WHEN PATIENTS THREATEN TO KILL:
A TEXAS VIEW OF TARASOFF

DISSERTATION

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A serious problem confronts the psychologist whose patient threatens, within the privacy of a therapy session, to inflict violent harm upon some third person. Therapists in Texas face a risk of unjust legal liability because of a lack of widely accepted, clearly and fully articulated standards. A questionnaire was submitted to Texas psychologists and Texas judges of mental illness courts. It involved a hypothetical case of a patient who threatened to kill his girlfriend. The hypothesis that no consensus exists at present among psychologists or judges appears to be supported by the data. Comparisons are made of the attitudes of psychologists and judges. Correlations between psychologist attitudes and certain demographic and practice variables are reported. The need for new legislation in Texas concerning legal liability of therapists for the violent behavior of patients is discussed. Proposed legislation for Texas is set out. Among its important features are (1) recognition that continued therapy is itself a protective strategy and (2) establishment of good faith as the standard by which the behavior of the therapist is to be judged.
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CHAPTER I

WHEN PATIENTS THREATEN TO KILL:

A TEXAS VIEW OF TARASOFF

A psychologist providing therapy may have several different objectives in view at one time. There are two objectives that cause considerable tension when they conflict with each other. One is to gain the trust and confidence of the patient by giving assurance that secret information will be kept secret. We might call this the confidentiality objective. The other is to avoid harm to an innocent victim, if the patient seems likely to kill or injure someone. We might call this the victim protection objective. There are cases in which the therapist has been caught in the conflict between these two objectives. Doubtless the case most widely discussed among mental health professionals is the Tarasoff decision, issued by the Supreme Court of California in 1976 (Tarasoff v. Regents of the University of California, 1976). More about that case will be said here in due course. This dissertation is concerned with the conflict between the confidentiality objective and the victim protection objective.

It is the underlying thesis of this dissertation that a great need exists for a clear, comprehensive and detailed
statement of the various factors that should be considered when a psychologist providing therapy in Texas is confronted with a conflict between the confidentiality objective and the victim protection objective. Such a statement would serve as a definition of the professional standards to govern the behavior of a Texas psychologist facing this problem. The lack of such a statement leaves every psychologist therapist in Texas vulnerable to the risk of being unjustly penalized in a civil lawsuit. If a jury finds that a defendant therapist has failed to adhere to the standards of the profession, and the plaintiff has been damaged by that failure, then a judgment for civil damages can be had against the therapist. But how does the jury decide what the standards of the profession are? It hears the testimony of one or more expert witnesses. The judge decides whether a given witness is an expert on standards of the profession. If the judge so decides, then the witness can give an opinion to the jury as to what the standards of the profession relating to the case on trial are and whether the defendant therapist lived up to those standards. The lawyers can argue before the jury as to whether the witness should be believed, based on his or her credentials. Other expert witnesses can offer conflicting opinions, and the lawyers can argue about their testimony, too. After all this, the jurors make whatever decision they want to make as to what the standards of the profession are and whether the
defendant has adhered to those standards. If they wish, they can reject the opinions of several of the expert witness and accept the opinion of just one. And if, later, ninety-nine out of a hundred psychologists who hear about the case were to say that the jury finding was all wrong, that would not change anything. The jury is the final judge of the credibility of the witnesses.

Since there is no clear, widely accepted statement as to just how a therapist in Texas should deal with the conflict between the confidentiality objective and the victim protection objective, every therapist is exposed to the risk of a court judgment based on the testimony of a single glib and persuasive witness whose comments about standards of the profession may be at odds with the consensus, if there is a consensus, of psychologists in Texas.

The means are at hand by which psychologists in Texas can reduce this risk. A number of psychologists, acting jointly, could undertake an extensive study to determine just how practicing psychologists are in fact dealing with this problem in real life situations. This could lead to the articulation of the very kind of detailed and comprehensive statement of factors and standards that is so much needed. The more widespread the participation in this study, particularly by influential Texas psychologists, the more authoritative and beneficial the final declaration
would be. Such a comprehensive statement would be an important factor in any litigation attempting to hold a psychologist financially liable for damages where a patient has killed or injured someone. Accordingly, the potential influence of some maverick expert witness giving testimony that does not actually reflect the consensus of Texas psychologists as to standards of professional behavior would be diminished.

To say that a need exists for a full and authoritative statement of this sort is not to say that no guidelines exist at all. There are Texas laws that bear on this topic. Also, there are relevant published statements of ethical standards espoused by Texas psychologists. These are all examined in detail in this dissertation, when we reach the literature review. The view expressed here is that when all of this is considered, there is still a lack of the kind of kind of comprehensive and authoritative statement that is needed.

To fill such a need is beyond the scope of a student's dissertation. However, it is hoped that this paper, and the empirical study here reported, might invite some consideration of the problem and possibly be of use to those members of the psychology profession who see a need for such an authoritative statement.

An Attitude Survey

It is probably a rare experience for a therapist to
experience the full brunt of the dilemma we have been describing, where there is no fully satisfactory solution. Depending on the exact fact situation, there can be a number of instances in which a good solution can be found. We will mention a few of these:

If there is clear and convincing evidence to show that the patient is mentally ill and that there is a probability of imminent physical injury by the patient to himself or to others, then a civil commitment proceeding in Mental Illness Court may result in confinement of the patient for involuntary mental health care (Vernon, R. C. S. Texas, Art. 5547-48). Under this situation the therapist in Texas has clear statutory authority to breach confidentiality. Such a proceeding might provide two very desirable objectives: needed therapy for the patient, and protection for the potential victim. Commitment, then, can be an ideal solution.

In other instances, the therapeutic alliance between therapist and patient may be so strong that the potential victim can, with the patient's consent, be called in to a joint meeting with therapist and patient, and the danger to the potential victim can be openly discussed. If not that, the patient may give consent for the therapist to apprise the potential victim of the danger, and the therapist may feel that this can be done without threatening the continuation of needed therapy for the patient. By such
adroit handling, the threat to the potential victim may be pressed into the service of therapeutic gain. But it may not be common for the therapeutic alliance to be so strong as to make such measures appropriate.

Another solution is possible. At the beginning of therapy, the therapist could require the patient to give consent to whatever disclosures the therapist might think are needed to protect someone that the therapist believes to be in danger. Just how this might impact on the prospect for effective therapy has been the subject of some discussion, mentioned in the literature review.

No doubt other solutions could be described. It is not our purpose here to list all possible solutions in all possible situations. The point is that sometimes good solutions are at hand in particular cases, as described above. The focus of interest for this paper is not on the easy cases, but on those situations where no fully satisfactory solution can be found. Every therapist faces the possibility of encountering a case in which it is not possible to protect the potential victim without destroying the therapeutic alliance and ending therapy, which may even increase the risk of harm to the potential victim. Our great concern here is, when the therapist is in that kind of bind, what is the appropriate way to go about working through the problem? What factors should be taken into account? What standards should be applied?
To gather information touching upon these issues, we conducted an attitude survey of health service provider psychologists in Texas. We asked each of them, "What would you do?" We submitted a brief, one-page vignette which presented a hypothetical case. It was designed to present the maximum tension between the confidentiality objective and the victim protection objective. The vignette is set out in full in Appendix A, appended to this dissertation. This was followed by a questionnaire. The questionnaire is set out in full in Appendix B, also appended hereto. More will be said about this empirical study, but first we should examine the literature upon which it is based.

Literature Review

The literature which provided the basis for this dissertation includes legal literature and mental health literature. We begin with a close, detailed examination of the Tarasoff opinion, as that is surely the most important milestone in the developing law of therapist responsibility for patient behavior. Since this case emanated from a California court, we then examine the development of the law in that state since the Tarasoff decision was published. Then we examine the extent to which the Tarasoff opinion has been accepted and followed in the courts of other American states. Then we reach a critical point in our literature review, the examination of the Texas law, and the prospect of the Tarasoff decision being followed in Texas, if and
and when a similar issue comes before the courts of Texas. We then turn from legal literature to an examination of mental health professional literature. The first of these sections deals with the published ethical guidelines for psychologists. The next describes those articles which pointed the way for the development of a design for our empirical attitude survey. We then discuss articles dealing with various clinical problems, among them the problem of attempting to predict violent attack. Finally, we examine the effort to deal with these issues made by an ad hoc committee of the American Psychological Association.

The Tarasoff Decisions

On December 23, 1974 the Supreme Court of California issued its decision in the Tarasoff case. That decision was explained by the court's published opinion, joined by five justices. There was a dissenting opinion joined in by two justices. The trial court's decision, which had dismissed the case against all defendants, was reversed. The case was sent back to the trial court for further proceedings (Tarasoff I, 1974).

Later the Supreme Court granted a rehearing and set aside its published opinion. A new opinion was published, this one dated July 1, 1976. This time only four justices joined in the majority opinion. The same two justices dissented, and one justice filed a specially concurring opinion. This meant that he agreed with the result, but
objected to some of the language of the majority's opinion. The case was again sent back to the trial court for further proceedings (Tarasoff II, 1976).

This somewhat unusual procedure of withdrawing one published opinion and substituting another in its place gave rise to the terms "Tarasoff I" and "Tarasoff II" as various commentators have talked and written about this case. Tarasoff II is the one which is legally binding, and the one to which most of our attention is directed. However, there are some very interesting differences between the two, and we mention these differences in due course. If, in making reference to the Tarasoff case, we fail to make adequate distinction between Tarasoff I and Tarasoff II, let it be understood that we are referring to Tarasoff II.

There has been a torrent of published comment about this case in legal and mental health literature. But what were the actual events that led to this lawsuit? Public knowledge is quite limited on this score. Often appellate court opinions are written after there has been a full and exhaustive trial of the case, with detailed testimony of witnesses, and jury findings on the essential issues. That did not happen in this instance. The case was never brought to trial. The plaintiffs, who were suing for civil damages for the death of their daughter, set out extensive allegations in the papers filed with the court. Both sides can allege what they hope to prove in a lawsuit, but
allegations are one thing; often the actual facts are quite a different thing. In this case the defendants came before the trial court and argued that even if everything the plaintiffs alleged were true, it would still not entitle the plaintiffs to recover anything in the lawsuit. This legal maneuver was called a "demurrer." The trial judge agreed with the defendants, granted the demurrer and dismissed the lawsuit. The plaintiffs appealed, and the case in due course reached the Supreme Court of California. That court ruled that the trial court was in error, and that the case should not have been dismissed. Accordingly the Supreme Court sent the case back to the trial court for further proceedings. In doing this, the Supreme Court did not decide any of the facts of the case. It merely ruled that if certain facts were found to be true, then the plaintiffs would be entitled to recover something. That leaves it for a jury in the trial court to decide the facts of the case, after hearing evidence from both sides at a trial on the merits.

But that did not happen either. After the Supreme Court's decision, the parties apparently arrived at an out-of-court settlement of the case, so it was never tried. Settlements do not prove any facts either; typically all accusations are stoutly denied in the settlement agreement. There are often good reasons to compromise and settle, even when the other side's allegations are challenged. So, in
fairness to everyone concerned, it should be kept in mind that, for all the widespread discussion of the "facts" of the Tarasoff case, there has never been judicial determination of any of the facts. The plaintiffs' allegations have neither been proved nor disproved.

Prosenjit Poddar was tried for the murder of Tatiana Tarasoff, and found guilty in the trial court. However, his conviction was reversed on appeal (People v. Poddar, 1974). The material examined in this study does not indicate how the prosecution was finally disposed of. Poddar was not a party to the civil lawsuit we have been discussing.

One way to describe the alleged events of this case is to mention the various personalities, and the part each of them played in this tragedy. So a "dramatis personae" will be offered, even though this is no stage play. Again, this is all based on plaintiffs' allegations:

Prosenjit Poddar: Voluntary outpatient receiving therapy at the campus hospital at the University of California at Berkeley.

Dr. Gold: Psychiatrist at campus hospital, first examined Poddar.

Dr. Moore: Psychologist at campus hospital, therapist to Poddar when Poddar said he was going to kill a girl, identifiable as Tatiana Tarasoff, when she returned home from spending the summer in Brazil.

Dr. Yandell: Psychiatrist, assistant to campus
hospital director of psychiatry. Concurred in Dr. Moore's decision that Poddar should be committed for observation in a mental hospital, as did Dr. Gold.

Officers Atkinson and Teel: Officers of campus police department. Were orally notified by Dr. Moore that Dr. Moore would request commitment of Poddar.

William Beall: Campus chief of police. Received letter from Dr. Moore requesting police assistance in securing Poddar's confinement.

Officers Brownrigg and Halleran: Working with officer Atkinson, took Poddar into custody. Satisfied that he was rational, they released Poddar on his promise to stay away from Tatiana.

Dr. Powelson: Director of campus hospital department of psychiatry. Asked the police to return Dr. Moore's letter, directed that all copies of the letter be destroyed, along with the notes that Moore had taken as therapist. Ordered that no action be taken for commitment of Poddar.

Tatiana Tarasoff: Killed by Poddar some time after the foregoing events.

Vitaly Tarasoff and spouse: Parents of Tatiana. Filed wrongful death lawsuit. The other persons listed here, except Poddar, were named as defendants in that suit.

Regents of the University of California: Also named as defendants, as the other defendants were employees of the University.
Judge Bostick: Judge of the Superior Court of Alameda County, the trial court in which the case was filed. Granted demurrer for all defendants, and dismissed lawsuit.

Mr. Justice Tobriner: Judge of the Supreme Court of California. Author of the majority opinion, concurred in by three other justices.

Mr. Justice Mosk: Author of an opinion in which he concurred in the result of the case, but dissented from some of the rules of law set out in the majority opinion.

Mr. Justice Clark: Author of the dissenting opinion. This dissent favored affirming the trial court's judgment, and opposed the judicial opinion issued by the majority. Since then served as National Security Adviser. Has recently served as U. S. Secretary of Interior.

Mr. Justice McComb: Joined Justice Clark's dissent.

Justice Tobriner, speaking for the Supreme Court of California majority, dealt with two principal legal grounds by which the Tarasoffs claimed they were entitled to recover damages from the defendants. One of these was that Poddar was a dangerous mental patient who should have been committed, and the defendants should have followed through on the procedure to have him committed. The court denied this claim, holding that all the defendants were immune from liability because of the legal doctrine of government immunity. Since all the defendants were agents of the state, they were protected from liability for whatever they
did or did not do about having Poddar committed.

The other grounds upon which the Tarasoffs sought to recover was the failure of any of the defendants to warn Tatiana or her family of the danger she was in. Here again the court examined the law of governmental immunity and concluded that the chief of police and all the other police officers were immune from liability because of governmental immunity. But the court ruled that governmental immunity did not apply to the psychologist and the three psychiatrists as to failure to warn. Why governmental immunity protected the four therapists from the charge of failure to commit, but did not protect them from the charge of failure to warn, involves highly technical legal concepts that are outside the scope of this paper. Readers who may have a special interest in the legal doctrine of sovereign immunity are referred to the majority's opinion for this discussion.

