2021

Judicial Decision Making and the Duty To Warn: An Empirical Study of Case Law

Casey Dunn Ravitz

JUDICIAL DECISION MAKING AND THE DUTY TO WARN:

AN EMPIRICAL STUDY OF CASE LAW

by

Casey D. Ravitz M.S.

A Dissertation Presented to the College of Psychology

of Nova Southeastern University

in Partial Fulfillment of the Requirements

for the Degree of Doctor of Philosophy

Nova Southeastern University

2021

DISSERTATION APPROVAL SHEET

This dissertation was submitted by Casey D. Ravitz, M.S., under the direction of David Shapiro, Ph.D., Chairperson of the dissertation committee listed below. It was submitted to the College of Psychology and approved in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Clinical Psychology at Nova Southeastern University.

Approved:

7/19/21
Date of Defense

David L Shapiro Ph.D
David Shapiro, Ph.D., Chairperson

tom kennedy
Thomas Kennedy, Ph.D.

Kathy L. Cerminara
Kathy Cerminara, J.D.

8/12/21
Date of Final Approval

David L. Shapiro Ph.D
David Shapiro, Ph.D., Chairperson

Acknowledgements

To Dr. Shapiro, my heartfelt thanks for setting me on the path towards this project. I can still remember nervously asking if you would take me on as a student during interview day. When you sat me down to discuss this line of research five years ago, I had no idea how fascinated—and frustrated—I would be by what I found. This topic so perfectly pairs my love of law and psychology and I am truly grateful for the day you suggested I dig in. Thank you for being an excellent supervisor and mentor these last seven years.

Dr. Kennedy, thank you for always letting me come by your office to talk your ear off about anything and everything. I know I am not the only student who considers you a vital part of their training and support system at Nova. Thank you for always encouraging me to do more and believing in me.

Professor Cerminara, thank you for allowing me to rope you into this project! Your enthusiasm, suggestions, and willingness to educate me on important legal topics has been instrumental in the completion of this project.

To Dr. Michael Quinones, I cannot begin to articulate what your friendship has meant to me. I can say without a doubt in my mind that if it was not for you I would have quit a long time ago. Being able to share in this graduate training process with you is what has made it all worth it. I look forward to many more nights toiling away in the Fortress of Productivity, interspersed with laughter and fast food.

Dr. Nina Levenson, I am forever grateful for the guidance and support you have provided since I was a young child. Meeting you put me on the path I am on today, and I am so thankful for your continued role in my life. With this project I complete the dream you helped inspire over two decades ago.

To my Mom, Debbie Dunn, thank you for always encouraging me to follow this dream. You have been helping me manage my nerves about dissertation since I first learned what it was as a young child. Thank you for talking me through anxiety, heartbreak, and frustration. Thank you for celebrating with me as I inched ever closer to becoming a psychologist. I would not be where I am today without your constant support and unconditional love.

To my Dad, Leslie Ravitz, I cannot express how much I wish you were here to see me complete this dream. Some of my last memories of you are sitting by your hospital bed telling you about the psychology programs I was applying to. And now here I am, writing to you in the acknowledgements of my dissertation. I know you would be so proud of me.

Table of Contents

JUDICIAL DECISION MAKING AND THE DUTY TO WARN:

AN EMPIRICAL STUDY OF CASE LAW

by

Casey D. Ravitz

Nova Southeastern University

Abstract

Duty to warn is an important staple of psychologists' ethics training. It is also a widely misunderstood and problematic law that does not necessarily capture the intricacies of working with high-risk or potentially violent clients in outpatient settings. While inpatient settings allow for some control over one's clients, outpatient settings increase the difficulty in performing risk assessments in duty to warn situations, as well as with managing clients who are not within one's custody. While researchers have long identified issues related to psychologists' understanding of the duty to warn, none have empirically explored whether the trends seen in individual cases apply across the spectrum duty to warn cases. This project utilized content analysis to code seventeen state supreme court and state appellate court duty to warn cases. The project used a most similar case design with basic inclusionary criteria of 1). State has an established duty to warn law, 2). The case occurred after the law was created, and 3). The case named an outpatient mental health professional. The results of this study identified several commonly occurring themes, of which negligence and foreseeability were the most common and had the highest impact on outcome.

Statement of Original Work

I declare the following: I have read the Code of Student Conduct and Academic Responsibility as described in the Student Handbook of Nova Southeastern University. This dissertation represents my original work, except where I have acknowledged the ideas, words, or material of other authors.

Where another author's ideas have been presented in this dissertation, I have acknowledged the author's ideas by citing them in the required style.

Where another author's words have been presented in this dissertation, I have acknowledged the author's words by using appropriate quotation devices and citations in the required style.

I have obtained permission from the author or publisher—in accordance with the required guidelines—to include any copyrighted material (e.g., tables, figures, survey instruments, large portions of text) in this dissertation manuscript.

_Casey D. Ravitz, M.S.,________
Name

_07/24/2021____________________
Date

Chapter 1: Statement of the Problem

The most recent research on psychologist knowledge of the duty to warn suggests three quarters of psychologists are unaware of or misinformed about their state's specific duty to warn statutes, despite *Tarasoff* law being a staple of psychologists' ethics training (Pabian, et al., 2009). Researchers point out many flaws with these statutes, citing issues related to specificity, consistency, and clarity that may significantly affect mental health professional's comprehension of and ability to follow these important guidelines (Felthous & Kachigan, 2001; Felthous, 2006; Herbert & Young, 2002). In addition, legal researchers who focus on the duty to warn repeatedly express their bafflement at the outcomes of these cases in higher courts, particularly when these cases expand duties prescribed by existing statutes (Herbert & Young, 2002; Pettis & Guthiel 1993; Thomas, 2009). While many legal researchers reported the initial over burdening of psychologists after the original *Tarasoff* case had lessened with a trend towards more concrete duties, new cases suggest this trend is shifting once again (*Greenberg v. Superior Court,* 2017; O'Matz, 2019; *Volk v. DeMeller,* 2014). Legal scholars point to issues like misapplied medical malpractice precedent, poor understanding of the training and abilities of psychologists, and confusion regarding how laws are applied in inpatient versus outpatient settings. This last issue is of particular interest in this project, as while inpatient psychologists have a duty to control their patients, outpatient therapist do not have the ability to control their patients—something researchers have highlighted repeatedly when discussing problematic duty to warn case law. However, no one has used qualitative content analysis to examine the judicial decision making behind these expanded duties. It is reasonable to question if these concerning trends are supported empirically. Or are a few concerning cases capturing the interest of researchers? To psychologists, it appears as if the “facts” are being ignored, but what arguments are these judges supporting instead? And when judges are deciding in line with the psychological research on violence/risk, are there differences in court decisions based on how the appellants and the respondents structure their arguments, or the facts of the case? Which trends truly exists, and what do they potentially tell us? Qualitative content analysis combines the strengths of interpretive legal scholar work and scientific inquiry by providing concrete, replicable evidence to support or reject these suppositions, significantly reducing issues related to bias.

Research Question: What issues are Higher Court Judges discussing in outpatient duty to warn cases?

Chapter 2: Literature Review

Introduction

Tarasoff v. Regents of the University of California (1974/1976) first discussed psychologists' duty to warn, loosely defined as a psychologists' legal responsibility to respond to a client's threat of violence with a warning to the victim and/or law enforcement. The case and its effect on the field are a staple of our ethics training. However, research has consistently shown that psychologists have a poor grasp of their state's duty to warn responsibilities (Leedy, 1989; Pabian, Welfel & Beebe, 2009). Most recently, Pabian et al. (2009) found 76.4% (n = 299) of respondent psychologists sampled across Ohio, Michigan, New York, and Texas could not correctly identify their state's duty to warn parameters. What makes this more concerning is only 10.5% of this sample expressed any concern regarding their duty to warn knowledge. Moreover, these psychologists' knowledge was not improved by attending continuing education (CE) seminars in ethics. Even respondent psychologists who reported having some experience with potentially dangerous clients failed to respond accurately on vignettes assessing knowledge on the duty to warn.

Though the specific mechanism of psychologists' lack of duty to warn knowledge is unknown, the literature has consistently highlighted the difficult-to-interpret nature of duty to warn laws, which differ significantly in wording, specificity, and clarity (Felthous & Kachigan, 2001; Felthous, 2006; Herbert & Young, 2002). Additionally, the statutes and codes prescribing duty responsibilities are always open to legal interpretation and there is no standard method for sharing changing interpretations with local psychologists (Bersoff, 2014; Herbert & Young, 2002; Knapp & Leoncelli, 2005). Court decisions either affirm or adjust duty parameters, the latter often expanding duties beyond psychologists' abilities (Thomas, 2009). Reviewing decisions by judicial bodies can leave researchers feeling as if there is a widespread fundamental misunderstanding of the therapist-patient relationship, a therapist's responsibility towards their patient, and a therapist ability to influence or control a patient's actions. Particularly, researchers highlight how these laws are often inappropriately applied to situations where the mental health professional has no ability to control their patients conduct (i.e., outpatient settings). Even when presented with highly similar duty to warn cases in states with similar duty to warn statutes, state's higher courts produce distinct verdicts. For example, court decisions in Idaho, Alabama, Michigan, and Ohio have protected psychologists from liability when no explicit threat was made, while Arizona, Wisconsin, and Missouri extended duty responsibilities to all 'foreseeable' acts of violence by clients (Werth, Welfel, & Benjamin, 2009). As a result, laws may arise that psychologists struggle to interpret, written and applied by judicial bodies for situations they appear not to understand. In other words, judicial and psychological lenses for understanding these issues appear to differ significantly.

However, research on judicial decision-making highlights several issues with the way psychologists are attempting to interpret *Tarasoff* cases. Kritizer (2010) discusses how courts balance issues between what is best for the consumer or the practitioner, suggesting courts may be expanding duties that protect the consumer and related third parties, ignoring the real world issues that arise for practitioners from their decision

(Edwards, 2014). Robertson (2010), in his chapter on Appellate law discusses the high likelihood that Higher Court Judges are driven by a desire to achieve policy ends rather than merely review cases and apply the law as accurately as possible (i.e., legal realism). Hall and Wright (2008) explain that systematic content analysis adds an empirical basis for the kinds of interpretations legal scholars develop to explain judicial decision making, regardless of any additional reasoning by the judges the decision fails to capture. Applying content analysis to a set of duty to warn cases can help bridge the gap between what is occurring in the courts and the way psychologists are interpreting their duties.

A method for applying systematic content analysis will be reviewed and applied in terms of this project. This research will first discuss duty to warn laws in terms of their structure, interpretability, and potential areas for confusion. This will both provide vital information for understanding the issues with these laws as well as highlight what sort of guidelines are necessary for mental health professionals to recognize and respond appropriately to duty to warn situations. Further, this section will be referred back to when discussing criteria for eligible cases. This research will go on to discuss problematic themes currently identified by legal scholars in duty to warn cases, potential explanations posited by researchers, and, when appropriate, how these issues affect psychologists attempting to practice.

Duty to Warn Laws

Definitions and Terminology. Duty to warn statutes show significant variability, making generalized discussion of these laws difficult. Researchers have highlighted that even after four decades a clear and ubiquitous method is lacking for determining when to apply the duty to warn (Adi & Mathbout, 2018). While some of these laws are written as if they apply only to specific entities such as psychiatrists or counselors, these laws should be interpreted as applying to all mental health professionals regardless of inpatient or outpatient settings (MHP) (Werth et al., 2009). Thus, duty to warn cases name a variety of MHPs including social workers and case workers, who may completely lack training in risk assessment. People often use the terms duty to warn and duty to protect interchangeably, though they are in fact distinct methods for safe guarding third parties from potentially violent clients. The duty to warn requires breaching confidentiality, while the duty to protect allows for alternative actions, such as hospitalization or intensifying treatment (Werth, et al., 2009). Some duty to protect states may still require warning to fulfill all duties associated with the statute, thus requiring MHPs to take multiple steps to ensure compliance with the law. In addition to the duty to warn or protect, some states also have a duty to control, which is associated with inpatient services. The duty to control specifically focuses on the idea of physical custody, in that a hospital or doctor who takes charge of an inpatient has the responsibility to not negligently supervise or release a potentially dangerous individual (Felthous & Kachigan, 2001). These three duties are distinct, but may overlap, making it difficult to determine what responsibilities an individual MHP has in different settings. Further, this duty to control can be inappropriately applied in outpatient settings due to misapplication of special relationships to outpatient therapy (i.e., special relationships require the ability to control).

Duties are either mandatory, or permissive, specifying whether a psychologist is required or permitted to act when the duty is triggered. In other words, in each case the psychologist has permission or the legal responsibility to act to *warn* law enforcement and/or potential victims, or act in some other way that *protects* the public from their client. The duty can also be discretionary or nondiscretionary, referring to whether a psychologist can rely upon clinical judgement regarding the authenticity of a threat or must act once a threat is verbalized (Herbert & Young, 2002). For simplicities sake, this proposal will use the term duty to warn (DTW) to discuss the overarching theme all these laws fall under.

However, discerning these distinctions based on a reading of DTW laws can be difficult. Important guidelines are often stated vaguely or left out completely. For example, Kentucky's statute lacks any information on what actions an MHP should take once a duty arises, solely stating "No duty to warn/protect exists unless the patient has communicated an actual threat of physical violence against a clearly or reasonably identified victim or if they have communicated a specific violent act," (Ky. Rev. Stat. §202A.400). Duty parameters can hinge upon conjunctions (e.g., and versus or), leaving MHPs unclear on what actions to take. For example, the statute in Ohio allows psychologists to choose from a variety of options while the Arizona statute is unclear regarding which or how many actions are required to successfully discharge the duty to warn (Werth, et al., 2009). In short, many researchers conclude that confusion is inevitable.

Duty Interpretation. In an initial attempt to code state duty to warn laws, this author created a database breaking each state's laws into various descriptive categories (Ravitz, 2017). State DTW statutes and case law were drawn primarily from two sources: The National Conference of State Legislatures (NCSL) website (2018), and information compiled in the appendix of <u>The Duty to Protect</u> by Werth, Welfel, and

Benjamin (2009). Werth et al., provided highly detailed, informative, and complete interpretations of states duty to warn laws up until 2009. Although more current, the NCSL web resource is often missing interpretive information informed by caselaw and nuances found when looking up each law individually. Developing this database identified five areas that must be addressed in order for MHPs to have enough information to interpret their duty to warn responsibilities: Duty type; Triggering Event; Warning; Protective Options; and Immunity. MHPs opportunity for civil liability skyrockets without clear and specific instructions about the actions they are legally responsible for regarding DTW, and these five categories allow for informed decision making.

Duty Type. In regard to Duty Type, one must determine if the state has a duty to warn or protect and whether those duties are mandatory or permissive. This could be dictated by statute or by common law, for example, while California's statute is written as if it is a permissive law, case law has altered the DTW parameters to make the duty mandatory (Werth et al., 2009). Mandatory DTW statutes often begin by stating MHP's are immune from failure to warn litigation except in a specified set of circumstances. Permissive statutes generally use terms such as may/can versus must or specify that within a set of circumstances MHPs are allowed or permitted to disclose confidential information. However even states with permissive duties can find MHPs negligent or otherwise responsible for failure to warn when the court determines the psychologist should have acted differently based on hindsight. The online resource provided by NCSL indicates whether a duty exists and if it is permissive or mandatory, assisting MHPs in this regard. Despite this, many psychologists appear to assume they are under a mandatory duty to warn across states (Pabian et al., 2009).

