

## *Legal Developments*

# Therapist's Duty to Protect Third Parties: Balancing Public Safety and Patient Confidentiality

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## Introduction

What should a therapist do when, in the context of the therapeutic relationship, a client threatens violence to someone else? **Tarasoff v. Regents of the University of California**, 551 P2d 334 (Cal. 1976), a case that broke new ground in California, had and continues to have local as well as national implications for therapists confronted with a client threatening harm to a third party. The case embodies the potential for conflict between the expectation of therapist-patient confidentiality and public safety interests. For therapists who work in either private practice or community-based programs and provide services to persons with mental disorders who also have histories of criminal offenses, the duty to protect can be of particular relevance.

Both clinicians and program administrators need to be aware of the requirements of applicable law in this area. On a state-by-state basis, case law as well as statutory and regulatory provisions may be relevant. Professional codes of ethics likely also weigh in on this subject. Practitioners should recognize when it may be necessary to consult with legal counsel regarding specific cases that arise in practice, given the ambiguities that remain in the law (Almason, 1997), and develop prudent approaches to managing such exceptions to confidentiality in the therapeutic relationship.

This column reviews the legal background of the **Tarasoff** case, and how it changed the law on duty to disclose in California and, through its influence, in other jurisdictions nationally, including legisla-

tive responses. Although the "duty to warn," is sometimes used interchangeably in the literature with the "duty to disclose" and "duty to protect," the latter term conveys the broader standard applied by the **Tarasoff** court (Anfang & Appelbaum, 1996). The column surveys developments in relevant law on duty to protect since **Tarasoff**, and touches on recommended approaches to handling this type of exception to therapist-patient confidentiality.

## Legal Background

Before **Tarasoff**, therapist liability stemming from harm to third parties was significantly more limited. While the general rule under common law states that no duty is owed by one person to another for controlling another's conduct or for warning those threatened by it, exceptions to that rule create a duty when a special relationship exists between the defendant and the dangerous person or the potential victim (551 P2d at 343). Therapist liability to third parties had been found previous to **Tarasoff** in inpatient situations, where the special therapist-patient relationship included physical control or custody of patients with violent histories or intent, and where negligent release resulted in harm to others (Rogge, 2000). With **Tarasoff**, the nature of the special relationship triggering a duty to disclose owed to third parties by therapists grew in scope to encompass outpatient treatment.

## The *Tarasoff* Case

A brief review of the facts and holding in **Tarasoff** follows. **Tarasoff** was heard twice by the California Supreme Court; here we review the determinative second opinion.

**Police Called After Threat, But Target Not Warned.** Prosenjit Poddar, a stu-

dent at UC Berkeley, threatened to kill his ex-girlfriend, Tatiana Tarasoff, in a therapy session at the college counseling center. The counseling center requested that the police pick him up and transport him to the hospital to be involuntarily committed. However, the police determined upon interviewing Mr. Poddar that he did not appear dangerous or seriously mentally ill, and did not pursue the hospitalization. The counseling center made no further attempt to restrain Mr. Poddar from carrying out his threat or to warn Ms. Tarasoff. Two months later, Mr. Poddar murdered Ms. Tarasoff.

**Duty to Warn.** Ms. Tarasoff's family sued the therapists, as well as the campus police and the university (Rogge, 2000). The question before the court that is pertinent here was whether the clinicians involved in the case had a duty to warn the foreseeable victim, Ms. Tarasoff, of the threatened violence, having determined that the patient, Mr. Poddar, posed a serious threat of harm to her (**Bradley v. Ray**, 904 SW2d 302, 307). The court held that:

When a therapist determines, or pursuant to the standards of the profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances. (551 P2d at 431)

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Arguments against a duty to warn were made regarding the inability of therapists to accurately predict violent behavior, in that they often over-predict and erroneously assess dangerousness. The court answered both that failure to predict violence was not an issue in the present case; and that in any event the standard requires only that the therapist exercise the reasonable degree of skill ordinarily exercised by the profession under similar circumstances (551 P2d at 438).

