuit seems to have elaborated and expanded the seriousness requirement in *Jablonski*. The patient in *Jablonski* made no clear, specific threat against the potential victim.[101] Nonetheless, the court found that a duty existed because the psychiatrist should have secured and scrutinized the patient's past psychiatric records.[102] Had he done so, he would have learned that Jablonski had raped his previous wife and had committed other acts of violence against her. The court concluded it would have been easy to infer from these records a present and serious threat of danger.[103]

Jablonski further complicated the meaning of threat by imposing a duty where the patient does not articulate a threat.[104] The *Jablonski* court inferred both the existence of the threat and the seriousness of its character from a source other than the patient.[105] It is questionable whether evidence of violence from prior history uniformly constitutes the serious foreseeable risk of harm contemplated by the court in *Tarasoff*. Depending upon the nature and quality of the records, it is easy to imagine situations where the imposition of a duty would be unwarranted. Thus, the result in *Jablonski* may allow other courts to infer seriousness perhaps from vague references in past records and pronounce a duty on the basis of hindsight.

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98. Mavroudis v. Superior Court, 102 Cal. App. 3d 594, 162 Cal. Rptr. 724 (1980).
99. *Id.* at 601, 162 Cal. Rptr. at 730.
100. Brady v. Hopper, 570 F. Supp. 1333, 1338 (D. Colo. 1983).
101. Jablonski by Pahls v. United States, 712 F.2d 391, 398 (9th Cir. 1983).
102. *Id.* at 398.
103. *Id.*
104. *Id.*
105. *Id.*

In sum, case law provides that in order to impose a duty to protect, the patient must make a sufficiently serious threat. Unfortunately, the courts have failed to define the contextual parameters of seriousness. It remains unclear whether seriousness is defined as the likelihood that a threat will be carried out or the severity of the danger. As a result, it is difficult for the therapist to determine exactly how serious a threat must be which would require him to act.

D. The Type of Harm Threatened

Another issue which arises concerns the type of harm which the patient threatens. The court in *Bellah v. Greenson*[106] interpreted *Tarasoff* as applying to threats of personal injury directed against third parties.[107] The *Bellah* court explained that *Tarasoff* is founded upon the public policy of protecting potential victims from violent assault.[108] The *Bellah* court decided that disclosure is not mandatory in cases involving self-inflicted harm, suicide, or property damage.[109] Thus, only where physical injury is the type of harm threatened does a duty to warn the foreseeable victim arise.[110]

E. To Whom the Decision Applies

Finally, the court in *Tarasoff* did not explicitly state to whom the holding of the decision applies.[111] While the *Tarasoff* case involved two psychiatrists and a psychologist,[112] many other mental health professionals provide some form of psychological counseling. Social workers, guidance counselors, occupational

106. 81 Cal. App. 3d 614, 146 Cal. Rptr. 535 (1978).

107. *Bellah*, 81 Cal. App. 3d at 620-22, 146 Cal. Rptr. at 539-40 (deciding that a therapist is under no duty to protect a suicidal patient by warning her parents).

108. *Id.* at 621-22, 146 Cal. Rptr. at 539-40.

109. *Id.*

110. *Id.*

111. *Tarasoff II*, 17 Cal. 3d at 436, 551 P.2d at 343, 131 Cal. Rptr. at 23.

112. *Id.* at 430, 551 P.2d at 349-40, 131 Cal. Rptr. at 19-20.

therapists, marriage and family counselors and psychiatric nurses, for example, could all be said to engage in therapy with their patients or clients.[113] Although several cases have documented the application of the *Tarasoff* duty to psychiatrists and psychologists,[114] whether the duty applies to other mental health workers under common law remains unclear.[115]

F. California Civil Code Section 43.92

As the above discussion illustrates, there is considerable ambiguity surrounding the interpretation and application of the *Tarasoff* decision. In 1984, the California State Psychological Institute contended that the psychotherapeutic community needed succinct and specific language to replace the inadequate guidance provided by the then existing case law.[116] In response to requests of mental health professionals for reasonable boundaries in an area of uncertain liability,[117] Governor Deukmejian and the California

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113. *Suing Psychotherapists*, *supra* note 16, at 359.

114. *See, e.g.*, *Tarasoff II*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (application of duty to psychiatrists and a psychologist); Hedlund v. Superior Court, 34 Cal. 3d 695, 669 P.2d 41, 194 Cal. Rptr. 805 (1983) (two psychologists held to owe a duty under *Tarasoff*); Jablonski by Pahls v. United States, 712 F.2d 391 (9th Cir. 1983) (duty owed by a psychiatrist).

115. The issue of whether a duty to warn and protect applies to parties other than mental health professionals has also been raised. Courts have been reluctant to impose a *Tarasoff* duty on the police absent a promise to warn or protect a third party from harm. *See, e.g.*, Davidson v. City of Westminster, 32 Cal. 3d 197, 649 P.2d 894, 185 Cal. Rptr. 252 (1982) (holding that there was no special relationship sufficient to establish a duty by the police to warn the victim of potential harm where police conducted a stakeout of a laundromat to apprehend a man who stabbed several women in laundromats on prior occasions and, during the stakeout, the victim entered the laundromat and was murdered by the suspect); *cf.* Morgan v. County of Yuba, 230 Cal. App. 2d 938, 41 Cal. Rptr. 508 (1964) (holding police had a duty to warn due to woman's dependence on the police's promise to warn the woman when the man who threatened her was released; police failed to do so and woman was killed). For a discussion of whether attorneys or clergymen could be held liable under *Tarasoff*, see Marc L. Sands, *The Attorney's Affirmative Duty to Warn Foreseeable Victims of a Client's Intended Violent Assault*, 21 TORT & INS. L.J. 355 (1986); Jacob M. Yellin, *The History and Current Status of the Clergy-Penitent Privilege*, 23 SANTA CLARA L. REV. 95, 142-48 (1983).

116. *See Hearing on A.B. 2900 Before the Senate Comm. on Jud.*, Cal. Leg. Reg. Sess. (1983-1984) (statement of California State Psychological Institute at hearing attended by Leslie Small, author of *Psychotherapists' Duty to Warn: Ten Years After* Tarasoff, 15 GOLDEN GATE U. L. REV. 271, 294 (1985)).

117. *See* Small, *supra* note 116, at 292-94 (discussing critics' contention that *Tarasoff* does not provide adequate standards for determining liability).

Legislature enacted section 43.92 of the California Civil Code.[118] Section 43.92, which became effective January 1, 1986, provides that when the patient has made a serious threat against an identifiable victim, the therapist is obligated to warn and protect by communicating the threat to the victim and to a law enforcement agency.[119]

Section 43.92 clarifies the psychotherapist's duty to third parties and the ways in which this duty may be discharged. First, the code defines the class of psychological counselors owing a duty to potential victims by referring to the definition of psychotherapist in California Evidence Code section 1010.[120] Second, the psychotherapist's liability is limited by statute to situations involving actual knowledge of potential violence.[121] The patient must *communicate* a serious threat to his therapist before a duty to warn and protect is imposed. In requiring that the therapist's patient articulate a threat of violence before a duty arises, section 43.92 appears to overturn *Jablonski's* ruling that an actual threat need not be disclosed.[122] Third, the statute seems to reaffirm the holding in *Bellah* by specifying the category of threats which establish the psychotherapist's duty.[123] Serious threats of physical violence as

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118. CAL. CIV. CODE § 43.92 (West Supp. 1993). The statute provides:

> (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 violent behavior *except where the patient has communicated to the psychotherapist a serious threat of physical violence against a readily 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.*

Id. (emphasis added).

119. *Id.*

120. CAL. EVID. CODE § 1010(a) (West Supp. 1993). Section 1010 provides that a psychotherapist is:

> (a) A person authorized, or reasonably believed by the patient to be authorized, to practice medicine in any state or nation who devotes, or is reasonably believed by the patient to devote, a substantial portion of his or her time to the practice of psychiatry.

Id. The statute's definition of psychotherapist includes a psychologist, clinical social worker, school psychologist, and marriage, family and child counselor as well. *See id* § 1010(b)-(e).

121. CAL. CIV. CODE § 43.92(a) (West Supp. 1993).

122. *See id.*; Jablonski by Pahls v. United States, 712 F.2d 391, 398 (9th Cir. 1983).

123. CAL. CIV. CODE § 43.92(a) (West Supp. 1993); Bellah v. Greenson, 81 Cal. App. 3d. 614, 621-22, 146 Cal. Rptr. 535, 539-40 (1978).

opposed to threats of suicide or property damage form the basis of the therapist's duty to warn third parties.[124]

In addition, the statute defines psychotherapists' duty more clearly. Specifically, the statute imposes a duty on the psychotherapist to warn and protect potential victims from harm. Yet, although section 43.92 provides, in broad language similar to *Tarasoff II*, that the psychotherapist must protect a potential victim,[125] the means by which he is obligated to do so is reminiscent of the duty enunciated in *Tarasoff I*.[126] Subsection (b) of the statute explicitly states that the psychotherapist's duty will be discharged by reasonable attempts to notify the potential victims and the police, thus reflecting the duty to warn imposed in *Tarasoff I*.[127] Finally, the particular parties the therapist must attempt to apprise of potential danger is specified in subsection (b) of the code.[128]

Although section 43.92 clarifies the psychotherapist's duty to some extent, many issues remain unresolved. The statute provides no content for such critical terms as "serious threat," "reasonably identifiable victim," and "reasonable efforts to communicate" a threat. Nor does the statute address the extent of the psychotherapist's potential liability for failure to warn. Section 43.92 places no limitations on the application of common law rules for determining the proximate damages for breach of duty. Therefore, the traditional "foreseeable injury" principles applied in *Hedlund* apparently still control.[129]

California Civil Code section 43.92 clarifies much of the ambiguity in the prior case law, while leaving some issues open to interpretation. Whether the statute strikes the proper balance

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124. CAL. CIV. CODE § 43.92(a) (West Supp. 1993). The argument could be made that threats of physical violence "against a reasonably identifiable victim" encompasses potential suicide threats. The authors feel, however, that the statute will not be interpreted in this manner.

125. *Tarasoff II*, 17 Cal. 3d at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

126. Tarasoff v. Regents of Univ. of Cal., 13 Cal. 3d 177, ___, 529 P.2d 553, 561, 118 Cal. Rptr. 129, 137 (1974), *vacated, Tarasoff II*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

127. *See supra* note 118 (providing text of § 43.92).

128. *Id.*

129. Hedlund v. Superior Court, 34 Cal. 3d 695, 705, 669 P.2d 41, 46, 194 Cal. Rptr. 805, 810 (1983).

between providing adequate professional guidance and being sufficiently broad to apply to varying factual circumstances remains to be seen. At present, the court has interpreted section 43.92 strictly to require strong evidence from an assailant's prior behavior that an assault was likely to occur.[130]

III. CRITICISMS OF THE *TARASOFF* DECISION

A. *Problems Predicting Potential Dangerousness*

The question of whether foreseeable harm exists in a particular case depends upon the presence of potential dangerousness in the patient.[131] Liability under *Tarasoff*, its progeny, and California Civil Code section 43.92 is premised upon the therapist's ability to identify potential dangerousness in patients.[132] The *Tarasoff* court adopted a standard of liability which requires the therapist to exercise the reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of the professional or specialty, under similar circumstances, in determining the mental status of the patient.[133]

This standard presents four serious problems. First, it has been widely argued that therapists are poor predictors of potential dangerousness.[134] In fact, psychological literature indicates that

130. Barry v. Turek, 218 Cal. App. 3d 1241, 1246, 267 Cal. Rptr. 553, 555-56 (1990).

131. *Tarasoff II*, 17 Cal. 3d at 437-38, 551 P.2d at 343-444, 131 Cal. Rptr. at 24-25; *Hedlund*, 34 Cal. 3d at 703, 669 P.2d at 45, 194 Cal. Rptr. at 809.

132. *Tarasoff II*, 17 Cal. 3d at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25 (citing various cases).