Less clear, however, is whether one is in a discretionary or nondiscretionary state. Nebraska has been identified as a nondiscretionary state where psychologists are potentially liable when a client makes a threat, even if it is not judged to be a believable threat (Herbert & Young, 2002). The Nebraska 2007 statute reads, "There is no cause of action or duty to warn except when a patient has communicated a serious threat of physical violence against a reasonably identifiable victim or victims," (Neb. Rev, Stat, §38-3132). In other words, even if an MHP assesses the situation to be low or no risk, they are only safe from liability if they choose to warn anyway as the statute also protects them from liability for the disclosure. Conversely, Oklahoma is an example of a permissive discretionary state, as the statute requires the client has "the apparent intent and ability to carry out the threat" to trigger the duty to warn and lists several scenarios where clinicians are permitted to act (Okla. Stat. Tit.59 §1376). Another example of a nondiscretionary state is Montana. While the state code sets clear expectations for the triggering event, "the patient communicates an actual threat of physical violence by specific means and against a clearly identified or reasonably identifiable victim," it fails to address whether clinical judgement can be applied to determine the veracity of said threat (Mont. Code Ann. § 27-1-1102). Overall, there is still significant confusion as to the expectations of MHPs in duty to warn situations (Adi & Mathbout, 2018).

Triggering Event. It is important for MHPs to be able to determine what circumstances trigger the duty to warn. Tarasoff laws often fail to address assessment practices and instead typically indicate the duty is triggered once a threat is made

(Felthous, 2006). Although research surrounding risk assessment and management has improved over the forty plus years since Tarasoff, this is problematic as the outpatient clinicians who are responsible for managing DTW situations often lack exposure to that literature or fail to pay heed to this important topic (Adi & Mathbout, 2018; Kivisto, 2016). In a 2003 study, Tolman and Mullendore found outpatient clinicians were significantly less likely to have used any of the common risk assessment measures typically utilized by forensic psychologists. Overall, outpatient clinicians are less likely to have training in the static and dynamic factors that assist clinicians in making decisions about violence risk levels (Kivisto, 2016).

The general form suggested in the *Tarasoff II* opinion and adopted by many states requires a specific threat be made against an identifiable victim. One of the major issues with identifying triggering events is when the law specifically indicates that MHPs are liable when they "should" have recognized the DTW had arisen. For example, Virginia state code specifies that the duty has arisen when "the provider reasonably believes or should believe according to the standards of his profession, that the client has the intent and ability to carry out that threat immediately or imminently" (Va. Code §54.1-2400.1). However, clinicians and courtrooms may differ on whether they considered a threat as serious (Felthous, 2006). A man who comes into session every day angry and talking about wanting to punch his boss may represent a vastly different degree of risk to a clinician than a judge or jury, as clinicians understand violent fantasies do not necessarily translate into violent behavior (Adi & Mathbout, 2018; Gellerman & Suddath, 2005). It also is not clear whether clinicians and courts will agree on what makes a potential victim "reasonably" or "readily" identifiable, common terms in DTW laws.

In terms of triggering event, twenty-seven states have DTW laws directly addressing the circumstances. For example, Arizona's statute outlines "the patient has communicated to the mental health provider an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such a threat," (Ariz. Rev. Stat. Ann. § 36.517.02). Even when not as clearly stated, most statutes and common law duties address this issue in some form. Eight state laws refer to more ambiguous circumstances triggering the duty, such as the Connecticut statute which states the "psychologist believes in good faith that there is a risk of imminent personal injury to… other individuals," (Conn. Gen. State. § 52-146c). Approximately twenty-one of these laws ask for MHPs to predict violence in some way. Though all are not as plainly stated as the following example from Ohio, which states a MHP "may be held liable…for serious physical harm or death resulting from failing to predict, warn of, or take precautions…" (Ohio Rev. Code Ann. §2305.51A). Overall, the variability in these three statutes highlights some of the important nuances to these laws in terms of when an MHP should know the duty has been triggered.

Warning & Protective Options. After the DTW is triggered, MHPs have a variety of potential responsibilities that fall under two categories: Warning and Protective Options. About 75% of states have relatively clear instructions on what information must be provided, and to whom, to discharge the duty to warn. These laws generally use terms such as reasonably or readily identifiable victim(s), meaning MHPs may be expected to do detective work to identify potential victims. Typically, when warning is indicated MHPs are expected to warn both potential victims and appropriate law enforcement officers. However, some states such as Texas only permit warning law enforcement and do not require MHPs warn others at all (Werth et al., 2009). To once again put the heightened risk of litigation into perspective, nearly half of Texas psychologists in the Pabian et al., 2009 study incorrectly asserted they were legally permitted to disclose to potential victims. In actuality, Texas has repeatedly rejected the adoption of a Tarasoff duty and rather has a section of their Health and Safety code that states disclosures regarding potential dangerousness can only be made to law enforcement or medical professionals (Tex [Health and Safety] Code Ann. §611.004; Werth et al., 2009).

This Texas law is interesting when compared with the recent changes to DTW in Florida. After the tragic shooting at Marjory Stoneman Douglas High School in Parkland, Florida, several survivors attempted to sue Henderson Behavioral Health Inc for failure to warn or protect third parties from the shooter's dangerousness (Smith, 2021). Florida courts held that neither inpatient nor outpatient therapists have a responsibility to predict violence or warn third parties based on of a patient's generalized threats of violence (*Pollack v. Cruz;* Smith, 2021). Thereafter, on July 19th, 2019, Florida legislature met and created a mandatory duty to warn law enforcement officers of specific threats of violence, while the law is still permissive in regards to warning third parties (Hall & Tardif, 2020). Hall and Tardif (2020) conducted a study to explore whether expanding the DTW law this way would be effective, as there is scant literature on the topic of police responding to warnings of threats made by mental health professionals. While they determined that most law enforcement agencies in Florida have some sort of policy for dealing with *Tarasoff* situations (90%), they also determined that about 50% of individuals MHPs report are not detained or questioned by police, making it unclear how effective this policy will ultimately be (Hall & Tardif, 2020). Further, Florida higher courts appear to remain steadfast in their view that MHPs are not responsible for failure to warn outside of specific threats of violence (*Boyton v. Burglass; Green v. Ross; Pollack v. Cruz,*).

In DTW laws, it is not always clear whether warning is also required when Protective Options are available, or whether protective actions must be explored in addition to warning. This is one of the more problematic areas, as determining one's correct course of action can hinge on interpreting a grammatical conjunction. The Ohio statute states, "Acceptable action includes hospitalization, commitment, a treatment plan, notifying law enforcement, and communicat[ing] to the victim or the victim's guardian," but specifies elsewhere in the code that any of these four options can be taken to discharge the DTW (Ohio Rev. Code Ann. §2305.51). It is important to note that, again, these additional directives are not included in the section of the code provided by the interpretive NCSL online guide but were found when looking up the statute in its entirety. This kind of discrepancy was not uncommon and highlights another reason why MHPs may struggle with knowing and interpreting these laws even if they make the effort to obtain this information on their own. Delaware provides another example of unclear wording, their code uses the term "or" when listing the warning and protective options, but the law is interpreted as requiring both warning and initiating hospitalization (Del Code Ann. Tit. 16 § 5402; *Naidu v. Laird,* 1988).

Additionally, being in a duty to protect state does not necessarily mean MHPs can rely on clinical judgement to pick the best intervention for their potentially violent client as DTW laws can restrict which options are legally available. Twelve states only offer hospitalization as an alternative or in addition to warning, whereas there are other treatment options that perhaps should be taken prior to more drastic measures like warning or hospitalization (e.g., medication, increasing session frequency). However, it is unclear whether psychologists who take those evidenced based steps for assisting their clients will be penalized for failing to predict a sudden shift in severity that leads to violence. Only six states have multiple protective options listed, while twenty-five state laws fail to reference any actions outside of warning. This potentially disregards many of the steps MHPs may have been taking to manage their client's risk potential. Examples of duty to protect laws with potential legal quagmires are easy to identify. Tennessee lists several options as well as any "course of action consistent with professional standards," but fails to identify any actual standards that may dictate actions in these cases (Borum & Redy, 2001; Tenn. Code Ann. §33-3-207; Thomas, 2009). In Colorado, a mandatory DTW state, a MHP is expected to make efforts to warn a potential victim as well as law enforcement "or to take other appropriate action, including but not limited to hospitalizing the patient," (Colo. Rev. Stat. § 13-21-117) However, later on the statute outlines that MHPs will still be held liable for failure to involuntarily hospitalize even outside of warning. This heightens the likelihood of inappropriate hospitalizations and breach of confidentiality.

Immunity. Lastly, it is important MHPs know whether they have immunity for good faith breach of confidentiality when the DTW arises. Confidentiality is at the core of the psychologist patient relationship and breaching it can bring harsh financial and career related consequences. The APA ethics code states, "Psychologists have a primary obligation to take reasonable precautions to protect confidential information…" (APA ethics Code 4.01). The U.S Supreme Court has also maintained that confidentiality is of the upmost importance (*Jaffee v. Redmond*, 1996; *Trammel v. United States*, 1980). In *Jaffee v. Redmond* (1996) Justice John Paul Stevens wrote, “the psychotherapist-patient privilege is rooted in the imperative need for confidence and trust,” as clients who cannot trust their therapist will be limited in their therapeutic process. The court recognized the “mere possibility” of disclosure could be enough to interrupt the development of a successful therapeutic relationship. Several court opinions reject this assumption and dismiss the importance of confidentiality when establishing a legal duty to warn (*Schuster v. Altenberg* 1988; *Tarasoff II,* 1976;).

At least twenty-seven states protect psychologists from liability in some form for good faith breaches of confidentiality in DTW situations. Arizona, which has a relatively detailed DTW statute in comparison to other states, has a well written section on labiality, “… the mental health provider, for the purpose of reducing the risk of harm, can disclose confidential communications and shall be immune from liability for such disclosure,” (Ariz. Rev. Stat. Ann. § 36.517.02). These types of clauses are vital as each warning brings the potential for liability for inappropriate breach of confidentiality. However, despite appearing to offer immunity from breach of confidentiality suits, some states may still find against psychologists who choose to warn. For example, in New Jersey’s *Runyon v. Smith* (2000), the court found that because the MHP waited six months to act, the danger was no longer “imminent” and thus they were not protected under the statute (Werth et al. 2009).

Duty to Warn Caselaw

Illustrating the Problem. Every duty to warn and protect law, no matter how seemingly clearly written, is open to interpretation by legal bodies. Per legal scholars on the topic, it appears as if higher courts are likely to reinterpret duty to warn laws and remand cases back to lower courts even without evidence of a specific threat against a readily identifiable victim (Robertson, 2010). Even an MHP who is able to find, read, and interpret their state's DTW law cannot be assured a court decision will not abruptly alter duty parameters (Herbert & Young, 2002). MHPs may not be made aware when the statute is changed; Ohio for example changed their duty to warn statute three times in less than a decade with no discernable method for informing psychologist of this change (Knapp & Lemoncelli, 2005; Pabian, et al, 2009). Perhaps the best example of an abrupt change is *Tarasoff* itself, which initiated a legal responsibility to breach client confidentiality in a way MHPs had specifically *not* been allowed to do so previously. In reading the *Tarasoff* decision, one finds that the doctors responsible for Poddar's care, as well as the officers who failed to hold him on those doctors' directives, were not found at fault for failure to initiate hospitalization as they were immune from liability under the laws related to involuntary hospitalization. Instead, the courts established a new duty; meaning the MHPs in *Tarasoff* were held liable for failing to do something they were not legally allowed to do until after their actions could have made a difference. *Tarasoff* is not a case where a client's dangerousness went unnoticed, in fact his treatment team breached confidentiality at least once to warn the police (Bersoff, 2014). Scholars indicate duty to warn case law is peppered with examples where the case did not fit the established law, and for whatever reason, the judge shifted the law to provide relief for the appellants (Jacobson et al., 2001). Whether this trend is supported empirically is one of the questions this dissertation seeks to explore.

The following section focuses on cases that have been previously identified by legal scholars as capturing some of the difficulties in duty to warn caselaw. This author has reviewed the cases firsthand as well as read the relevant research and has often chosen to provide a general explanation rather than another legal scholar's specific claim due to the general agreement across the literature on duty to warn case law as to the issues raised below. As the initial coding method will be grounded in the theories and trends highlighted by these cases, their inclusion in this literature review is important regardless of whether they will ultimately be used in the proposed study. Further, it is important to provide an understanding as to how psychologists must potentially respond to these decisions in ways outside the scope of their regular or best practice.

Foreseeable Victims (Class). While some higher courts affirm existing DTW laws, others appear to radically modify duty parameters, often beyond the scope of a psychologists' abilities to meet. One common way this occurs is by adding liability for "foreseeable victims." In *Almonte v. NY Medical College* (1994), the courts found a trainee disclosing they had pedophilic desires to their psychiatrist supervisor triggered the DTW. Although the trainee was expelled from the program, this was not considered enough of an effort on the supervisor's part. The court ultimately concluded that while the intern had not threatened named victims, future victims were foreseeable as a *class* due to the trainee's stated desire to work with children. But what was exactly expected of this psychiatrist? To somehow guarantee this student was blacklisted from any other avenue of study? To monitor him from afar in a time before one left a digital footprint?

Following that logic, a psychologist could be held liable for any hate crime committed by their client if that client made racist remarks in session. While other common law duties out of Connecticut establish no duty shall arise unless there is an identifiable victim or class of victims, that leaves a lot of ground for a psychologist to cover and not enough direction on how to do so (Werth et al., 2009). California has also established a DTW when a class of victims can be identified. In *Barry v. Turek* (1990), the majority found that Dr. Turek, a psychiatrist, did not have a duty to warn appellant Margaret Barry, a hospital office manager, about an inpatient's propensity for inappropriately touching female nurses because prior to his attack on Ms. Barry as his actions were not construed as being seriously violent. However, the court majority did establish that any woman working around the patient was part of a reasonably identifiable group of potential victims, which can be interpreted as expanding the duty to include classes of victims (Werth, et al., 2009).