In that fashion the majority denied all claims against the police officers, and denied the failure to commit claim against the therapists. But that leaves the claim of failure to warn against the therapists, and against the University regents as the employers of the therapists. It is on this score that the majority formulated rules of law that have engendered so much comment and criticism. The heart of this decision is set out in one sentence, quoted here directly from the majority opinion: "When a therapist
determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger." The court did not say that the therapist is obliged to warn the victim; the obligation is to use reasonable care. Reasonable care might require warning the victim in some cases, but different measures, such as notifying the police, in other cases. Notifying the police, of course, is precisely what Dr. Moore is alleged to have done. Whether this fulfilled his obligation to use reasonable care would be for a jury in the trial court to decide. A jury trial would have developed detailed information that is not before us. This might have thrown light on exactly what Dr. Moore did, and on whether it amounted to reasonable care to protect Tatiana. Since there was no jury trial, the reading public may never know.

The opinion by Justice Mosk agrees that the case should be sent back to the trial court. But he disagrees with the majority's ruling that the therapist can be held liable when, pursuant to the standards of his profession, he should determine danger of violence to another. The word "should" is what troubles Justice Mosk. In the case before the court, the therapist had apparently determined in fact that there was a danger, since he had allegedly called the police. To Justice Mosk this was sufficient basis for a
jury issue as to whether the therapist had used reasonable care to protect the intended victim. But he did not agree that the therapist could be liable because he should have determined the danger if in fact he did not do so. He observes that no one can predict violence accurately. He takes note of an impressive body of literature that indicates that psychiatrists are no better equipped than others to predict violence accurately. To the suggestion that a therapist, "pursuant to the standards of his profession" should be able to predict violence, Justice Mosk asks "what standards?" His final words were, "The majority's expansion . . . will take us from the world of reality into the wonderland of clairvoyance."

Some of the language the majority uses limits the scope of the therapist's obligation: "... the therapist need only exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by members of that professional speciality under similar circumstances . . . proof, aided by hindsight, that he or she judged wrongly, is insufficient to establish negligence."

Traditionally, when courts are laying down rules of law, they limit the scope of the rules to that which is necessary to dispose of the case before the court, but not this time. The practical effect of all this is that, in California at least, juries must retry, as a fact issue in each case, the question of whether professional standards
exist requiring therapists to determine accurately which of their patients' threats of violence will be carried out and which will not.

Justice Clark's dissent is very strongly worded. He clashes with the majority in two major areas: First, whether the California statutes, properly construed, support the majority's ruling, and, second, whether, as a matter of public policy, the majority decision actually diminishes public safety rather than enhancing it. The first area involves a technical legal debate over how the California confidentiality statutes should be applied to this case. There are two such statutes. One is a part of the Evidence Code governing disclosures of confidential information in court proceedings in general. The other relates to the rights and duties of the mentally infirm and those charged with their care.

The dissent contends that these statutes forbad the therapists from disclosing to Tatiana their confidential knowledge of her danger. The majority points to the provision in the Evidence Code that, while confidential disclosures in general are privileged, the privilege does not exist where the patient appears to be dangerous and disclosure is necessary to prevent threatened danger. The dissent counters with the argument that, because disclosure to Tatiana or her family would have necessarily been made outside of any court proceeding, such a disclosure would not
be governed by the Evidence Code in any way.

The dissent and the majority also clash mightily, in a highly technical argument, over the issue of whether the confidentiality provisions of the mental illness law apply to the therapists in the case before the court. If they do, then apparently they would have forbid the therapists from warning Tatiana. The dissent says they do apply to this case; the majority says they do not.

In criticizing the majority opinion on public policy grounds, the dissent used these words: "Given the importance of confidentiality to the practice of psychiatry, it becomes clear the duty to warn imposed by the majority will cripple the use and effectiveness of psychiatry. Many people, potentially violent--yet susceptible to treatment--will be deterred from seeking it; those seeking it will be inhibited from making revelations necessary to effective treatment; and, forcing the psychiatrist to violate the patient's trust will destroy the interpersonal relationship by which treatment is effected. . . the majority's duty to warn will not only impair treatment of many who would never become violent but worse, will result in a net increase in violence." The dissenting judge spoke here of psychiatry, but what he said would apply with equal force to psychotherapy furnished by a psychologist.

The majority opinion more or less dismissed this argument as "speculative." The majority appear to assume
that their ruling will result in a net decrease in violence. With one side predicting net decrease and the other predicting net increase, both predictions appear to be speculative. If "speculative" is a fatal vice, then the majority's prediction must also succumb. In the view of this observer, the serious and important public policy issue raised by the dissent deserves a more carefully considered response than it got from the Supreme Court of California majority.

The majority appear to have made two assumptions, both of which are likely to be questioned by psychologists. One of these, challenged by Justice Mosk, is that psychotherapists have at their command reliable means by which they can determine which threats of violence will be carried out and which will not. A great deal of the published criticism of the majority opinion is directed toward this assumption, and to the manifest unfairness of holding therapists civilly liable for failure to make accurate predictions if indeed no one can make accurate predictions.

The other questionable assumption has to do with the value of effective therapy as a means of saving lives by curbing violent behavior. It is self-evident that society is benefitted when an innocent life is saved. The problem is that warning an intended victim may prevent saving a life by continuing effective therapy. The Tarasoff
majority seem to assume that a net saving of life would result from requiring that confidentiality be breached, without ever addressing the possibility that lives can be saved by continuing therapy. These justices had to deal with the loss of life of an identified innocent person. Tatiana was a real person, and her surviving relatives are real people left with real grief. It is not easy to override these concerns with theories about how some nameless person’s life might be saved because her nameless would-be assailant is receiving effective therapy. It is not easy, but it may save lives in the long run. If a therapist saves the life of a prospective victim by keeping the patient’s threat secret and going ahead with therapy that makes the dangerous patient less dangerous, it can never be publicly known. This life-saving achievement must be kept confidential, along with the rest of the confidential information. But the life saved is no less precious just because there are no screaming headlines to tell about it.

The sad irony of the Tarasoff case is that confidentiality was breached anyway, according to the allegation that Dr. Moore notified the police when he learned of the danger. If the court had limited its lawmaking to cases where confidentially was already breached, there would be much less reason to criticize their opinion. We are left with the tantalizing question: What
might have happened if, instead of calling the police, Dr. Moore had continued therapy with Poddar? Might he have saved Tatiana's life? This is not to suggest that he should have done so; the limited information we have provides no basis for criticizing what he did or did not do.

For all the harm that this decision, according to its numerous critics, has done, there is one narrow point as to which it may prove to be beneficial. We may speculate that the reason the therapists, according to the allegations, did nothing after the police released Poddar had to do with the California confidentiality statutes. It is quite possible, and again this is speculation, that they received legal advice to the effect that they were required by law to make no further disclosure of information after the police released Poddar. That appears to be the view that Justices Clark and McComb take in their dissent in *Tarasoff II*. Looking back to how a therapist might have understood the law before *Tarasoff I* was published in 1974, we see a cruel paradox. Confidentiality has been breached, properly enough, by reporting the danger to the police. Further therapy is unlikely because the patient probably holds the therapist responsible for his arrest. Now that confidentiality no longer serves any useful purpose, the therapist nevertheless may be required, by the terms of the statutes, to maintain silence, no matter how much he might wish to protect the potential victim. This is an illogical
burden to be thrust upon the therapist, one that may have been unexpected when the exact wording was chosen for these confidentiality statutes. The Tarasoff decision has solved the problem for California therapists. Where confidentiality has already been breached by an abortive effort to commit the patient, then go ahead and do whatever reasonable care to protect the intended victim requires, regardless of confidentiality.

Before turning our attention to developments in the law that followed Tarasoff II, we should discuss some interesting differences between Tarasoff I and Tarasoff II. For one thing, Tarasoff I held the police officers liable for failure to warn. The Tarasoff I dissent attacked this position sharply and, apparently, successfully, because in Tarasoff II the majority relieved the police officers of such liability and upheld the trial court's action in dismissing the entire case as to the police officers.

Perhaps the major difference between the two opinions is that Tarasoff II described the basis of liability in broader terms. In Tarasoff I the essence of the tort was failure to warn. In II, it was failure to use reasonable care to protect the intended victim. Under II, other protective action might, in a given fact situation, be more appropriate than warning.

Another difference was that in Tarasoff II, the court mentioned an amicus curiae argument advanced by the American
Psychiatric Association. Perhaps this is what lured Justice Mosk away from the majority opinion. But the burden imposed on psychotherapists is at least as heavy in the latter decision as in the former.

A very interesting argument somehow got lost between Tarasoff I and Tarasoff II, one that may come up again somewhere some day. In Tarasoff I, the argument was advanced that, whether or not the therapist was obliged to warn when he first heard the threat, he acquired a duty to warn when he made his abortive effort to have Poddar committed, because, so the argument goes, this action put an end to therapy. Therapy, had it continued, might have saved Tatiana. Justice Clark, the vigorous dissenter, seems to agree: "The majority's opinion correctly holds that when a psychiatrist, in terminating treatment to a patient, increases the risk of his violence, the psychiatrist must warn the potential victim." But none of the three opinions in Tarasoff II makes any reference to this argument. But there is an interesting implication here. Can warning the potential victim be regarded as a breach of duty to the potential victim, if the warning brings about termination of treatment, treatment which might have saved the victim's life? Without a crystal ball in perfect working order, the therapist seems to be vulnerable to the ever-present possibility of being subjected to a lawsuit, whatever she or he might do.
California After Tarasoff

One of the difficulties of understanding and explaining points of law is that the law is forever changing. Courts sometimes expand their prior rulings, sometimes restrict them, and sometimes overrule them altogether. And legislatures sometimes come along and revise the law laid down in judicial opinions. So what have the past nine years done to Tarasoff as a statement of California law? Essentially, the decision still stands, as of this writing. But there have been some refinements, which we shall now examine. Later we shall concern ourselves about the extent to which it expresses law outside of California.

One California court has considered the question of whether the Tarasoff decision requires that the therapist be held liable for failure to warn interested persons of the danger that the therapist's patient may commit suicide (Bellah v. Greenson, 1977). The therapist, upon concluding that his adult patient was disposed to suicide, did not warn her parents of the danger. The California Court of Appeals held the therapist not liable to the parents for this omission, as these facts did not give rise to a duty to warn. The court held that, while breaching confidentiality for the protection of third persons is required by the Tarasoff rule, breaching confidentiality for the protection of the patient herself is distinguishable and not required.

Another California Court of Appeals has ruled that a
sheriff can be held liable for failure to warn a prisoner's wife and daughter of the prisoner's impending release, where such failure led to the prisoner's death by suicide (Johnson v. County of Los Angeles, 1983). Among the special circumstances of this case are the notice of suicidal tendency the wife allegedly gave to sheriff's deputies, and the promise the deputies allegedly made, and allegedly broke, that he would be hospitalized and given medication. Like Tarasoff, this case is an appeal from a demurrer, so the actual facts are not fully developed. As in Bellah, the court applied the Tarasoff rule, but reached a different result. Tarasoff dealt with the therapist's duty of protection toward a readily identifiable potential victim. Since Tarasoff, the California courts have declined to extend this duty to unidentifiable victims. But how much effort must the therapist invest to learn the identity of possible victims? It is difficult to generalize, so we will examine some cases:

Tarasoff II deals with this in a footnote (fn. 11, p. 27):

We recognize that in some cases it would be unreasonable to require the therapist to interrogate his patient to discover the victim's identity, or to conduct an independent investigation. But there may also be cases in which a moment's reflection will reveal the victim's identity. The matter thus is one which
depends upon the circumstances of each case ..."  
(Tarasoff II, 1976)

The Supreme Court of California further considered this matter in Thompson v. County of Alameda, 1980. In that case a public agency released a young man to the custody of his mother. The agency was allegedly aware of his expressed intention to kill a young child (unidentified) in the neighborhood. After he did so, suit was brought alleging, inter alia, a duty by the releasing agency to warn the local police, the parents of children in the neighborhood, and the boy's mother. The court, after an extensive examination of several factors, concluded that extending the Tarasoff rule to require a warning in this case "would be unwieldy and of little practical value". The court continued:

Notification to the public at large of the release of each offender who has a history of violence and who has made a generalized threat at some time during incarceration or while under supervision would, in our view, produce a cacophony of warnings that by reason of their sheer volume would add little to the effective protection of the public (Thompson v. County of Alameda, 1980).

There was a dissent filed in this case, written by Justice Tobriner, the author of the Tarasoff opinion. While not insisting that a warning to the whole neighborhood was required, he contended that protective action could have
been taken, in the form of a warning to the boy's mother, and that this might have prevented the tragedy. The majority responded to this argument, saying: "Such attenuated conjecture . . . cannot alone support the imposition of civil liability."

The case that perhaps goes furthest in imposing an obligation on the therapist to seek out information that will identify the potential victim is Jablonski by Pahls v. United States, (1983). This case was decided by the U. S. Court of Appeals for the Ninth Circuit, on appeal from a judgment rendered by a U. S. District Court in California, under California law. The judgment was in favor of the child, Meghan, of a murder victim, Melinda, against a veterans hospital. The victim had been living with the man who killed her, Jablonski. As the facts were reported in the court's opinion, Jablonski had a violent history and had committed violent acts against women, including Melinda's mother, Mrs. Pahls. Mrs. Pahls reported these matters to the police, who in turn reported them to Berman, the hospital supervisor where Jablonski was being evaluated. But apparently the information did not reach Kopiloff, the doctor treating Jablonski. Kopiloff cautioned Melinda to stay away from Jablonski, as did her priest, as did another doctor. One of the grounds on which the trial court granted recovery was the hospital's failure to warn Melinda of the danger she was in. The trial court ruled in effect that the
warning given was non-specific and inadequate and that an appropriate warning based on full information about Jablonski's background might have prevented the tragedy, and failure to give such a warning was grounds for the hospital's liability. As one reads this opinion one looks in vain for some kind of limit on the therapist's obligation to dig out all information that might establish the identity of someone who is entitled to a warning, and that might provide the necessary particulars to make the warning sufficiently forceful. Also, a different issue comes to mind. Should there be a legal duty to tell people what they already know? One gets the feeling, reading this case, that Melinda knew she was in grave danger and that no amount of warning or well-intended advice would have caused her to flee from that danger. This case must be disturbing to people who wish to practice psychology responsibly but wonder what the courts are going to judge to be responsible behavior. There is a small measure of comfort to be found in the procedural aspects of this case. There was no jury, so the trial judge was the trier of the facts as well as the law. This brings into play some rather heavy presumptions in favor of the trial judge's rulings. The appellate court did not say that the trial court's rulings were correct. It merely said that they were not clearly erroneous. To disturb the judgment, the appellate court would have to find the trial court's rulings clearly erroneous. In contrast, we
have looked at several cases where the issues come before the appellate court on appeals from demurrers. In that situation, the appellate court can deal with pure questions of law and leave questions of fact to the jury. The impact of the Jablonski opinion as legal precedent may be lessened by the procedural environment in which it was issued.