133. *See id.* at 451, 551 P.2d at 354, 131 Cal. Rptr. at 34 (Mosk, J., concurring and dissenting) (citing People v. Burnick, 14 Cal. 3d 306, 535 P.2d 352, 121 Cal. Rptr. 488 (1975)); *Hedlund*, 34 Cal. 3d at 707-708, 669 P.2d at 48, 194 Cal. Rptr. at 812 (Mosk, J., dissenting). *But see Tarasoff II*, 17 Cal. 3d at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25 (arguing that because psychological prediction is analogous to other medical diagnoses, a doctor should be held to a particular professional standard of care, additionally contending that the community standard mitigates prediction problems, obviating the need for perfect accuracy, and dismissing the prediction problem by adding that the therapists in this case had already predicted that Poddar would kill).

134. David T. Simpson Jr., Note, *Involuntary Civil Commitment: The Dangerousness Standard and its Problems*, 63 N.C. L. REV. 241, 249 (1984); Schopp & Quattrocchi, *supra* note 47, at 23; Howard Gurevitz, Tarasoff: *Protective Privilege Versus Public Peril*, 134 AM. J. PSYCHIATRY 289, 292 (1977); Bernard L. Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U. PA. L. REV. 439, 447, 451 (1974) (stating that evidence of failure to predict accurately is unequivocal); CLINICAL

therapists have difficulty diagnosing mental illness in general, and that the context in which an individual is found may influence professional perceptions more than the individual's behavior itself.[135] Predicting dangerousness based on uncertain diagnoses and poorly recognized contexts further challenges the psychotherapist.[136]

Several empirical studies demonstrate that psychotherapists are poor predictors of future violent behavior.[137] In part, the problem arises because there is no accepted definition of dangerousness.[138] Moreover, it is virtually impossible to predict the occurrence of dangerous behavior because dangerous behavior is such an infrequent event.[139] The literature concludes that across all circumstances, predicting dangerousness is difficult at best, and that predicting accurately is virtually impossible.[140]

ASPECTS OF THE VIOLENT INDIVIDUAL 28 (Am. Psych. Ass'n Task Force Report 1974) [hereinafter *Task Force Report*] (stating that no physical expertise in predicting dangerousness has been developed); Bruce J. Ennis & Thomas R. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693, 696, 734, 752 (1974) (stating that there is no evidence to suggest that psychiatrists are better than anyone else in predicting dangerousness and that prediction is impossible); Fleming & Maximov, *supra* note 33, at 1045; BRUCE J. ENNIS, PRISONERS OF PSYCHIATRY: MENTAL PATIENTS, PSYCHIATRISTS, AND THE LAW 227 (1972) (stating that psychiatrists are more often wrong than right in predicting potential dangerousness). *But see* J. Monahan, *Mental Disorder and Violent Behavior*, 47 AM. PSYCHOLOGIST 511, 521 (1992) (for changing view that violence and mental disorder *are* related).

135. David Rosenhan, *On Being Sane in Insane Places*, 179 SCIENCE 250, 258 (1973); Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CAL. L. REV. 54, 58 n.14 (1982).

136. Some critics argue, however, that dangerousness is difficult to assess precisely because it does not correspond with any particular diagnosis. *See, e.g.*, Schopp & Quattrocchi, *supra* note 47, at 32.

137. Joseph J. Cocozza & Henry J. Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence*, 29 RUTGERS L. REV. 1084, 1099 (1976); Henry J. Steadman & Joseph J. Cocozza, *Selective Reporting and the Public's Misconceptions of the Criminally Insane*, 41 PUBLIC OPINION Q. 523, 533 (1978).

138. Fleming & Maximov, *supra* note 33, at 1068.

139. *Id.* at 1061.

140. Recent evidence, however, suggests that while predicting dangerous behavior is clearly a difficult matter, there are circumstances when it can be predicted better than others. Thus, there is evidence that the incidence of violent behavior among those who meet the criteria for diagnosis of bipolar disorder, major depression, or schizophrenia is more than five times higher than it is for those with no disorder. And for those who have been diagnosed with drug or alcohol abuse/dependence, the incidence of violent behavior is 12-15 times higher than it is for those without disorders. J. Swanson et al., *Violence and Psychiatric Disorder in the Community: Evidence from the Epidemiologic Catchment Area Surveys*, 41 HOSP. & COMMUNITY PSYCHIATRY 761, 770 (1990).

Second, therapists' failure to predict dangerousness has several important consequences. The psychological literature indicates that therapists are more likely to label healthy patients as dangerous than to label dangerous patients as healthy.[141] These false positives may translate into frequent unwarranted warnings.

Psychotherapists also face the problem of deciding when to take protective measures. Psychiatric patients routinely make threatening statements during the course of therapy.[142] The psychotherapist must determine which, if any, of these statements are evidence of potential dangerousness of the caliber contemplated by *Tarasoff* and the subsequent case law.

Because the costs to the psychotherapist of ignoring a loaded threat are large, psychotherapists may well err on the side of overpredicting dangerousness.[143] Therapists will necessarily make more improper warnings based on their inaccurate predictions.[144] Additionally, because of their inability to predict and their fear of *Tarasoff* liability, they may overcommit patients to mental hospitals.[145]

Overprediction and subsequent warnings hurt both patient and psychotherapist. One critic writes that once a therapist warns a

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Moreover, evidence from other sources indicates that those who are actively experiencing symptoms which indicate serious psychological disturbance are involved in violent behavior much more frequently than nondisordered members of the general population. B. Link et. al., *Violent and Illegal Behavior of Current and Former Mental Patients Compared to Community Controls*, AM. SOC. REV. (publication forthcoming). Thus, it seems fair to conclude that there is a relationship between active mental disorder and the propensity to violence. As one commentator observes, however, the relationship while significant, is modest--sufficient that psychotherapists ought to attend to it, but not so robust that one can expect accurate prediction under most circumstances. J. Monahan, *Mental Disorder and Violent Behavior: Perceptions and Evidence*, 47 AM. PSYCHOLOGIST 511, 521 (1992). In this regard, it is worth noting that the Wisconsin Study concluded that 75% of their respondents nationally, and in all psychiatric professions they surveyed, indicated that they could make probable to certain dangerousness predictions. *The Wisconsin Study*, *supra* note 4, at 463.

141. *Task Force Report*, *supra* note 134, at 325-27; Ennis & Litwack, *supra* note 134, at 696; Rosenhan, *supra* note 135, at 385.

142. *Tarasoff II*, 17 Cal. 3d at 441, 551 P.2d at 347, 131 Cal. Rptr. at 27; Ennis & Litwack, *supra* note 134, at 711.

143. Schopp & Quattrocchi, *supra* note 47, at 29.

144. C. J. Meyers, *The Legal Perils of Psychotherapeutic Practice (Part II): Coping with* Hedlund *and* Jablonski, 12 J. PSYCHIATRY & L. 39, 45 (1984); Diamond, *supra* note 134, at 447.

145. *Tarasoff II*, 17 Cal. 3d at 461-62, 551 P.2d at 360-62, 131 Cal. Rptr. at 40-41 (Clark, J., dissenting).

potential victim, he invariably antagonizes and ultimately loses the patient.[146] Patients may also bring actions against therapists for breaches of privacy and confidentiality, defamation, and intentional infliction of emotional distress.[147] Psychotherapists additionally risk being sued for treble damages for unauthorized knowing and willful breaches of confidentiality under the California Welfare and Institutions Code.[148]

There is also evidence that concern over whether therapists can accurately predict dangerousness results in psychotherapists avoiding potentially dangerous patients.[149] As a result, patients who are in great need of psychological care are denied treatment. Dangerous patients remain untreated and may commit more violent acts than if psychotherapists were under no *Tarasoff* duty and were, thus, willing to treat all those in need.[150]

Third, imposing a duty on psychotherapists may impede their ability to treat patients.[151] Therapists may concentrate so focally upon diagnosing whether the patient is dangerous for *Tarasoff* purposes that they may inadvertently reduce the effort spent on treating the patient. Patients thus denied valuable care may become violent, circumventing the positive effect of the law.[152]

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146. Meyers, *supra* note 144, at 43.

147. Schaffer v. Spicer, 215 N.W.2d 134, 138 (S.D. 1974) (allowing a medical practitioner to be held liable in damages to patients for unauthorized disclosure). *But see* MacDonald v. Clinger, 84 A.D.2d 482, 487 (N.Y. App. Div. 1982) (allowing a defense for breach when patient presents a danger to self or others).

148. CAL. WELF. & INST. CODE §§ 5328, 5330 (West 1984 & Supp. 1993). Section 5328(r) authorizes the therapist to release information where a patient is dangerous to himself or others. *Id.* § 5328(r). If a therapist incorrectly assesses the patient as dangerous to himself or others, then the disclosure of information becomes unauthorized. Section 5330 creates a cause of action for treble damages when the unauthorized breach of confidentiality is willful and knowing. *Id.* § 5330.

149. Meyers, *supra* note 144, at 44.

150. *See* James C. Beck, *Violent Patients and the* Tarasoff *Duty in Private Psychiatric Practice*, 13 J. PSYCHIATRY & L. 361, 362 (1985) (noting critics' contentions that the *Tarasoff* decision does not adequately protect the public).

151. *See generally* Paul S. Appelbaum, *Implications of Tarasoff for Clinical Practice in the Violent Patient*, *in* JAMES C. BECK, THE *TARASOFF* DECISION AND PSYCHIATRIC PRACTICE 109 (1985).

152. *Suing Psychotherapists*, *supra* note 16, at 362. Lest this concern seem mere hyperbole, the court in *Hedlund* pointed out that "a negligent failure to diagnose dangerousness in a *Tarasoff* action is as much a basis for liability as is a negligent failure to warn." Hedlund v. Superior Court, 34 Cal. 3d 695, 703, 669 P.2d 41, 45, 164 Cal. Rptr. 809, 808 (1983).

Fourth, considering the inability (or in light of recent evidence, the quite modest ability) of psychotherapists to predict potential dangerousness, critics argue that *Tarasoff* holds therapists to an ill-defined community standard.[153] Under *Tarasoff*, a therapist has a duty to protect a potential victim if he decides *or should have decided* that the patient is potentially dangerous.[154] Determining whether the therapist should have diagnosed the patient as dangerous is problematic because the standard depends upon agreement in the mental health community.[155] If psychotherapists as a group can only weakly and imprecisely predict future dangerousness, then there can be no criteria against which to judge therapists' actions. Although the *Tarasoff* court cautioned against using hindsight to determine negligence on the part of the therapist,[156] it provided little other than hindsight for making that determination.

Thus, the fact that violence is, at best, only weakly associated with mental illness creates serious problems for the law and for clinicians. In the first place, no widely accepted definition of dangerousness exists. Moreover, regardless of definition, violent behavior is a relatively rare event, and rare events are by their nature difficult to predict. The tort liability to which psychotherapists are exposed encourages them to *overpredict* dangerousness. Such an increase in the incidence of false positives translates both into avoiding dangerous patients and, when they are not avoided, into many unwarranted warnings. In the face of such ambiguity, when should psychotherapists take protective measures? Indeed, given the ambiguities of prediction, psychotherapists may well attempt to cut anticipated losses by attending carefully to the diagnostic (and prognostic) matters of dangerousness, rather than actually treating those who require treatment.

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153. *Hedlund*, 34 Cal. 3d at 709, 669 P.2d at 49, 194 Cal. Rptr. at 813 (Mosk, J., dissenting); *Tarasoff II*, 17 Cal. 3d at 460-63, 551 P.2d at 360-62, 131 Cal. Rptr. at 40-42 (Clark, J., dissenting); John C. George, Hedlund *Paranoia*, 41 J. CLINICAL PSYCH. 291, 292 (1985).

154. *Tarasoff II*, 17 Cal. 3d at 431, 551 P.2d at 343-44, 131 Cal. Rptr. at 23-24 (emphasis added).

155. *Id.* at 462, 551 P.2d at 361, 131 Cal. Rptr. at 41 (Clark, J., dissenting).

156. *Id.* at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25.