Foreseeable Victims (Reasonably). Nebraska presents another example of common law that expands MHPs duty past identified victims to those that are foreseeable. In *Lipari v. Sears, Roebuck & Co.* (1980), an individual receiving care through the VA purchased a shotgun from Sears and used it to shoot randomly into a crowded nightclub after terminating treatment against his psychiatrist's advice. The court held that a duty to protect arose even without a specific threat being made by the client, because the defendant doctor could 'reasonably foresee' the client's mental state could put other's at risk (Thomas, 2009). While MHPs may be 'experts' in determining the presence and treatment of mental illness, few if any mental health disorders are so causally linked with violence that clinicians should determine the diagnosis will automatically lead to a client harming another (APA, 2019). Additionally, many of the typical risk assessment tools have not been validated in outpatient settings or in non-forensic settings (Adi & Mathbout, 2018). While Anti-Social Personality Disorder (ASPD) has been identified as a static risk factor for future violence, research has shown only specific symptom clusters signify risk in other major mental health disorders (Kivisto, 2016). So, while those with schizophrenia, bipolar disorder, or major depressive disorder do in fact show higher rates of violence, research by the NIMH and ECA suggests the difference is approximately 16% of people with major mental illness to 7% of people without a diagnosis (Kivisto, 2016). Further, these differences are far less noticeable when controlling for other risk factors such as substance use, divorce, or other adverse circumstances (Kivisto, 2016). Additionally, some ‘validated’ risk assessment tools such as the Historical, Clinical and Risk Management-20 scales fail to sufficiently predict risk in seriously mentally ill or personality disordered individuals (Adi & Mathbout, 2018). But under Nebraska’s DTW logic where the patient’s mental state is considered a potential indication of danger, MHP’s should be carefully considering their need to warn someone whenever a client with a diagnosis that’s linked with heightened risk of violence leaves treatment. Although Nebraska enacted a statute nearly three decades later that requires a threat be made against reasonably identifiable victim(s) to trigger the DTW, there is no guarantee a Nebraska judge will not reextend the duty to include foreseeable victims or case law that should no longer be applicable, which is what occurred in Washington state in 2017 in *Volk v. DeMeerleer*, which is discussed in detail in the following section about foreseeable violence.

Foreseeable Violence. Not only do duty to warn laws at times extend to foreseeable victims, but to situations where the resulting violence is considered foreseeable as well. Judges point to patient characteristics that apparently make violence foreseeable, when MHPs training does not necessarily support those assertations. As the state that started it all, it should not be surprising that California has suffered through a variety of frustrating expansions to their DTW laws. While establishing a permissive statute in 1985, subsequent case law has created an expansive mandatory duty to warn. One of the best examples of this is *Ewing v. Goldstein* (2004). In *Ewing*, it was determined the communication of a threat by a close family member of the patient is enough to trigger the duty to warn. Despite Dr. Goldstein initiating voluntary hospitalization for the patient based on a call from the patient's father, when the patient was discharged against Dr. Goldstein's urging Dr. Goldstein was deemed liable because he did not warn the potential victim of the patient's release (Thomas, 2009; Werth et al., 2009). To highlight how unusual this case is, the inpatient doctor who discharged the patient despite Dr. Goldstein's urging was found not to be liable to the third parties—despite his negligent release being central to the facts of the case (*Ewing v. Goldstein,* 2004*)*. What is particularly frustrating about this finding is it does not extend to all third-party warnings of patient dangerousness and decisions should be based on 'relevant patient characteristics,' meaning that sometimes one must breach confidentiality or take action when a third-party calls with a warning, and sometimes one must not (*Ewing v. Goldstein*, 2004). How then should a MHP determine which calls are coming from a jilted ex significant other and which should be heeded immediately? What if the person calling is posing as a family member, and our breach of confidentiality allows an abuser to track down their victim? What training does an MHP receive to prepare them for such a decision? Conversely, MHPs do receive training around keeping confidentiality of their clients when speaking to third parties over the phone.

Washington state presents the most recent concerning expansion of DTW responsibilities and liability under common law via *Volk v. DeMeerleer* (2016). This is the second time that Washington state has developed problematic DTW caselaw. The original DTW law in Washington was established via *Petersen v. State of Washington (1983)* and also created expansive duty responsibilities until Washington psychologists lobbied for a remedied statute in 1987 (*Volk v. DeMeerleer*, 2016). VA psychiatrist Dr. Howard Ashby saw Mr. Jan DeMeerleer on and off for nine years for bipolar disorder. Mr. DeMeerleer withdrew from treatment three months prior to killing his ex-fiancé, one of her sons, and himself. At the time of discharge, Dr. Ashby contends Mr. DeMeerleer was stable and voiced no thoughts of violence towards himself or his then fiancé and her family. This information was corroborated by family and close friends of Mr. DeMeerleer (*Volk v. DeMeerleer*, 2016). Dr. Ashby was sued by surviving family members of the ex-fiancé, claiming the doctor “might have prevented the attack by either mitigating DeMeerleer’s dangerousness or warning,” (*Volk v. DeMeerleer*, 2014). Although Dr. Ashby should have been protected by state statute as Mr. DeMeerleer had not voiced any threats of violence, let alone a specific threat, the appellate court found the statute only applied to inpatient services and that *Petersen* could still be applied. The Washington Supreme Court determined “those with specials powers, skills and knowledge gained through the doctor-patient relationship must protect society at large from dangerous persons,” which potentially extends the DTW to any possible victim(s)

(*Volk v. DeMeerleer*, 2014*)*. A liability conscious Washington psychiatrist could interpret this as meaning the DTW is triggered anytime a client with a 'high-risk' diagnosis is noncompliant with their psychotropic medication. Under HIPAA MHPs cannot even acknowledge a client is receiving services without a release. Under *Volk* however, an MHP is safer inappropriately breaching confidentiality than providing treatment that meets the standard of care.

Rulings Across Jurisdictions. Navigating the vague nuances of these laws is made more difficult by how differently courts can rule in DTW cases across jurisdictions. While of course there will be variability in how different states with different statutes and case law rule on different cases, one would expect some agreement from states with similar statutes and similar cases. This author has identified several highly similar cases with differing results that dealt specifically with violence that occurred without any expressed intent. Courts have applied the DTW in several cases where an inpatient client with a violent history injured someone unaware of those tendencies. In *Turner v. Jordan* (1982), Tennessee Supreme Court found that a psychiatrist, when treating a client with a history of violence, had a duty to warn or otherwise protect a nurse working at the same facility. This is in opposition of the triggering event laid out by state code, which requires an actual threat be made against an identifiable victim (Tenn. Code Ann. §33-3-207; Werth, et al., 2009). Similarly, in *Powell v. Catholic Med. Ctr.* (2000)*,* New Hampshire's Supreme Court found that the hospital had a duty to warn a plaintiff phlebotomist of a patient's propensity for violent outbursts (Werth, et al., 2009). This is also in opposition to guidelines laid out by all three of New Hampshire's duty to warn statutes. Conversely, the Ohio Supreme Court found a hospital had no duty to warn one patient attacked by another patient of the first patient's dangerousness in *Campbell v. Ohio State Univ. Med. Ctr* (2006). Further, the Maryland Court of Special Appeals barred a suit where a violent inpatient struck a nurse, who fell and injured an elderly client in *Falk v. Southern Maryland Hospital* (1998) (Werth, et al., 2009). Both court decisions cited lack of intent as required by each state's existing DTW laws, which appears to be what should have also occurred in the first two cases discussed. Issues like this continue to highlight the need for empirical analysis, as these trends may have an explanation eluding biased, frustrated psychologists. Conversely, demonstrating a lack of discernable pattern further strengthens the assertion these laws are too nebulous to follow correctly.

Misapplication of Special Relationships to Mental Health Professionals. In addition to the problematic assumption that MHPs can predict violence, legal scholars point to a potential fundamental misunderstanding about how much control a therapist has over clients in outpatient settings. The DTW hinges on the "special relationship" *Tarasoff* established between MHP and client and is central to how courts find therapists liable for failure to warn (Thomas, 2009; Bersoff, 2014). In the American legal system, an individual owes no liability to third parties for the acts of another except when there exists a special relationship. As Bersoff illustrated in his 2014 article, the original special relationship related law *Tarasoff* pulled from only applies in cases where, "A operates a private sanitarium for the insane. Through the negligence of the guards employed by A, B, a homicidal maniac, is permitted to escape. B attacks and causes harm to C. A is subject to liability to C." This does not apply to most of the cases where courts have established a duty to warn (Werth et al., 2009). Or, in other words, this logic which would be completely appropriate for establishing a duty to control does not necessarily fit in situations where one may have the duty to warn. Rather, some legal scholars argue courts appear to expand the duty to warn when they perceive negligence has occurred at some point but cannot establish liability under the current duty to warn parameters. As Pettis and Gutheil discussed in their 1993 article on misapplication of Tarasoff to negligent driving cases, they highlighted several cases in which they determined the judge had stretched the legal requirements of causation in order to provide compensation. Of particular note was *Naidu v. Laird*, because while Dr. Naidu appeared to have negligently released a patient, he had the duty to control, he should not have been held responsible for a negligent driving accident over five months after the patient was released (Pettis & Gutheil, 1993). This raises the question as to whether judges are focused on creating sustainable policy or providing some sort of relief to the third-party petitioner who has been affected by violence (Edwards, 2014). It is as if in this United States suing culture, there is always someone who can be found responsible for something while Europe and the UK have continually rejected establishing a *Tarasoff* duty (Perlin, 2006; Thomas, 2009).

A great illustration of where a court appears, to psychologists at least, to have appropriately interpreted and applied the idea of special relationships to the duty to warn can be found in Florida. In *Boyton v. Burglass* (1991) the court determined *Tarasoff* had misconstrued special relationship to mean MHPs can control their patients, when what they had found instead was the relationship between client and therapist causes the therapist to become sufficiently involved to gain certain responsibilities regarding safety of the patient and third parties (*Tarasoff II,* 1976*;* Thomas, 2009). Outpatient therapists cannot control their client's behavior, nor is the outpatient therapist's job to control their client. In fact, it would be circumspect if any therapist appeared to exert enough influence over their client that they could control that client's actions. As the Florida court determined, "Once suggestion of control is eliminated, there is nothing in the nature of the relationship between a psychiatrist and his patients to support an exception to tort law presumption," *(stone supra note 4, at 366 Boynton v. Burglass*). In other words, if an MHP cannot control their clients, then there is no exception to the general assumption that one does not owe liability to third parties for another individual's actions. While there is obvious concern by MHPs at the recent change in the Florida DTW statute discussed earlier in this paper, it appears as if Florida courts continue to establish common law that protects MHPs from being held responsible to third parties for failure to warn (*Pollack v. Cruz*; Smith, 2020*)*. However, a different fact pattern could lead Florida courts to rule differently in the future (e.g., specific threats).

Summary

The cases and issues discussed above represent a sample of problematic duty to warn case law and is hardly exhaustive. Take Vermont's *Peck v. Counseling Serv. of Addison County, Inc.* (1985), where the duty to warn was expanded to include threats to property (Werth., et al., 2009). As previously discussed, in *Ewing* judges found Dr. Goldstein (the outpatient MHP) liable while dismissing the claims against the inpatient MHP who was actually responsible for the patient's release. Despite Dr. Goldstein's many attempts to protect third parties in *Ewing*, his failure to warn a potential victim—who was never named to him by his patient—lead to the decision to hold him liable. There is no shortage of frustrating DTW cases with rulings that appear to complicate MHPs typical role in treating individuals. However, literature on this type of legal scholarship warn that studying higher court appeals fails to take into consideration the cases that are never appealed, nor whose appeals are rejected, and thus are never published (Hall & Wright, 2008; Robertson, 2010). Further, legal scholars are more likely to focus on cases that illustrate their points, leading to potential bias. The following section will discuss how qualitative content analysis can allow for empirical exploration into many of the problems raised above.

Chapter 3: Methods

Method Justification

Qualitative Methods. Legal scholars have typically eschewed the empirical methods readily used in the social sciences (Hall & Wright, 2008; Robertson, 2010; Vaismoradi et al., 2013). It is difficult to identify established qualitative methodologies for use in case law. Hall and Wright (2008) reviewed 134 legal studies using some form of content analysis to study judicial reasoning in their article proposing a systematic method for content analysis of judicial opinions. Of these, two projects in health law met their rigorous criteria for inclusion, which required researchers actually code the material traditionally used in interpretive legal methods, and neither project was related to duty to warn. Searches in Westlaw, Heinonline, and PsycInfo for empirical studies on duty to warn caselaw did not return any results either, suggesting qualitative analysis would represent a new way of studying the duty to warn issue.

This presents the problem of how to best address coding duty to warn case law. Previous research suggests when legal researchers first attempt to apply qualitative methods to their work, they work through trial and error, not recognizing they are essentially reinventing the wheel (Hall & Wright, 2008). The following sections discuss some of the theoretical underpinnings for the content analysis design this author chose to apply from the field of nursing research.

Content Analysis. Content analysis is a general term that encompasses several different strategies that can be used to analyze textual information (Vaismoradi et al., 2013). This inferential process varies depending on the research question posed (Weber, 1984). Content analysis focuses on developing an understanding of a phenomenon based on informational content versus developing a theory about that phenomenon (Forman & Damschroder, 2008; Weber, 1984). Rather than doing away with traditional legal interpretation, it provides informational support in the form of uncovering observable, replicable patterns (Hall & Wright, 2008). Using this method requires systematically reading a set of documents, coding consistent features, and developing inferences about them (Hall & Wright, 2008). This method has been used for understanding a variety of processes, including judicial decision making (Forman & Damschroder, 2008; Hall & Wright, 2008; Phillips & Egbert, 2017).

Systematic content analysis appears to have arisen from a desire to add scientific support to legal scholarship (Hall & Wright, 2008). Content analysis has been increasing in use over the last several decades within legal scholarship in coding judicial opinions (Hall & Wright, 2008; Phillips & Egbert, 2017). Because content analysis is dealing with revealing patterns in information, it addresses some of the issues legal scholars have regarding whether judicial decisions can be taken at face value. While the decision may be influenced significantly by outside forces (e.g., politics, desire to shift policy), one can trust that the judges have at least illustrated the legal and factual arguments necessary to support said decisions (i.e., legal positivism) (Edwards, 2014; Hall & Wright, 2008). Content analysis is appropriate when attempting to understand a large number of decisions that are roughly similar. Thus, while there are limitations, content analysis is particularly useful for confirming or debunking established theory.

There are three phases of content analysis: case selection, case coding, and analysis of the data (Carley, 2003; Hall & Wright, 2008). While literature on use of content analysis in nursing highlights both inductive and deductive methods for content analysis, both methods encourage careful review of current theories and associated literature prior to initiating case selection (Elo & Kyngas, 2008; Hall & Wright, 2008). Thus, while Hall and Wright (2008) recommend developing a code book prior to starting, Elo and Kyngas (2008) highlight how inductive content analysis can allow for the development of a codebook while simultaneously analyzing data. There are no systematic rules for content analysis, other than its focus on classifying textual information into increasingly smaller categories (Elo & Kyngas, 2008). Inductive methods recommend careful reading of the data prior to beginning an open coding process followed by a categorization process (Elo & Kyngas, 2008; Forman & Damschroder, 2008; Neuendorf, 2017). Internal validity can be established with this method by training individuals in coding methods and looking for interrater reliability (Hall & Wright, 2008; Neuendorf, 2017; Vaismoradi et al., 2013). If the same patterns are being observed by multiple raters, then one can make inferences based on the available data and associated literature while maintaining a higher level of objectivity than traditional legal scholars (Hall & Wright, 2008). Potentially, with enough cases, quantitative methods such as multiple regression can be applied to establish patterns and potentially predict outcomes in future cases (Hall & Wright, 2008; Neuendorf, 2017). Content analysis appears to have strong utility for use in the study of case law and judicial decision making.