Perhaps a little comfort may also be found in a decision issued a few weeks earlier by the same U. S. Court of Appeals for the Ninth Circuit in a case arising in California, Vu v. Singer Co., (1983). The Singer Co. ran a Job Corps center. Six men and some women from the Corps entered the plaintiffs' home, stole some property. One of the plaintiffs was raped. Plaintiffs alleged that Singer, as operator of the center, owed them a duty of care in supervising of Corps members. The U. S. District Court, applying California law, granted the defendant Singer Co. a summary judgment. The circuit court affirmed this ruling. The court, citing Tarasoff, Thompson, and other cases, held that, both as to the duty to warn and the duty to supervise, the victim must be foreseeable and specifically identifiable. In the Jablonski case, discussed above, the court distinguished Vu v. Singer Co., saying that Vu fell squarely within the rule of the Thompson case, but that the Jablonski case does not. The court also suggested that Job Corps facilities must be treated more tenderly than veterans hospitals.
Other California cases have extended the Tarasoff rule in other ways. In *Hedlund v. Superior Court of Orange County*, (1983), LaNita and son Darryl sued the therapists for failure to diagnose the danger to LaNita presented by their patient, Stephen, with whom LaNita was living. The therapists had asked the trial court to grant a demurrer, alleging, among other things, that the complaint filed on Darryl's behalf failed to state a cause of action. The trial court denied the demurrer. The Supreme Court of California affirmed the trial court's ruling. In so doing, the court added a new dimension to the Tarasoff rule. It held that therapists who should have diagnosed danger to LaNita owed a duty of protective care, not only to LaNita but to her child Darryl, who was never threatened and not physically injured, but who allegedly suffered emotional distress as a result of being close by when his mother was injured. Has California become the happy hunting ground for people who wish to sue psychotherapists? One commentator (Laughran, 1984), herself a California attorney, seems to have some fears in that direction. Her assessment of the *Hedlund* decision is this: "What the Court has done, in effect, is to cause the psychotherapist to be the insurer against harm caused by his or her patients."

In the *Hedlund* case Justice Mosk, in a vigorous dissent joined by two other justices, takes up his old lance and goes once again after the windmill of should-know versus
does-know. Recalling his Tarasoff dissent, he again rails against a rule that assumes the existence of a non-existent technique—the ability to predict dangerous behavior accurately.

One more California case should be mentioned. In Mohlsbergen v. United States, (1985), the widow of a Navy pilot sued the government. The pilot had allegedly been sent on a mission over Nagasaki, Japan, soon after the detonation of the nuclear bomb and thereby was exposed to cancer-causing radiation. One ground for recovery was that, when the Navy discovered that this state of affairs constituted a danger to the pilot, it should have located him and warned him of the danger, even though he had long since been discharged from the Navy when the Navy discovered the peril. The U. S. District Court sitting in California dismissed the claim and the widow appealed. The U. S. Court of Appeals for the Ninth Circuit held that the question of the existence of a duty to warn was in this case a matter of California law. Citing Tarasoff, the court held that, even though the government's behavior was innocent in the light of the state of scientific knowledge at the time the pilot was sent over Nagasaki, it acquired a duty to warn upon learning, after the fact, of the existent of danger. The circuit court reversed and sent the case back to the district court for further proceedings. Once again, let us look at the procedure. No judgment has yet been entered.
against the government. The circuit court merely ordered the district court to hold a trial. What the circuit court assumed to be facts on appeal from dismissal may not be facts at all when the jury findings are entered. And if a judgment is entered against the government in the district court, the circuit court may be presented with a whole new set of legal issues. The U. S. Supreme Court may eventually get a look at this one. But this case is important to us because it represents a very recent extension of the legal concept of the duty to warn. In a sense it all started with Tarasoff.

From these cases we can gain some view of how California law has developed in the courts since Tarasoff II. On September 20, 1985, the Governor of California signed into law an Act of the California Legislature which deals with the issue we have been discussing. This law limits therapists' liability to cases where "the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims." The new law further provides: "If there is a duty to warn and protect under the limited circumstances specified above, the duty shall be discharged by the psychotherapist making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency" (A. M. Miller, personal communication, September 20, 1985). The full text of this legislation is set out as
Appendix E to this dissertation. The letter from Anita M. Miller, Director Governmental Affairs, California State Psychological Association, transmitting this bill to the author, is set out as Appendix F hereto.

**Beyond California--Courts of Last Resort**

Each state, of course, has its own laws and its own system of courts. Decisions by the courts of one state are not binding as legal precedents upon the courts of other states. However, a decision from any state can have great influence on subsequent decisions in other states. This is particularly true when a court encounters a novel question that does not appear to be answered by prior decisions from the court's own state, or other binding authority. How great that influence is depends on several factors. Probably the most important single factor is this: if a judge finds the reasoning of an out-of-state opinion particularly appealing and persuasive, then the judge is likely to cite that case and base a ruling on it. *Tarasoff* has been cited in numerous cases from at least nineteen states as of this writing. Actually it has been cited in more states than that, but we will confine our attention to cases that have some bearing on the issues we are exploring in this dissertation. Our concern at this point is with the extent to which the *Tarasoff* ruling has been accepted as law in other states. It should be kept in mind that the coming week could bring new decisions that might
We will look at each of the more revealing cases, but first, a few general observations: No court seems to have outright rejected Tarasoff II as an expression of common law. One court declined to follow Tarasoff because of a local statute (Shaw v. Glickman, 1980). More will be said about that case in due course. Several courts have approved Tarasoff. Some, as will be noted, seem to have gone a bit beyond California law (McIntosh v. Milano, 1979). Dissenting judges in Pennsylvania (Pittsburgh Action Against Rape, 1981), and Idaho (Alegria v. Payonk, 1980) have approved the dissent in Tarasoff, but otherwise the Tarasoff dissent does not appear to have been followed. Several cases have discussed Tarasoff but expressly refused to accept it or reject it. Sometimes this occurs when the court explains that the Tarasoff rule does not apply to the case being decided. Otherwise, the courts that have discussed Tarasoff have done so with at least some measure of approval. Except in Texas, which is discussed separately, there would seem to be a definite trend toward acceptance of the Tarasoff rule.

As we look at these cases in detail, we can see that Tarasoff is often cited to support the legal proposition that an injured party can, under some circumstances, recover for negligent release of someone in custody. The Tarasoff rule is much broader than that and imposes liability on the
therapist for harm inflicted by someone not previously in detention and over whom the therapist has no control. Negligent release, involving, as it does, the elements of custody and control, is obviously on a different legal footing. There is nothing new or radical about liability for negligence in exercising control. The courts were dealing with this long before Tarasoff (e.g., Fair v. United States, 1956, and Underwood v. United States, 1966). Our interest, in this dissertation, is not squarely directed toward the problems of providing therapy for persons in custody. But in studying the extent to which the Tarasoff rule has been accepted by other states, we find ourselves reading a lot of negligent release cases. Cases that actually turn on the giant step in extending tort liability taken by the Tarasoff decision are not nearly so common as negligent release cases that cite Tarasoff.

Sometimes negligent release cases also involve a question of failure to warn. But the warning involved is likely to be a warning that the dangerous person is being released (e.g. Fair v. United States, supra). Such a warning would not involve a breach of confidentiality, as the fact of someone's release is not ordinarily information gained in the privacy of a therapy session. This is a different matter altogether from the Tarasoff duty to warn, which is a duty to breach confidentiality. To recall our initial premise, the focal point of interest for this paper
is the tension between the confidentiality objective and the victim protection objective.

We will first examine those states where the state's court of last resort has made some mention of Tarasoff in a majority opinion. They are Georgia, Idaho, Iowa, Kansas, Massachusetts, Minnesota, Missouri, Nevada and Washington.

Among these, the court that seems to have given the strongest approval to the Tarasoff decision is the Supreme Court of Washington, in Peterson v. State, (1983). But this, too, was a negligent release case. The therapist's offense was in discharging the patient from involuntary detention and not seeking further involuntary detention. Judgment was rendered in the trial court against the state on a jury verdict. The opinion makes no mention of any recovery against the therapist individually, although the conduct of the therapist, Dr. Miller, was the basis of the state's liability. There was a good deal of evidence that the patient, Knox, was a dangerous person, and Dr. Miller had joined in seeking one extension of his involuntary detention at the state hospital. During this involuntary detention he was granted a one-day liberty. That evening he was apprehended by hospital security personnel while driving his car on the hospital grounds in a reckless fashion that involved spinning his car in circles. Witnesses said he seemed "drugged up." Nevertheless Dr. Miller discharged him the next morning. A few days later he collided with the
plaintiff's automobile, causing her injuries. Some time later he murdered a couple and raped their daughter. Apparently these latter victims were not parties to this case, but these events were in evidence in this case. In discussing whether the psychiatrist had a duty to seek additional confinement, the Supreme Court said: "The seminal case regarding the duty of a psychiatrist to protect against the conduct of a patient is Tarasoff . . . " The court then proceeded to quote Tarasoff at great length, apparently with approval, ultimately concluding that Dr. Miller indeed had such a duty. The court noted that the requirement of foreseeability as to identity of the potential victim was imposed by Thompson v. County of Alameda, discussed above, but chose to go beyond the Thompson restriction. Citing Lipari v. Sears Roebuck & Co., 1980, a U. S. District Court case arising in Nebraska, the court held that the duty of care extended to any person foreseeably endangered by the negligent acts of the defendant. Lipari itself relies heavily on Tarasoff. The Washington Supreme Court was concerned with a problem as to whether Dr. Miller was required, or even allowed, under Washington law to disclose the confidential information that would have enabled him to gain an extension of the involuntary detention. There were two ways he could have kept Knox in confinement. One was through criminal proceedings, since Knox was on probation from a criminal
conviction, and Dr. Miller could have reported violations of parole conditions to the probation officer. However, the Supreme Court held that this information was confidential and could not be lawfully reported under the state's confidentiality statute. However, he apparently could have lawfully sought civil commitment proceedings, and it was his failure to do so that provided the basis for liability. The state's attorneys tried to escape liability by pleading sovereign immunity. But this was overruled. In Tarasoff, the therapists were all held entitled to the protection of sovereign immunity, as to the claim for failure to seek civil commitment. Of course each state has its own law on sovereign immunity.

The next cases we will examine arose in Kansas. There are three separate published opinions, each entitled Durflinger v. Artiles. One is by the U. S. District Court, for the District of Kansas, 1981. Another is by the U. S. Court of Appeals for the Tenth Circuit, 1984. The other is by the Supreme Court of Kansas, 1983. Again, these cases are concerned with negligent release. Trial in the district court resulted in judgment for the plaintiff against a psychiatrist and two other medical doctors at a state hospital. The trial court published an opinion. The defendants appealed to the circuit court. The circuit court considered the question of whether plaintiffs' claim comprised a valid cause of action to be a question governed
by Kansas law. Accordingly, the circuit court submitted the question to the Supreme Court of Kansas. That court published an opinion setting forth its answers to the question. Based on that answer, the circuit court affirmed the district court's judgment.

The dangerous patient in this case was scheduled for a transfer from the hospital in Kansas to a facility in Oregon, the state where his immediate family lived. But the clinical director, Dr. Artiles, opposed this, essentially because of the expense to the Kansas hospital. Soon after the patient was discharged as no longer in need of treatment. Soon after that he killed his mother and his brother. As we might expect, there was considerable history of violence prior to his discharge.

The Supreme Court of Kansas held that, although Tarasoff was a case of failure to warn rather than negligent release, the rationale of Tarasoff applies with equal force to the issue of negligent release. It then quoted Tarasoff at great length, apparently with approval, and concluded that the therapists' duty extended to potential victims. At one point in the opinion one might be tempted to assume that the Kansas Supreme Court had embraced Tarasoff with whole-hearted approval. But the Court provided itself an escape route: "We are not called upon in this case to decide whether, in Kansas, liability may be predicated upon a therapist's failure to warn . . . and accordingly,
decline to decide . . . " A notable feature of this case arises from the circuit court's opinion. A clinical psychologist had testified for the plaintiffs, on the issue of the applicable standards that should have governed the behavior of the therapists, who were medical doctors. The defense asked the circuit court to rule that this testimony should have been excluded, because the expert witness was something less than a professional peer of the defendants. The circuit court overruled this argument and agreed with the trial court that the testimony was admissible. Since that court permitted a clinical psychologist to testify against a psychiatrist as to professional standards, we should not be too surprised if, on another day in another trial, a psychiatrist is permitted to testify against a psychologist as to professional standards.

We will now examine a Georgia case, Bradley Center Inc. v. Wessner (1982). This case provides an interesting study of the difference between ordinary negligence and gross negligence and the legal consequences of that difference. Gross negligence may be described as reckless and wanton disregard for the possibility of harm to another. This is another negligent release case, but it leaves us wondering what the law is in Georgia. Here the dangerous patient was given an unrestricted weekend pass by a private mental hospital. He was very disturbed about his wife's extramarital affair, and there was much evidence that he
posed a threat to the wife and her paramour. On the weekend he found them together at his home and shot and killed them both, for which he was convicted of murder and sentenced to the penitentiary. The opinion had little to say about Tarasoff. It was cited, along with ten other cases, including Underwood v. U. S. (1966), which we have described above as a negligent release case that long pre-dates Tarasoff. These cases were cited in a very short paragraph noting that "the duty to conform to a standard of conduct in this case is a well-recognized and well-established principle of law in other jurisdictions."

The court denied that it was creating a new tort, maintaining that it was merely applying traditional tort principles. The court said that ordinary negligence was the standard by which to judge the behavior of the defendants. It was this holding that brought about a major split within the Supreme Court of Georgia. Three of the justices concurred specially, saying that gross negligence, not ordinary negligence, should be required before the plaintiff can recover, where the criminal act of another was the intervening cause of the injury. These justices agreed with the result of the case, because they believed that the evidence showed gross negligence, but they objected to the statement in the majority opinion to the effect that ordinary negligence should be the test. Two other justices dissented outright, but they did not favor us with an
opinion, so we do not know the basis of their dissent. Accordingly we do not know how they feel about ordinary negligence vs. gross negligence. But apparently less than a majority of the justices agree with the result and the opinion, as written. So what would the Supreme Court do in a case where ordinary negligence, but not gross negligence, were shown?