B. Confidentiality and the Psychotherapeutic Alliance

While the matter of prediction seems both dire and exceedingly difficult, the effects of *Tarasoff II* on confidentiality are no less so. In what is perhaps the most widely cited phrase in the *Tarasoff* opinion, Justice Tobriner made clear that "[t]he protective privilege ends where the public peril begins."[157] Confidentiality has long been regarded as the cornerstone of the psychotherapeutic alliance.[158] The establishment of trust between a patient and his doctor is viewed as a fundamental aspect of clinical practice.[159] The sanctity of confidentiality has been embodied in statutes and in the ethical dictates of the medical and psychological professions.[160] Thus, the Principles of Medical Ethics of the American Medical Association (A.M.A.) provide: "[A] physician may not reveal the confidence entrusted to him in the course of medical attendance. . . ."[161] The idea of confidentiality, however, is not sacrosanct. The confidentiality mandate is suspended in particular circumstances.[162] For example, A.M.A. ethical principle section 9 allows a doctor to reveal confidential communications when he or she is required to by law, or where it becomes necessary in order to protect the welfare of the individual or the community.[163] Similarly, California Evidence Code section 1024 declares that there is no privilege of confidentiality where the psychotherapist reasonably believes that the patient's mental or emotional condition poses a danger to himself or to the person or property of another.[164] Under such circumstances, disclosure is necessary to prevent the threatened

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157. *Id.* at 442, 551 P.2d at 347, 131 Cal. Rptr. at 27.

158. Louis Everstine et al., *Privacy & Confidentiality in Psychotherapy*, 35 AM. PSYCHOLOGIST 828, 836 (1980).

159. William O. Faustman et al., *Considerations in Prewarning Clients of the Limitations of Confidentiality*, 60 PSYCH. REPS. 195, 195 (1987).

160. *See, e.g.*, CAL. EVID. CODE § 1014 (West 1966 & Supp. 1993) (psychotherapist-patient privilege); AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS § 9 (1959) (applying to all physicians, including psychiatrists) [hereinafter A.M.A. § 9].

161. A.M.A. § 9, *supra* note 160.

162. *See The Stanford Study*, *supra* note 6, at 165-66.

163. A.M.A. § 9, *supra* note 160.

164. CAL. EVID. CODE § 1024 (West 1966).

harm. These pre-existing exceptions to both the psychotherapist-patient evidentiary privilege and the ethical mandate to maintain confidentiality formed the basis of the California Supreme Court's formulation of the legal duty to protect in *Tarasoff*.[165]

However, several detrimental effects of requiring psychotherapists to breach confidentiality have been noted. First, without a guarantee of confidentiality, people may be deterred from seeking psychological help.[166] It is well recognized that in our society a stigma frequently attaches to persons undergoing psychological counseling.[167] The fear of such stigma inhibits people from consulting mental health professionals for their psychological problems.[168] While the psychotherapist's assurances to preserve confidentiality alleviates this reluctance, limitations on the therapist's ability to guarantee confidentiality may rekindle fears of stigmatization and cause persons to avoid needed psychological treatment.[169] Second, once treatment has begun, complete candidness and disclosure of information is necessary for effective psychological counseling.[170] Psychotherapists maintain that the therapist-patient relationship depends on the patient's uninhibited discussion and voluntary revelation of personal and sensitive material.[171] Without the psychotherapist's assurance of confidentiality, the patient's conscious and unconscious inhibitions may deter him from expressing his innermost thoughts.[172]

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165. *Tarasoff II*, 17 Cal. 3d at 441-42, 551 P.2d at 347-48, 131 Cal. Rptr. at 27-28.

166. *Id.* at 458-59, 551 P.2d at 359, 131 Cal. Rptr. at 39 (Clark, J., dissenting) (citing Ralph Slovenko, *Psychiatry and a Second Look at the Medical Privilege*, 6 WAYNE L. REV. 175, 187-88 (1960)).

167. *Tarasoff II*, 17 Cal. 3d at 459, 551 P.2d at 359, 131 Cal. Rptr. at 39 (Clark, J., dissenting).

168. *Id.*; *see* Robert M. Fisher, *The Psychotherapeutic Professions and the Law of Privileged Communications*, 10 WAYNE L. REV. 609, 617 (1964); Slovenko, *supra* note 166, at 188.

169. *Tarasoff II*, 17 Cal. 3d at 459, 551 P.2d at 359, 131 Cal. Rptr. at 39 (Clark, J., dissenting).

170. *Id.*

171. *Suing Psychotherapists*, *supra* note 16, at 366. There is little empirical evidence to support this contention. A study conducted to evaluate the impact of informed consent procedures on response rates and response quality in social survey research, however, found that assurances of confidentiality had a small but significant effect on participants' willingness to respond. Furthermore, there was some suggestion that guaranteeing confidentiality enhances the quality of answers to questions on sensitive issues. Eleanor Singer, *Informed Consent: Consequences for Response Rate and Response Quality in Social Surveys*, 43 AM. SOC. REV. 144, 150-51 (1978).

172. *Tarasoff II*, 17 Cal. 3d at 459, 551 P.2d at 359, 131 Cal. Rptr. at 39 (Clark, J., dissenting).

Third, even if a patient is not deterred from full disclosure, the potential for a breach of confidentiality may still erode his trust in the therapist to such a degree as to hinder the possibility of successful treatment. Establishing a trusting relationship is considered a fundamental aspect of effective psychotherapy: "The essence of much psychotherapy is the construction of trust in the external world and ultimately in the self, modelled upon the trusting relationship established during therapy."[173] Thus, if the trust between the therapist and patient is not developed because of the potential revelation of confidential communications to outside parties, the likelihood of achieving success in therapy may be frustrated.[174]

Some critics contend that the cumulative impact of these countertherapeutic effects will circumvent the intent of the *Tarasoff* decision.[175] They argue that imposing a duty to warn third parties may actually increase the likelihood of violent attacks on third parties by decreasing the number of people who receive effective psychological care or even any care at all.[176] One commentator predicted "the imposition of a duty to protect, which may take the form of a duty to warn threatened third parties, will imperil the psychotherapeutic alliance and destroy the patient's expectation of

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173. *Id.* at 460, 551 P.2d at 359, 131 Cal. Rptr. at 39 (Clark, J., dissenting) (citing Donald J. Dawidoff, *The Malpractice of Psychiatrists*, 1966 DUKE L.J. 696, 704 (1966)); *see* Everstine et al., *supra* note 158, at 836.

174. *Tarasoff II*, 17 Cal. 3d at 460, 551 P.2d at 359-60, 131 Cal. Rptr. at 39-40 (Clark, J., dissenting). Some commentators contend that applying the *Tarasoff* duty in a clinical setting can produce therapeutic benefits for patients. Specifically, they argue that involving the patient in the warning process: (1) Allows the patient in therapy to focus on his relationship with the potential victim, and (2) allows the patient to observe the therapist apply a verbal solution to a potentially violent situation. *See* David Wexler, *Patients, Therapists and Third Parties: The Victimological Virtues of* Tarasoff, 2 INT'L J. PSYCHIATRY 1, 128 (1979); Lawson R. Wulsin et al., *Unexpected Clinical Features of the* Tarasoff *Decision: The Therapeutic Alliance and the "Duty to Warn,"* 140 AM. J. PSYCHIATRY 601, 606 (1983).

175. *See generally* C. J. Meyers, *Hard Cases: The "Duty to Warn" As a Felt Necessity of Our Time*, 15 J. PSYCHIATRY & L. 189 (1987); *Suing Psychotherapists, supra* note 16; Everstine et al., *supra* note 158.

176. *Tarasoff II*, 17 Cal. 3d at 462, 551 P.2d at 361, 131 Cal. Rptr. at 41 (Clark, J., dissenting); Faustman & Miller, *supra* note 159, at 198.

confidentiality, thereby thwarting effective treatment and ultimately reducing public safety."[177]

The court in *Tarasoff* succinctly dismissed all these objections.[178] It concluded that the public policy protecting confidential communications between patient and therapist must yield where necessary to avoid danger to potential victims. But one suspects that the court did not fully anticipate how destructive increasingly expansive interpretations of the dangerous patient exception would be to the psychotherapist-patient privilege. Three recent cases simply eliminated confidentiality and privilege for patients who have demonstrated that they are, will be or have been dangerous.[179] As Charles Meyers observes:

> [such cases] which draft psychotherapists into an army waging war against antisocial behavior, are part of a trend that extends back to *Tarasoff* and that includes the child abuse reporting laws. But in these three recent cases, psychotherapists are being ordered to do more than serve as society's early warning system: if they fail to protect potential victims, psychotherapists are being required to become hostile witnesses, providers of testimony likely to ensure that their patients will be convicted and punished.[180]

Interestingly, the commentators have not generally distinguished the application of the preceding criticisms of the *Tarasoff* duty from the pre-existing ethical limitations on the confidentiality standards.[181] As noted above, the ethical dictates of the mental health professions traditionally include exceptions to the obligation

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177. *Suing Psychotherapists, supra* note 16, at 368.

178. *Tarasoff II*, 17 Cal. 3d at 440-42, 551 P.2d at 346-48, 131 Cal. Rptr. at 26-28.

179. People v. Wharton, 53 Cal. 3d 522, 809 P.2d 290, 280 Cal. Rptr. 631 (1991); Menendez v. Superior Court, 7 Cal. App. 4th 147, 279 Cal. Rptr. 521 (1991), *rev'd in part*, 3 Cal. 4th 435, 834 P.2d 786, 11 Cal. Rptr. 92 (1991); People v. Clark, 50 Cal. 3d 583, 789 P.2d 127, 268 Cal. Rptr. 399 (1990).

180. Charles J. Meyers, *Where the Protective Privilege Ends: California Changes the Rules for Dangerous Psychotherapist Patients*, 19 J. PSYCHIATRY & L. 26, 26 (1991).

181. *See, e.g., Suing Psychotherapists, supra* note 16, at 373-74; Ralph Slovenko, *Psychotherapy and Confidentiality*, 24 CLEV. ST. L. REV. 375, 392-93 (1975) ("Moreover the [*Tarasoff*] decision does not drastically affect the psychiatrist as it has long been the general practice to discreetly warn appropriate individuals or law enforcement authorities when a patient presents a distinct and immediate threat to someone").

to preserve confidences where a patient poses a risk of violence to third parties.[182] Assuming the ethical dictates regarding disclosure have some force, many of the detrimental effects imputed to the *Tarasoff* decision would appear to apply to the ethical standards as well. To the extent that the legal duty and ethical duty to disclose can be regarded as similar, the dire consequences that are imputed to *Tarasoff* on clinical practice might well have arisen in the absence of that decision.

There are, of course, significant differences between the legal duty imposed under *Tarasoff* and the psychotherapist's obligations to disclose under the ethical rules. Most importantly, a judicially-imposed duty is generally regarded as much more intrusive than an ethical dictate. Though dangerousness preceded *Tarasoff*, the vigorous debate about the psychotherapist's obligation to endangered third parties did not arise until the court imposed the duty. Moral obligations are weaker and the potential liability for violation of a legal duty is typically greater than for an ethical principle, thereby giving much stronger force to the legal obligation.[183] In light of these distinctions, it is likely that a legal duty to reveal confidences will more markedly affect the psychotherapeutic alliance than will ethical duties. For example, the Stanford Study, conducted one year after *Tarasoff II*, reported that therapists were devoting more of their clinical energies to their patient's minor threats, and feeling more anxiety when a patient's potential violence became an issue.[184] Additionally, a small but significant number of therapists reported reluctance to discuss issues that might reveal patients' propensities to commit violence.[185] To the extent that effects on clinical practice such as these have continued to occur seventeen years after *Tarasoff*, the impact of the legal duty established in *Tarasoff* should not be underestimated.

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182. *See supra* notes 157-164 and accompanying text (discussing the psychotherapist-patient privilege, embodied in the California Evidence Code and the A.M.A. Principles of Medical Ethics).

183. Although severe sanctions do exist for violations of ethical rules, i.e., loss of one's license to practice, such sanctions are generally only applied in extreme circumstances.