Case Selection. Several arguments are made for case selection in legal qualitative studies. Content analysis appears to encourage working with a large set of cases, with published studies ranging in sample size from 100 cases to over 20,000 (Hall & Wright, 2008; Neuendorf, 2017). Recent suggestions for narrowing sample frames highlight ways this can be done outside of random sampling while also managing the potential increase in bias. Systematic sampling can be appropriate, with researchers choosing arbitrary criteria to reduce sample size, like picking every 10th case from the available population of cases (Hall & Wright, 2008; Linos & Carlson, 2017; Webley, 2010). However, theoretically informed sampling can assist in reducing the number of cases required for analysis. Some examples of this are using a most difficult case design (i.e., cases where one's theory is least likely to hold true), most similar case design (i.e., cases that have similar values on theoretically important characteristics), and most different case design (i.e., cases that differ significantly on all variables but have similar outcomes) (Linos & Carlson, 2017). These methods are best used when testing an established theory but can be used for exploratory or descriptive studies if one does the requisite literature review and other preparatory steps as has been done in this project (Elo & Kyngas, 2008; Hall & Wright, 2008; Linos & Carlson, 2017).

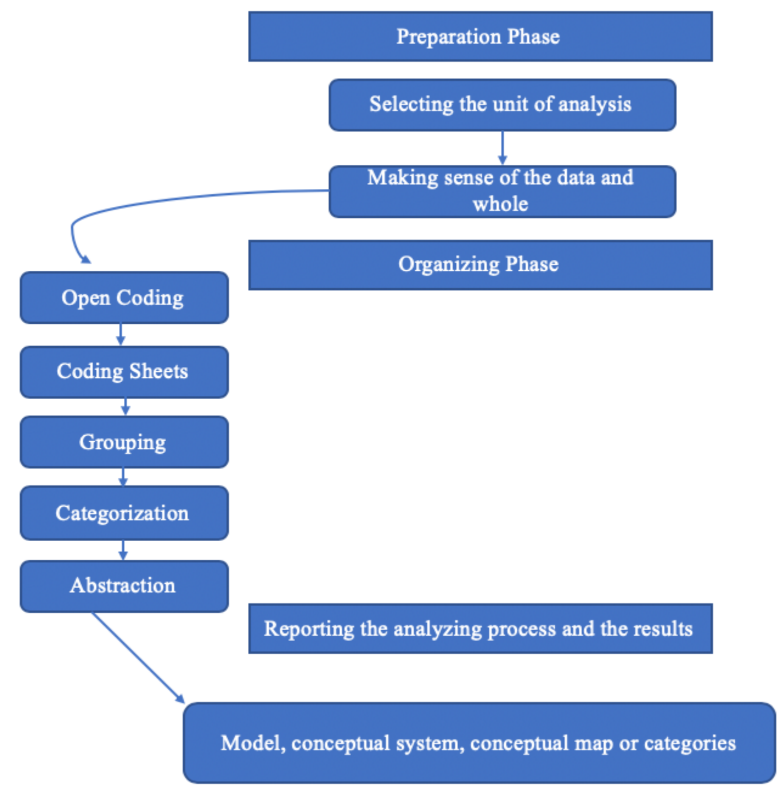
Similar Studies. There is some difficulty in conducting a literature review of qualitative methods used in case law analysis within health law, as very few studies have tackled this issue. Hall and Wright (2008) only identified two, one of which was an empirical analysis on the role of courts in shaping health policy (Jacobson et al., 2001). Within this study, Jacobson and colleagues (2001) hoped to provide insight into judicial explanations for resolving issues related to managed care through the analysis for 450 related cases. Authors argued systematic case content analysis was necessary to explore the claim that courts were usurping policy change in this area--similarly to how legal scholars comment on duty to warn case law. The authors point out the differing goals of healthcare policy makers (i.e., allocation of finite resources) and courts (i.e., protecting individual liberties and rights), and how attempts to reconcile these approaches presented policy makers with a massive challenge. They highlight the problem between how a doctor may not be permitted to provide a service due to restrictions placed by managed care facilities, but that the courts appear to take the side of the individual patient who was denied services—literally going against the established health care policy. Jacobson and colleagues used a deductive method for coding their data, picking categories and developing a ‘survey’ to be filled in based on each case’s content. In analyzing their data, authors generated descriptive statistics for each of the relevant codes, qualitative information on party characteristics, and calculated bivariate statistics to compare directions of rulings for each of their chosen categories. The resulting data was used to discuss the observed patterns and how they either supported or differed from existing theory and to generate important questions for future research. The authors reported several limitations with their methods: they only addressed a subset of the cases that are ultimately litigated, case type categories were not mutually exclusive, there was insufficient sample size for studying certain codes of interest, and acknowledged the inherent subjectivity in their chosen method. Ultimately, they conclude that these methods complement traditional legal scholarship by identifying case trends, suggesting hypothesis for future research, and exploring relationships not easily identified by traditional legal scholarship.

Purpose of the Study

Previous legal scholarship on the duty to warn suggests that courts are radically modifying responsibilities beyond situations where a client has made a threat against an identifiable victim more often than they are interpreting duties narrowly based on the specific wording in the statute (Bersoff, 2014; Felthous & Kachigan, 2001; Felthous, 2006; Herbert & Young, 2002; Thomas, 2009). This continues to occur despite *Tarasoff II* (1976) attempting to resolve the issue only two years after the original *Tarasoff* (1974) decision. This project asks the question, what arguments are higher court judges using in duty to warn cases? Is there actually a trend of higher courts modifying duty parameters? Are there important aspects missing from the relevant legislature when cases are remanded (i.e., duties were unclear)? Similarly to Jacobson and colleagues (2001), this proposed study hopes to resolve confusion between mental health professionals working to establish tenable duty to warn policy and judicial decision making on the topic.

Qualitative Design

This author is using descriptive content analysis with a most similar case design. Content analysis has been used increasingly in legal scholarship, although many of the examples found specific to legal work appeared deductive (Hall & Wright, 2008; Jacobson, et al., 2001; Linos & Carlson, 2017). This author utilized the inductive methodology offered by Elo and Kyngas (2008) which includes a Preparation, Organization and Reporting phase (Vaismoradi, et al., 2013). As this project is being initiated due to the potential bias in legal scholarship on the duty to warn (i.e., scholars identifying trends on a case by case basis without empirical study), it would be inappropriate to determine coding categories a priori. However, to have the appropriate scientific rigor, choices regarding codes, their measurement, and coding rules should be made prior to the final coding process (Neuendorf, 2017). To obtain this ideal in an inductive content analysis, this requires a separation between the open coding process and the final coding process. The inductive method of content analysis used in qualitative nursing research appears appropriate for this exploratory analysis of the duty to warn due to the reliance on an open coding phase to determine codes prior to the final coding process.



Elo & Kyngas (2008)

Figure 1. Inductive methodology offered by Elo and Kyngas (2008)

In the preparation stage, the theory and rationale for the project must be determined (Elo & Kyngas, 2008; Neuendorf, 2017; Vaismoradi, et al., 2013). This project included a significant literature review on the duty to warn and content analysis, and perusal of 70+ relevant duty to warn cases. Through this process, the research question was developed, potential themes were elucidated through the text, and a final sample was determined.

There are several stages in the organization phase of content analysis. First, one completes an open coding phase, which is the process in which documents are read and codes are allowed to rise organically from the text (Elo & Kyngas, 2008; Neuendorf, 2017; Vaismoradi, et al., 2013). Through this process, a coding scheme is developed, and codes are identified prior to beginning the final coding process (Neuendorf, 2017). A coding sheet is typically utilized, either externally or using specialized software (i.e., ATLAS.ti). Codes are then organized under higher order categories. Finally, meanings are abstracted, and one moves into the reporting phase where the analyzation process is explained, and results are organized and described.

Sampling

To use the most similar case design, several strict inclusion criteria were developed. Cases were chosen from states that have duty to warn laws, as the project is focused on how judges rule when there is an established statute, not how they navigated the issue prior to these laws being developed. As such, cases were ultimately excluded if they occurred prior to the duty to warn law being established in that state. Only cases by or against outpatient mental health professionals were included in the study. This is due to a desire to separate duty to warn or protect cases from duty to control cases, which are often regulated by a separate statute, law, or code related to having custody over the patient—leading to an increased level of responsibility. Cases were not excluded if the client had been hospitalized at some point during their treatment, as long as the outpatient therapist and/or outpatient clinic was the person named in the ensuing lawsuit.

There was a significant reduction in sample size from the time of the proposal (155) to the final analysis (17). In the initial proposal, potential cases were identified through Nexus Uni using the terms "duty to warn" and "psych*" between 1974 (i.e., *Tarasoff I*) and present day. Cases were excluded if they came from states without a duty to warn statute or code (Georgia, Iowa, Kansas, Maine, Missouri, Nevada, North Carolina, North Dakota, Pennsylvania, South Dakota, Vermont, Wisconsin, West Virginia) as established by Werth and colleagues (2009), from individual research, and checked against the NCSL website. This returned nearly 2,000 cases. Cases were then excluded based on inpatient versus outpatient settings, as this study is focused on the duty to warn versus the duty to control, by adding the term "outpatient," resulting in 155 cases.

In the second sampling process, this author repeated the search described above and skimmed through the 155 initial cases to identify those which could be appropriate for inclusion in this study, resulting in 72 total cases. For the most part, cases were excluded for being focused on inpatient services despite the search criteria. Cases were also excluded for naming non mental health professionals in the lawsuit, for example, several cases were focused on probation officers duty to warn. A document was developed with short summaries of each case, with cases organized by state.

Each of the 72 cases identified were perused and a case was included in the final sample if it: 1) Was a duty to warn case; 2) Named the outpatient mental health professional/clinic in the suit; and 3) Occurred after the duty to warn statute was enacted in that state. All cases were read carefully even if it was clear early on in the discussion they would not meet full criteria. This process led to a vast majority of cases being excluded. Overwhelmingly, cases were excluded because they occurred prior to the statute being enacted in that state, which was something this author did not consider during the initial and secondary sampling process. There were also still a handful of cases focused on inpatient mental health. However, there were several other reasons cases did not meet criteria, including but not limited to: Suits against medical professionals versus mental health professionals; Duty to warn of side effects of medication rather than duty to warn of potential violence; Related to suicide not risk of violence; Duty to control case not a duty to warn case; Focused on mandated reporter duties (e.g., failure to report child abuse or domestic violence); The original case included a duty to warn element but the appeal did not deal with the issue of duty to warn at all; and Suit was focused on breach of confidentiality not failure to warn. Because this process lead to such a significant reduction of the sample size, this author recruited another reviewer to complete a blind review of the same 72 cases for interrater agreement, which will be discussed further on in this section. The reviewer was tasked with reading the same 72 cases and determining whether they met the three inclusionary criteria stated at the beginning of this paragraph.

Ultimately, 17 cases were chosen for inclusion across 12 states (See Table 1).Of these states, Alabama, California, Illinois, Louisiana, Massachusetts, Michigan, New Jersey, Tennessee, Utah, and Washington all have mandatory duty to warn laws. Conversely, at the time these cases occurred Texas and Florida were both permissive duty to warn states (i.e., Florida's recent law changes). Additionally, California, Illinois, Massachusetts, Michigan, New Jersey, and Tennessee have an identified duty to protect as well as a duty to warn while Alabama, Florida, Louisiana, Texas, Utah, and Washington do not. The vast majority of states (10) explicitly state in their duty to warn statute that a direct threat must be made to trigger the duty to warn, with only Texas and Massachusetts differing in this regard.

Table 1

List of Cases Selected

Case	State	Year law passed
Calderon v. Glick	California	1985
Coleman v. Martinez	New Jersey	1991
Dawe v. Dr. Reuven Bar	Michigan	1989
Ewing v, Goldstein	California	1985
Grady v. Riley	Louisiana	1986
Green v. Ross	Florida	1987
Greenberg v. Superior Court	California	1985
Kehler v. Eudaly	Texas	1979
King v. Smith	Alabama	1975
McGrath v. Yosry	New Jersey	1991
Robinson v. Mount Logan clinic	Utah	1988
Shea v. Cartias Carney	Massachusetts	1989
Sherer v. Sarma	Illinois	1990
Stewart v. Fekhruddin	Tennessee	1989
Tedrick v. Cmty. Res. Ctr.	Illinois	1990
Thapar v. Zezulka	Texas	1979
Volk v. DeMeerleer	Washington	1983

Procedure

This author used the inductive content analysis model proposed by Elo and Kyngas (2008). In the initial proposal, this author was planning to use Quirkos, a specialized software for qualitative analysis, but the program proved to be unsuited to this particular project. The program controls proved to be visually confusing and unwieldly for reviewing judicial opinions due to the formatting used in legal documents. Specifically, the program does not seem able to tell the difference between the body of text and footnotes making the documents appear as a jumbled mess. Ultimately, ATLAS.ti was identified as being an appropriate tool to systematically analyze the sample of cases. ATLAS.ti allows for open coding, grouping into themes, categorization, and abstraction.

After the initial literature review, a review of the 72 cases identified in the second sampling process assisted this author's immersion into the topic. During this reading, simple notes were taken about emerging themes. Moving into the Organization phase, the 17 cases included in the final sample were uploaded to Atlas.TI, reread in detail, and open coded. In open coding, this author made note of the themes the appeared repeatedly across the sample and developed these into codes. After the open coding process, the methods for determining when to apply different codes was operationalized in an informal code book (e.g., capturing the necessary key words and phrases) and a final coding scheme was developed. While all mention of different coded topics was included in the open coding process, once operationalized, final codes were only applied when the judges were discussing the issue rather than when, for example, the decision was reviewing the petitioner's motion. Further, it was determined that where the code appeared within a document was not important, allowing for simplification of the coding sheet. Therefore, the coding sheet asked for whether a code appears at all in the decision.

In the open coding process, it became clear that frequency with which a specific word appeared (e.g., prediction) was not a good indication of strength, meaning, or directionality of an argument (e.g., whether or not the court feel MHPs can predict violence) (Carley, 2003). Rather, it was a sign to mark off "risk prediction" on the coding sheet and to then look carefully for which way the court ultimately rules on this issue. This precluded use of certain computer automated content analysis (CATA) processes, such as looking at the frequency of a word and it's synonyms (e.g., predictability) to make inferences. It can be difficult to separate latent from manifest content with CATA procedures, and this project was focused on uncovering the common themes discussed in duty to warn cases (Carley, 2003). Thus, the coding scheme focused on determining whether or not an issue arose within a given case, and how the court ultimately ruled on that issue. For example, was ambiguous language discussed, and if so, did the court agree or disagree that the language used in the statute was ambiguous? So, for each of the above mentioned categories, cases were coded as to whether or not these issues were mentioned, and then directionality was captured. For example, if the case mentioned duty to third parties, it was necessary to also capture whether the judges decided there was a duty to third parties or if there was not.