We will examine two decisions by the Supreme Court of Minnesota, **Cairl v. State** (1982), and **Lundgren v. Fultz** (1984). **Cairl** is in the familiar pattern of cases involving negligent release, but it also has a failure to warn issue. The dangerous patient was a firebug who, on temporary Christmas release from a state hospital, burned down the apartment building where his mother lived, killing one sister and severely injuring another. In addressing the issue of whether the defendants were under a duty to warn the mother of her son's dangerous propensities, the court said: "This is an issue of first impression in this court. We are guided, however, by decisions of the California Supreme Court." The court then proceeded to discuss three California cases, including **Tarasoff** and **Thompson**. At the end of this discussion, the court stated: "... if a duty to warn exists, it does so only when specific threats are made against specific victims." The court then proceeded to conclude that, in the case before it, the firebug did not appear to pose any greater threat to the plaintiffs that he
posed to any member of the public with whom he might be in contact when seized with the urge to start a fire. The trial court had granted a summary judgment in favor of defendant, and the Supreme Court upheld that ruling. Thus the Supreme Court of Minnesota has clearly embraced the Thompson v. County of Alameda limitation on the Tarasoff rule, but whether it has embraced the basic Tarasoff rule is more questionable. A dissenting opinion was filed, but it dealt with questions of whether certain regulations were complied with and whether sovereign immunity was properly invoked and said nothing directly about the question of whether the defendant's duty extended to the plaintiff.

Justice Yetka, who wrote the dissent in Cairl, wrote the majority opinion in Lundgren. At last we come to a case that does not principally involve negligent release, although the dangerous patient had been in detention. He was free at the time of the events that are crucial to this decision. Allegedly, he had some guns that had been surrendered to the police. He asked for their return, but the police refused, saying they wanted a letter from his therapist. The therapist complied, saying in the letter that the patient was cured of his mental illness, and that "I feel he can have the firearms... returned to him." About two and a half years later he killed the victim in a random and unprovoked attack. It is not clear if the same
weapons were used. The trial court granted summary judgment to the defendant therapist. The Supreme Court reversed and remanded the case for trial. This was based on the court's view that jurors might conclude that the therapist had some control of the killer's access to handguns. The court said:

... a jury could find that Dr. Cline assisted his patient in gaining access to deadly handguns and that the patient later used one of those guns in a random homicide. There is a limit to the protection given the discretion in a professional relationship. That limit is exceeded where a psychiatrist places the gun in a potential assassin's hand under the guise of fostering trust between patient and psychiatrist (Lundgren v. Fultz, 1984).

Perhaps the most remarkable thing about this case is that no mention is made of Tarasoff. In that respect, this case may stand alone among recent cases dealing with the duty of a psychiatrist toward his patient's victim.

In five other cases where state courts of last resort took some notice of the Tarasoff decision, the therapists were held not liable. The Supreme Court of Iowa, in refusing to permit a murderer to recover from her psychiatrist for failing to warn her victim, which warning would have allegedly saved the murderess from the distress of being convicted of murder, said, "We have not adopted the rationale in Tarasoff. If we were to do so, it would not
control the question here" (Cole v. Taylor, 1981). In a later case, Matter of Estate of Votteler (1983), the same court again declined to accept or reject Tarasoff. "We do not decide in this case whether the Tarasoff rule will be adopted in Iowa. Instead we hold that summary judgment for defendant was appropriate in this case even if the rule were adopted." Lola, the dangerous patient in this case, had a long record of threatening people and indeed once threatened to kill Ramona, the plaintiff. Lola and Ramona were long-time acquaintances. Lola's husband finally left her and began seeing Ramona socially, whereupon Lola ran over Ramona with her car in a parking lot. It appears that some of the facts about Lola's dangerousness were unknown to her therapist, Dr. Votteler. Ramona might have known this record better than the doctor did. But she contended the doctor had a duty to ask appropriate questions to elicit the full information. She also contended that she would have responded differently to a warning from Dr. Votteler than she did from her own knowledge of Lola's dangerous proclivities. The court stated that "... plaintiff's theory attenuates the Tarasoff rule beyond the breaking point. Even if we were to adopt that rule, we could not allow recovery in a case like this. Nor has any other jurisdiction done so." We may assume that while this case was being considered, the Supreme Court of Iowa had not read the Ninth Circuit's opinion in Jablonski, discussed above.
A Supreme Court of Missouri case, *Sherrill v. Wilson* (1983), is another negligent release case. The killer failed to return from a two-day pass from a state mental institution. The court held that the treating physicians did not owe a duty to the general public in deciding which involuntary patients should be released on pass. The court discussed *Tarasoff* and another case which followed *Tarasoff* closely and said: "The cases are distinguishable from this one, and we do not have to decide whether we would follow them." The court went on to point out that the case being decided did not involve threats to specific individuals, but merely danger to the public generally. The Supreme Court affirmed the trial court's order dismissing the case as to the therapist.

*Stepakoff v. Kantar* (1985) was recently decided by the Supreme Judicial Court of Massachusetts. This was a suicide case, and in the trial court the jury exonerated the therapist of negligence in treating the patient. But the plaintiff, husband of the deceased, appealed, contending the therapist owed an additional duty, a duty of protective care, based on the fact that the therapist knew or should have known that the client presented a danger to herself and that the plaintiff was entitled to jury instructions to this effect. The Supreme Judicial Court's response was this: "We are unwilling to disturb our longstanding rule that a physician, practicing a specialty, owes to his or her
patient a duty to comply in all respects with the standard set by the average physician practicing that specialty. We are not moved to a different conclusion by Tarasoff . . . The instant case involves a psychiatrist's duty to his patient, not to third parties. In cases like this one, even California courts apply the "average qualified physician" standard . . . (Stepakoff v. Kantar, 1985)

One more case, not involving psychotherapy, warrants brief mention. In Mangeris v. Gordon (1978), the Supreme Court of Nevada affirmed the trial court's order dismissing plaintiff's complaint for failure to state a cause of action. A man had taken a taxicab to a massage parlor in Las Vegas, and the same driver later picked him up to take him to another location. At some time thereafter the passenger murdered the cab driver. Allegedly, the operators of the massage parlor had information that the passenger had committed violent criminal acts and was a fugitive wanted by the police. The alleged basis of liability was that the massage parlor operator had failed to warn the driver or the police that the passenger was dangerous to other persons. The Supreme Court recited the Tarasoff rule, and then stated the following:

Applying these principles to the present case, we are unable to conclude that respondents had a duty to warn Mangeris of potential harm. Indeed, even assuming a
special relationship existed, an issue which we need not and, therefore, do not here decide, a reasonable person would not, from the facts alleged, foresee a risk ... Absent the foreseeability of such a risk, respondents had no duty to warn Mangeris ... (Mangeris v. Gordon, 1978).

Beyond California—Lower Courts

Lower courts in several states have published opinions citing Tarasoff. What we are calling lower courts includes any court whose opinions are published in the standard national legal publications, other than courts of last resort. This includes intermediate appellate courts of the various states, federal district courts and courts of appeals, and a very few state trial courts whose opinions are published. It does not appear that Tarasoff has been mentioned by the U. S. Supreme Court, as of this writing. Of course, in the absence of a ruling on a particular point of law by the state's court of last resort, lower court opinions are generally the best available evidence of how the high court would rule.

The one case which provides the strongest support for the Tarasoff opinion is a New Jersey trial court opinion, McIntosh v. Milano (1979). It provides strong support in that it expresses approval of Tarasoff and follows it. Beyond that, it provides strong support in that it deals with the same legal questions as does Tarasoff, based on a
similar factual situation. We have looked at many cases where the real issue is negligent release. Some courts have appeared to assume that the legal issues are the same whether the factual context is negligent release or negligent failure to warn. As we have noted, these issues involve very different legal concepts. McIntosh is a pure failure to warn case. In some ways it goes beyond Tarasoff. In Tarasoff the therapist knew of the danger and took some action to deal with it. In the court's account of the evidence in McIntosh, there is no showing that Dr. Milano was aware of the likelihood of harm to the victim in time to prevent it. But the court's holding is that if he SHOULD have known, that is sufficient to fix liability. That, it will be recalled, is the very problem that Mr. Justice Mosk's special concurring opinion in Tarasoff II deals with. There is another point on which McIntosh seems to go further than Tarasoff. Tarasoff attempts to put some limits on liability, saying that hindsight alone is not enough to establish liability. The McIntosh opinion does somewhat the same thing, but the exact wording is noteworthy: "This is not to say that isolated or vague threats will of necessity give rise in all circumstances and cases to a duty." Some inferences can be drawn from this statement. Will threats that are neither vague nor isolated give rise, in the McIntosh court, to a duty to take preventative action, regardless of whether the threats are viewed as presenting a
real danger, regardless of how destructive to therapy such preventative action might be, and regardless of how convinced the therapist might be that continued therapy offered better protection for the alleged intended victim than any other measures at the therapist's command? In this respect McIntosh court seems to go a step beyond the Tarasoff court. The McIntosh opinion, like Tarasoff, leaves unanswered the final outcome of the case. It was the trial court's explanation of its ruling in denying the defendant psychiatrist's motion for summary judgment.

In another New Jersey case, Rozycki v. Peley (1984), an attempt was made to extend the McIntosh rule so as to impose liability on the wife of a man who had committed sexual and physical assault on infant boys. The wife was not accused of having any part in the assault, but merely of failure to warn of the man's proclivities. The court refused to impose such a duty on her, essentially on the ground that she was not a mental health professional. Another ground mentioned was the court's view of the public interest in marital harmony. In distinguishing between health care professionals and others, the court had a great deal to say about the duty owed by health professionals to the public at large, as well as to their patients. It was statements to this effect in the McIntosh opinion that enabled the Rozycki court to distinguish the McIntosh case. In Rozycki, a motion for summary was granted to the wife.
The trial court's opinion explained that ruling.

In Lipari v. Sears Roebuck & Co. (1980), a U. S. District Court undertook to determine how the Supreme Court of Nebraska would rule if confronted with the case before the federal court. The survivors of a victim of a random shooting sued Sears for selling the killer the gun, and Sears in turn sued the Veterans Administration for failing to detain the killer. The government's motion to dismiss was overruled by the District Court which issued this opinion. In referring to Tarasoff and McIntosh, the court said: "... this Court may be guided by these decisions since they provide a 'just and reasoned' analysis of the issues raised in the instant case." However, after using Tarasoff as the basis for holding the government liable, the court expressly rejected Tarasoff on the issue of requiring that the prospective victim be identifiable. The court acknowledged that the government's therapists were totally unaware of the existence of the victim, but nevertheless held that the danger to a class of persons to which the victim belonged was foreseeable, and therefore a basis for liability. But the opinion does not disclose any facts upon which a genuine classification of persons can be drawn, so the effect of the opinion is to extend the duty to all members of the general public. So the Tarasoff limitation to identifiable victims, later made explicit in Thompson v. County of Alameda (1980), is totally emasculated in the
In *Davis v. Lhim* (1983), the Michigan Court of Appeals upheld a judgment granted in trial court on a jury verdict. In so doing, it embraced *Tarasoff*, and rejected *Lipari*. Two grounds for recovery were asserted: one that the defendant psychiatrist negligently authorized the killer's discharge, and the other, that he failed to warn the victim, the killer's mother, of the danger to her. Both were upheld. The court rejected the *Lipari* rule of duty extending to the entire general public, and professed to adhere to the *California* rule of duty to warn extending only to readily identifiable victims. However, this may be the classic case for showing how little it takes to make a victim identifiable in advance. An entry on the patient's chart indicated that on one occasion he was acting strange, and "keeps threatening his mother for money." The plaintiff's expert witness testified: "... to get drugs and/or alcohol, you need money, and this individual would have to get that money from somebody. His mother was one possible source." The court held this evidence to be sufficient to support a jury finding that defendant should have known, pursuant to applicable medical standards, that the patient posed a serious threat to his mother. The defendant therapist is therefore liable for not having so warned his mother. Perhaps more than most cases we have examined, this case underscores the basic premise of this dissertation.
One expert witness can give his own perception of professional standards and express the opinion that the therapist on trial has fallen short of those standards. The jury can then accept his testimony and reject the testimony of another therapist, who says in effect that the defendant acted properly according to standards. Once that jury verdict is in, it does not seem to matter what the professional consensus might be as to what the standards really are.

In *Chrite v. United States* (1983), citing *Davis* on similar facts, the U. S. District Court held that "... it appears that the Michigan Supreme Court would hold that defendant could be liable for failing to warn Chrite of Smith's dangerous propensities when he was released from custody." The victim was the defendant's mother-in-law. The government's motion for summary judgment was denied.

In *Duvall v. Goldin* (1984), the Michigan Court of Appeals reversed a summary judgment granted by the trial court to the defendant psychiatrist. The plaintiff was injured by the doctor's patient in an auto collision. In that case the alleged professional misconduct was in failing to warn the patient—not the victim, but the patient—that the drugs he was taking made it dangerous for him to drive. Moreover, the court held that the readily identifiable victim limitation set out in the *Davis* case, discussed above, and in *Tarasoff*, did not apply to the case before the
court. The court made this distinction on the ground that cases of the patient's propensities to assaultive violence are on a different legal footing from other cases. A dissenting judge objected to extending the law of the state to impose a duty on a physician in favor of unidentified third persons. The dissenter said: "The courts must refrain from further imposing upon the medical profession duties and obligations that interfere with the reasonable practice of medicine."

In *Estate of Mathis v. Ireland* (1981), the Indiana Court of Appeals reversed a trial court order dismissing the case as to all defendants except the killer. The appellate court's holding was that a trial must be held on the claims of the victim's survivors against the killer's mother, his grandparents and the psychiatric centers involved with his treatment. The order dismissing the claim against the killer's father was upheld, because it was not alleged that the killer, an adult, was living with his father at any time relevant to the case. Apparently the appellate court found it to be a rather disagreeable duty to require a trial on the claims against the mother, the grandparents and the therapists. "He is grasping at the finest of threads to produce an acceptable legal ground for liability, and it is only under the most unusual set of circumstances that any of his arguments may prove successful." The court held that the issue to be tried was whether anyone had taken charge of
the defendant, had actual knowledge that he was extremely dangerous, and failed to exercise reasonable care under the circumstances. Tarasoff was one of the cases cited. A dissenting judge pointed that the therapists not only had no duty to confine the killer, they had no right to. As to any duty to make recommendations, the dissenter argued that any such duty would not extend to the general public.

In Schrempf v. State (1985), the New York Supreme Court, Appellate Division (an intermediate appellate court) affirmed a trial court judgment which found a New York state institution negligent in care and treatment of the killer and thus liable to the victim's survivors. There was no opinion filed for the majority, but a dissenting opinion was filed. The dissenter agreed that the state could be liable for negligent care of an inmate, or negligent release, but not in the case of an outpatient, over whom the clinic has no more control than a private therapist would have. This case gives us some clue that Tarasoff might be accepted by the courts of New York. The dissenter cites Tarasoff and complains that the case before the court does not meet the Tarasoff criterion of duty running to readily identifiable potential victims. The victim, says the dissenter, did not meet that criterion.