**Balance of Interests.** The court also balanced the relative interests of patient-psychotherapist confidentiality and the public safety considerations underlying the duty to disclose. The court recognized the importance of confidentiality in the effective treatment of mental illness. However, referencing an exception to the psychotherapist-patient privilege in the California Evidence Code that vitiates the evidentiary privilege in the event disclosure is necessary to prevent threatened danger, as well as a similar exception relating to physicians generally in the Principles of Medical Ethics of the American Medical Association, the **Tarasoff** decision balanced the interests in favor of public safety concerns:

We conclude that the public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins. (551 P2d at 442)

**Expansion of Therapist's Duty.** As Rogge (2000) states, the **Tarasoff** decision broke new ground in a number of ways:

- It applied the therapist duty to warn third parties to outpatient treatment;
- It made the therapist's responsibility nondiscretionary, allowing for findings of civil liability and monetary damages if violated; and finally,
- It articulated a broad but ambiguous duty to protect standard (a potentially broader standard than duty to warn or disclose) for therapists to attempt to follow.

### Unanswered Questions

In the years since **Tarasoff** established the duty to protect in California, mental health practitioners have generally adopted some version of the duty as standard practice (Fliszar, 2000). However, as a result of the myriad unanswered questions left by the benchmark decision, the holding in **Tarasoff** has given rise to the most inquiries received

by the American Psychiatric Association's legal consultation service on any issue (Anfang & Appelbaum, 1996; Perlin, 1992). What types of mental health practitioners, and what level of therapeutic relationship, are bound by the duty to protect? Do the potential victims have to be identifiable by the therapist? To what degree of certainty must the clinician determine that the patient can or will carry out the threat? What reasonable steps should be taken to protect threatened third parties? How much should be disclosed, and to whom? Might more than warning or disclosure be required of the therapist in certain cases? These are some of the questions clinicians have wanted to see further defined, in order to know how to balance the competing interests of public safety and confidentiality in appropriately responding to a patient who threat-

sion, Missouri joined these states. Since **Bradley**, Pennsylvania case law has adopted this standard, **Emerich v. Philadelphia Center for Human Development, Inc.** 720 A.2d 1032 (Pa. 1998).

The **Bradley** court went on to state that Connecticut and Delaware cases adopt the duty to warn as well, but stipulate a more expansive standard of identifiable classes of third parties who may be harmed within those who must be warned. **Almonte v. New York Medical College**, 851 F.Supp. 34 (D. Conn. 1994); **Naidu v. Laird**, 539 A.2d 1064 (Del. 1988). Further, according to **Bradley**, Arizona, Wisconsin, North Carolina, and Nebraska cases embrace the most expansive standard, adopting a duty to warn any foreseeable victim, regardless of whether a specific threat regarding an identifiable victim has been made. **Schuster v.**

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ens others. Some jurisdictions have given further guidance on one or more of these questions through subsequent case law or statutory codification, varying state by state. In other jurisdictions the **Tarasoff** duty has been neither adjudicated nor legislated, with therapists left to rely on local standard practice and their professional codes for guidance. As Almason (1997) states, "Confusion regarding the exact requirements of this duty and which jurisdictions enforce it continues to plague therapists" (p. 478).

### Post-Tarasoff: How Other States Approach the Issue

While **Tarasoff** made law only in California, it has proved highly persuasive elsewhere. Since the opinion was written, 24 states besides California have adopted some variation of a duty to warn or protect, either by case law or by statute (Rogge, 2000).

In **Bradley v. Ray**, 904 SW2d 302 (1995), a Missouri case that establishes a therapist duty to warn in that state, the court provided a comprehensive review of state by state post-**Tarasoff** developments in the law up to that time. According to the **Bradley** court, Michigan, Vermont, and New Jersey courts have held that psychotherapists have a duty "to warn readily identifiable victims of the violent intentions of their patients" (904 SW2d at 308). With the **Bradley** deci-

**Altenberg**, 424 NW2d 159 (Wis. 1988); **Currie v. United States**, 644 F. Supp 1074 (NC 1986); the Arizona and Nebraska cases cited by **Bradley** have been superseded by legislation, see below. The application of this most expansive standard has not gone without criticism. As Fliszar (2000) states, "Such broad language seems to extend the duty to include warning an almost unlimited group of potential victims. Such a holding is both over-inclusive and unworkable" (p. 208). This standard was later limited in Nebraska by statute to "any reasonably identifiable victim or victims" (Neb Rev. Stat. §§ 71-1, 206.30, 71-1, 336), and in Arizona to "a clearly identified or identifiable victim or victims" (Ariz. Rev. Stat. § 36-517.02).