Other important information was also coded including: Diagnosis, whether the client made a verbal threat against an identifiable victim directly to the mental health professional named in the suit, the type of case, and the case outcome. Several codes were considered when developing a coding scheme but were ultimately discarded after open coding due to issues with ambiguity. For example, this author initially hoped to code when the mental health professional had performed a formal risk assessment as researchers have indicated that doing so, even if the results incorrectly indicate the individual is not a major risk, should protect MHPs from losing duty to warn litigation. However, the majority of cases do not directly address this issue, and this author did not want to incorrectly extrapolate “risk assessment” from “intake assessment” unless stated clearly. A code for whether the MHP attempted to take protective action was discarded for similar reasons.

Several other codes were developed but ultimately discarded prior to the final coding process (i.e., not included on the final coding sheet). Codes that were discarded included but are not limited to: Whether Tarasoff was directly referenced, whether duty to warn/non duty to warn case law was referenced, whether the rules for summary judgement were reviewed, whether psychological research was referenced (it never was), if supreme court decisions were referenced (i.e., typically *Jaffee v. Redmond*), and whether or not there existed a triable issue. In the end, these codes were discarded because they did not appear to add to the understanding of the arguments being addressed in these cases, or the concept was better captured by another code. This author attempted to capture issues that would be of interest to either psychological or legal scholars, but due to limitations in egal knowledge, at times it was unclear what might be considered informative to someone with a legal background. Thus, while many of these things were captured in open coding, they were not included in the final coding scheme/sheet.

Finally, a major area of interest that was coded was whether the decision specifically addressed statute interpretation. Not only was the presence of interpretation coded, but also whether courts chose to reinterpret the statute. Interestingly, as courts most often claimed to not be reinterpreting statutes, an additional code as to whether the judges were in fact creating new case law when they claimed not to be was added.

In the grouping and categorization process, codes focused on whether an issue was mentioned were grouped by theme with the codes addressing which way the courts ruled on those issues. For example, codes ‘predictability MENTIONED,’ ‘CAN predict’ and ‘CANNOT predict,’ were grouped together under ‘predictability.’ Thus, the theme of predictability was captured within one category. Some codes were ultimately collapsed into each other, for example, in terms of identifiability, there were initially two different sets of codes, one dealing with whether there was a readily identifiable victim and one dealing with whether the court felt there needed to be a readily identifiable victim to trigger the duty to warn. In the end, it was found that these codes were not capturing distinct ideas and should be collapsed. In the final abstraction process, final code values were captured within an excel spread sheet and studied for observable themes.

Analysis

Since this is an inductive, qualitative, exploratory study, the majority of the data is reported as simple frequencies. While writing the initial proposal, this author was hopeful that a large enough sample size would allow for bivariate or regression analyses, unfortunately the small sample size violates the assumptions required for these kind of quantitative analyses. Further, as Jacobson & colleagues (2001) pointed out in their work, there is often too great of variability between cases to test certain codes quantitatively. As there are more codes then there are cases, one can see how this is also the case for this project. Nevertheless, the descriptive statistics allow for patterns that arose in the coding process to be compared with existing assumptions raised in the literature, for example, whether the idea of foreseeability is more often accepted or rejected. The strength of this study is in its ability to cautiously confirm or bely the current concerns of psychologist and legal scholars on the duty to warn and highlight areas where future research is necessary. Cautious interpretations can be found in the discussion section.

It should be noted that this author is aware of the inherent subjectivity of much of the decision making in this project. While some codes were clearly objective, for example, the type of case and its outcome, others such as those related to statute interpretation were particularly subjective. Overwhelmingly, qualitative researchers recommend the use of multiple raters to establish interrater reliability (Hall & Wright, 2008; Neuendorf, 2017; Vaismoradi, et al., 2013). An individual who previously graduated from Nova Southeastern University with a PsyD in clinical psychology with a concentration in forensics was recruited as an interrater. While the initial proposal indicated a psychology and a law student would be recruited to each recode 5% of cases, due to time constraints, additional research on content analysis, and pandemic related recruitment difficulties it appeared more appropriate to train a single individual who was familiar with law, psychology, and the duty to warn to recode 15% of the sample. The subsample was chosen using a random number generator. The interrater was kept blind of the research question and the exact purpose of the study in order to reduce bias that could compromise reliability (Neuendorf, 2017). The interrater received training in the final coding scheme (i.e., how to determine when a code was or was not present) and coded two cases under this authors supervision in order to assess their ability to apply the coding scheme prior to recoding three cases (18% of total sample) for interrater reliability.

To establish reliability, this author focused on interrater agreement and utilized a percent agreement statistic referred to as 'proportion agreement, observed' (PA_o) (Neuendorf, 2017). There are two statistics for this, one when all raters rate the same sample of cases (i.e., interrater agreement on which cases to include) and when there is a difference in the total number of cases coded by each (i.e., testing the full sample against the interrater's 18%). For the first method, the equation is expressed as $PA_o = A/n$, with A being the total number of agreements between the two coders, and n is the total number of cases. For overall interrater reliability, Holsti's method (1969) will be applied as $PA_o = 2A/(n_A + n_B)$, where A is the number of agreements between two coders on the commonly coded cases, and n_A and n_B are the number of total cases coded by both coders. Both equations provide a statistic that ranges from .00 (no agreement) to 1.00 (perfect agreement). To establish interrater agreement, each of the codes included in the final coding sheet will be compared between this rater and the independent coder using Holsti's method, resulting in a PA_o for each theme/category.

Chapter 4: Results

As explained within the methods, each of the main issues raised within the sample of duty to warn cases was assigned a descriptive code that denotes the presences of the argument, as well as directionality. To summarize the themes discussed in these cases and the direction of these codes, this included: Ambiguous language (yes or no), confidentiality (critical or not-critical), control (can or cannot), expert witness testimony (credible or incredible), foreseeability (was or was not), identifiability (was or was not), medical malpractice (was or was not), negligence (was or was not), risk prediction (can or cannot), special relationships (was or was not), standard of care (met or did not meet), duty to third parties (have a duty or do not have a duty), and statute interpretation (yes, no, or claims no but creates caselaw). Additional informational codes included: Diagnosis, threat made, statute requires threat, type of case, and outcome. In the following section, the descriptive statistics for each of these codes will be reported. Please see Appendix A for a simple chart highlighting the information discussed by judges in each case.

Interrater Agreement

The proportion agreement observed was calculated comparing which cases each rater felt should be included in the study (PA_o = 70/72) (Neuendorf, 2017). The independent reviewer suggested inclusion of only 15 cases, rejecting two that were considered appropriate by this author, leading to 97% agreement between raters ($PAo = .97$). One of the two cases the rater rejected was due to not considering a caseworker a mental health professional (*Coleman v. Martin)*. The other was rejected because to the rater it appeared as if the statute was established after the case occurred (*Robinson v.*

Mount Logan Clinic), however the statute is directly referenced in the case discussion leading to this author choosing to include it despite the interrater's rejection.

The second coder completed coding of three cases, *Ewing v.* Goldstein, *Greenberg v. Superior Court*, and *Tedrick v. Community Resource Center*. These cases were picked using a random number generator set to pick numbers between 1 and 17. In comparing the codes of this author and the interrater across the three cases coded, this resulted in a strong indication of interrater agreement. If the opportunity to code correctly in each of the 17 categories is represented by 1, then there were 51 opportunities for agreement across the three cases. The interrater and this author agreed on 47 of the codes for these three cases, resulting in a PA_o of .92, or 92%. However, when attempting to apply Holsti's method, this resulted in rather poor interrater agreement ($PA_o = .27$). This is easily explained by the vast number of potential codes (289 across the 17 cases) as compared with the 18% of cases (3) the interrater recoded (51 across 3 cases), and indicates one of two things. Either a different method of interrater agreement would have been more appropriate, or the second rater needed to complete a larger number of cases. There were only four instances of disagreement across the three recoded cases. Assuming this would hold true if the second coder had recoded the entire sample, this may have resulted in agreement in 266 of the 289 codes (92%). Using this number, the percent agreement observed would be nearly 96%. Ultimately, it appears as if Holsti's method was ill-suited for this project and additional cases need to be coded to establish stronger interrater agreement in the future.

Type of case and outcome

Out of the seventeen cases identified as being appropriate for analysis, the majority (70%) were appeals or review requests of summary judgement. Of those twelve cases that were appeals/reviews of summary judgement, eleven (91%) were third parties appealing summary judgements made in favor of the mental health professional or outpatient clinic. The five remaining cases included: An MHP appealing a case that was decided in favor of the third party (1/6%); An MHP seeking a writ of mandate from the superior court to direct the trial court to grant him summary judgement (1/6%); A third party appealing a dismissal in favor of the MHP (2/12%), and finally one case that granted a review for many issues alleged by both the MHP and the third party (1/6%). Thus, one can infer that 76% (13) of cases were in favor of the MHP at the trial court level, while 24% (4) were appeals from MHPs of cases that found in favor with the third party at the trial court level.

In terms of outcomes, judgements were either affirmed (53%) or reversed and remanded to trial courts (35%) (no cause of action (1/6%), writ issued (1/6%)). After the cases were heard by the superior courts, only 59% (10) of judgements were in favor of the mental health professional (i.e., *King v. Smith, Calderon v. Glick, Grady v. Riley, Green v. Ross, Greenberg v. Superior Court, Kehler v. Eudaly, McGrath v. Yosry, Shea v. Cartias Carney, Sherer v. Sarma,* & *Thapar v. Zezulka)* and 41% (7) were in favor of the third party (i.e., *Ewing v. Goldstein, Coleman v. Martinez, Dawe v. Dr. Reuven Bar, Robinson v. Mount Logan Clinic, Stewart v. Fekhruddin, Tedrick v. Community Resource Center,* & *Volk v. DeMeerleer)*. Of the thirteen cases where the trial court either found in favor of/granted summary judgement for the MHP, five (38%) were reversed in favor of the third party. Of the four cases where MHPs appealed rulings in favor with the third party, two (50%) cases were reversed or otherwise found in favor with the mental health professionals.

Threat

In the majority of cases, no threat was verbalized to the mental health professional on trial (14/82%). This explains the many summary judgement rulings, as the trial courts across jurisdictions commonly ruled that without a direct threat, no triable issue existed. Only two (12%) cases included direct evidence that the patient verbalized threats to the mental health professional named in the suit, while one case (6%) did not explicitly address the issue. Interestingly, of the two cases where direct threats were made to the MHP named in the suit, superior courts actually found in favor of the mental health professional. Of the 14 cases where no threat was made to the MHP directly, there were five cases with 'exceptional' circumstances. Specifically, there was evidence in two (14%) cases that the individual uttered a verbal threat to another MHP that was not named in the suit, two (14%) cases included family members reaching out to the MHP about concerns regarding the patient's potential for violence, and one (7%) acknowledged a history of homicidal ideation towards someone else ten years prior (but denied recent ideation). Judges ruled in favor of the third party in all five of these cases.

Of the twelve states included in this study (i.e., Alabama, California, Florida, Illinois, Louisiana, Massachusetts, Michigan, New Jersey, Tennessee, Texas, Utah, Washington), ten (83%) have statutes that require an explicit threat be made against a readily identifiable individual to trigger the duty to warn (although wording varies across statutes). The only two that do not require an explicit threat to trigger the duty to warn are Texas and Massachusetts. Texas has a permissive statute allowing disclosure to law enforcement if the MHP feels there is an imminent probability of violence (Tex. [Health and Safety] Code Ann. §611.004). In Massachusetts, the duty to warn can be triggered when the MHP has knowledge that the patient has a history of physical violence and the MHP has reason to believe the patient currently presents a clear danger (Mass. Gen. Laws Ann. Ch. 123 § 36B). Overwhelmingly, however, these cases occurred in states that require an explicit threat be made to trigger the duty to warn.

Diagnosis

Of the seventeen cases included in the final sample, four (23%) did not explicitly discuss the diagnosis of the patient who was violent towards a third party. The majority of the cases (35%) included individuals who had comorbid diagnoses, or who received multiple diagnoses from different providers. These comorbid diagnoses included a combination of everything from personality disorders, mood disorders, somatoform disorders, neurodevelopmental disorders, trauma and stressor-related disorders, to psychotic disorders. Several cases only reported one diagnosis, which were: Anti-Social Personality Disorder (6%), Asperger's Spectrum Disorder (6%), Bipolar Disorder (12%), Major Depression Disorder (12%), and Psychosis (6%). There was no observable pattern between diagnosis and case outcome.

Themes Within the Judge's Written Decisions

Statute Interpretation. When coding for statute interpretation this author relied on observations as to whether the judges directly referenced the wording and parameters of the DTW statute within the decision. Some merely mention the statute but fail to discuss its meaning (i.e., no interpretation), while others go into explicit detail about their interpretation of the statute (i.e., interpretation). Additionally, of those cases that provided some sort of interpretation, if the judges appeared to deviate from the obvious wording of the statute, this was considered reinterpretation. Of the cases that directly addressed statute interpretation (12/70%) (*Ewing, Calderon, Dawe, Grady, Green, McGrath, Robinson, Shea, Sherer, Stewart, Thapar* & *Volk)*, two (16%) failed to restate the statute in the text (i.e., *Grady* & *Dawe*). Otherwise, when statute interpretation occurred, typically the judges restated the statute within the decision.

Regarding cases that directly discussed statute interpretation, the majority (10/83%) expressed that they were not reinterpreting the current statute, with only *Stewart* and *Dawe* directly admitting they were reinterpreting the statute. A second code was developed to capture when judges who claimed they were not reinterpreting statutes did in fact produce new case law. Of the ten cases that claimed not to be reinterpreting the statute, it was clear that two (20%) of them resulted in new case law (*Ewing,* & *Volk).* In three (30%) of the cases that discuss interpretation, it is unclear whether the rulings substantially reinterpret the existing law (*McGrath, Robinson,* & *Shea*). The last five (50%) cases interpret but do reinterpret the law, a supposition that is supported by all five of those cases finding in favor of mental health professionals who did not warn due to a lack of triggering event (i.e., there was no specific threat against an identifiable victim). While *McGrath* and *Shea* resulted in rulings in favor of mental health professionals, *Stewart, Dawe, Volk, Ewing,* and *Robinson* lead to rulings favorable to the third parties, suggesting that statute reinterpretation does not always directly correlate with outcome.

Negligence. Negligence was the single most common theme in this sample of duty to warn cases, with 88% (15) of cases addressing this issue (*Calderon v. Glick, Grady v. Riley, Greenberg v. Superior Court, Kehler v. Eudaly, McGrath v. Yosry, Shea* *v. Cartias Carney, Sherer v. Sarma, & Thapar v. Zezulka, Ewing v. Goldstein, Coleman v. Martinez, Dawe v. Dr. Reuven Bar, Robinson v. Mount Logan Clinic, Stewart v. Fekhruddin, Tedrick v. Community Resource Center, & Volk v. DeMeerleer*). Significantly, all seven (47%) cases where superior courts suspected negligence led to rulings favorable to the third parties. Conversely, the other eight (53%) cases where the superior courts did not feel the MHP acted negligently ruled in favor of the MHP. Negligence appears to be the single greatest predictor of case outcome within this sample.