184. *The Stanford Study, supra* note 6, at 187-88.

185. *Id.* at 188.

IV. METHOD

This study was based on a 1987 survey mailed to 600 licensed psychiatrists and 1200 licensed psychologists in the state of California.[186] "The *Tarasoff* Project" materials were mailed on January 9, 1987.[187] Each survey participant received a cover letter explaining the purpose of the study, a self-addressed stamped return envelope, and the *Tarasoff* survey.[188] The survey comprised thirty-nine multiple choice questions. These questions focused on five primary issues: (1) biographical information; (2) familiarity with and understanding of the *Tarasoff* decision and California Civil Code section 43.92; (3) ability and willingness of therapists to comply with *Tarasoff*; (4) how therapists have responded to the decision; and (5) the particular effects of *Tarasoff* upon psychotherapeutic practice. Upon receipt, each questionnaire returned before March 1, 1987 was numbered. Multiple-choice responses were entered into a computer. Responses to open-ended questions were later recorded and interpreted.

The *Tarasoff* survey examines therapists' perceptions of the broad effects which *Tarasoff* has had on psychotherapeutic practice over the years. We asked therapists questions which encouraged them to reflect upon the whole of their practice since the *Tarasoff* decision.

In contrast, the Wisconsin Study examined therapists' conduct in the most recent case wherein the therapist exercised his duty to protect.[189] In so doing, the Wisconsin researchers sought to avoid socially desirable answers to broad questions regarding psychotherapists' behavior.[190] While we recognize that some of

186. We limited our survey to members of the Northern California Psychiatric Association because of expense. The roster of psychiatrists was obtained from the Northern California Psychiatric Society. One of every two psychiatrists was randomly selected to participate in the survey. A list of 7200 psychologists was provided by the California Board of Medical Examiners. One of every six psychologists was invited to respond to the questionnaire. In cases where the sixth psychologist resided outside of California, the next person on the list with a California address was chosen.

187. The study was originally entitled "The *Tarasoff* Project."

188. A copy of the *Tarasoff* Survey and the cover letter are attached as Appendix A.

189. *The Wisconsin Study*, *supra* note 4, at 456.

190. *Id.*

our questions could have enticed psychologists and psychiatrists to answer in a socially desirable fashion, the benefits of learning about the overall effects of the decision upon psychotherapeutic practice seemed to us to outweigh this potential cost.

V. RESULTS AND DISCUSSION

A. Background Information

A total of 872, or 47.1%, of the questionnaire recipients returned the *Tarasoff* survey.[191] Of the 872 respondents, 30.7% were clinical psychiatrists (M.D.), 56% clinical psychologists (Ph.D.), 1.2% clinical psychologists (M.A.), and 5.2% retired practitioners.[192] Additionally, 6.7% of the questionnaires were returned as "others." The data regarding the respondents' occupations are set forth in Table 1.

191. The questionnaire was mailed to 1850 psychiatrists and psychologists. Approximately forty were returned by the Post Office as "Addressee Unknown." This effectively reduces our sample size to 1810, but increases our response rate to 48.2%.

192. As might be expected, retired practitioners often returned the questionnaire without answering the vast majority of questions. Where appropriate, statistics were corrected for this result by using valid percentages.

TABLE 1
OCCUPATION OF RESPONDENTS

Occupation	Frequency	Valid Percent
Clinical Psychiatrists (M.D.)	266	30.7%
Psychologists (Ph.D)	488	56.3%
Psychologists (M.A.)	10	1.2%
Retired Practitioners	45	5.2%
Others	58	6.7%

Of the survey participants indicating their sex, 72% were male and 27.3% were female. The majority (62.6%) of respondents fell between the ages of 31 and 47. The distribution of respondents' ages is contained in Table 2.

TABLE 2
AGE OF RESPONDENTS

Age (In Years)	Frequency	Valid Percent
22 to 30	20	2.6%
31 to 37	163	21.5%
38 to 47	313	41.2%
48 to 56	119	15.7%
57 to 65	94	12.4%
greater than 65	50	6.6%

Of those respondents who indicated their gross income, forty percent were earning between $41,000 and $80,000 annually. Gross income figures for psychiatrists were higher than for psychologists. Slightly under sixty percent of the responding psychologists reported earning between $20,000 and $60,000 annually, as

compared with almost 25% of the responding psychiatrists. Almost 46% of the psychiatrists reportedly earned between $81,000 and $150,000, as compared with roughly 26% of the psychologists. Data regarding respondents' income are reported in Table 3.

TABLE 3
INCOME OF RESPONDENTS

Income	Frequency			Valid Percent		
In Thous. $	Psycol	Psycia	Overall	Psycol	Psycia	Overall
Less than $20	12	3	17	2.4%	1.1%	1.9%
$20 to $40	72	16	90	14.5%	6.0%	10.3%
$41 to $60	182	50	240	36.6%	18.8%	27.5%
$61 to $80	67	41	109	13.4%	15.4%	12.5%
$81 to $100	73	47	120	14.7%	17.7%	13.8%
$101 to $150	55	75	130	11.1%	28.2%	14.9%
$151 to $200	5	15	20	1.0%	5.6%	2.3%
$201 to $300	5	5	10	1.0%	1.9%	1.1%
Greater than $300	2	1	3	0.4%	0.4%	0.3%
Missing	24	13	133	4.8%	4.9%	15.3%

While most of the respondents were institutionally affiliated, a substantial proportion were also engaged in private practice. Eighty-one percent of responding psychiatrists and 94.1% of the psychologists were involved in some form of private practice. The data concerning specific affiliations are shown in Table 4.

TABLE 4
PSYCHOTHERAPISTS' AFFILIATIONS

Affiliation	Frequency			Percentages*		
(Institution)	Psycol	Psycia	Overall	Psycol	Psycia	Overall
Private Hospital	164	162	327	34.4%	60.9%	37.5%
Public Hospital	62	52	116	12.7%	19.5%	13.3%
Correctional Facility	18	7	25	3.7%	2.6%	2.9%
Primary, Secondary School	25	5	30	5.9%	1.9%	3.4%
University	150	114	266	32.0%	42.9%	30.5%
No Affiliation	97	17	122	21.9%	6.4%	14.0%
Other Affiliations	112	28	142	24.9%	10.5%	16.3%

*Percentages exceed 100% as some therapists provided multiple responses.

Regarding experience, over 47% of responding practitioners had practiced between five and fifteen years. Approximately one-third of the respondent psychologists had practiced between five and ten years, whereas under 17% of psychiatrists have practiced this length of time. Additionally, almost one-half of the psychiatrists had practiced for over fifteen years, as compared to roughly 29% of the psychologists. Table 5 contains the data reflecting the length of respondents' practice time.

TABLE 5
LENGTH OF RESPONDENTS' PRACTICE TIME

Length Of Practice	Frequency			Valid Percent		
Time in Years	Psycol	Psycia	Overall	Psycol	Psycia	Overall
0 to 5	86	33	122	17.7%	12.5%	15.9%
5 to 10	155	44	199	31.9%	16.7%	26.0%
10 to 15	106	56	163	21.8%	21.2%	21.3%
greater than 15	139	131	282	28.6%	49.6%	36.8%

Respondents were asked how many patients they counsel annually.[193] Almost 42% of practitioners answering this question reported counseling between 31 and 100 patients annually. Thirty-nine percent indicated they had seen over 100 patients per year, and 19.5% saw between zero and thirty patients yearly. Annual caseloads for psychologists and psychiatrists vary slightly and are noted in Table 6.

193. *See infra* app. A, question No. 5.

TABLE 6
ANNUAL NUMBER OF PATIENTS SEEN BY PSYCHOTHERAPISTS

Number Of Patients	Frequency			Valid Percent		
(in categories)	Psycol	Psycia	Overall	Psycol	Psycia	Overall
0	4	0	6	.8%	0.0%	0.8%
1 to 5	11	1	13	2.3%	0.4%	1.7%
6 to 10	13	7	21	2.7%	2.7%	2.8%
11 to 20	26	15	44	5.3%	5.7%	5.8%
21 to 30	48	15	64	9.9%	5.7%	8.4%
31 to 50	95	39	135	19.5%	14.9%	17.7%
51 to 100	128	55	184	26.3%	21.0%	24.2%
greater than 100	161	130	294	33.1%	49.6%	38.6%

Given that anger is a core ingredient of violence, and that the negotiation of anger is often a theme of psychotherapy, *Tarasoff* could potentially affect a large number of clinical practitioners. Respondents were asked if they had counseled a potentially dangerous patient post-*Tarasoff*.[194] Sixty-four percent of respondents overall and 74.1% of those answering this question reported counseling dangerous patients after the decision. In addition, 72% of the survey sample--84% of those answering the question--found themselves counseling *at least one* potentially dangerous patient per year.[195] While almost forty percent of the respondents reported counseling one or two dangerous patients annually, 56.3% of the sample reported counseling between one and five dangerous patients per year.

194. *See infra* app. A, question No. 21.
195. *See infra* app. A, question No. 22.

In short, while the base rate for violent behavior is low in the community, and while potentially violent people do not occupy a substantial proportion of a psychotherapist's caseload, it is clear that nearly every practicing therapist has seen a potentially violent person in treatment. At the very least, many therapists have had an opportunity to contemplate their *Tarasoff* obligations.

B. Therapists' Knowledge and Understanding of the Law

The survey results sustain the view that many therapists had actually considered the *Tarasoff* decision. Over 84% of the entire sample indicated that they have heard of *Tarasoff*.[196] Further, of those therapists who answered this question, over 98% knew of the decision. Finally, roughly 86% of the respondents indicated that *Tarasoff* has manifested specific effects upon their practice.[197]

In order to determine practitioners' understanding of the case, therapists were questioned about the precise elements of *Tarasoff*. Specifically, therapists were asked to whom they thought the decision applies, whether a specific individual must be named, whether a threat must be likely to occur, and to what types of threatened harm the case is addressed.[198]

Eighty-six percent of the therapists felt that *Tarasoff* applies to psychiatrists and 85.1% would apply the decision to clinical psychologists.[199] This result is consistent with the court's ruling that a *Tarasoff* duty arises whenever a special relationship exists between a therapist and his patient.[200]

Although the case law does not explain to whom the decision applies, surveyed psychiatrists and psychologists would extend

196. Overall, 86.4% of the respondents have heard of the *Tarasoff* decision--98.9% of the psychiatrists and 97.5% of the psychologists.

197. *See infra* app. A, question No. 32. Roughly 86% of the respondents indicate that *Tarasoff* produced at least one of the effects enumerated in question No. 32.

198. *See infra* app. A, question Nos. 8, 10, 13, & 9, respectively.

199. *See supra* notes 111-115 and accompanying text (discussing the professionals to whom the decision applies).

200. *See supra* notes 45-47 and accompanying text (discussing the special relationship).

liability to other clinical mental health practitioners.[201] Over 81% of the respondents believed that *Tarasoff* applies to clinical social workers. But fewer than four percent of respondents would apply *Tarasoff* to priests and religious counselors.

The *Tarasoff* court held that a duty to protect arises when a patient poses a serious threat of danger or violence to a foreseeable victim.[202] Recent decisions, however, diminish this foreseeability requirement. *Jablonski*, holding that foreseeability may be assessed from past psychiatric records, and *Hedlund*, holding that a duty of care extends to all victims who may be injured as a result of an unchecked threat, challenge the courts' mandate that a named victim must be foreseeable to the therapist in order that a duty arise.[203]

Despite these changes in the law, almost all of the practitioners surveyed indicated that the patient must identify a specific victim for *Tarasoff* to apply. In particular, 96% of the therapists answering this question--82.5% of the entire sample--believed that the patient must identify a specific victim to invoke *Tarasoff*. Four percent of the responding therapists thought that the decision applied where the patient makes a general threat. Fourteen percent of the sample did not respond to this question.

The most probable interpretation of these results is that therapists understand *Tarasoff*, but are unaware of the *Jablonski* and *Hedlund* decisions. Alternately, it may well be that practitioners are aware of the recent changes, but do not think that the courts will enforce them in subsequent decisions. It is also possible that respondents narrowly construed the question as applying only to *Tarasoff* and not to other cases which have subsequently modified the decision.