Along with imposing a duty to warn, courts in many states, including Ohio, Georgia and North Carolina, have held a duty exists to protect and control the patient from harming others in the context of inpatient treatment. **Littleton v. Good Samaritan Hospital and Health Center**, 529 NE2d 449 (Ohio 1988); **Bradley Center, Inc. v. Wessner**, 296 SE2d 693 (Ga. 1982); **Pangburn v. Saad**, 326 SE2d 365 (NC 1985). In **Estates of Morgan v. Fairfield Family Counseling Center**, 673 NE2d 1311 (Oh. 1997), the Ohio Supreme Court applied this duty to the outpatient setting as well. Alabama and Illinois courts have stated in dicta

that, although they have not yet applied a **Tarasoff**-like duty because of the nature of the facts in the cases before them, given a fitting case they would likely apply the doctrine. **Morton v. Prescott**, 564 So.2d 913 (Ala. 1990); **Eckhardt v. Kirts**, 534 NE2d 1339 (Ill. 1989).

In **Thapar v. Zelulka**, 994 SW2d 635 (1999), the Texas Supreme Court rejected imposing a duty on psychotherapists to warn third parties of threatened violence by patients. Florida and Virginia courts have rejected adopting a duty to protect on grounds that the nature of the psychotherapist-patient relationship did not meet the criteria of a special relationship, **Boynton v. Burglass**, 590 So2d 446 (Fla. 1991); **Nasser v. Parker**, 455 SE2d 502 (Va. 1995). However, the Florida legislature subsequently adopted a statute that allows psychiatrists to disclose information necessary to warn threatened parties or police (Fla. Stat. Ann. § 455.2415), and Virginia passed more extensive statutory provisions regarding the duty to warn (Va. Code Ann. § 54.1-2400.1). Maryland courts have declined to accept or reject a **Tarasoff**-type duty (**Shaw v. Glickman**, 415 A2d 625 (Md. 1980), see also **Falk v. Southern Maryland Hospital Inc.**, 742 A2d 51 (Md. 1999)). However, Maryland, like Virginia, has imposed a version of the duty through legislation (Md. Ann. Code § 5-315).

Many states have adopted statutory provisions that, in general, impose a variation of the duty to warn or protect readily identifiable potential victims from a communicated threat, and that shield therapists from liability for breach of confidentiality for acting in accordance with the statute. These statutes can be helpful in clarifying the scope of the duty to protect in a particular state, and should provide answers to at least some of the questions posed earlier in this column. The following states, at least, have statutory provisions regarding the duty to warn: Alaska, Arizona, California, Colorado, Florida, Idaho, Indiana, Kentucky, Louisiana,

Maryland, Massachusetts, Minnesota, Montana, New Hampshire, New Jersey, Ohio, Tennessee, Utah, Virginia and Washington (Anfang & Appelbaum, 2000).

### Model Duty to Protect Law

A model duty to protect statute was drafted by The American Psychiatric Association's Council on Psychiatry and Law (Appelbaum et al, 1989). For those in jurisdictions that have not acted with regard to duty to protect, this model statute can provide some guidance regarding generally acceptable practice in this area. For example, the model statute defines reasonable steps to protect the identifiable victim(s) that the therapist might take, depending on the nature of the situation. These include: communicating the threat to them; notifying a law enforcement agency local to the neighborhood of the identifiable victim(s); arranging for the patient's voluntary hospitalization; or initiating involuntary hospitalization.

### Guidance for Clinicians

Much has been written about managing **Tarasoff**-type situations. To name but a few examples, Anfang and Appelbaum (1996) distill the literature on recommended approaches for therapists, and Monahan (1993) provides guidelines to help therapists limit potential liability that might arise from duty to protect cases. Following is a sampling of what they suggest clinicians do, as well as some general recommendations, all of course depending on the nature of the particular case:

- **Know the law:** Be sure you are familiar with the requirements of state law, and consult with legal counsel especially in the event of questions arising in a specific case. If the duty to protect has not been addressed in your state, consensus in the literature that "...it has become standard practice for mental health professionals to warn an identifiable third party of their patient's threatened violence against that third party..." (Fliszar,

2000, p.201) can provide some guidance.

- **Assess risk:** Make a careful and adequate assessment of risk of violence, in accordance with local standards. As part of this assessment gather information from the patient, significant others, and case records.
- **Take clinically appropriate steps.** Conduct a risk-benefit analysis of interventions being considered. Pursue what is clinically appropriate for the patient, for example, hospitalization if necessary. Involve the patient in decisions where possible. Consult with other clinicians.
- **Keep good records:** Document all information gathered, actions taken, and the reasoning behind them.
- **Warn when necessary.** Where substantial risk of harm to third parties cannot be avoided through less intrusive means, warn the potential victim(s) and/or law enforcement.

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