Foreseeability. Issues related to foreseeability were discussed at length in the earlier sections of this paper. Unsurprisingly, it was a theme in the majority of cases (70%). Of the twelve cases that discuss the issue of foreseeability (King, Ewing, Calderon, Coleman, Dawe, Greenberg, Kehler, Shea, Sherer, Stewart, Tedrick, & Volk), five (42%) ruled that the danger was potentially foreseeable, while six (50%) ruled the danger was not foreseeable, and one (8%) mentioned foreseeability but ultimately failed to address whether or not they viewed the violence as potentially foreseeable. All of the five cases that indicated danger was potentially foreseeable resulted in outcomes in favor of the third party (i.e., Ewing, Coleman, Dawe, Tedrick, Volk). Of the six cases were danger was ruled as not being foreseeable, five (83%) ultimately ruled in favor of the MHP while one (17%) ruled in favor for the third party. The idea of foreseeability was observed to also substantially influence outcome and was often a key aspect of the negligence finding, which will be delved into more within the discussion.

Ambiguity. Ambiguity of statute language is a much discussed topic in the literature and within the initial sections of this paper. However this issue was only brought up in two cases (i.e., Ewing v. Goldstein, & Green v. Ross). In Ewing, the court rejected the petitioners assertion that the statute in California is 'fatally' ambiguous and did ultimately find in favor of the third party. Conversely, in Green, which found in favor with the MHP, the court agreed the language was ambiguous but declined to interpret the permissive statute as the judges felt the interpretation in Boyton v. Burglass (1991) was clear enough and saw no reason to add to the legislation on the issue.

Special Relationships. As discussed earlier in this paper, the duty to warn hinges on the idea of special relationships, as this is the reason MHPs are considered liable to third parties. Typically, one is not liable to third parties outside of a special relationship. Thus, it would be expected that this issue would be central to many of these cases. In actuality, the issue of special relationships was only discussed in six (35%) of the seventeen cases (i.e., *King, Dawe, Kehler, Sherer, Tedrick, Volk)*. Half of the cases (3/50%) decided that outpatient MHPs and patients do meet the requirements to establish a special relationship which made the MHP responsible to third parties, and the other half ruled conversely. There was no observable pattern between establishing or finding a special relationship and the outcome of the case.

Standard of Care. Standard of care is an important code to measure for several reasons, including how often this wording appears in DTW statutes. Additionally, researchers have repeatedly highlighted the failure of statutes, courts, or legislative bodies to identify what standard of care they are referencing. Standard of care was address in seven (41%) cases (i.e., *Coleman, Dawe, Greenberg, Kehler, McGrath, Stewart, Volk)*. Of those cases, three (43%) indicated the MHP had met the standard of care, while four (57%) indicated a failure to do so. This also appears to be a good predictor of outcome, as the three cases that found the MHP met the standard ultimately ruled in favor of the MHP and converse occurred in the four other cases.

Duty to third parties. As discussed in the section regarding special relationships, typically individuals are not responsible to third parties under the American legal system. Ten (59%) cases discussed the idea of liability to third parties (i.e., *Calderon, Coleman, Dawe, Greenberg, Kehler, Robinson, Sherer, Tedrick, Thapar,* and *Volk*), with only four (40%) ultimately deciding that MHPs should be liable to suits brought by third parties—and all four of those resulting in rulings favorable to the third party. Interestingly, this did not mean that the six remaining cases were decided in favor of the MHP, as *Robinson* v. *Mount Logan Clinic* was still decided in favor of the third party. *Robinson* however, is an interesting case, in that the court found that while the therapist had no duty to warn because no threat had been made, once the therapist chose to warn (i.e., chose to answer the police officers question as to whether or not the client had a gun), she had a responsibility to do so non-negligently (i.e., she was wrong when she stated the client did not have a gun, and knew the client brought weapons to therapy in the past). This may explain why the court ruled that while typically she would not be held liable to the third party, her choice to take affirmative action required her to do so nonnegligently.

Confidentiality. The right to confidentiality is an integral piece of the therapeutic process, a fact that has even been recognized by the U.S. Supreme Court (Edwards, 2014). However, duty to warn scholars have expressed concerns that the right to privacy is being disregarded by courts in duty to warn cases. Of the seventeen cases in the sample, only five (29%) addressed the idea of confidentiality (i.e., *Ewing v.*

Goldstein, Green v. Ross, Sherer v. Sarma, Thapar v. Zezulka, Volk v. DeMeerleer), with four of those cases (80%) indicating that inappropriate breaches of confidentiality can have a negative impact on the therapeutic process. The single case that rejected this assertion (*Volk v. DeMeerleer*) expressed the view that individual privacy cannot override the need to protect the public at large, and rejected the assertion that this ruling could potentially dissuade individuals from seeking therapy. Two of the five cases (40%) ultimately ruled in favor of the third party (i.e., *Volk* & *Ewing*). There was no observable pattern between discussions of confidentiality and case outcome.

Control. Legal scholars focused on the duty to warn have suggested judicial bodies misapply the duty to control to outpatient mental health professionals, collapsing the duty to control into the duty to warn. Five (29%) of cases addressed the issue of control (i.e., *Kehler v. Eudaly, Robinson v. Mount Logan, Stewart v. Fekhruddin, Tedrick v. Cmty. Res. Ctr.,* and *Volk v. DeMeerLeer)*, with three (60%) determining that outpatient mental health professionals do not have the responsibility to control their patients, one (20%) determining that MHPs do have the responsibility to control their patients (*Volk v. DeMeerleer)*, and one (20%) that failed to clearly state which way they fell on this issue. Although there does not appear to be a pattern as to the directionality of the ruling on control and the outcome of the case, every case that mentioned the idea of control except for one (i.e., *Kehler*) ultimately ruled in favor of the third party.

Expert Witness Testimony. This writer was initially interested in what type of arguments were used to justify judge's decisions in duty to warn cases (i.e., case law versus empirical research). However, there was not a single case that independently discussed research on the topic of duty to warn, risk assessment, or risk prediction.

Rather, these topics sometimes arose during expert witness testimony. Overwhelmingly, judicial bodies were justifying decisions based on of previous case law or discussing how that jurisdiction 'typically' responds to similar situations. Because every case utilized case law and that case law was unique to that state, codes related to caselaw were ultimately dropped from the final coding scheme. There were five (29%) incidences of expert witness testimony (i.e., *Dawe v. Dr. Reuven Bar, Greenberg v. Superior Court, McGrath v. Yosry, Stewart v. Fekhruddin, Volk v. DeMeerleer)*, four (60%) that the court found credible, and one (20%) that the courts found incredible (i.e., *Yosry)*. This is a surprising finding, as one would expect all of these cases to utilize expert witness testimony. It is possible that there was expert witness testimony used at the trial or appellate court level as the Higher Court judges do not always discuss these previous cases in full detail. In every case where there was a credible expert witness for the third party, the superior courts found in favor with the third party.

Identifiability. Under most duty to warn statutes, potential victims must be readily or reasonably identifiable. The idea of identifiability was discussed in three (18%) of the total sample of cases (i.e., *Ewing*, *Kehler,* and *Shea)*. Of these three cases, two (66%) determined the victim was not readily identifiable, and one (33%) found the victim was readily identifiable. Concerning case outcome, the two cases where the individual was found not to be identifiable resulted in ruling in favor of the MHP, while the converse is true of the one case where the victim was considered readily identifiable.

Medical Malpractice. Research suggests that medical malpractice may be being applied in duty to warn cases to find MHPs liable when cases do not fit into the parameters laid out by duty to warn laws. There were only four (24%) cases that addressed the issue of medical malpractice (*Calderon, Dawe, Greenberg, Volk*). The majority of these cases (3/75%) rejected attempts to apply medical malpractice standards by third party petitioners, although there was no observable pattern for the outcomes of these cases (i.e., mix between finding in favor of the MHP and third party). Conversely, the only case that applied the medical malpractice standard did indeed find in favor of the third party (i.e., *Dawe*).

Risk. There is a substantial amount of literature indicating that MHPs are poor predictors of risk, even using formalized risk assessments. As indicated earlier, codes assessing whether MHPs attempted to assess for risk had to be discarded due to ambiguity (e.g., not being able to infer formal risk assessment from general comments regarding assessment). Five (29%) cases addressed risk prediction (i.e., *Ewing, Calderon, Sherer, Stewart, Volk*), with three (60%) indicating that MHPs cannot be held liable for failure to predict risk and two (40%) indicating MHPs can and should be held responsible for failing to predict violence (i.e., *Volk* & *Stewart)*. Both *Volk* and *Stewart* found in favor of the third party. There was not an observable pattern between outcome and the issue of risk prediction, as two favored the MHP and one favored the third party in their ruling.

Chapter 5: Discussion

This project sought to explore the research question: What issues are Higher Court Judges discussing in outpatient duty to warn cases? As demonstrated in the results section, some topics came up in the majority of cases and others occurred in far fewer. In order of most to least common, the themes that arose were negligence (88%), foreseeability (71%), statute interpretation (71%), duty to third parties (59%), standard of care (41%), special relationships (35%), confidentiality (29%), control (29%), expert witness testimony (29%), risk prediction (29%), medical malpractice (24%), identifiability of the victim (18%), and ambiguous language (12%). Several of these domains were observably related to the final outcome of the case, for example, anytime negligence was discussed and the judges found the possibility the MHP acted negligently—regardless of whether or not a threat was made against an identifiable victim—they ruled in favor of the third party. The themes that appeared to significantly influence the outcome of the case were statute interpretation, negligence, foreseeability, duty to third parties, standard of care, and special relationships. Thus, these issues will be elucidated in more detail within this discussion.

Statute Interpretation and Outcome

Literature on duty to warn suggests mental health professionals can be found liable to third parties for failure to predict or warn of possible violence regardless of whether their client ever made a specific threat against a reasonably identifiable victim (Bersoff, 2014; Thomas, 2009). The assumption raised in previous research suggested this was due to courts reinterpreting statutes and creating case law (Bersoff, 2014; Felthous & Kachigan, 2001; Felthous, 2006; Herbert & Young, 2002; Thomas, 2009).

When looking specifically at cases that interpreted or reinterpreted the local duty to warn statute, there are some observable patterns but additional research is necessary to establish this connection due to the small sample of cases. Many cases that interpreted the statue refused to engage in any reinterpretation. For example, in *Calderon*, the judges stated clearly that the case did not meet the necessary standards to create a duty to warn and declined to reinterpret the statute in order to make the situation fit. In *Green*, the judges declined to reinterpret the statute because they saw no reason to deviate from the arguments raised in *Boynton v. Burglass* that outpatient therapists do not have the necessary control over their patients to impose such a duty.

Conversely, there are several examples of decisions where judges deny reinterpretation but still establish new caselaw. *Ewing* very clearly states they are not reinterpreting the law while simultaneously expanding the term ‘patient communication’ to include messages from family. Much of the decision seeks to claim that family communication is already accepted as patient communication in psychological services, when in reality MHPs can rarely speak with family members without the patient first signing a release. In *Volk*, common law under *Petersen v. State* (1983) was reestablished through the *Volk* decision despite the statute being enacted in the late 80s in direct response to *Petersen.* In fact, research suggests the DTW statute was enacted after *Petersen* because of a rise in inappropriate hospitalizations related to dangerousness—suggesting this common law ruling had a negative impact on the standard of care typically provided by Washington MHPs (Kuszler & Price, 2018). The judges in *Volk* justified this decision by explaining that the duty to warn statute only applied to inpatient settings—neglecting to mention that the reason the code existed within the inpatient legislature is because at the time there was no separate legislature for inpatient versus outpatient therapists. Research since *Volk* suggests that of MHPs who are aware of the decision (89% of WA MHPs), 70% were considering changes to their practice while 50% had already applied changes, including but not limited to: Increased screening to avoid high risk clients, resorting to asking law enforcement for assistance in situations they would have previously dealt with themselves, and increasing referrals for intensive services and involuntary commitments (Kuszler & Price, 2018). Further, because *Volk* did not include a threat of violence, these changes are affecting individuals who are labile, engage in therapy irregularly, or who do not comply with their medications—issues that should not affect whether or not these client's receive quality therapy (Kuszler & Price, 2018). In other words, the reinterpretation of the DWT statute through *Volk* appears to already be negatively affecting the standard of care received by high-risk clients in Washington. Research by Edwards (2014) suggests that *Tarasoff* created an incentive for patients to withhold disclosure of homicidal ideation and incentive for doctors not to probe deeply into potential homicidal ideation. One could see how *Volk* would create a similar incentive.

As mentioned in the results, there were three cases where it was unclear whether the decisions led to new case law. In *Shea*, the Massachusetts' duty to warn statute includes knowledge of a history of violence as a triggering event for the duty to warn. However, the judges reject the MHP's attorney's assertion that this history of violence needs to be connected to the victim, and interprets the statute as not requiring this caveat. From a reading of the statute, this author feels either interpretation could be made, and that this ruling did not substantially reinterpret the statute—even if it did provide an interpretation of sorts. Regardless, *Shea* found in favor of the mental health professional because the MHP was not negligent, and the violence was not foreseeable because the client repeatedly denied homicidal ideation. In *McGrath,* even though the courts ruled in favor of the MHP, they asserted that MHPs can act negligently in duty to warn cases even if there is no specific threat made against a readily identified victim. Thus, while the case is not necessarily leading to new common law, it does leave the door open for duty to warn litigation outside of the parameters laid out in the statute. Finally, in *Robinson*, the judges stated that if a person chooses to warn, they have a responsibility to do so nonnegligently. This may create new caselaw because it leaves room for individuals who are warned about client's potential for violence to sue MHPs who did not warn them 'accurately enough.' However, these are very subjective views and do not necessarily correctly capture the issue from a legal stand point.

Negligence and Outcome.

Ultimately, while it appears that statue reinterpretation (whether or not the decision acknowledges this reinterpretation) has some effect on outcome, the theme most commonly linked to outcome is the idea of negligence. Specifically, all seven of the cases that were decided in favor of third parties included a discussion about potential negligence on behalf of the MHP. In *Ewing,* despite the valiant efforts of Dr. Goldstein to manage his client's dangerousness (i.e., increasing sessions, hospitalization etc.), these efforts were used as proof of his knowledge of the client's dangerousness and subsequently negligence for failure to warn. This is despite CA having a duty to protect built into their duty to warn statute, meaning that in CA one may still be held liable for failure to warn if one chooses to protect first.

Each case established negligence differently. In *Coleman v. Martinez*, the potential for negligence surrounded the idea that the client's therapist "should have known" the client was experiencing psychosis three weeks prior to the violent stabbing of plaintiff caseworker, and "should have" reported it to the client's psychiatrist rather than simply recommending the client keep a scheduled appointment with the psychiatrist. Judges and the plaintiff contend if this occurred, anti-psychotic medication would have been prescribed which could potentially have stopped the violence from occurring. Despite observations from defendant and plaintiff that the client was experiencing signs of psychosis, the client repeatedly denied psychotic symptoms and made no threats of violence against others to the defendant MHP. It is not clear whether a report to the psychiatrist would have led to immediate care, as psychiatric appointments are often difficult to schedule on short notice. Regardless, the cause of action for negligence was sustained, as the courts felt the plaintiff was able to establish the four elements of negligence (i.e., duty of care, a breach of duty, proximate cause, actual damages). Specifically, that the MHP had a duty of care related to duty to warn, breached that duty by failing to alert the psychiatrist, which lead to worsening of psychotic symptoms, and severe physical damages related to the client's violent attack. The judges in *Tedrick* ruled similarly, focusing on these four factors to establish the potential for negligence after rejecting the first two appeals submitted by the plaintiffs. Ultimately, while the judges acknowledged circumstances in *Tedrick* did not meet the criteria set by the DTW statute, the case was found in favor of the third party under the ideas of transferred negligence and voluntary undertaking.