The *Tarasoff* court also decided that a duty to protect is partly contingent upon the existence of a "serious threat of danger or

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201. *See supra* notes 111-115 and accompanying text (discussing the professionals to whom the decision applies).

202. *See supra* notes 48-89 and accompanying text (discussing the foreseeability requirements after *Tarasoff*).

203. *See supra* notes 70-89 and accompanying text (discussing the *Jablonski* and *Hedlund* cases).

violence."[204] Later decisions acknowledge this requirement. The *Jablonski* court would have gleaned the seriousness of the threat and its seriousness from the patient's past psychiatric records.[205]

The majority of therapists in this study believed that *Tarasoff* applies where the patient poses a threat which is likely to be carried out. Seventy-one percent of respondents who answered this question believed that *Tarasoff* applies only to likely threats.[206] Meanwhile, 28.9% of responding therapists believed that *Tarasoff* applies to all threats.[207] Almost 15% of those surveyed did not respond.

Practitioners were then asked about their understanding of the type of threatened harm contemplated by *Tarasoff*.[208] The results indicate that 67.9% of respondents overall stated that the decision applies to threats of personal injury; 81.4% indicated that *Tarasoff* applies where a patient threatens homicide; and 11.9% responded that the case relates to threats of property damage. There were no significant differences between the responses given by psychiatrists and those given by psychologists.

The clear majority of practitioners recognize that *Tarasoff* applies when a patient threatens some type of physical injury. This view is consistent with the court's ruling in *Bellah v. Greenson*, which limited the application of *Tarasoff* to threats of personal harm.[209] Interestingly, practitioners distinguished between the

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204. *See supra* notes 90-105 and accompanying text (discussing the nature of a threat).

205. *See supra* notes 102-105 and accompanying text (discussing evidence from prior records).

206. Our findings are lower than those of the Wisconsin Study which determined that 95% of psychologists and 94% of psychiatrists in California believe that *Tarasoff* applies when a patient threatens harm to another and when the therapist believes that there is a serious possibility that the patient might do so. *The Wisconsin Study*, *supra* note 4, at 461. The results are also lower than the Wisconsin Study's discovery that 89% of psychiatrists and 93% of psychologists in California believe that *Tarasoff* applies when a client threatens harm to another and a reasonable therapist would believe that there is a serious possibility that the patient may do so. *Id.* at 462. It should be noted that the format of this question in the Wisconsin Study may have suggested the answer to respondent psychotherapists, and would explain why the Wisconsin Study's findings are so much higher.

207. These numbers reflect valid percentages.

208. This question has mutually exclusive answers. We did not control for respondents giving more than one answer. The sum of the percentages thus exceeds 100%.

209. *See supra* notes 106-110 and accompanying text (discussing *Bellah*). These findings are consistent with those of the Stanford Study. The study indicated that nearly 75% of the respondents believed that the decision applies when a patient threatens murder or violent physical injury. *The*

types of physical injury intended. The more grave the danger, the more willing therapists are to apply *Tarasoff*. Under *Bellah*, this distinction is unnecessary since therapists are bound when a patient threatens any physical injury.[210]

The court in *Bellah* further held that *Tarasoff* does not apply where a patient threatens self-inflicted harm or suicide.[211] Despite this holding, 14.8% of responding therapists believed that *Tarasoff* applies in suicide cases. Interestingly, psychologists' and psychiatrists' responses differ on this question. While 23% of psychologists believed that *Tarasoff* applies to suicidal threats, only six percent of psychiatrists held this belief. In spite of this finding, the overwhelming proportion of the sample--85.2%--correctly understood that *Tarasoff* does not apply to suicidal threats.[212]

In sum, the majority of therapists believed that *Tarasoff* applies to clinical psychologists, psychiatrists, and social workers. They additionally believed that *Tarasoff* applies when a specific victim has been identified, when a patient's threat is likely to be carried out, and when the threat involves personal injury or homicide. These perceptions are consistent with *Tarasoff* and the majority of subsequent decisions. To the extent that *Hedlund* and *Jablonski* have modified the law, however, the psychotherapists' responses do not reflect knowledge of current legal doctrine.

In addition to studying psychotherapists' grasp of the case law, we examined therapists' familiarity with and understanding of California Civil Code section 43.92.[213] Thirty percent of the therapists reported being familiar with the statute, while 55% of the respondents were unaware of the statute, and 15% did not respond to the question. Of those who acknowledged familiarity with the

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Stanford Study, *supra* note 6, at 178.

210. *Bellah*, 81 Cal. App. 3d at 621-22, 146 Cal. Rptr. at 539-40.

211. *Id.*

212. The Stanford Study determined that 21% of respondents overall believe that *Tarasoff* applies to threats of suicide. *The Stanford Study*, *supra* note 6, at 178. Apparently more psychiatrists than psychologists have learned about the holding in *Bellah* during the last nine years.

213. *See supra* note 118 (providing the text of the statute in full).

statute, 40% of them were psychologists and 25.9% were psychiatrists.[214]

Therapists were also examined for their knowledge of the statute. Specifically, respondents were asked who must be warned under section 43.92.[215] Sixty-five percent of the practitioners thought section 43.92 requires therapists to warn potential victims, and 46.3% thought the statute requires warning the police.[216] Of the 30% of the sample who reported being familiar with section 43.92, only 50.5% of the respondents understood that the statute requires that *both* (and only both) the police and potential victims must be warned.

These results are surprising in view of prior requests by psychiatric and psychological organizations for statutory guidelines to safeguard psychotherapists from potential liability.[217] Either these organizations have not undertaken rigorous efforts to inform their members of the existence and provisions of section 43.92, or the membership has not absorbed the lessons.

C. *Therapists and the Prediction of Dangerousness*

Tarasoff has been widely criticized for imposing liability based upon practitioners' predictions of future dangerousness.[218] Critics contend that mental health professionals are simply unable to predict potential dangerousness in their patients. It has also been argued that *Tarasoff* inhibits effective therapy, and that therapists may avoid potentially dangerous patients as a result of the decision.[219]

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214. A significant positive relationship was found between therapists' familiarity with § 43.92 and the number of years that therapists were in practice. $x^2 = 9.91$; with 3 d.f., sig. at 0.02.

215. *See infra* app. A, question No. 12.

216. Additionally, 13% of respondents thought § 43.92 requires warning a potential suicide victim's family and 12.6% thought the statute requires warning any potential victim's family.

217. *See supra* note 116 and accompanying text (providing statement by the California Psychological Institute).

218. *See supra* notes 131-156 and accompanying text (discussing the predictability of dangerousness).

219. *See supra* notes 131-152 and accompanying text.

This study sought to determine whether and how the obligation to predict dangerousness imposed by *Tarasoff* affects psychotherapeutic practice. Therapists were questioned regarding the number of dangerous patients they counsel, their perceived ability to predict potential dangerousness, and whether and why they avoid counseling potentially dangerous individuals.[220] We found that the majority of practitioners face situations where they must assess potential dangerousness. Sixty-four percent of the respondents reported having counseled a potentially dangerous patient since *Tarasoff*.[221] In addition, 72% of the sample indicated that they see at least one potentially dangerous person annually.

Therapists were then asked to determine how well they believe they can predict potential dangerousness. Few psychotherapists reported that they could assess dangerousness "very accurately"--4.3% overall; 5.3% of psychologists, and only 1.6% of psychiatrists. Almost 30% of responding practitioners believed that they could predict potential dangerousness "somewhat accurately." Meanwhile, the overwhelming proportion of psychotherapists--72.5% of the psychiatrists, 63.7% of the psychologists, and 66.3% of the sample who answered this question--felt that they could predict dangerousness "better than chance" or "not at all." These data are reported in Table 7.

220. *See infra* app. A, question Nos. 22, 24, 23, & 23a, respectively.

221. *See supra* text accompanying notes 194-195 (discussing the survey questions related to the counseling of potentially dangerous patients).

TABLE 7
THERAPISTS' ABILITY TO PREDICT
POTENTIAL DANGEROUSNESS

Ability To Predict	Frequency			Valid Percent		
	Psycol	Psycia	Overall	Psycol	Psycia	Overall
Very Accurately	25	4	32	5.3%	1.6%	4.3%
Somewhat Accurately	146	67	218	31.0%	26.0%	29.4%
Better Than Chance	258	156	419	54.8%	60.5%	56.5%
Not At All	42	31	73	8.9%	12.0%	9.8%

The majority of psychotherapists are uncomfortable with their ability to predict. Although the findings do not speak to whether psychotherapists are *actually* able to assess potential dangerousness, they do indicate that therapists' *perceived* predictive efficacy is weak.[222] To the extent that perceived ability is a strong indicator of actual ability, these results suggest that psychotherapists' ability to predict future dangerous behavior is limited.[223]

The criticisms leveled at *Tarasoff* appear justified in view of psychotherapists' responses. *Tarasoff* imposes a duty upon practitioners based on an assessment which practitioners feel incompetent to make. As a result, therapists may overpredict dangerous behavior for fear of *Tarasoff* liability.[224] Such overprediction may also prompt psychotherapists to overcommit patients and to warn others unnecessarily.[225] Moveover, unless therapists are wholly misguided about their ability to predict, the results indicate that a community standard which judges prac-

222. *See generally* ALBERT BANDURA, SOCIAL FOUNDATIONS OF THOUGHT AND ACTION ch. 9 (1986) (discussing implications of self-efficacy).

223. The survey did not ask about the bases psychotherapists use to assess dangerousness.

224. *See supra* notes 143-145 and accompanying text (discussing post-*Tarasoff* risk of overprediction and unnecessary commitment).

225. *See supra* notes 146-148 and accompanying text (discussing risk of unnecessary warnings).

titioners' behavior based on their ability to predict dangerousness is untenable and inappropriate.[226]

To determine whether psychotherapists' perceived ability to predict dangerousness varies with the length of time they have been practicing, responses to questions two and twenty-four were examined.[227] No statistically significant results emerged.[228] Thus, practitioners do not become more comfortable with predicting dangerousness as they progress in their careers.

Another criticism of *Tarasoff* is that it deters therapists from counseling potentially dangerous patients.[229] To determine if this is true, therapists were asked whether and why they avoid counseling potentially dangerous patients. A surprisingly high proportion of the respondents--roughly 46% of the psychotherapists surveyed--reported that they do avoid counseling potentially dangerous patients. Additionally, of those therapists who avoid these patients, 40.3% answering this question indicated that they avoid potentially dangerous patients at least in part because of fear of *Tarasoff* liability.

Over sixty percent of respondents indicated avoiding potentially dangerous patients because of the nature of the work.[230] Specifically, 39% of responding psychotherapists stated that they avoid counseling potentially dangerous patients because "it is difficult work." Of the "other reasons" reported by psychotherapists, the most often cited rationale was fear for personal safety.

Although a substantial proportion of psychotherapists avoid counseling potentially dangerous individuals for reasons unrelated to *Tarasoff*, a striking minority indicate that the decision has influenced their behavior regarding treatment of potentially dangerous individuals. Patients who might ordinarily be admitted

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226. *See supra* notes 134-140 and accompanying text (discussing mental health professionals' inability to predict future dangerousness).

227. *See infra* app. A, question Nos. 2 & 24.

228. $x^2 = 10.78$, n.s.

229. *See supra* notes 143-145 and accompanying text (discussing post-*Tarasoff* risk of overprediction and unnecessary commitment).

230. *See infra* app. A, question No. 23a.

to treatment may have been denied proper psychological counseling at least in part because of the decision. Moreover, therapists who feel unable to assess potential dangerousness are no more likely to avoid counseling dangerous patients than those who feel competent at such assessments.[231] Self-perceived skill (or lack thereof) in predicting violent behavior seems unrelated to therapists' willingness to accept potentially dangerous patients in treatment.