Case v. United States (1981) is an opinion by a U. S. District Court in Ohio in support of its judgment after trial denying victim's survivors recovery against the
Veterans Administration for wrongful death. The court comes very close to holding that *Tarasoff* and *Lipari* do not express Ohio law. "While instructive, the citations of authority to *Tarasoff* . . . and *Lipari* . . . are not controlling." Then, in a footnote, "*Tarasoff* stands almost alone in its holding." However, the Ohio rule on negligent release recited by the court sounds not too different from *Tarasoff*. For negligent release to be actionable, it must be showed that the hospital "knew or should have known that the patient, upon his release, would be very likely to cause harm to himself or others. Such likelihood must be more than a mere possibility and not based on hindsight." The court concluded that there was no liability upon the United States for actions of a voluntary out-patient 14 months after his last date of treatment "where community standards have been followed."

In *Leedy v. Hartnett* (1981), a U. S. District Court in Pennsylvania granted summary judgment in favor of the defendant Veterans Administration hospital and published an opinion in support of this ruling. The attacker was a voluntary patient at the hospital. Failure to warn the victim of the patient's violent propensities was the only basis of claim. The court expressed its approval of the *Tarasoff* and *McIntosh* rule for appropriate cases. "When, as in *Tarasoff* and *McIntosh*, a particular victim can be identified, there is good reason to impose upon
psychiatrists or custodians a duty to warn . . . " The central issue of this case was whether the victims were identifiable. The court held they were not. The plaintiff's argument was that hospital personnel knew that the patient was a heavy drinker and dangerous when drinking to whomever happened to be around and knew that the plaintiff had a close personal relationship with the patient and was therefore likely to spend a good deal of time in his presence when he was discharged. The court concluded, however, that this is not the type of readily identifiable victim required by Tarasoff. It reached this conclusion as a matter of law, even though an expert witness for the plaintiff testified that hospital personnel should have warned the plaintiff.

In Hasenei v. United States (1982), a U. S. District Court in Maryland applied Pennsylvania law, citing Leedy with approval, and entered judgment for the Veterans Administration after trial. This was an auto collision case, the victim alleging various omissions by the therapist caused the patient-driver to inflict the injury. It is not clear why the case was tried before a federal court in Maryland, since the collision, and the alleged faulty treatment, both occurred in Pennsylvania. The driver was an out-patient at the VA clinic. Among other things, the plaintiff argued that the therapist was obligated to report to the state's department of motor vehicles that the patient
could not safely operate a motor vehicle, under a Pennsylvania statute. The court held that, under applicable federal confidentiality statutes binding on the VA clinic, the therapist could not lawfully have made such a report. The most interesting aspect of this case is certain comments made by the court, about certain judicial decisions, which apparently would include the Tarasoff case. The Tarasoff case, and many cases that cite it, point to Restatement of the Law of Torts, Sec. 315. Restatement is a widely respected, widely quoted set of model legal provisions, but it has no official governmental status as authoritative rules of law. However, various courts quote it and follow it on occasion. Tarasoff relied heavily on Sec. 315 as a basis for holding the therapists liable for the injury committed by their patient. The Hasenei court's comments on this subject are very thought-provoking:

None of the cases known to this Court which have recognized that the psychiatrist-patient relationship may impose affirmative duties upon the psychiatrist for the benefit of third persons appear to have indicated what it is about that relationship as such that brings it within the rule of Restatement Sec. 315. Restatement Sec 315 is 'a special application of the general rule stated in Sec. 314' that there is no duty to act for the protection of others. Restatement Sec. 315 Comment a. Section 315 thus first states the
general rule that an actor has 'no duty so to control the conduct of a third person as to prevent him from causing physical harm to another.' There is, however, an exception to this general rule whenever 'a special relationship exists between the actor and the third person which imposes a duty upon the actor to control the third person's conduct.' Implicit in that exception, however, is the proposition that such a special relationship must include the right or the ability to control another's conduct. Restatement Sec. 315 Comment c. In all of those relationships, the actor has either the right or the ability to control the third person's conduct. Thus, in the absence of a relationship involving such control, the exception to the general rule, that there is no duty to control the conduct of a third person for the protection of others, should not be applicable (Hasenei v. United States, 1982).

This rather technical legal analysis may not be easy to follow, but it appears to be the strongest and best statement set out in a published judicial opinion concerning the defect in judicial craftsmanship tucked away in the Tarasoff majority opinion. The simplest way to put it is that Justice Tobriner pulled something out of Restatement Sec. 315 that really is not there. But the Hasenei opinion does not go so far as to expressly reject the Tarasoff
opinion.

A U. S. District Court in Colorado had occasion to examine these issues in a case that drew national attention, Brady v. Hopper (1983). A young man named John Hinckley, Jr., attempted to assassinate President Reagan and, in the process injured the President and three other persons. Three of the injured persons (not including President Reagan) filed suit against Dr. Hopper. Dr. Hopper, a psychiatrist, had treated Hinckley for about four months preceding the month of the assassination attempt. There was no claim that Dr. Hopper knew that Hinckley was likely to attack the President or the plaintiffs. It was alleged, however, that if Dr. Hopper had asked the right questions he would have been able to put the pieces together and become aware of the danger to the President and his associates. The district court granted a motion for summary judgment, holding that, even if it were to be found that the therapy provided to Hinckley fell below applicable professional standards, the element of foreseeability could not be established. The defense argument contained the same comments about Restatement Sec. 315 as was contained in the court's opinion in Hasenei v. United States, discussed above, and the defense cited Hasenei in support of its argument. The district court in Hopper noted this argument, but did not rule on it one way or the other. The court also acknowledged the defense argument that, under Colorado law,
the confidentiality duty would have prevented a warning in any case. Again, the court did not rule on this argument. The court states that the "... requirement of foreseeability ... has led numerous courts to conclude that a therapist or others cannot be held liable for injuries inflicted upon third persons absent specific threats to a readily identifiable victim." The court goes on to say, however, that "... once the patient verbalizes his intentions and directs his threats to identifiable victims, then the possibility of harm to third persons becomes foreseeable, and the therapist has a duty to protect those third persons from the threatened harm."

The plaintiffs appealed the district court's order of dismissal, so we now have another opinion designated Brady v. Hopper, this one issued by the U. S. Court of Appeals for the Tenth Circuit, dated 1984. This opinion affirms the judgment of the District Court. Recognizing that points of law involved should be governed by Colorado law, the circuit court certified questions of law to the Supreme Court of Colorado. We saw a similar procedure used in the Kansas cases of Durflinger v. Artiles, discussed above. However, in the Hopper case the Supreme Court of Colorado declined to answer the certified questions, giving no reason for its action. After noting this non-action, the circuit court's opinion was largely an expression of approval of the district court's opinion. It quoted the following from the
district court: "In my opinion, the 'specific threats to specific victims' rule states a workable, reasonable, and fair boundary upon the sphere of a therapist's liability to third persons for the acts of their patients." And the circuit court goes on to quote further from the district court: "... the legal obstacle to the maintenance of this suit is that there is no relationship between Dr. Hopper and plaintiffs which creates any legal obligation from Dr. Hopper to these plaintiffs." This last sentence seems to bring back the argument about Restatement Sec. 315, which, read the way this circuit court seems to read it, would have relieved the Tarasoff therapists from any liability. So the Brady case leaves us in something of a quandary. If it is read once, it seems to support the Tarasoff rule of therapist liability, with the Thompson v. County of Alameda limitation to specific, readily identifiable victims. If it is read again, it seems to support the view that Tarasoff was an indefensible misapplication of Restatement Sec. 315. The argument can be made that the Tenth Circuit has not yet decided what to do with Tarasoff, except to send Dr. Hopper happily on his way.

We will end this phase of our discussion by noting cases from the one jurisdiction which has in some measure rejected Tarasoff, namely, the State of Maryland. In Shaw v. Glickman (1980), a husband, finding his wife in bed with her lover, shot the lover several times. In a refreshing
bit of judicial wit, the opinion notes that he was either a poor shot or an excellent one, because the wounds did not prove fatal. The lover sued the psychotherapist who was treating the whole group of them, alleging that the therapist should have known of the danger and warned him, citing Tarasoff. The Court of Special Appeals expressly declined to accept or reject the Tarasoff rationale as a valid expression of common law principles, but held that the therapist was barred by the non-disclosure statute from warning the intended victim even if he, the therapist, had known of the assailant's intention. This case will be further mentioned in our discussion of Texas law, because of similarity of the non-disclosure statutes.

In a later case by the same court, parents of a murder victim filed suit alleging negligence of therapists at a state hospital. The murderer was a patient at the hospital on the basis of a voluntary admission and left the hospital on his own. The therapists were allegedly negligent in not arranging his detention at a maximum security hospital. The Court of Special Appeals affirmed the trial court action in granting summary judgments. Shaw v. Glickman was mentioned, but nothing was said about the confidentiality statute which was so central to Shaw v. Glickman. This opinion examines the question of legal duty to come to the aid of an endangered person. The opinion opens with this paragraph:

According to the Book of Genesis, God did not answer
Cain's evasive question: "Am I my brother's keeper?" From that day to this man has individually sought to assume a moral responsibility to effect that purpose, but has consistently shied away from legally imposing such a responsibility (Furr v. Spring Grove State Hospital, 1983).

There is nothing in this case to suggest that the victim was a foreseeable target victim, so the question was whether the therapists owed a duty that extended to the general public, and the court held that they did not. The court expressed its approval of the specific identifiable victim limitation suggested in Tarasoff and, as this court says, "more carefully identified" in Thompson v. County of Alameda. The court then adds its comments about Restatement of Torts, 2nd Sec. 315, and perhaps deepens the confusion about what that section really says: "It is apparent that Tarasoff and Thompson are both saying what the Restatement section . . . is saying, i.e., for a doctor's Tarasoff duty to be imposed creating a special relationship to a victim, the victim must be readily identifiable." That is part of what it says. But does it not also say, when properly understood, as noted in the opinion in Hasenei v. U. S., that there must be some actual ability to control the behavior of the assailant? This latter element, of course, is NOT what Tarasoff is saying, because Tarasoff imposes liability on therapists who have no control over their
patient's behavior. The court notes in the *Furr* opinion that neither therapist had any right to restrain the assailant. The court's closing words for this opinion sound an appropriate note for closing this portion of our discussion:

That society has not yet acquired the clairvoyance to determine and restrain those bent upon preying on such youths as Kenneth Dawson is a phenomenon we can only hope to overcome. But when such violence is perpetrated it is not always the fault of those charged with seeking out such sinners. As pointed out by Prosser, frequently under our law it is the good Samaritan who tries to help somewhat and finds himself mulcted in damages, while the pervert and the deviate who pass on the side go on their cheerful way rejoicing. As we impose upon samaritans (and those who walk in their shadow) more obligations in the nature of Tarasoff's, we must avoid driving them to the other side of the road (*Furr v. Spring Grove State Hospital*, 1983).

**The Texas Law**

No published judicial opinion by a Texas court directly addresses the issue of confidentiality versus victim protection. It will serve our purpose to consider how a Texas court might deal with this issue if similar facts were to occur in Texas and a similar lawsuit be brought before
the Texas courts.

Much will be said here about the Texas statute on confidentiality of mental health information, Article 5561h, V.T.C.S. Let us begin with some relevant excerpts:

Sec. 2.(a) Communication between a patient/client and professional is confidential and shall not be disclosed except as provided in Section 4 of this Act.

Sec. 2.(c) Any person who receives information from confidential communications . . . shall not disclose the information except to the extent that disclosure is consistent with the authorized purposes for which the information was first obtained.

Sec. 4.(b) Exceptions to the privilege of confidentiality, in other than court proceedings, allowing disclosure of confidential information by a professional, exist only to the following:

Sec. 4.(b)(2) to medical or law enforcement personnel where the professional determines that there is a probability of imminent physical injury by the patient/client to himself or to others . . .

Sec. 5. . . . A person aggrieved by a violation of this Act . . . may prove a cause of action for civil damages (Vernon, 1970)
Some of the provisions not directly quoted here create other exceptions to the rule of non-disclosure. Consent of the patient is an example. Several exceptions relate to court proceedings. Under these, and under the Texas Rules of Civil Procedure, a trial judge has considerable authority to order a witness to make disclosure of confidential communications while giving testimony in a lawsuit that could not lawfully be made out of court.

Even though this statute purports to list all the exceptions to the rule of non-disclosure of confidential information, the child abuse reporting statute doubtless creates still other exceptions. We will omit that set of problems from our consideration in this paper and confine our concern to cases in which the intended victim is an adult.

Now let us turn to our hypothetical Texas version of the Tarasoff situation. Can Dr. Moore, under Texas law, call the police? We must look again to Sec. 4.(b)(2) above. Only one word, the word "imminent," gives us a problem. Even though Dr. Moore may have determined that there is a probability of physical injury by Poddar to Tatiana, how imminent is it? She is in Brazil, fairly safe until she returns home. Since Dr. Moore is said to have heard the threat on August 20, and Tatiana was spending the summer in Brazil, the probability of injury might have seemed fairly imminent to Dr. Moore.
So, under Sec. 4.(b)(2), it would seem that Dr. Moore would have a legal right to call the police. But what can the police do with this information? Under Sec. 2.(c) they cannot lawfully pass this information along to someone else "except to the extent that disclosure is consistent with the authorized purposes for which the information was first obtained." And what was the purpose for which Dr. Moore obtained this disturbing information from Poddar? Therapy. Therapy for whom? For Poddar. Would a police warning to Tatiana be consistent with such a purpose? Certainly it can be argued that the therapist who prevents a patient from committing murder is thereby providing therapy to the patient. But the uncertain language of the statute does bring about problems of application. Nothing in this statute or in other Texas statutes tell us expressly what the authorized purposes are. But apparently the legislature intended that somebody do something about this probability of imminent physical injury. Otherwise, why expressly authorize the professional to give enforcement personnel information that is otherwise protected? Under Sec. 26 of the Texas Mental Health Code (1985) the police would be authorized to arrest Poddar and present him immediately to a mental health facility for an examination by a physician. But how does that square with the confidentiality statute? Is this consistent with an authorized purpose for which the information was first obtained? Arguably, yes. Dr. Moore
obtained this information in the process of providing therapy to Poddar. If Dr. Moore has now decided that the therapy the patient needs involves commitment and hospitalization, then his arrest and presentation to a mental health facility would indeed be consistent with the original purpose, to-wit: therapy. That does not quite solve the puzzle about the statute's use of the word "authorized" in referring to purposes for which the information was originally obtained. That may remain a puzzle until an appellate court agrees or disagrees with what we have just said, or until the legislature decides to clarify this statutory language. But we do find a statutory pattern, authorizing the therapist, in certain restricted situations, to give privileged information to medical or law enforcement personnel, and authorizing such personnel to do something about it. Other provisions of the Mental Health Code authorize the examining mental health facility to hold the patient for what would normally be sufficient time to obtain a magistrate's warrant (Secs. 27 & 28). All this could lead, under the Mental Health Code, to court-ordered confinement for involuntary mental health treatment. This assumes, of course, that the evidence presented to the court meets the statutory requirements. Those requirements are quite detailed.

All this leads to the conclusion that, apart from commitment proceedings as described above, and apart from
exceptions expressly set out in the confidentiality statute, there are no provisions of any Texas statute that would authorize an out-of-court disclosure of privileged confidential information that some adult's personal safety has been threatened.