Similar to the voluntary undertaking theory of liability (i.e., when rendering services to another, one is subject to liability for physical harm if it is caused by one's failure to use due care) used in *Tedrick*, the MHP in *Robinson* was seen as liable due to their affirmative action. Specifically, while the MHP had no duty to warn the police officer who came to assist her with a high risk client (because that client made no threat towards the police officer), she was under a duty to make sure she did not provide negligent information when she 'chose' to answer the police officer's questions about whether or not the client had a weapon.

In two cases, expert witness testimony against the MHPs—even if it was contradicted by other expert witnesses—led to findings of potential negligence. In *Dawe*, the expert witness claimed that Dr. Reuven Bar did not properly asses the client's appropriateness for group therapy, which led the appellate court judges to determine negligence was an issue for a jury to decide. Ultimately they affirmed the trial court's decision to find in favor of the third party. In *Stewart*, the judges relied on expert witness testimony that the MHP had strayed from the typical standard of care. This was despite two expert witnesses for the MHP indicating the opposite. While the legal arguments in *Stewart* also highlighted that the judges were applying previous case law, it must be noted that the case law should not be applicable as it occurred prior to the duty to warn statute being established. This is similar to how previous caselaw from *Petersen* was applied in *Volk* to establish negligence.

Negligence is rarely highlighted within duty to warn research beyond the assertion that a thorough risk assessment, even if ultimately proven wrong, should be enough to protect MHPs from duty to warn litigation (Borum and Reddy, 2001).

Although this author attempted to code whether MHPs assessed for risk, this was rarely stated explicitly within the decisions, and never once was a formal risk assessment measure documented. Conversely, in several cases MHPs were reported to complete informal homicide assessments. In *Calderon, Coleman, Robinson, Volk,* and *Shea,* the MHPs reported assessing for homicidal risk and the client denying homicidal ideation. Outside of forensic or other specialized training, MHPs are typically not trained in when they need to follow-up a denial of homicidal ideation with a formalized risk assessment (Bersoff, 2014; Borum & Reddy, 2001; Felthous, 2006; Kivisto, 2016). Because there were no cases that discussed formalized risk assessments, this author cannot make inferences as to whether research suggesting a formalized risk assessment will protect MHPs is supported by this data.

The problem with these negligence findings is that warning is not the standard of care for treating potentially violent individual—it is a protective measure for third parties. It is important to discuss the complete lack of empirical support that the duty to warn has led to a decrease in violent acts by mentally ill individuals. While this research is less relevant to judicial decision making and more to the legislative decisions, it is necessary to highlight this research in terms of why judicial opinions finding negligence outside of the parameters in the statute are so problematic. To date, there has been no evidence that the duty to warn is providing any benefit to mental health providers, mental health consumers, or the public at large other than as a source for third parties to gain some sort of monetary recompense from therapists who happen to treat high-risk patients. In fact, a strong empirical analysis using a multitude of incredibly specific equations and analyses by Edwards (2014) indicated the passage of state mandatory duty to warn laws was associated with a 5% increase in homicides. In general, Edwards found a positive and persistent relationship between DTW laws and homicides, but noted this association was strongest in mandatory duty to warn states. This continues to highlight the issue of judicial bodies ignoring relevant research when updating and changing these laws, as recently occurred in Florida. Additionally, previous research conducted shortly after *Tarasoff* established a quarter of psychologists lost an average of three patients after providing informed consent regarding new duty to warn laws (Wise, 1978). Further, 40% of psychiatrists report being less willing to treat dangerous patients in the 10 years after Tarasoff (Givelbar et al., 1984). Rosenhan and colleagues (1993) determined that 80% of therapists reported their patients appeared reluctant to discuss violent thoughts, and that 60% of therapists felt this reluctance extended to sensitive information in general. Overall, this research supports the supposition that duty to warn laws are not leading to a decrease in homicides by mentally ill individuals, but rather negatively effecting the standard of care typically provided by MHPs to high-risk individuals.

Foreseeability and Outcome.

Foreseeability is the issue that arose the second most in cases and was highly connected with the outcome of the case. Every time judges indicated that the violence may have been foreseeable, the case was decided in favor of third parties. In *Ewing*, as discussed in the previous session, Dr. Goldstein's attempts to protect were used as evidence that violence was foreseeable. In *Coleman*, the judges deemed the violence was foreseeable because the MHP 'should have' been aware of the client's psychosis and potential for violence despite the client repeatedly denying psychotic symptoms or homicidal ideation—similar to how the negligence issue was decided. In *Dawe*, foreseeability rested on the idea that violence would be foreseeable if someone who was not a good fit for group therapy was inserted into a group—which is a bit of a stretch as there is no standard for establishing a client is appropriate for group therapy. In *Tedrick*, the MHPs were aware of the client's homicidal and suicidal ideation and were actively attempting to engage him in more intensive treatment, leading the court to determine violence was foreseeable. Finally, in *Volk* foreseeability was established under the *Petersen* standard discussed elsewhere in this paper.

As discussed extensively in this paper, foreseeability is a common issue in the duty to warn literature. Previous research indicates that courts will use the issue of potential foreseeability to expand the duty to warn to situations not necessarily captured within the statute, as was also observed within this sample (Thomas, 2009; Werth, et al., 2009). *Tarasoff II* was meant to narrow the duty to warn to situations where a client makes a specific threat against a reasonably identifiable victim. Research suggests many state statutes were enacted in similar attempts to narrow the scope of the DTW (Kuszler & Price, 2018). In terms of why MHPs should not be held to standard of potential foreseeability, there remains significant debate as to whether MHPs are able to predict violence even using established risk assessment methods (Edwards, 2014). Many of these risk assessment methods have yet to be validated in outpatient or non-forensic settings (Adi & Mathbout, 2018). When the issue of predicting violence arose in this sample (5/29%), judges mostly acknowledged that therapists cannot be expected to predict risk outside of specific threats of violence to an identifiable victim (i.e., *Ewing, Calderon, Sherer)*. Conversely, the *Volk* decision explicitly rejected the idea that MHPs cannot predict violence, basically stating that MHPs are often involved in risk assessment and thus must have some ability to predict risk. In *Stewart*, the decision highlights that prediction is included within the state statute, however, the exact wording still requires a specific threat which should have protected the MHP, "Mental health professionals may predict, warn or take precautions if and only if an actual threat of bodily harm against a clearly identified victim is communicated," (Tenn. Code Ann. §33-3-206). Even if risk prediction was not discussed in cases where the issue of foreseeability arose, several of the cases that established that violence or victims were foreseeable clearly expected MHPs to predict violence (e.g., *Coleman)*.

There were certainly cases within this sample that held to the standards established in the state's duty to warn statutes. For example, *Greenberg v. Superior Court* held that violence was not foreseeable because no threats of violence were made against the victims. In *Kehler v. Eudaly*, the judges determined that there is no duty in Texas without there being an identifiable victim and thus violence was not foreseeable. In *Shea v. Cartias Carney*, the client repeatedly denied violent ideation to the defendant leading to the ruling that violence was not foreseeable. In *Sherer v. Sarma*, there was no evidence the client ever made any comments about violent ideation to the MHPs named in the suit. In this sample, judges were about 50% as likely to determine something was foreseeable as they were to determine the opposite (i.e., mentioned in 12 cases, 6 not foreseeable, 5 foreseeable, 1 undetermined). Even in cases with incredibly similar fact patterns, jurisdiction appears to play a major role in the decisions regarding foreseeability. Research suggests that there may be hidden political agendas behind these choices, but these difference may also simply be due to how states view different issues such as negligence (e.g., strict liability versus negligence), or relevant case law within that state (Robertson, 2010; *Schuster v. Altenberg*, 1988). It is important that future research on this topic compare rulings within specific jurisdictions rather than across many jurisdictions as this project did, as this will help confirm whether these trends are state specific or based on the facts of the case.

Duty to Third Parties and Outcome.

Whether or not MHPs have a duty to third parties was an often discussed issue within this sample (10/59%). Cases varied as to why a duty was or was not established, with four cases establishing a duty to third parties and six the converse. In *Coleman*, case law related to foreseeability standards established a precedent for a duty to third parties. In *Dawe* and *Volk*, simply the existence of a (misapplied) special relationship between MHP and client created liability to third parties. Regarding *Tedrick*, liability to third parties was established through transferred negligence and voluntary undertaking law/case law. Unsurprisingly, in all of the cases where a duty to third parties was established, the judges ruled in favor of the third parties.

Several issues were discussed in the cases that did not establish a duty to third parties. In *Calderon*, judges found that there was no duty because facts of the case did not meet the standards of the duty to warn statute. *Greenberg* actually used *Calderon* as caselaw for not establishing a duty to third parties outside of situations that meet the standards of California's duty to warn statute. Similarly, *Sherer* judges determined there was no duty to third parties because there was no threat made to create a duty. Regarding *Kehler,* judges stated clearly that there was no duty to third parties for failure to breach confidentiality under Texas state law. Even the judges in *Robinson* established that typically there is not duty to third parties outside of situations that fit the DTW standard in Utah, but relied on the affirmative action of the MHP to create a duty to third parties outside of a DTW situation. Finally, in *Thapar*, judges sated there is no duty to third parties not to negligently misdiagnosis or mistreat patients, as the petitioner was alleging occurred.

The issue of duty to third parties is not typically explicitly discussed in duty to warn literature. It's understood that the existence of the duty to warn creates a major exception to the typical responsibility of individuals toward third parties. However, as this issue was raised so often within this small sample of cases, it is important that future research continue to explore how courts are determining duty to third parties outside of situations that fit state DTW parameters.

Standard of Care and Outcome.

The issue of whether or not the MHP met the standard of care was also discussed in a significant number of cases (7/41%). This issue was directly connected with outcome, with the four cases that established the MHP did not meet the standard of care finding in favor of the third party, while the converse is true of the three cases that determined the MHP did meet the standard of care. In *Coleman*, this was due to the MHPs failure to report potential psychotic symptoms to the client's psychiatrist—again, despite the client denying the presence of psychotic symptoms and homicidal ideation to the MHP. In *Dawe*, *Volk*, and *Stewart*, the judges relied on expert witness testimony to establish a failure to meet the standard of care. In *Greenberg*, despite conflicting expert witness testimony, the judges appeared to rely on testimony in favor of the MHP to determine the MHP met the standard of care. In *McGrath*, the judges ruled expert testimony from the third party's expert was incredible and thus found the MHP did meet the standard of care. Interestingly, *Kehler* highlighted that choosing to breach confidentiality would have actually gone against the established standard of care due to the way the Texas confidentiality statute is written.

Problems related to determining a standard of care are commonly discussed in duty to warn literature. Specifically, legal and psychological scholars continue to point out that the standard of care referred to in these cases is either uncertain or nonexistent (Thomas, 2009). While there are formal risk assessment procedures that evaluate the probability of future violent behavior, these methods are not taught outside of the forensic specialty nor are they particularly reliable (Bersoff, 2014; Borum & Redy, 2001). Further, they would not be helpful in a stereotypical *DTW* situation, as one does not typically have access to collateral contacts nor the other necessary information for determining risk that is necessary for a full, formal risk assessment (Borum & Redy, 2001). Additionally, these measures do not necessarily help an MHP determine how likely a client is to carry out a violent threat (Bersoff, 2014). Regardless, even if psychologists can sometimes make informed decisions about someone's risk level, MHPs cannot predict future violence. However, when states add language by statute or common law referencing a 'reasonable degree of skill' or 'professional standards,' it increases the likelihood a judicial body will use the benefit of hindsight to find against an MHP for failure to warn (Thomas, 2009).

In fact, in line with the ruling in *Kehler*, the most universal standard of care in the mental health field is the assurance of confidentiality (Edwards, 2014). One argument suggests the court erred in *Tarasoff* when they assumed meeting the burden of risk assessment the case established would only require professionals' exercise a reasonable degree of skill generally held by most MHPs in comparable circumstances (Bersoff, 2014). The truth is, while there are recommendations in the literature, very little clinical training (outside of specialized forensic programs) addresses non-suicide specific risk assessment. Further, current practices in risk assessment refer formal risk evaluations versus DTW situations, meaning again that there is no standard (Borum & Redy, 2001; Thomas, 2009).

Judge Mosk captured this idea well in his dissent in *Hedlund v. Superior Courts (1983),* another California DTW case that expanded duties in that state. Mosk stated, "The majority opinion unfortunately perpetuates the myth that psychiatrists and psychologists inherently possess powers of clairvoyance to predict violence… as if that subjective characteristic [i.e. violence] would be revealed through a stethoscope or by an X-ray." Courts continue to liken mental illness, or dangerousness, to much more clear-cut factors such as medical diagnoses or contagious diseases (*Schuster v. Altenberg,* 1988; *Tarasoff II,* 1976;. In reality, the treatment and signs of potential violence or dangerousness are not necessarily obvious. Static factors that have been identified as increasing risk of violence in forensic populations have less influence in DTW situations, whereas dynamic factors such as substance use contribute more to risk level in outpatient populations (Kivisto, 2016). Further, violent fantasies are common in normal populations (Gellerman & Suddath, 2005). Research has additionally shown that only a small percentage of individuals follow through with threats of homicidal violence (Kivisto, 2016). Although these individuals do have a higher rate of overall violence, it appears nearly half of the eventual victims differed from those originally identified in therapy (Kivisto, 2016). As such, while there is some logic to holding MHPs accountable for failure to act when a patient has made a credible threat, there is no standard for determining such a threat is credible. It is vital that future research continue to push the idea that there is no established standard of care in duty to warn situations. In fact, as discussed earlier in this section, if anything duty to warn has led to a deviation from the typical standard of care high-risk individuals may receive from mental health professionals.

Special Relationships and Outcome.

Despite special relationships being a staple part of duty to warn literature and research, this issue was only raised in 35% of the sample. The cases were split in half as to whether judges determined there was a special relationship between the MHP and the person who committed the violent act. In the three cases that determined there was a special relationship (i.e., *Dawe, Sherer,* & *Volk)*, this hinged on the *Tarasoff* established precedent that MHPs have special relationships with their clients that make them liable to third parties for the actions of those clients. There were two reasons judges denied the existence of a special relationship between the litigating MHP and their client in the other three cases. In *King v. Smith*, this was due to the contact between MHP and client being seen as too minimal to establish a special relationship. Regarding *Tedrick* and *Kehler*, judges in both cases decided that special relationships require a degree of control that did not exist because the patient was not in the MHPs custody. Thus, some courts appear to support the idea that special relationships do not apply in outpatient settings, while others continue to misapply the special relationship standard to outpatient mental health.