Tarasoff seems to have changed the nature of clinical practice.[232] Roughly 37% of therapists surveyed indicated that *Tarasoff* has led them to focus more frequently on dangerousness with their patients. In addition, 32% of therapists reported that they concentrate more often on patients' less serious threats. Although the results certainly indicate that *Tarasoff* has affected psychotherapeutic practice, it is unclear whether these effects are beneficial to patients.

Focusing upon dangerousness may benefit those patients who need to discuss this issue. Not every patient, however, requires psychotherapy which disproportionately centers on dangerousness. To the extent that *Tarasoff* forces therapists to focus upon dangerousness at the expense of exploring other issues, the decision hinders successful therapy.

Many psychotherapists encourage their patients to express themselves freely during therapy. In fact, patients often make trivial threats throughout their sessions.[233] As illustrated by the finding that therapists focus more frequently on less serious threats, therapists have difficulty deciding which threats are sufficiently serious to require action under *Tarasoff*. Consequently, practitioners may become too preoccupied with the seriousness determination to concentrate on other important issues.

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231. *See infra* app. A, question Nos. 23 & 24.

232. *See infra* app. A, question No. 32.

233. *See supra* notes 170-172 and accompanying text (explaining the nature of verbalization during therapy).

D. Confidentiality and the Therapist's Duty Under Tarasoff

Critics of the *Tarasoff* decision contend that requiring psychotherapists to breach confidentiality will detrimentally impact the psychotherapeutic alliance.[234] They argue that patients not given assurances of confidentiality will be deterred from seeking therapy, will divulge less sensitive information during therapy, and will distrust their psychotherapist--ultimately making therapy less effective.[235] Our survey examined (1) therapists' attitudes toward confidentiality, and (2) therapists' perceptions of whether their potential obligation to breach confidentiality has had countertherapeutic effects.

Confidentiality is considered a cornerstone of psychotherapeutic practice.[236] Nonetheless, 79% of the therapists surveyed believed that while absolute confidentiality is important for successful therapy, a breach of confidentiality may be warranted in certain circumstances. Only eight percent of the therapists felt confidentiality should be absolute.[237] A majority of these practitioners were in practice fifteen years or longer.[238] By comparison, the Stanford Study, conducted one year after *Tarasoff*, found that 26% of therapists surveyed thought confidentiality should never be breached.[239] The Stanford results are consistent with our findings that therapists who began practice prior to *Tarasoff* are more inclined to feel confidentiality should be inviolate. Such findings additionally suggest that therapists' attitudes toward confidentiality may have been influenced by the duty established in *Tarasoff*. In

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234. *See supra* notes 166-169 and accompanying text.

235. *See supra* notes 170-172 and accompanying text.

236. *See supra* notes 158-161 and accompanying text.

237. *See infra* app. A, question No. 14. Only 0.1% of the therapists believe confidentiality is "unimportant, of marginal value," and 13.3% of the therapists did not respond to this question. Attitudes toward confidentiality did not differ among psychologists and psychiatrists.

238. Of therapists who thought confidentiality was "essential, should never be breached under any circumstances," 8.7% have been in practice between 0-5 years, 13% have been in practice 5-10 years, 23.2% have been practicing 10-15 years, and 55.1% have been practicing fifteen years or longer.

239. The Stanford Study further found that 69.7% of surveyed psychotherapists thought confidentiality could be breached in certain circumstances, 0.9% thought confidentiality was of marginal value, and 3.3% did not respond. *The Stanford Study, supra* note 6, at 176 n.65.

particular, therapists' increased willingness to disclose patient confidences to outside parties might reflect the legal obligation imposed upon them since *Tarasoff.*

This interpretation, however, is softened in light of results which show that absent a duty to protect third parties, 97.5% of the respondents reported that they would or probably would warn a potential of harm.[240] This finding is consistent with the results of the earlier Stanford Study, which found that prior to *Tarasoff,* half of the surveyed therapists treating potentially dangerous patients had warned a potential victim, a potential victim's family, or the police on at least one occasion.[241] Thus, one might conclude that therapists' willingness to warn might not result from their *Tarasoff* obligation. Rather, the legal duty to breach confidentiality when patients threaten others parallels therapists' professional and ethical convictions. This, however, is not a viable conclusion regarding other warnable dangers, as we shall see.

Despite therapists' apparent willingness to breach confidentiality in certain cases, they are often unwilling to discuss the possibility of disclosure with their patients during therapy. Fifty-seven percent of responding therapists reported always discussing the general nature of confidentiality with their patients.[242] A much smaller percentage of respondents, 22.1%, however, always discuss the possibility that confidentiality might be breached by the therapist during therapy as a result of the patient's communications. In addition, 65.8% of all psychotherapists indicated they "almost always" or "sometimes" discuss the possibility of disclosure with their patients.[243] The results clearly indicate that the vast majority

240. Specifically, 28.4% of the responding therapists indicated they would warn regardless of a legal obligation, 69.3% answered it depended on the circumstances, and 2.5% answered that absent a legal obligation they would not warn.

241. *The Stanford Study, supra* note 6, at 183.

242. Of therapists responding to question No. 15, 42.3% sometimes discuss confidentiality with their patients, and 0.4% never discuss the issue with their patients at all. Sixty-six percent of psychologists, as compared with 42.9% of psychiatrists, reported always discussing confidentiality with their patients.

243. Of therapists responding to question No. 16, 15.8% almost always discuss the possibility of disclosure, 50.1% sometimes discuss this possibility, and 12.0% never discuss with their patients the possibility that confidentiality may be breached.

of therapists discuss their *Tarasoff* obligations with patients whom they perceive as dangerous when these patients threaten harm. A higher percentage of psychologists as compared with psychiatrists discuss the possibility of disclosure with *all* of their patients, and they discuss this possibility at the outset of therapy.[244] The findings regarding when and with whom therapists discuss the possibility of disclosure are shown in Tables 8 and 9.

TABLE 8
WHEN THERAPISTS DISCUSS POSSIBILITY
OF DISCLOSURE WITH PATIENTS

Time Of Discussion	Percentage Psycol	Percentage Psycia	Percentage Overall*
As a general practice at the outset of therapy	43.3%	12.0%	26.5%
As a general practice during therapy, but not at the outset	15.9%	13.5%	12.8%
When a patient asks directly	16.9%	24.8%	16.6%
When a patient threatens violence	52.8%	75.2%	51.4%

*Percentages exceed 100% as some therapists provided multiple responses.

244. As indicated in Table 8, 43.3% of psychologists, as compared with 12% of psychiatrists, discuss their *Tarasoff* obligations with their patients at the outset of therapy. $x^2 = 47.03$; these findings were significant beyond the .005 level with 1 degree of freedom.

Table 8 also indicates that 52.8% of psychologists, as compared with 75.2% of psychiatrists, discuss the possibility of disclosure only when their patients threaten harm. $x^2 = 107.94$; these findings are significant beyond the .001 level with 1 degree of freedom.

TABLE 9
WITH WHOM THERAPISTS DISCUSS THE
POSSIBILITY OF DISCLOSURE

	Percentage Psycol	Percentage Psycia	Percentage Overall*
All patients	38.6%	8.6%	22.4%
Patients perceived as dangerous	62.5%	74.1%	57.0%
Patients perceived as suicidal	15.0%	6.8%	10.2%
No patients	7.2%	13.9%	7.8%

*Percentages exceed 100% as some therapists provided multiple responses

Clinicians' reluctance to discuss their potential *Tarasoff* obligations may stem from a belief that doing so would have countertherapeutic effects. For instance, sixty percent of responding psychotherapists felt their patients were at least somewhat more reluctant to divulge sensitive information when aware that their confidences could potentially be disclosed.[245] Moreover, therapists who discuss their *Tarasoff* obligations when their patients voice a threat are more inclined to feel they have lost a patient due to a potential breach of confidentiality than therapists who discuss disclosure as a general practice during therapy, or when a patient asks whether his communications are absolutely confidential. These results suggest that the more a patient has reason to believe his confidences will be disclosed, the more likely he may be to terminate psychotherapy.

245. Specifically, when asked: "Once your patients become aware that you might discuss their case with a third party, do they seem reluctant to divulge certain information to you?", 13.3% of answering practitioners responded "Yes," 46.6% responded "Yes, somewhat," and 39.9% answered "No." *See infra* app. A, question No. 19.

Whether patients were in fact reluctant to disclose information cannot be empirically determined from this study. The results reflect only therapists' perceptions of their patients' behavior.

A significant proportion of therapists who discussed *Tarasoff* at the outset of therapy felt that they had lost patients as a result. Patients who are aware that their confidences could be disclosed may be more apt to leave therapy at the outset since a trusting therapist-patient relationship has not yet been established. The findings of the study are displayed in Table 10 below.

TABLE 10
TIMING OF DISCUSSION OF DISCLOSURE
AND PERCEIVED LOSS OF PATIENTS

Time of Discussion	Therapists Who Felt They Lost Patients as a Result
As a general practice at the outset of therapy	26.3%
As a general practice during therapy	8.5%
When a patient directly asks	15.1%
When a patient threatens harm	50.2%

With 3 degrees of freedom $x^2 = 104.37$; significant beyond .001.

Nevertheless, a significant percentage of practitioners, 39.9%, did not feel their patients' awareness of the possibility of disclosure altered the content of their communications. Also, 71.8% of the respondents did not think that any of their patients ever left therapy as a result of learning that confidentially may be breached.

In sum, although psychotherapists feel confidentiality is an important element of successful therapy, many concede it may be breached if their patients threaten harm. Nonetheless, most therapists refrain from discussing the possibility of disclosure with their patients during therapy. A possible explanation for this behavior is a belief by therapists that an illusion of confidentiality

is necessary for effective psychotherapeutic treatment.[246] Indeed, therapists note a reluctance on the part of patients to divulge confidential information once aware that their confidences could potentially be disclosed. To the extent that candid disclosure is necessary for successful psychotherapy, patients' awareness of the limits of confidentiality may decrease the possibility of achieving successful therapeutic results.

E. Warning Third Parties About Other Dangers

Potentially violent patients are clearly dangerous. But violence is not the only danger with which a therapist and society must contend. Patients can be dangerous for a variety of reasons: because they have herpes, for example, or syphilis or AIDS. We were concerned particularly with AIDS because it is presently both deadly and incurable. We asked: "Would you disclose to a sexual partner or potential sexual partner of one of your patients that the patient has contracted syphilis, herpes or the AIDS virus?"

Eighteen percent of the respondents failed to answer this question. Somewhat more than 13% said they would disclose, while another 2% indicated that their behavior would depend on the circumstances. But fully 62% indicated that they would not disclose to the patient's sexual partner or potential sexual partner that the patient had syphilis, herpes or AIDS.

Not everyone who has syphilis, herpes or AIDS necessarily transmits the disease each time he or she has sexual contact, any more than a potentially violent person will necessarily be violent on each interpersonal contact. Both sexually transmittable diseases and violence-proneness are probabalistic disorders. Yet therapists take a vastly different view of violence-proneness than AIDS. The one is to be reported, the other, in the main, concealed. Why should that be? Surely the ethical requirements to warn relevant others are similar for both kinds of dangers. It is difficult to avoid

246. *See The Stanford Study, supra* note 6, at 184 (stating that most therapists believe that their patients assume communications within the relationship are confidential).

the conclusion that therapists feel duty-bound by *Tarasoff* and statute in the first instance, and not at all in the second.

F. Psychotherapists and Warning Behavior

This survey aimed to discover how *Tarasoff* has affected psychotherapeutic practice. Because prior studies demonstrated that California psychologists and psychiatrists overwhelmingly interpret *Tarasoff* to require therapists to warn third parties, the survey focused on therapists' warning behavior. Specifically, psychotherapists were asked: (1) Whether they have warned since *Tarasoff*; (2) if so, who therapists warn; (3) how often they warn; and (4) what primarily influences their decision to warn.