**Tarasoff** has been discussed in two separate law review articles published in Texas. Law reviews are unique publications. The academic faculty of a law school where a law review is published "pins its reputation before the public upon the work of undergraduate students" (Llewellyn, 1951). Both the law review articles quoted here were written by law students, but a good deal of faculty supervision and approval may be assumed.

One such commentator expressed uncertainty about the outcome should the **Tarasoff** situation arise in Texas, in this language:

A possible impediment, however, to the adoption of **Tarasoff** liability in Texas is found in the new confidentiality provisions of the **Mental Health Code**. Mental health professionals are under a duty not to disclose any communication with a client unless it falls under a special exception. In one exception to the privilege of confidentiality, a professional who determined there is a probability of imminent physical injury by his patient to others is only allowed to disclose this information "to medical or law
enforcement personnel." It is not clear if a literal reading of the statute would preclude informing potential victims of a dangerous patient. There are both advantages and disadvantages to imposing civil liability for failure to warn potential victims of dangerous patients. Whether Texas will choose to adopt Tarasoff liability is unclear at this time (Hammond, 1980).

The other law student commentator was less uncertain, and had this to say about the prospect of Tarasoff liability in Texas:

In Texas, however, the Act makes such disclosure to third persons subject to the patient's/client's right to civil damages. By authorizing disclosure of this type of information to medical and law enforcement personnel, but not potential third-party victims, the Act appears to circumscribe the psychotherapists's duty to warn. Indeed, the Act implies that medical and law enforcement personnel, and not psychotherapists, should be responsible for warning third persons. Therefore, a Tarasoff situation in Texas courts should be decided differently (Green, 1980).

It is perhaps worth mentioning that the Texas confidentiality statute was enacted in 1979, a few years after Tarasoff. Since Tarasoff aroused considerable published comment nationwide, it could be argued that this
statute was the Texas Legislature's answer to Tarasoff.

In the Tarasoff decision, the Supreme Court of California held that the California counterpart of the Texas confidentiality statute does not apply to all therapists, but only to a restricted class of therapists, in restricted situations. As noted, this was the subject of a great debate between the majority and the dissenting justices. The majority ruled that it did not apply to the therapists in the Tarasoff case.

But as to the Texas confidentiality statute, there does not seem to be much room for such debate. The definition of "professional" is quite broad enough to include all licensed medical doctors and licensed psychologists providing psychotherapy, and other mental health professionals providing psychotherapy. It even includes persons reasonably believed by the patient to be such [Sec. 1.(a)]. And a "patient/client" is defined as any person who consults or is interviewed by such a professional for mental health care [Sec. 1.(b)]. So there seems to be little doubt that this statute would apply to the behavior of the therapists if such a case were before the Texas courts.

The Maryland case of Shaw v. Glickman (1980), mentioned previously, throws some light on how Tarasoff might fare in a Texas court, because it involves a state confidentiality statute somewhat similar to our Texas 5561h, as far as the dangerous patient problem is concerned. Of all the cases we
have examined from other jurisdictions, this case seems to be most closely in point should the Tarasoff situation come before a Texas court.

Only one Texas case has mentioned Tarasoff in the nine years since the Tarasoff II opinion was issued, and that case neither approves nor disapproves Tarasoff, but holds it is not applicable to the case being decided (Gooden v. Tips, 1983). In that case the Court of Appeals of Texas at Tyler overruled a summary judgment granted by the trial court in favor of a psychiatrist. The psychiatrist had allegedly prescribed a drug for his patient that had an intoxicating effect, without warning the patient not to drive a car while taking such drug. Allegedly the plaintiff was injured in an auto collision caused by the patient under the influence of the drug. The appeals court found no prior Texas decisions that addressed the legal issue before the court, and, based on several decisions from other jurisdictions, concluded that the physician had a duty to warn his patient of the effect of the drug, and that the plaintiff had a right to recover if this duty were breached. The court expressly declined to hold that the physician had a duty to prevent his patient from driving. The duty goes no further than a duty to warn. And it should be noted that this duty to warn is a duty to warn the patient, not a duty to warn possible victims. The court said: "... we do not hold that a duty arose on the part of Dr. Tips to control the conduct of
his patient, as was imposed in cases such as Tarasoff . . . McIntosh . . . Lipari . . . and Bradley . . . "

Each of these cited cases has been discussed in this paper. A careful reading of Tarasoff and McIntosh does not support the Gooden court's conclusion that these decisions were based on a finding that the therapist exercised control of the patient's behavior. There is no such finding in Tarasoff or McIntosh. What the courts imposed in those cases was not a duty to control the conduct of the patient, but a duty to take appropriate action to protect the potential victim, such as warning the potential victim of the danger. The Gooden court declined to apply what it thought (mistakenly) was the Tarasoff rule, because "there is no allegation that Dr. Tips had 'taken charge' of Mrs. Goodpasture, nor . . . that she was a person of violent or dangerous propensities." Perhaps the most relevant thing we can say about this case is that it throws little, if any, light on whether a Texas court would follow Tarasoff if confronted with an actual Tarasoff situation. The warning that the Gooden court had in mind did not involve any breach of confidentiality.

So we may hazard a guess (the word "hazard" is especially appropriate here) that a Texas court would, more likely than not, hold that the therapists could not have warned Tatiana of the danger she was in without violating Poddar's legal rights under the Texas confidentiality
statute. Accordingly, the therapists would not be liable for failure to give such a warning.

A possible argument for holding the therapists liable under Texas law in the Tarasoff situation would be that, since confidentiality had already been breached when Poddar was arrested and released, it was of no help to anyone to keep the information secret after that. Accordingly, our hypothetical therapists should have done the decent human thing and somehow let Tatiana know the danger she was in. But for that argument to prevail, the Texas court would have to impose an affirmative duty upon the therapist to violate the plain requirements of the confidentiality statute. This does not seem likely.

But this state of affairs does impose a peculiar burden on the therapist in Texas in one possible situation. After confidentiality has been lawfully and properly breached and no longer serves any useful purpose, should there not be some lawful means by which persons of good will can take some protective action to prevent an innocent person from being killed or injured? To all appearances, there is no such under the present law of Texas. To do so would appear to require a violation of the present Texas confidentiality statute.

To summarize what appears to be the Texas solution: If you have determined that there is a probability of imminent physical injury by the patient to some person, and you
believe that there is a fair prospect that the Mental Illness Court will find the patient to be mentally ill and order involuntary treatment for mental illness, then call medical or law enforcement personnel and set in motion a commitment proceeding. If you have not determined such a probability, in the absence of one of the exceptions spelled out in the confidentiality statute, keep your patient's secrets in confidence, continue therapy and hope that it will make your patient less dangerous.

The Texas solution appears to be burdensome in the abortive commitment situation. If the patient is arrested but then released without involuntary treatment being ordered, the therapist can be left with the situation described above, forbidden by the letter of the law from warning an intended victim, even though confidentiality is already breached and no longer serves any useful purpose.

Ethical Guidelines

Up to now we have been describing legal guidelines that, to some extent, define appropriate behavior for the therapist confronted with the conflicting demands of confidentiality and victim protection. We now turn to the published ethical guidelines for psychologists in Texas.

The Ethical Principles of Psychologists issued by the American Psychological Association have, in some measure, the force of law in Texas. We can say this because the Texas State Board of Examiners of Psychologists is a
a governmental agency created by legislative enactment (Article 4512(c) V.C.T.S.). It has the right to revoke, cancel or suspend the license or certification of any psychologist in Texas (id., Sec. 23), if the psychologist has been guilty of unprofessional conduct, as defined by the rules established by the Board (Sec. 23 (a) (4)). Among the powers and duties of the Board is to adopt and publish a Code of Ethics (Sec. 8 (a)). One of the rules established by the Board provides that a violation of the code of ethics is unprofessional conduct and is a violation of the Board rules (General Rulings, 461.3). Accordingly, a violation of the code of ethics could be the basis for revocation of a psychologist's license by action of the Board. The annual publication of the Board which includes the roster of Texas health service providers, licensed psychologists, certified psychologists and psychological associates also includes the American Psychological Association Ethical Principles of Psychologists (Texas State Board of Examiners of Psychologists, 1985). Thus it is apparent that the Ethical Principles of Psychologists is the code of ethics contemplated by the Texas statute.

Some of the terms of Ethical Principles of Psychologists appear to be applicable to the therapist's dilemma we have been examining: Psychologists should "... strive for the preservation and protection of fundamental human rights" (Preamble). They should use their
professional knowledge "... for the promotion of human welfare" (Preamble). They should be guided by "... concern for the best interests of clients ... and society" (Preamble). "As practitioners, psychologists know that they bear a heavy social responsibility because their recommendations and professional actions may alter the lives of others" (Principle 1, Responsibility). And, perhaps most importantly, this excerpt:

Psychologist have a primary obligation to respect the confidentiality of information obtained from persons in the course of their work as psychologists. They reveal such information to others only with the consent of the person or the person's legal representative, except in those unusual circumstances in which not to do so would result in a clear danger to the person OR TO OTHERS (Principle 5, Confidentiality). (Emphasis added.)

These provisions, and especially the last sentence quoted, can be read so as to impose an ethical duty on the psychologist confronted with the Tarasoff situation to warn the potential victim, even without client consent, and even though to do so would breach confidentiality, destroy the therapeutic alliance, and terminate therapy. But as we continue reading the rules issued by the Texas State Board of Examiners of Psychologists, we may be forced to a different conclusion. "In the event of conflict among state or federal principles of psychologists and Board rules,
state or federal statute(s) control (General Rulings 461.14). And further:

A psychologist may not intentionally reveal information about a patient or client without written authorization by the patient, client or guardian, or without a proper court order, or unless a state or federal statute requires it. A PSYCHOLOGIST IS BOUND BY THE PROVISIONS OF 5561h (V.T.C.S.) UNLESS SOME OTHER STATE OR FEDERAL LAW REQUIRES THE PSYCHOLOGISTS TO REVEAL INFORMATION" (Rules of Practice, 465.2). (Emphasis added.)

Thus the Board has decreed that statutes must prevail over other provisions, ethical or legal. And further, the Board has recognized one particular statute, 5561h, the Texas confidentiality of mental health information statute which we examined at length in a previous portion of this paper, as binding on psychologists in Texas. From this it seems likely that the Board's position would be that the psychologist confronted with the Tarasoff situation must strictly observe the limitations imposed by 5561h. He or she may disclose the threat to medical or law enforcement personnel, but not to anyone else. This, of course, would be in direct contradiction to the position of the Supreme Court of California, in Tarasoff II.

Models for Research Design

In arriving at a research design for our attitude
survey, we searched for guidance in published studies. We found that two studies have probed the attitudes of therapists toward the Tarasoff ruling. One of the studies was accomplished about a year after Tarasoff II (Wise, 1978). The other was much more recent, completed in 1984 (Givelber, Bowers, and Blitch, 1984). At this point in our inquiry, we are more interested in methods than we are in the content of the findings, but we will report briefly on the published findings. The first of these was published in a note in the Stanford Law Review. The survey population was restricted to the state of California. There is a certain logic to this, since the ruling was by a California court, and there was then, and is yet, great uncertainty as to the extent to which other states will follow the California court. A sampling of psychologists and the entire membership of the California Psychiatric Association were surveyed. The reason for this distinction may possibly be found in the fact that the Psychiatric Association distributed the questionnaires to its membership.

Approximately the same percentage of the two groups responded, 34% of the psychologists and 35% of the psychiatrists. Over 80% of the respondents reported seeing at least one patient a year regarded as potentially dangerous. It may be that for the most part the ones who saw dangerous patients are the ones who had enough interest in these issues to respond.
Although our survey and the Stanford survey were both concerned with issues raised by the Tarasoff decision, the nature of the information sought was very different. While our basic concern here was whether a consensus exists among Texas psychologists as to how they should deal with a situation similar to, but not precisely identical with, the Tarasoff situation, the Stanford study was directed to such matters as how the Tarasoff decision itself has influenced the behavior of therapists in California, and whether expectations of supporters and critics of the decision have come to pass. The researchers were very circumspect in their report, and make no brash claims for having resolved any important issues with any great degree of confidence. Perhaps the most remarkable conclusion they offer is that a substantial number of therapists had warned potential victims prior to the Tarasoff decision. It is not clear how many of these were breaches of confidentiality; a warning made with the knowledge and consent of the patient does not violate confidentiality. The conclusion was offered that Tarasoff "has had potentially detrimental effects on psychotherapy." The data were interpreted as showing increased anxiety on the part of therapists from the problem of potential liability for acts of dangerous patients, and a great deal of increased activity to escape such liability, activity that might dilute efforts to provide effective therapy to the patient. For example, more time was spent
talking to patients about confidentiality. One of the most interesting facts developed is that one-fourth of the therapists who responded believe that they have had patients withdraw from therapy out of fear that confidentiality might be breached. It would have been most interesting to learn whether this phenomenon tended to increase after Tarasoff, but so far as the report discloses, this distinction was not made. This report is recommended reading, not because it settles anything, but because it touches upon a number of factors that anyone concerned about these issues should consider.

The more recent study (Givelber et al., 1984) was published in the Wisconsin Law Review. Like the Stanford study, this study was concerned with the question of how, and to what extent, the Tarasoff decision had influenced the behavior of therapists. The report of the Wisconsin study contains many quotes from and references to the Stanford study. The Wisconsin questionnaire was sent to psychiatrists, psychologists and social workers in eight metropolitan areas across the nation. Somehow, no Texas area was included. The response was even stronger than the Stanford study. Sixty-two percent of the psychologists responded. The questionnaires were mailed in 1980, some three years or so after the Stanford questionnaires were distributed. The increased response suggests to this observer that interest in these issues is increasing.
Apparently our questionnaire was the first that any substantial number of Texas psychologists have received on these issues or closely related issues. The Wisconsin researchers were concerned with drafting their questions in a way that therapists would likely respond. They proceeded on the assumption that "therapists are most comfortable providing rich, detailed information with respect to a single case and least comfortable trying to describe their behavior over a series of cases." Perhaps this tactic contributed to the strong response. For our own questionnaire we did not, as the Wisconsin researchers did, ask the therapists to key on a recent case of their own. We did, however, place major emphasis on a single case—our hypothetical case vignette.