Tarasoff is not just a staple of psychologists' ethics training, but also a regularly discussed case in Tort law classes because it creates such an a-typical exception to American law (Edwards, 2014). As discussed in Bersoff (2014), special relationships in mental health were originally meant to exists only when, “A operates a private sanitarium for the insane. Through the negligence of the guards employed by A, B, a homicidal maniac, is permitted to escape. B attacks and causes harm to C. A is subject to liability to C.” However, since the original *Tarasoff* ruling, this standard has also been applied to outpatient mental health settings.

Strengths

This study contained many strengths. While cases reviewed in this sample are discussed in detail in duty to warn literature, the trends expressed within that literature had not previously been tested. Simply, no one else has empirically reviewed the issues discussed in duty to warn cases using qualitative analysis. This project provides initial support for many of the issues legal and psychological scholars have suggested may be central to decisions in duty to warn cases. For example, there is ample discussion regarding the issue of foreseeability overriding the typical expectation that no duty exists outside of when an explicit threat is made against a reasonably identifiable victim. This is supported by findings from this project, that indicate foreseeability was commonly used to find MHPs liable despite duty to warn parameters that should have protected them.

One important finding from this study was the role of negligence in determining an MHP potentially owed a duty to the injured third party. While duty to warn literature talks around the idea of negligence (e.g., performing a formal risk assessment should protect from negligence), the lack of explicit discussion about how commonly this issue arises is concerning. Moreover, these kind of assertions regarding performing formal risk assessments fail to take into account how these assessments have not been validated in many settings, and how they are not necessarily appropriate for making duty to warn decisions (Adi & Mathbout, 2018; Kivisto, 2016). Specifically, formalized risk assessments are not meant to determine if someone presents an immediate threat to the person they are expressing homicidal ideation toward. Rather, an understanding of the static and dynamic risk factors that influence the likelihood of violence (Kivisto, 2016), as well as knowing the steps for a thorough (if informal) risk assessment like that proposed by Borum and Reddy (2001), are vital aspects of appropriately assessing risk in DTW situations. Thus, it is necessary that future literature continue to establish what exactly *is* the standard of care in duty to warn situations. Further, these methods must become a standard part of training for social workers, counselors, therapists, psychologists and all other types of mental health professionals—as we are all subject to duty to warn litigation.

Another strength of this project is the variety of research questions it produced. Some of these trends appear to hold across jurisdictions, but what about within a specific jurisdiction? Why do courts and legislative bodies continue to support the idea that warning is effective when there is no empirical support for this claim? Now that we have a sample of data from outpatient mental health duty to warn cases, do the same trends exist in inpatient duty to warn cases? How can MHPs utilize expert witness testimony to effectively prove they met standards of care or otherwise acted non-negligently? Would a wider sample of cases lead to an increase in discussion about ambiguous language in duty to warn statutes (as this is such a significant part of the DTW literature)? Similarly, would a larger sample have resulted in more examples of statute reinterpretation? These are only a few of the questions raised by the results of this project.

Limitations

There were several limitations with this study. The first being the small sample size. While the inclusion criteria (i.e., 1. Established duty to warn law, 2. Case occurred after law was enacted, 3. Case involves outpatient therapists/clinics only) was purposeful and theory driven, it lead to a substantial decrease in the expected sample. The hope was to be able to discuss trends that occur within and across jurisdictional lines rather than focus on one state in particular. Because the 17 cases represented rulings across 12 states, it is difficult to determine what is a trend versus an anomaly. If this author had known ahead of time that the resulting sample would be so small, a different methodology would have been applied. Specifically, this author may have chosen two states and reviewed all of the duty to warn cases available and compared trends within and across just those two jurisdictions. Finally, while inductive content analysis allows for cautious inferences to be made, those inferences are from a very small subsample of duty to warn cases. It is important that any future research using this coding scheme be conducted using a larger sample size to allow for statistical analysis to confirm or reject the observable patterns found in this study.

Regarding study design, this research project was also limited due to the small number of raters. Other than the subsample of cases recoded by the interrater, open coding, coding scheme development and the final coding process were conducted by one person, this author. Typically, the coding process is completed by multiple raters to ensure that the coding scheme is unbiased. However, this being a dissertation and not a funded research project, the opportunity to recruit multiple coders was small. Unfortunately, while there was strong percentage agreement observed when comparing the three cases recoded for interrater reliability ($PA_o = .92$), Holsti's method resulted in poor overall interrater agreement ($PA_o = .27$). While this appears to be due to using too small of a sample of recoded cases, it does represented a problem for pursuing publication and must be adjusted. Any future research must be conducted with more than two coders and included a greater number of cases coded for interrater reliability.

Other limitations to this study were related to this authors' background and training in forensic psychology rather than law. For example, this author lacked understanding about some basic facts regarding legal decision making. Specifically, this author did not previously understand how judges were limited to responding to issues raised within motions or petitions submitted by the attorneys. Upon the initiation of this project, this author was under the impression that judges were picking the issues discussed within these cases, not that they were responding. Increased legal knowledge may have influenced this author to adjust the research question to capture the issues attorneys are raising within duty to warn cases and how judges respond to them, which may have led to a different coding scheme.

Further, someone with legal training may have determined different explanations for the specific rulings. For example, this author was able to extrapolate that the *Tedrick* decision relied on arguments related to voluntary undertaking and transferred negligence, but would still struggle to describe the legal decision making behind establishing these two findings. Someone with a stronger background in legal studies may have been able to make more specific determinations. In future projects, it may be important to collaborate closely with a legal researcher in order to address this limitation. Further, this could allow any findings be made more applicable to legal studies or legislative decision making as well as psychological studies. Overall, however, because this was a project meant to increase psychologists understanding of duty to warn cases, not to detail the legal arguments used to make those decisions, this was not a major limitation.

Conclusion

In conclusion, this project uncovered several common themes that appear to directly influence the outcome of duty to warn cases. Statute interpretation, negligence, foreseeability, duty to third parties, standard of care, and special relationships appeared to have the strongest effect on the outcome of the cases. However, this does not discount the importance of issues related to ambiguity, confidentiality, control, expert witness testimony, identifiability, medical malpractice, and risk prediction. Future research with a larger case sample may led to these themes carrying different weights, especially if the sample is large enough to apply quantitative methods to the analysis. These findings provide important information for practicing mental health professionals, as the prominence of negligence findings encourage MHPs to develop a deeper understanding of the factors surrounding potential dangerousness. Unfortunately, it also highlights how from the perspective of a psychologist, many of these findings of negligence do not make sense as they rely on a nonspecific standard of care. Simply referring to what a reasonable mental health professional in the same or similar situation would have done does not appropriately capture the standard of care in mental health, because there is such a wide variety of mental health professionals and standards. It is important that future researchers seek to establish clearer guidelines for MHPs for responding to DTW situations. Further, additional research using this coding scheme can help elucidate the divide between what MHPs think is expected of them, and how superior courts may view the situation.

References

Adi, A., & Mathbout, M. (2018). The duty to protect: Four decades after Tarasoff. American Journal of Psychiatry Residents' Journal.

Almonte v. New York Medical College, 851 F. Supp. 34

Barry v. Turek, 218 Cal. App. 3d 1241

Bersoff, D. N. (2014). Protecting victims of violent patients while protecting confidentiality. *American Psychologist*, 69(5), 461.

Boynton v. Burglass, 590 So. 2d 446

Borum, R., & Reddy, M. (2001). Assessing violence risk in Tarasoff situations: A fact-based model of inquiry. *Behavioral sciences & the law*, 19(3), 375-385.

Brady v. Hopper, 570 F. Supp. 1333

Calderon v. Glick, 131 Cal. App. 4th

Cane, P., & Kritzer, H. (Eds.). (2010). The Oxford handbook of empirical legal research. OUP Oxford.

Coleman v. Martinez, 2019 N.J. Super. Unpub. LEXIS 2324

Dawe v. Dr. Reuven Bar-Levav & Assocs., P.C., 289 Mich. App. 380

Edwards, G. (2014). Doing their duty: an empirical analysis of the unintended effect of Tarasoff v. Regents on homicidal activity. The Journal of Law and Economics, 57(2), 321-348.

Ewing v. Goldstein 15 Cal. Rptr. 3d 864

Felthous, A., & Kachigan, C. To Warn and to Control: Two Distinct Legal Obligations or Variations of a Single Duty to Protect?"(2001). *Behav. Sci. Law,* 19, 355-at.

Felthous, A. R. (2006). Warning a potential victim of a person's dangerousness: clinician's duty or victim's right?. *Journal of the American Academy of Psychiatry and the Law Online*, 34(3), 338-348.

Ford, Carol A., Susan G. Millstein, Bonnie L. Halpern-Felsher, and Charles E. Irwin. 1997. Influence of Physician Confidentiality Assurances on Adolescents' Willingness to Dis- close Information and Seek Future Health Care. Journal of the American Medical As- sociation 278:1029–34.

Forman, J., & Damschroder, L. (2007). Qualitative content analysis. In Empirical methods for bioethics: A primer (pp. 39-62). Emerald Group Publishing Limited.

Gellerman, D. M., & Suddath, R. (2005). Violent fantasy, dangerousness, and the duty to warn and protect. *Journal of the American Academy of Psychiatry and the Law Online*, 33(4), 484-495.

Givelber, D. J., Bowers, W. J., & Blitch, C. L. (1984). Tarasoff, myth and reality: An empirical study of private law in action. Wis. L. Rev., 443.

Grady v. Riley, 01-1187

Green v. Ross, 691 So. 2d 542

Greenberg v. Superior Court, 172 Cal. App. 4th 1339

Hall, R. C., & Tardif, I. (2020). Florida Law Enforcement Policies for and Experience With Tarasoff-Like Reporting. The Journal of the American Academy of Psychiatry and the Law.

Hall, M. A., & Wright, R. F. (2008). Systematic content analysis of judicial opinions. Calif. L. Rev., 96, 63.

Hedlund v. Superior Court, 669 P. 2d 41

Herbert, P. B., & Young, K. A. (2002). Tarasoff at twenty-five. Journal of the American Academy of Psychiatry and the Law Online, 30(2), 275-281.

Jacobson, P. D., Selvin, E., & Pomfret, S. D. (2001). The role of the courts in shaping health policy: An empirical analysis. The Journal of Law, Medicine & Ethics, 29(3-4), 278-289.

Jaffee v. Redmond, 518 U.S. 1

Kehler v. Eudaly, 933 S.W.2d 321

King v. Smith, 539 So. 2d 262

Kivisto, A. J. (2016). Violence risk assessment and management in outpatient clinical practice. *Journal of clinical psychology*, 72(4), 329-349.

Knapp, S., & Lemoncelli, J. (2005). The Role of a State Psychological Association in Promoting Ethical Conduct. *Professional Psychology: Research and Practice*, 36(6), 663.

Linos, K., & Carlson, M. (2017). Qualitative methods for law review writing. U. Chi. L. Rev., 84, 213.

McGrath v. Yosry, 2008 N.J. Super. Unpub. LEXIS 2821

Mills, J., Bonner, A., & Francis, K. (2006). The development of constructivist grounded theory. International journal of qualitative methods, 5(1), 25-35.

Naidu v. Laird, 539 A. 2d 1064

O'Matz, M. (2019, January 16th). Health Provider had long history with Parkland shooter negligent? *South Florida Sun Sentinel*, retrieved from www.sun-sentinel.com

Pabian, Y. L., Welfel, E., & Beebe, R. S. (2009). Psychologists' knowledge of their states' laws pertaining to Tarasoff-type situations. *Professional Psychology: Research and Practice*, 40(1), 8.

Perlin, M. L. (2006). You Got No Secrets to Conceal: Considering the Application of the Tarasoff Doctrine Abroad. *U. Cin. L. Rev.,* 75, 611.

Petersen v. Washington State 100 Wn.2d 421

Pettis, R. W., & Gutheil, T. G. (1993). Misapplication of the Tarasoff duty to driving cases: a call for a reframing of theory. *Journal of the American Academy of Psychiatry and the Law Online,* 21(3), 263-275.

Powell v. Catholic Med. Ctr., 145 NH 7

Robinson v. Mount Logan Clinic, LLC, 2008 UT 21

Rosenhan, David L., Terri W. Teitelbaum, Kathi W. Teitelbaum, and Martin Davidson. 1993. Warning Third Parties: The Ripple Effects of Tarasoff. Pacific Law Journal 24: 1165–1231.

Runyon v. Smith, 749 A. 2d 852

Schuster v. Altenberg, 424 NW 2d 159

Shea v. Caritas Carney Hosp., Inc., 79 Mass. App. Ct. 530

Sherer v. Sarma, 2014 IL App (5th) 130207

Smith, M. S. (2021, March 29). *4th DCA Affirms Mental Healthcare Providers Owe No Legal Duty to Warn Unidentifiable Potential Victims*. RumbergerKirk. https://www.rumberger.com/insights/4th-dca-affirms-mental-healthcare-providers-owe-no-legal-duty-to-warn-unidentifiable-potential-victims/

Strauss, A., & Corbin, J. (1994). Grounded theory methodology. Handbook of qualitative research, 17, 273-85.

Stewart v. Fakhruddin, 2010 Tenn. App. LEXIS 357

Tedrick v. Cmty. Res. Ctr., Inc., 373 Ill. App. 3d 761

Thapar v. Zezulka, 994 S.W.2d 635

Thomas, M. (2009). Expanded liability for psychiatrists: Tarasoff gone crazy. Spring 2009 *J. Mental Health L*., 45.

Trammel v. United States, 445 US 40

Turner v. Jordan, 957 SW 2d 815

Volk v. DeMeerleer, 184 Wn. App. 389

Werth Jr, J. L., Welfel, E. R. E., & Benjamin, G. A. H. (2009). The duty to protect: Ethical, legal, and professional considerations for mental health professionals. American Psychological Association.

Wise, Toni Pryor. 1978. Where the Public Peril Begins: A Survey of Psychotherapists to

Determine the Effects of Tarasoff. Stanford Law Review 31:165–90.

Appendix A: Coding of Cases

Case	Ambiguity	Confidentiality	Control	Expert Witness	Foreseeability	Identifiability	Med. Malpractice	Negligence	Risk Prediction	Sp. Relationship	Standard of Care	3rd Parties	Interpretation
King v. Smith					?					O			
Ewing v, Goldstein	O	X			X	X		X	O				O
Calderon v. Glick					O		O	O	O			O	O
Coleman v. Martinez					X			X			O		
Dawe v. Dr. Reuven Bar				X	X		X	X		X	O	X	X
G rady v. Riley								O					O
Green v. Ross	X	X											O
Greenberg v. Superior Court				X	O		O	O			X	O	
Kehler v. Eudaly			O		O	O		O		O	X	O	
McGrath v. Yosry			O	O				O			X		O
Robinson v. Mount Logan clinic								X				O	O
Shea v. Cartias Carney					O	O		O					O
Sherer v. Sarma		X			O			O	O	O		O	O
Stewart v. Fekhruddin			?	X	O			X	X		O		X
Tedrick v. Cmty. Res. Ctr.			O		X			X		X		X	
Thapar v. Zezulka		X						O				O	O
Volk v. DeMeerleer		O	X	X	X		O	X	X	X	O	X	O

Key:
X- Mentioned and agreed with
O- Mentioned and disagreed with
?- Mentioned but not addressed