Our results indicate that psychotherapists typically warn third parties. Indeed, 91.4% of responding psychotherapists had never refrained from warning a potential victim where they thought *Tarasoff* applied.[247] Thirty-nine percent of the respondents had warned a potential victim on at least one occasion; 54% of the clinicians had warned a potential suicide victim's family;[248] and 46% had warned the police.[249]

The percentage of therapists warning third parties has increased substantially since the *Tarasoff* decision. The Stanford Study concluded that prior to *Tarasoff*, 16.7% of respondent psychotherapists had warned a potential victim.[250] A comparison of the two studies reveals that twice as many therapists are warning potential victims after *Tarasoff* than before. A somewhat higher proportion of therapists have warned potential suicide victims' families after the decision. Furthermore, since *Tarasoff* almost twice as many practitioners have warned the police.

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247. Of the 8.6% of respondents who have refrained from warning a potential victim, the two most frequently provided explanations were: (1) Breaching confidentiality may detrimentally affect the therapeutic relationship; and (2) uncertainty regarding the likelihood that the threat will be carried out.

248. While 54.2% of the therapists have warned the family of a patient's danger to himself, 45.8% indicated that they have not warned. There were no significant differences between psychiatrists and psychologists.

249. The results for psychologists and psychiatrists are similar.

250. *The Stanford Study*, *supra* note 6, at 179.

On average, psychotherapists in the present study had warned potential victims 2.61 times.[251] Potential suicide victims' families were warned, on average, 5.7 times.[252] Further, therapists warned the police an average of 3.28 times.[253]

Psychotherapists provide several explanations for why they decide to warn.[254] The predominant reason cited is their concern for the patient or potential victim. The second most frequently mentioned reason is fear of *Tarasoff* liability. The next most popular response is fear of liability under California Civil Code section 43.92.

The fact that therapists warn potential suicide victims' families out of concern for the patient is not surprising. While the law does not impose a legal duty to warn where a patient threatens suicide,[255] psychotherapists may warn families because of a protective or an ethical, not legal, impulse.

Many therapists also warn the police out of concern for the potential victim, even though the police are neither bound to protect or warn.[256] They may warn police out of fear of *Tarasoff*

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251. For the mean number of times therapists have warned potential victims, the variance = 4.58 and the standard deviation = 4.59.

252. For the mean number of times therapists have warned the family of a patient's potential suicide, the variance = 90.4 and the standard deviation = 90.6.

253. For the mean number of times therapists have warned the police, the variance = 4.90 and the standard deviation = 4.92.

254. Therapists cite several factors which have primarily influenced their decisions to warn a potential victim: Fear of *Tarasoff* liability, 39.4%; fear of liability under California Civil Code § 43.92, 14.6%; concern for the patient, 41.9%; and "other reasons," 4.1%.

Therapists also cite several reasons why they warn the patient's family of a patient's danger to himself: Fear of potential liability under *Tarasoff*, 13.8%; fear of liability under California Civil Code § 43.92, 9.0%; and "other reasons," 4.4%. The rationale most often mentioned, 70.7% of the time, is concern for the patient.

Finally, therapists provide several explanations why they decide to warn the police: Potential *Tarasoff* liability, 29.0%; fear of statutory liability, 14.1%; concern for the patient, 54.6%; and "other reasons," cited 1.9% of the time.

The above percentages reflect the explanations psychotherapists reported as primarily influencing their decisions to warn. Since these answers are not mutually exclusive, we cannot infer whether a given response was the sole motivation factor in therapists' decisions to warn.

255. *See supra* notes 107-109 and accompanying text (discussing the duty to warn about suicide threats).

256. *See supra* note 115 and accompanying text (discussing application of duty to warn beyond mental health professionals).

liability, or because they believe that warning the police fulfills the "reasonable steps" requirement of *Tarasoff II*.[257]

Approximately as many therapists have warned potential victims out of fear of *Tarasoff* liability as from a concern for the potential victim. While *Tarasoff* seems to be a prime motivating force behind therapists' decisions to warn, many also warn potential victims out of an ethical concern. In fact, 97.5% of the respondent psychotherapists say they would warn a potential victim of threatened harm regardless of liability under *Tarasoff* or section 43.92. These findings suggest that psychotherapists feel both ethically and legally obligated to warn.

G. Specific Effects of Tarasoff

Although many psychotherapists would have been willing to warn regardless of *Tarasoff*, all psychotherapists must contend with potential *Tarasoff* liability. Forty-nine percent of therapists surveyed said they were more afraid of lawsuits since *Tarasoff*.[258] The Stanford Study, conducted one year after the decision, found that 55.7% of the therapists surveyed were more fearful of being sued under *Tarasoff*.[259] The present findings suggest that *Tarasoff* did not have an ephemeral effect on therapists, but has continued to generate concern eleven years after the decision.

The results show that *Tarasoff* seems to have directly shaped psychotherapeutic practice in a variety of ways. For example, *Tarasoff* has affected the content of patient-therapist communications during therapy. Thirty-seven percent of the respondents indicated a greater tendency to discuss patients' propensities to commit violence.[260] Thirty-two percent of the psychotherapists

257. *Tarasoff II*, 17 Cal. 3d at 430-31, 551 P.2d at 340, 131 Cal. Rptr. at 20.

258. Out of 872 respondents, only two reported being sued under *Tarasoff*--one psychologist and one psychiatrist. Each individual indicated he had been sued only once.

259. *The Stanford Study, supra* note 6, at 181 n.86.

260. The Stanford Study found 26.8% of the respondent therapists reported the *Tarasoff* ruling led them to focus more often on the issue of dangerousness during therapy. *Id.* at 181 n.83. Interestingly, the Stanford Study also found that 16% of respondents felt the decision led them to avoid exploring issues of dangerousness with their patients. *Id.* at 182 n.87.

reported attending more to their patient's minor threats.[261] Fifty-one percent of the subjects more frequently inform their patients that they might be obliged to discuss the patient outside the clinical setting.[262]

Thus, it appears that *Tarasoff* is having its intended effect. Therapists are making more extensive inquiries into patients' violent tendencies, and may thereby discover more instances where their patients threaten harm. But this benefit must be weighed against the potential cost of diverting clinicians' energies away from exploring other important issues with their non-violent patients.

Psychotherapists' desire to avoid legal liability has also been reflected in other aspects of their practice. Thirty-two percent of the therapists noted that their record-keeping methods have been influenced by the *Tarasoff* decision. Similarly, the Stanford Study found that 28.1% of the therapists surveyed noted changes in their record-keeping behavior.[263] Whether therapists are actually keeping more detailed records cannot be determined from the results of our study. However, regardless of the direction in which record-keeping habits have moved, this change has presumably been motivated by therapists' efforts to avoid legal liability.[264]

Additionally, 41.0% of the subjects noted that, as a result of *Tarasoff*, they were more inclined to consult with other professionals when treating potentially dangerous patients.[265] Approximately eight percent more of the therapists noted such a change than in the earlier Stanford Study.[266] And to the extent

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261. This finding represents a 13% increase over the Stanford Study's findings. *See id.* at 181.

262. This finding was higher for psychologists than psychiatrists. Sixty-six percent of psychologists as compared with 51% of psychiatrists reported informing their patients more often that they might be obligated to discuss the patient to persons outside the clinical setting.

263. *The Stanford Study, supra* note 6, at 182 n.88.

264. *Id.*

265. *See infra* app. A, question No. 32. Only .2% of the practitioners felt less inclined since *Tarasoff* to consult with the police when treating a dangerous patient.

266. *See The Stanford Study, supra* note 6, at 181 n.85. Subjects in the Stanford Study were asked whether *Tarasoff* has increased or decreased their contacts with professionals when treating a dangerous patient. Although therapists probably interpreted "professionals" to mean colleagues, they may have been referring to consultations with professionals outside the mental health profession, i.e., with attorneys. *Id.* The Stanford Study found that 32.9% of respondent therapists increased their

these consultations provide therapists with second opinions on whether patients' threats will be carried out, therapists may be less likely to give unnecessary warnings.

These results suggest that the Stanford Study findings did not reflect a temporary reaction to the sensationalism that surrounded *Tarasoff* when the decision was in its infancy. Rather, it appears that *Tarasoff* has greatly influenced clinical practice in the past decade, and will, in all likelihood, continue to exert an influence on clinical practice in the future.

VI. CONCLUSION

Tarasoff plunged psychotherapists into uncharted waters. Until that decision, therapists viewed treatment as a collaborative arrangement; one in which the patient was maximally honest, and the therapist maximally helpful. The notion of a therapeutic alliance, in which both therapist and patient joined for the patient's welfare, seemed to capture the spirit of the endeavor. With *Tarasoff*, the nature of the therapeutic endeavor changed quite perceptibly. Psychotherapists with no prior experience in the fora now needed to assess their legal vulnerability with each and every treatment encounter. They attended quite carefully to the possibility that a patient was dangerous to others. In the main, wherever possible and for whatever reasons, they tried to avoid such patients. But once admitted to treatment, a substantial proportion took seriously *all* threats, and not only those that were likely to eventuate in violence. They altered the nature of their practice, now inquiring more into violent propensities, subtly shifting the focus of treatment to investigations that might shed light on their patient's dangerousness, and away from other emotional issues, all in the hope of protecting society and avoiding liability themselves.

It has been an uphill and unsatisfying contest. For victory in these encounters depends almost wholly on the therapists' ability to predict violent behavior, and very few therapists--only 4.3%--feel that they can predict dangerousness very accurately. The vast

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contact with professionals when counseling a potentially dangerous patient. *Id.*

majority of therapists perceive their abilities more modestly, feeling that they can predict dangerousness only better than chance, or not at all. Thus, the law is predicated on skills that even now, in data obtained some eleven years after *Tarasoff*, psychotherapists feel they have not acquired, and may in fact not ever acquire.[267]

In accord with law, psychotherapists continue to warn patients that certain conversation is not confidential and will need to be revealed to relevant third parties. And in accord with expectation, many of these patients simply abandon treatment. We do not know how many flee and continue to menace society, and how many remain in treatment despite the threat to confidentiality, and emerge the better and safer for that treatment. But we do know that the numbers in each case are substantial. Close to three-quarters of the therapists counsel at least one dangerous person. And a substantial proportion counsel many.

Does the law, with the burdens placed on psychotherapists and the consequent avoidance of treatment by (at least some) dangerous persons, substantially protect society? Readers will arrive at their own judgments in this matter. But that judgment will likely remain clouded until we have some decent data on the efficacy of treatment for preventing violence. At this writing, those data are lacking.[268] Were there positive evidence for the utility of psychotherapy for preventing violent behavior, one could quarrel more vigorously with Justice Tobriner's adage that "the protective privilege ends where the public peril begins." To the extent that the "protective privilege" is part of the putative efficacy of psychotherapy, and to the extent that one could locate evidence for the utility of psychotherapy in the treatment of violence, one might well want to augment the protective privilege when the public peril is involved. Unfortunately, that is not yet the case.

Tarasoff and "duty to warn" have remained catchwords to a large number of psychotherapists; catchwords for liability that

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267. *But see supra* note 140 (discussing recent findings regarding the relationship between mental disorder and violent behavior).

268. *See generally* D.L. ROSENHAN & M.E.P. SELIGMAN, ABNORMAL PSYCHOLOGY chs. 15, 18, 19 (2d ed. 1986) (discussing treatment of violent individuals).

simultaneously seem to invoke both vigilance and avoidance. Of vigilance we have already written. Relatively unnoticed, however, is the fact that psychotherapists seem to have avoided dealing with some aspects of the law, and particularly seem not to have wrestled with the details of the law. Most of them seem not to have heard of the California Civil Code that regulates psychotherapists' behavior in matters of violence. They seem unaware of their obligation to notify *both* the victim *and* the police; that only serious threats are of legal concern; that only threats of violence to others, and not to self, are the concerns of the law; or that families need not be notified.