The researchers concluded that Tarasoff had substantially modified the behavior of therapists, and that their data tended to weaken the arguments of the critics of the Tarasoff decision. They stopped short of open approval of the decision. "We are not suggesting that the data we present here resolve the question of whether Tarasoff was a good decision or, even, that the data and the conclusions we draw from our study are unassailable." They concluded that the majority of therapists nationwide believe they are governed by the Tarasoff rule. They also concluded that Tarasoff did not discourage therapists from treating dangerous patients. They further concluded that, whether or
not therapists are able to predict violence, they tend to believe that they can. They also found that Tarasoff has not brought about an increase in involuntary hospitalization. They found an increase in the frequency of therapists warning potential victims. The abstract of the report concludes with this assertion: "With certain reservations, most therapists reported their belief that the Tarasoff duty is consistent with their professional and ethical obligations." A close examination of the report, however, shows that this statement may not be entirely consistent with the data. This calls for some detailed discussion:

The question asked of the therapists was the following: "Does the principle of responsibility on the part of a therapist for the physical well-being of another person threatened by his patient/client apply to you?" The question called for an answer of yes, no or unsure, and a selection of one of several possible reasons for the answer. A therapist who believes that a goal of therapy should be to make the patient less dangerous and less likely to hurt someone would readily answer yes to this question, even though that same therapist might, in a given situation, be reluctant to breach confidentiality, warn a threatened person, and thereby threaten the therapeutic alliance, when there is doubt whether the threat will actually be carried out. This fairly obvious point seems to have escaped these
researchers altogether. They professed to have difficulty understanding why therapists who, in the main, answer yes to the foregoing question feel, as many of them feel, that in giving the Tarasoff warning they had to compromise clinical judgment. These researchers seem to assume that "clinical judgment" is somehow antagonistic to concern for public safety. But it is difficult for this observer to imagine that very many therapists are, or ever have been, indifferent to whether their patients kill people or hurt people. One of the troublesome questions that arises from the Tarasoff decision is whether such a rule of law as this was really needed to whiplash therapists into adopting a sense of concern for public safety.

There is another difficulty in assessing the real value of the Wisconsin study. Throughout the report much is made of the point that most therapists misunderstand the Tarasoff rule, believing that it imposes a duty to warn when in truth (as truth is perceived by the researchers), it imposes a duty of reasonable care. The title of the report, "Taraoff, Myth and Reality" reflects this interest. Presumably, the "myth," as perceived by the researchers, is that a duty to warn is imposed, and the "reality" is that a duty of reasonable care is imposed. Tarasoff I speaks in terms of duty to warn, and Tarasoff II speaks in terms of duty of reasonable care. In analyzing the data, the researchers take pains to separate the majority of the
therapists, those who "mistakenly" believe that the rule imposes a duty to warn from the therapists who "correctly" believe that it imposes a duty of reasonable care. The problem with all this is that, in the view of this observer, the "mistaken" therapists are closer to grasping the practical truth of the matter than the researchers are. If different words meant different, discrete realities, then the researchers would be on solid ground. The difficulty is that "duty to warn" and "duty of reasonable care" are not mutually exclusive terms. Reasonable care is a broader term and certainly includes duty to warn. As recognized by the Wisconsin researchers, in the Tarasoff case itself the only possible breach of reasonable care was failure to warn. This factual context is part of the rule of law, as in every judicial opinion. When one reads the Jablonsky opinion, discussed above (as the Wisconsin researchers did) the "real meaning" of Tarasoff, carried to its logical destination, emerges. If there is anything at all that the therapist could have done but didn't do, or did but could have done differently, that might possibly have saved the victim's life, then let the jury find the therapist liable if it wants to. (The words "real meaning" are in quotes because this observer must take responsibility for this paraphrase of the Tarasoff-Jablonsky rule.) So when will there not be a duty warn? When warning the threatened victim is not includable in the concept of reasonable care. When will
that be? When there is nothing to warn of, and nobody to warn. But such cases appear to be beyond the scope of the 
Tarasoff rule. Of course there can be cases where, under the 
Tarasoff rule, there is no duty to warn because the 
therapist according to "professional standards" was 
justified in believing that the threat did not represent a 
danger. But in such a case, no duty to warn is the 
equivalent of no duty of reasonable care. Either way, it is 
a question of fact, not of law, and the jury will decide 
about that. Accordingly, prudent therapists who do not 
relish spending a lot of time defending lawsuits will 
resolve doubts in favor of warning the threatened victim. 
Other commentators (e.g. Denkowsky and Denkowsky, 1982) have 
helped spread the misleading half-truth that Tarasoff II 
does not impose a duty to warn. All things considered, the 
Wisconsin report's elaborate belaboring of the alleged 
mistake of therapists in believing that Tarasoff imposes a 
duty to warn adds to the confusion that abounds in grappling 
with the numerous problems created by the Tarasoff decision. 
While we found the Wisconsin report useful as an example of 
sophisticated research methodology for an extremely 
difficult area of study, the one unassailable position that 
the researchers took is that their conclusions are not 
unassailable.

The study that proved most useful in pointing the way 
for design of our own attitude survey was not preoccupied
with the Tarasoff case, and in fact never mentioned it, but was very relevant to our inquiry (Tymchuk et al., 1982). This study was concerned with the criteria used by psychologists in making ethical decisions. The conclusion was reached that when psychologists agree on how a situation involving ethics should be dealt with, they tend to agree on the criteria that should be applied in reaching the decision. The questionnaire was mailed to a nationwide sampling of 500 psychologists. Of these, 23% (113) were returned. Background information about the respondents was elicited. Twelve vignettes of hypothetical cases, each involving a different issue of professional ethics, were presented. An answer was given with each vignette, and the respondent was asked to agree or disagree, and to indicate the criteria which governed the decision from a list of thirteen criteria. One of these vignettes was very much within the area of interest for this dissertation. In some ways it resembles the vignette that we have made the cornerstone of our attitude survey. It is fairly brief, so we will quote it here verbatim:

A client, at the close of one of his therapy sessions with you, mentions that he has a secret plan to kill his roommate and that he has a gun. You have reason to believe he has the potential for violent behavior (that there may be clear and imminent danger) and you wish to spend more therapy time dealing with this issue. Your
client states that he will not return next week.

Should you tell anyone his secret? (Tymchuk et al., 1982).

The answer presented to the respondents was: "As his psychotherapist, you should inform either the police or his roommate." Eighty-four percent of the respondents agreed with this answer, nine percent disagreed and the other seven percent made no response. Presumably this seven percent responded to other vignettes, but not this one. The criteria used in reaching this decision, listed here in order of the percentage of respondents using a given criterion, are as follows: the interests of the community, 72%; the interests of the client, 62%; state or federal law, 54%; individual rights, 40%; confidentiality, 37%; public policy, 30%; standards of morality, 24%; the therapist's judgment, 24%; informed consent or agreement, 19%; personal freedom, 15%; freedom of expression, 10%; therapeutic leverage, 8%; and financial issues, 2%. These percentages sum to a good deal more than 100, so it apparent that the respondents chose more than one of the criteria.

It is interesting that interests of the community and interests of the client sum to 134%, which indicates that a number of the respondents felt that both criteria were applicable to the decision being made. This lends some support for the view expressed elsewhere in this paper that interest in the client's well-being and interest in the
safety of potential victims are not antagonistic interests. It is regrettable that the report did not delineate which of these various percentages reflect application of a given criterion by therapists who agreed with the proposed answer, as contrasted with those who did not. However, since such a small percentage were in disagreement, we may still assume that an important number of therapists felt that client interest and community interest were both applicable and both led to support for the proposed answer. Tymchuk and his colleagues report that 58% of the therapists queried felt that they were not well enough informed about ethical issues in psychology. This lends support to our belief that the profession in Texas would support a systematic attempt to define factors and standards for the issues we are studying, if such an attempt were undertaken.

Predicting Violent Attack

Except for this one explanatory sentence, this author will refrain from using the term "predicting dangerousness" in this paper. This objectionable phrase is mentioned here because it is used so often in the literature relevant to our topic (e.g., Hammond, 1980; Curran, 1984; Mulvey and Lidz, 1984; Givelber et al., 1984; Menzies et al., 1985). When the expression "predicting dangerousness" is used, the context shows that what is really meant is either diagnosing dangerousness, or predicting violent behavior. The latter term would seem to be preferable, because it has been said,
authoritatively, that dangerousness falls outside the purview of clinical diagnostics (Menzies, Webster, and Sepejak, 1985). Never are the people who use the two-word phrase here objected to talking about predicting that a person who is not now dangerous will at some time in the future become dangerous. Our search has turned up zero literature on that subject. This quibble might be inappropriate if the entire subject were not so burdened with confusion already. Extra confusion from imprecise language does not help any.

Can anyone know for sure who is dangerous and who is not? Some light on this problem can be found in an excerpt from the remarks of Mr. Alan J. Hruska, addressing federal appellate judges at the Second Circuit Judicial Conference: "To quote the now-famous words of a former superintendent of a mental hospital in New York, 'At least 65 percent of the inmates of this hospital are not dangerous, but I don't know which 65 percent.' (Laughter)" (Hruska, 1978)

Perhaps the most persuasive criticism of the Tarasoff decision is that expressed by Justice Mosk in his concurring opinion—that the decision assumes the reality of a non-existent expertise in determining when a client's threat to harm someone reflects a real danger and when it does not. It seems fair enough to hold a medical doctor liable for failure to diagnose third trimester pregnancy upon examining the patient, because there is not much doubt that
the means exist whereby a physician who does the job properly can successfully diagnose third trimester pregnancy if that's what the patient is experiencing. But there is great reason to doubt that the means exist whereby a psychologist or anyone else can distinguish between a threat that reflects a real danger and one that does not.

The researchers for what we have called the Wisconsin study (Givelber et al., 1984) seem to think they have put this criticism to rest by showing that therapists believe they can predict violent behavior with substantial success. They say that "If therapists believe there are common professional standards or practices, it is difficult to fault a court for believing so also." But what their data show is that less than a fourth of their respondents believe that they can determine that a patient was certain to attack another person. The rest speak in terms of almost certain to attack, would probably attack, would possibly attack, etc. And what does attack mean in this context? Their questionnaire asked this question, giving choices ranging in seriousness from slap or kick to homicide. But the published report says nothing whatever about the answers given to that question. There would seem to be a great difference in, on one hand, saying that someone is certain or likely to attack another in some way, and, on the other hand, predicting with certainty whether or not that person would carry out a specific threat of serious harm directed
to some identifiable person. And at that, only one-fourth to one-third of the therapists believe that one hundred percent of their respected colleagues would agree with their assessment. The rest believed that ninety percent or less of their respected colleagues would agree. And all of this relates to predicting that violence will occur, and says nothing about predicting that violence will not occur. So what the majority of the therapists who responded to the Wisconsin study said in answer to the researchers' questions falls short of claiming the kind of certainty with which our hypothetical physician should be able to diagnose third-trimester pregnancy. But that is exactly the kind of certainty that a therapist needs who must live under the Tarasoff rule. If a therapist lives where Tarasoff applies, and a patient makes a specific threat, and the therapist does not warn the threatened victim because she or he concludes that the threat does not represent a real danger, what would be the therapist's legal position when that conclusion proves wrong and the patient kills the threatened victim? The therapist had better get busy looking for those respected colleagues, and see if any of them are willing to testify under oath that they would have made the same assessment that our therapist whose name is all over the evening newscast made. The plaintiff will be able to find a witness to testify to the contrary, and the battle of the experts will be on, and the jury will have the opportunity
to decide if they like the way the therapist parts his or her hair. The point offered here is that, for Tarasoff to be a fair rule, there needs to be a fail-safe technique that will work every time when applied without negligence, in the absence of some extraordinary force majeure. There are many such techniques in many fields, and modern every-day life is heavily dependent on them. When a new bridge is opened and we drive our autos across it, we depend on the existence of fail-safe technique by which engineers decide how to combine concrete and steel and the other materials involved. The Tarasoff rule might be a fair rule if a comparable technique existed by which therapists could determine which patient threats involve real danger, and which do not. A survey of the research literature reflects that no such technique exists, or even comes close.

Judicial comment on this question of the existence of such a technique for predicting violence has run from one extreme to another. We will set out two examples here from judicial opinions. Each of these is written by a judge of a state court of last resort:

... the judgment of the therapist ... in predicting whether a patient presents a serious danger of violence is comparable to the judgment which doctors and professionals must regularly render under accepted rules of responsibility (Tarasoff v. Regents of the University of California, 1976).
And another excerpt from a judicial opinion:

Numerous studies have demonstrated the inaccuracy of attempts to forecast future violent behavior. Two commentators summarized the results as follows:

'Whatever may be said for the reliability and validity of psychiatric judgments in general, there is literally no evidence that psychiatrists reliably and accurately can predict dangerous behavior. To the contrary, such predictions are wrong more often than they are right.

Neither psychiatrists nor anyone else have reliably demonstrated an ability to predict future violence or 'dangerousness.' Neither has any special psychiatric 'expertise' in this area been established (People v. Murtishaw, 1981).

One is tempted to speculate that the two judges who wrote these two excerpts must be rather antagonistic toward one another, since they differ so strongly on whether therapists can predict violent behavior. But the surprising truth is that these two excerpts were written, not by two different judges, but one. And that one is Justice Tobriner, the author of the Tarasoff II opinion, from which the first excerpt above is quoted. In fairness it must be pointed out that the legal issue being addressed was very different in the two cases. We need not further belabor here the issue being addressed in Tarasoff. In Murtishaw, the defendant had been assessed the death penalty. Part of
the testimony was by a psychologist who told the jury of his prediction of future assaultive behavior by the defendant. Judge Tobriner and the Supreme Court of California majority held that admission of such testimony was error and reversed the assessment of the death penalty.

Two recent reports have reviewed the research on prediction of violent behavior. Mulvey and Lidz (1985) began by noting that interest in this topic increased in the early 1970's because of widespread concern that confining people merely because they needed mental health care deprived people of civil liberties. A requirement was adopted that a showing be made that the patient was dangerous to himself or to others as a prerequisite to confinement. Therapists were called upon to testify in civil commitment cases, and their testimony required an assessment of dangerousness. This led to studies of their effectiveness as predictors of violence. From these studies Mulvey and Lidz conclude that clinicians of many types are more likely to be wrong than right in predicting that a person will be violent over an extended period. They support the view that there exists no adequate typology of violent persons. Instead, certain people may be dangerous in certain situations, and testing for the presence of dangerousness as if it were a trait that will eventually emerge greatly oversimplifies the interactive nature of the behavior in question. These observers are not convinced
that predicting violent behavior is something that can never be done. They acknowledge that it has not yet been done, and that it is not yet proved that it can be done. They feel that what should have been the first step to systematic inquiry has not been taken and should now be taken. They advocate descriptive research, to ascertain just what it is that clinicians do when they go about attempting to predict violent behavior. They hold that "... as yet the clinical prediction of dangerousness has not been described in sufficient detail to allow for a consensus about relevant variables, yet alone likely relationships between these variables ... the next important step that must be taken in research on the prediction of dangerousness is to document the prediction process as it actually occurs." (In this quotation we see one more example of the pervasive use of the term "prediction of dangerousness.")