Most disturbing of all is the failure of psychotherapists to understand the ethical and legal dilemma posed by patients who have contagious diseases: herpes, syphilis and especially AIDS. Nearly 20% failed to respond to the survey question addressing this dilemma. Of those who did, 62% said they would not inform the sexual partner or potential sexual partner if one of their patients was infected with one of these viruses. The question itself elicited a veritable outpouring of notes and comments. Some 2%, for example, said that what they would do depended on the circumstances; 4.5% indicated in writing that they would disclose for AIDS alone; while only 9.4% would disclose for all three diseases. Nothing made clearer how much the concern about *Tarasoff* was a concern about *physical violence*, arising from the traditional anxieties about the relationship between madness and brutality. It is not centrally one about harm to others, harm which may arise from more modern diseases, even in consensual contexts. Such concerns may not impress themselves on psychotherapists' consciousness until, unfortunately, new case law intrudes.

Practitioners believe that confidentiality is important to psychotherapy, but are willing to breach confidentiality in limited circumstances. Nonetheless, therapists are generally unwilling to discuss the possibility of disclosure, except when patients perceived as dangerous threaten harm. Many therapists believe patients who are aware that their confidences may be revealed are more reluctant to divulge certain information during therapy. Most therapists,

however, do not believe they have ever lost a patient due to a potential breach of confidentiality.

Our study determined that many psychotherapists have warned third parties since *Tarasoff*. A major motivating factor behind therapists' decisions to warn is concern for the potential victim or patient. This conclusion is consistent with our discovery that psychotherapists would warn absent a common law or statutory obligation. Many psychotherapists warn because of their own ethical beliefs; thus, *Tarasoff* may not represent a radical departure from therapists' pre-existing views. Rather, *Tarasoff* may be considered a legal embodiment of therapists' ethical convictions.

Fear of *Tarasoff* liability was also frequently cited as a driving force behind therapists' decisions to warn. This fear has generated several specific effects upon clinical practice. As a result of *Tarasoff*, therapists (1) are more inclined to discuss dangerousness with their patients, (2) focus more often on their patients' less serious threats, (3) are more inclined to consult with other professionals when involved with potentially dangerous patients, and (4) have changed the manner in which they keep their records. The resultant effects demonstrate the continuing influence *Tarasoff* has had on psychotherapeutic practice in the eleven years since the decision.

APPENDIX A

January 3, 1987

Dear Dr.

We are studying the effects of the California Supreme Court's decision in Tarasoff v. The Regents of the University of California, 17 Cal. 3d 425 (1976) on mental health practitioners.

Eight years ago, the Stanford Law Review published a similar study shortly after the Court decided Tarasoff. Now that the decision is well beyond its infancy, we want to understand whether and in what ways Tarasoff has influenced the practice of psychology and psychiatry.

We are distributing the enclosed questionnaire to psychologists and psychiatrists licensed in the State of California. Please complete the questionnaire and return it in the self-addressed, stamped envelope as soon as possible.

This survey is absolutely confidential. If you have any questions or comments, feel free to contact us at (415) 969-8937 or (415) 723-3502.

We depend upon your cooperation to insure the reliability of our results. Again, we would appreciate a quick response.

Sincerely,

Kathi Weiss

Terri Wolff

David Rosenhan

The Tarasoff Survey

1. What is your occupation?
   ( ) clinical psychiatrist (M.D.)
   ( ) clinical psychologist (Ph.D.)
   ( ) clinical psychologist (M.A.)
   ( ) retired
   ( ) other _____
   ( ) not a clinical practitioner.

If you are not a clinical practitioner, please stop here and return the questionnaire.

2. How long have you been practicing?
   ( ) 0-5 years ( ) 6-10 years ( ) 11-15 years
   ( ) 16-20 years ( ) greater than 20 years

3. Are you in private practice?
   ( ) Yes ( ) No

   3a. If yes, what proportion of your professional time is spent in private practice?
   ( ) None ( ) 1-20% ( ) 21-40% ( ) 41-60% ( ) 61-80%
   ( ) 81-99% ( ) 100%

4. Are you affiliated with a: [*check all that apply*]
   ( ) private hospital ( ) public hospital
   ( ) correctional facility ( ) primary or secondary school
   ( ) university ( ) no affiliation ( ) other

5. How many patients do you see per year?
   ( ) None ( ) 1-5 ( ) 6-10 ( ) 11-20 ( ) 21-30
   ( ) 31-50 ( ) 51-75 ( ) 76-100 ( ) 101-150
   ( ) greater than 150

6. Have you heard of the Tarasoff v. Regents of the University of California case? ( ) Yes ( ) No

7. How did you hear of the Tarasoff decision?
   ( ) colleagues ( ) professional association
   ( ) attorney ( ) professional journals ( ) school ( ) media
   ( ) other _____

8. To whom do you think the Tarasoff decision applies? [*check all that apply*]
   ( ) psychiatrists ( ) clinical psychologists
   ( ) clinical social workers ( ) marriage and family counselors
   ( ) clergymen and religious counselors
   ( ) lawyers ( ) other _____

9. To what type of threat does Tarasoff apply? [*check all that apply*]
   ( ) threat of physical injury ( ) threat of homicide
   ( ) threat of property damage ( ) threat of suicide
   ( ) other _____

   9a. What interventions does Tarasoff require?
   ( ) warning potential victims
   ( ) warning guardian, family, or friends
   ( ) informing the police
   ( ) using reasonable care to protect the victim
   ( ) involuntary commitment of patient
   ( ) notification of superiors or administrators
   ( ) consultation with colleagues

10. In which situation does Tarasoff and its progeny apply?
   ( ) where a specific individual is threatened
   ( ) where a threat had been made, but no specific individual has been threatened
   ( ) where the victim is readily identifiable

11. Does Tarasoff apply to unarticulated threats?
   ( ) Yes ( ) No

12. Are you familiar with California Civil Code Section 43.92 (1985) which codifies the Tarasoff decision?
   ( ) Yes ( ) No

   12a. If yes, who must be warned? [*check all that apply*]
   ( ) the potential victim
   ( ) a potential suicide victim's family
   ( ) any victim's family
   ( ) the police

13. Tarasoff and its progeny applies to: [*please check one*]
   ( ) only those threats that have a high likelihood of being carried out
   ( ) threats which are somewhat likely to be carried out
   ( ) threats in which you are unable to determine this likelihood

14. How important to successful therapy is absolute confidentiality between patient and therapist?
    ( ) essential, should never be breached under any circumstances
    ( ) important, but may be breached under certain circumstances
    ( ) unimportant, of marginal value

15. Do you discuss confidentiality with your patients?
    ( ) always ( ) sometimes ( ) never

16. In light of Tarasoff, do you discuss with your patients the possibility that you might be obliged to contact third parties as a result of something said in therapy?
    ( ) always ( ) almost always ( ) sometimes ( ) never

17. Under what circumstances do you discuss the possibility of having to breach a patient's confidentiality? [*check all that apply*]
    ( ) as a general practice at the outset of therapy
    ( ) as a general practice during therapy, but not at the outset
    ( ) only if a patient asks directly
    ( ) when a patient threatens violence

    17a. If you do inform patients of your potential Tarasoff obligation, do you do so
    ( ) through discussion with the patient?
    ( ) by written document?
    ( ) by another method?

18. Do you discuss your Tarasoff obligations with [*check all that apply*]
    ( ) all of your patients
    ( ) those whom you perceive as dangerous
    ( ) those whom you perceive as suicidal
    ( ) no patients

19. Once your patients become aware that you might discuss their case with a third party, do they seem reluctant to divulge certain information to you?
    ( ) Yes ( ) Yes, somewhat ( ) No

20. Have you ever felt you lost a patient because he/she feared a breach of confidentiality?
    ( ) Yes ( ) No

    20a. If yes, how many patients?
    ( ) 0-2 ( ) 3-6 ( ) 7-10 ( ) 11-15 ( ) more than 15

21. Since Tarasoff, have you counseled a potentially dangerous patient?
( ) Yes ( ) No

22. How many patients do you see per year whom you consider to be potentially dangerous?
( ) None ( ) 1-2 ( ) 3-5 ( ) 6-8 ( ) 9-15
( ) 16-25 ( ) 25+

23. Do you avoid counseling patients whom you consider to be potentially dangerous?
( ) Yes ( ) No

23a. If you avoid these patients, why? [*check all that apply*]
( ) fear of Tarasoff liability
( ) in part, due to fear of Tarasoff liability
( ) it's difficult work
( ) fear for personal safety
( ) other _____

24. How well do you feel you can predict the potential dangerousness of your patients?
( ) very accurately
( ) somewhat accurately
( ) better than chance
( ) not at all

25. Since Tarasoff (1976) have you ever warned a potential victim of a patient's threats?
( ) Yes; if so, how many times? _____ ( ) No

26. If you have warned a potential victim, what factors have influenced your decision to warn? [*check all that apply*]
( ) potential liability from the Tarasoff decision
( ) potential liability under Cal. Civ. Code Section 43.92
( ) concern for the potential victim
( ) other _____

26a. What has been the primary influence upon your decision to warn? [*check only one*]
( ) potential liability from the Tarasoff decision
( ) potential liability under Cal. Civil Code § 43.92
( ) concern for the potential victim
( ) other _____

27. Since Tarasoff, have you ever warned a family of a patient's danger to himself/herself?
( ) Yes; if so, how many times? _____ ( ) No

28. If you have warned a patient's family, what factors have influenced your decision to warn?
( ) potential liability from the Tarasoff decision
( ) potential liability under Cal. Civ. Code § 43.92
( ) concern for the patient
( ) other _____

28a. What is the primary influence upon your decision to warn? [*check only one*]
( ) potential liability from the Tarasoff decision
( ) potential liability under Cal. Civ. Code § 43.92
( ) concern for the patient
( ) other _____

29. Since Tarasoff, have you ever notified the police of a patient's danger to self or others?
( ) Yes; if so, how many times? ____ ( ) No

30. If you have notified the police, what factors have influenced your decision to notify?
( ) potential liability from the Tarasoff decision
( ) potential liability under Cal. Civ. Code § 43.92
( ) concern for the patient or potential victim
( ) other _____

30a. What is the primary influence upon your decision to warn? [*check all that apply*]
( ) potential liability from the Tarasoff decision
( ) potential liability under Cal. Civ. Code § 43.92
( ) concern for the potential victim
( ) plans to detain patients on a 72-hour hold
( ) other _____

31. Have you refrained from warning a potential victim when you thought Tarasoff applied? ( ) Yes ( ) No

    31a. If yes, why?
    ( ) convictions concerning confidentiality
    ( ) notified superiors
    ( ) notified the police
    ( ) notified the patient's family
    ( ) feared lawsuit for breach of confidentiality

32. Has the Tarasoff decision had any of these specific effects on your practice? [*check all that apply*]
    ( ) increased your contacts with other mental health professionals when you are involved with a dangerous patient
    ( ) decreased your contacts with other mental health professionals when you are involved with a dangerous patient
    ( ) led you to focus more often on dangerousness with your patients
    ( ) led you to focus less often on dangerousness with your patients
    ( ) led you to focus more often on dangerousness at the expense of exploring other issues with your patients
    ( ) led you to focus more frequently on less serious threats by your patients
    ( ) led you to alert more patients that circumstances could arise in which you would be obliged to speak to someone outside the clinical setting about the patient
    ( ) led you to keep more detailed records
    ( ) led you to keep less detailed records
    ( ) increased your fear of lawsuits

33. Have you ever been sued for failing to warn under Tarasoff?
    ( ) Yes; if yes, how many times? _____ ( ) No

34. If there were no obligation to warn under the Tarasoff decision or Cal. Civ. Code § 43.92, would you warn a potential victim?
    ( ) Yes ( ) No ( ) Depends on the circumstances

35. Would you disclose to a sexual partner or a potential sexual partner of one of your patients that the patient has contracted the A.I.D.S. virus?
    ( ) Yes ( ) No ( ) Depends on the circumstances

36. What is your age?
    ( ) 22-30 ( ) 31-37 ( ) 38-47 ( ) 48-56 ( ) 57-65 ( ) 66+

37. Sex: ( ) Male ( ) Female

38. What is your gross annual income? (in thousands)
( ) less than 20 ( ) 20-40 ( ) 41-60 ( ) 61-80
( ) 81-100 ( ) 101-150 ( ) 151-200 ( ) 201-300
( ) greater than 300

Thank you for your participation.