Views consistent with the foregoing are set out in another recent report, this one describing research on a test instrument designed to aid in the prediction of violent behavior (Menzies et al., 1985). They quote another researcher (Monahan, 1981) as saying that "What is necessary for moral and legal ... progress in the area of prediction is a dramatic increase in the degree to which mental health professionals articulate what it is they are predicting, and how they went about predicting it." Menzies and his colleagues have devised an instrument they call the
Dangerous Behavior Rating Scheme (D.B.R.S.). The original scale comprised 22 items to be rated on a seven-point continuum aggregated into five major dimensions of dangerous behavior: personality factors, situational factors, facilitating factors, global estimates, and rater's confidence in judgments. Analysis of data from pilot testing by two raters on several subjects resulted in the 22 items being reduced to 15. The raters worked in observation rooms where they could see and hear without being seen while the subjects were being given clinical interviews. The subjects were defendants in criminal proceedings. The raters were not clinicians but were university graduates. They worked independently of each other. Using the instrument they made predictions as to some but not all of the subjects. The research also entailed a two year followup to determine the number of incidents of violent behavior for each of the subjects. Nine external judges were given detailed instructions on rating these incidents to arrive at "danger outcome scores" for each subject. Predictions were made for 77 subjects, just under half the subjects studied. Fifty-three clear hits were recorded by the raters (28 true positives and 25 true negatives); conversely, assessors erroneously predicted 18 patients to be dangerous, 6 to be non-dangerous. The researchers conclude that rendering predictions in only extreme cases of perceived dangerousness or non-dangerousness reduces error
rates. They say that "only to the extent that psychiatrists (either with or without such instruments) can generate more accurate predictions than other groups, can dangerousness be treated in practice as a medical reality. To the present, such data have not been forthcoming." They point out that the D.B.R.S. is intended for research rather than clinical use. They go on to say that

It is abundantly clear that forensic assessments of dangerous behavior, even under the most advantageous conditions, will never approach perfect accuracy. In fact it has been suggested (citing sources) that the .40 "sound barrier" for prediction—outcome correlations represents a more realistic perimeter for competence (Menzies et al., 1985).

This last quoted statement would seem to be a fair summary of the literature on research into prediction of violent behavior. But the Supreme Court of the United States is not yet willing to accept such a blanket assessment. In a 1983 case appealing a death sentence imposed in Texas (Barefoot v. Estelle, 1983), the American Psychiatric Association filed an amicus curiae brief, as it did in some other cases, arguing that the Supreme Court should bar from American courtrooms on constitutional grounds all testimony by psychiatrists on the likelihood of future violent conduct (Curran, 1984). According to a law-medicine note in the New England Journal of Medicine,
the Supreme Court majority firmly dismissed this argument. The note goes on to say:

The opinion by Justice White treated the position of the association quite abruptly and with a strong flavor of disdain for the cautious statistical approach taken in the brief. Justice White began his commentary by asserting that to accept the argument of the association that all psychiatric testimony about the potential for violence should be totally excluded from evidence was 'like asking us to reinvent the wheel.'

... Justice White observed caustically that it would make 'little sense, if any' to argue that psychiatrists, out of the entire universe of persons who might have an opinion on the subject, would 'know so little' about the subject that they should be totally excluded from testifying (Curran, 1984).

The literature we have examined says a great deal about the lack of therapists' ability to predict violent behavior accurately, the lack of clear articulation of what clinicians actually do when they set out to predict violent behavior, and the courts' persistent insistence that such predictions are part of the clinician's responsibility. This all seems to lend support to the underlying thesis of this dissertation, that Texas psychologists need a clearer and fuller articulation than now exists of the standards that ought to apply and the factors that ought to be applied
when the therapists faces conflict between the confidentiality objective and the victim protection objective.

Other Clinical Issues

Apart from the difficulties of attempting to predict violent behavior, other problems are raised by the Tarasoff decision. We now turn to published comments on some of these problem areas by mental health professionals. Dr. Robert Miller, assistant professor of psychiatry at Duke University Medical Center, put the case rather simply: 
"... the Tarasoff decision, requiring therapists to warn potential victims as a result of patient revelations in psychotherapy, while unofficial outside of California, has had an increasing negative impact on the supposedly confidential nature of patient-therapist communication." (Miller, 1981).

One of the strongest direct condemnations of the Tarasoff decisions comes from Alan A. Stone, Professor of Law and Psychiatry in the Faculty of Law and Medicine, Harvard University, and one-time president of the American Psychiatric Association. He concludes that the decision will "reduce the ability of the mentally ill in California to obtain effective therapy and consequently will diminish public safety. The decision is counterproductive of the goal of public safety it professes. It is a disservice to the citizens of California." Dr. Stone attacked the court's
failure to recognize the devastating effect that a Tarasoff warning would have on the trusting relationship so necessary for effective therapy. The last thing the therapist needs is for his patient to perceive that the therapist has a loyalty to some third person greater than his loyalty to the patient. If the third person is, as in Tarasoff, the female object of the male patient's romantic interest, the therapist can get himself killed if a deranged patient suspects that the therapist may be a competitor for the lady's affection. Dr. Stone's argument that a warning is by no means certain to reduce the violence in the situation is impressive. Another point he makes is that if the therapist has a duty to warn, he may well have a corollary duty to admonish the patient at the outset of therapy that he has a duty to warn should the occasion arise. Dr. Stone notes the effect of such an admonishment would be that the patient would resolve to keep to himself a great deal of what he might otherwise reveal. This, again, would have a detrimental effect on therapy. Another predicted effect of the decision is that psychotherapists will be less willing to accept dangerous patients, and will find ways to avoid accepting them as patients. Thus people who need mental health care most will not get it. (Stone, 1976).

Dr. Stone did not expressly say so, but his argument seems to be based on the underlying assumption that psychotherapy is generally effective, and that the effect of
successful psychotherapy is to make dangerous patients less dangerous. This assumption seems to be shared by the Tarasoff dissenters, but it is not at all clear that the Tarasoff majority judges would agree.

Dr. Stone's point that a duty to warn threatened victims creates a duty to give the patient something of a "Miranda warning" (my term, not Dr. Stone's) at the beginning of therapy is echoed in a published report of members of the Committee on Privacy and Confidentiality of the California State Psychological Association (Everstine et al., 1980). These authors note that the right of privacy has come to be legally recognized as one of the important rights of citizenship. "In effect, the client may inadvisedly waive his or her right to privacy by entering into a therapeutic relationship. Our committee takes the view that the client should be given an opportunity for reflection on whether or not to waive this right." The authors then propose a nine-point statement of client's rights to be presented at the beginning of therapy. The last of these nine items reads in part as follows:

You should also know that there are certain situations in which, as a psychotherapist, I am required by law to reveal information obtained during therapy to other persons or agencies—without your permission. Also, I am not required to inform you of my actions in this regard. These situations are as follows: (a) If
you threaten grave bodily harm or death to another person, I am required by law to inform the intended victim and appropriate law enforcement agencies . . . (Everstine et al., 1980).

It should be noted that, whatever the merits of the proposals set out in this article, the quoted passage is not a precisely accurate rendering of the California law as given in the Tarasoff II opinion. Under the quoted passage, every threat of grave bodily harm is required to be reported. Not so under Tarasoff. Under Tarasoff the threats that reflect a real danger should be reported, and those that do not should not. And the therapist is supposed to have some means of sorting out one from the other. The problems with this supposition have been discussed at length herein and need not be belabored here.

Not all mental health professionals are in full agreement with Dr. Stone. Two commentators from Fort Worth, Texas, seem to differ with some of Dr. Stone's positions, although their views are not expressly stated as replies to Dr. Stone. They make this statement:

There is good indication that the limits being placed on client confidentiality have not diminished the extent to which mental health treatment is being sought or provided. For example, counseling and psychotherapy seem to be thriving in both California and Texas, the two states that have through legislation limited client
confidentiality most stringently. And despite the
dogmatic insistence of psychoanalytically oriented
therapists that absolute confidentiality is essential
for sound treatment, no mass exodus of such
practitioners from these two states has been reported.
Cumulative observations such as these indicate that
mental health professionals are tacitly agreeing that
conditional confidentiality is sufficient for effective
therapy (Denkowski and Denkowski, 1982).

These authors take note of the Tarasoff decision, but
do not appear to be disturbed by it, as Dr. Stone is, and
seem to suggest that mental health professionals generally
are not disturbed by it. Whether or not this is true, the
reasons given by Denkowski and Denkowski in support of this
view do not appear to prove much of anything. Counselling
and psychotherapy could thrive in California and Texas, at
least as a business enterprise, whether or not they are
promoting public safety as effectively as before Tarasoff.
Murder and other criminal violence also seem to thrive in
Texas and California. The lack of a mass exodus of
analytically oriented therapists from these states doesn't
seem to prove much either. Where would they go to find
absolute confidentiality?

Another author, a law professor, has directly and
expressly challenged Dr. Stone’s views of Tarasoff (Wexler,
1980). His approval of the Tarasoff decision is almost
exuberant in tone. He concludes that Tarasoff has brought and will bring about improvement in therapy because it will induce therapists to bring the threatened victim directly into the therapy process, and this is what they ought to be doing anyway. He reports interesting data suggesting that victims often contribute to their own demise. He offers interesting if somewhat involved theories about how to manipulate victim control laws to induce therapists to make greater efforts to bring victims into the therapy process.

Another critique of the Tarasoff decision is made by two gentlemen by the name of Griffith, one the dean of a law school, the other a medical doctor and psychiatry professor. It is an intriguing but unanswered question as to how these gentlemen are related to each other, if at all (Griffith and Griffith, 1978). Their conclusions are about the same as Dr. Stone's, but are somewhat more direct in asserting that therapy makes dangerous patients less dangerous. "There is no doubt that the patient's successful treatment diminishes the threat of danger to others." These authors also state well the case against the Tarasoff court's assumption that warning the intended victim is a satisfactory solution to the problem:

There is reason to fear that the therapist's disclosure may further complicate the situation. If instead of promoting caution by the third party, the warning engenders disquietude and anxiety, there may be grounds
for attaching liability against the therapist for the consequences of such an unnerving disclosure. It is to be presumed that not everyone can calmly accept the news of impending danger with gratification. More often than not such a suggestion persuades the potential victim that the danger is imminent and that he must take steps to secure himself from his aggressor's onslaught. But even short of that, from the time that the danger is communicated to the potential victim he may shudder every moment in anticipation of his lurking attacker. Such emotional distress alone may constitute a basis for complaint by the victim whose welfare was in mind when the therapist took his initial step in the protective process (Griffith and Griffith, 1978).

One psychiatrist, who is also a lawyer, gives a published account of a case which seems to show how impossible it is to predict what will happen as a result of a Tarasoff warning (Finney, 1982). He reports "... I decided to follow the Tarasoff rule, and found unexpected results." His patient was a thirty-two year old woman, divorced with two children. At one session she expressed much anger against a boyfriend, who had deserted her and taken up with another woman. She said she was thinking of killing him. Moreover, she had a specific method in mind. The therapist asked her how serious she was. She answered
that she was perfectly serious and that she would do it. The therapist told her that it was his duty to warn the boyfriend that she intended to kill him. Her reply to this was: "Oh, no. I didn't mean what I said. I am not really going to kill him." The therapist decided to give the warning nevertheless and was able to get the man's address from the patient, with some apparent reluctance. So a letter was mailed. Dr. Finney describes the outcome in the following language:

It was nearly three months before I saw the patient again. She was cheerful. I asked whether she had killed her boyfriend. She said: 'He got your letter. He left the other woman. He has come back to me now. We're living together now. And we are happy!' The thought arose that this was not exactly the outcome that Justice Tobriner had had in mind when he wrote the Tarasoff decision (Finney, 1982).

A recurring criticism of the Tarasoff decision is that it will increase the extent to which patients refuse to reveal to their therapists information that should be revealed and dealt with in therapy. A recent study developed data that suggest that patients do indeed hold back information from their patients (Weiner and Shuman, 1984). Questions were asked of three groups of people in the Dallas, Texas, area. These were a lay group (persons not involved in therapy), a patient group, and a group of
psychiatrists. The lay group were asked about information they would expect to withhold if they were in therapy, and the patient group about information they had in fact withheld. A non-disclosure rate was worked out by computing a percentage of each group that withheld (or expected to withhold) information in one or more of the categories proposed. The non-disclosure rate was not greatly different between the two groups, over forty percent for each. In the patient group, thoughts of violence toward self or others was the category of information most frequently withheld by men. Sexual experiences and fantasies was the category most frequently withheld by women. Information in this category was withheld most, overall. The researchers considered possible explanations for these phenomena. For example, the possibility that the fact most of the women patients have male psychiatrists might account for the reticence of the women in sexual areas was considered. Answers to questions posed to 74 psychiatrists indicated that patient disclosure was influenced by the therapist's threat of revealing to a third party or an actual revelation, whether as a warning to endangered third party or as part of courtroom testimony. Two indicated that patients had terminated prematurely following the warning of a third party. Two patients in therapy at the time their psychiatrist made courtroom disclosures concerning them also terminated therapy. This data seems to suggest that a "Miranda warning" might tend to
discourage full revelation. The article reporting this study was accompanied by comments of several medical doctors who had read the report. In general these seemed to support the view that patients withhold important information from their therapists. Dr. Alan A. Stone found the report "... remarkable to my mind because it suggests how much withholding of important and presumably relevant material goes on in the patients surveyed." (Stone, 1984). Dr. Paul S. Appelbaum stated that the extent of non-disclosure revealed in this study is "... surprising only in being as low as it is." (Appelbaum, 1984). Dr. Robert L. Sadoff in his commentary made use of the expression "psychiatric Miranda warnings." (Sadoff, 1984).

In this paper we have been concerned with persons traditionally regarded as mental health professionals: psychologist, psychiatrists, social workers, marriage counsellors, and family counsellors. There is another important group of counsellors that we should mention, the clergy. We will not try to trace the status of priests, pastors, ministers and rabbis under the various statutes. But we will mention something about the positions of some of the denominations. This was discussed in an article which appeared in the Santa Clara Law Review (Yellin, 1983). The article quotes the Lutheran Church position as follows:

No minister of the Lutheran Church in America shall divulge any confidential disclosure given to him in the
course of his care of souls or otherwise in his professional capacity . . . except with the express permission of the person who had confided to him or in order to prevent the commission of a crime (Yellin, 1983).

According to this article, American Baptist policy recognizes that confidentiality is not absolute, but may be abridged when "conscience so requires."

The article quotes the Catholic Church position as follows:

The seal of confession must always be meticulously safeguarded and observed in regard to all matters that come under it. The law of the seal admits of no excusation. No cause, however great, whatever the circumstances, will justify its violation. The seal is inviolable... (Yellin, 1983).

According to this article, not all private communications by parishioner to priest are under this severe rule, even if the parishioner thinks they are. There are procedural requirements to invoke the seal. As to such information given in confidence but not under the seal, "... the obligation of professional secrecy ceases whenever this measure is urgently necessary for warding off a serious evil (damnum grave) from the common welfare."

The report of members of the Committee on Privacy and Confidentiality of the California State Psychological
Association, quoted earlier in this paper (Everstine, et al., 1980), had something to say about the clergy privilege. It should be remembered that in speaking of legal provisions this report is oriented toward California law, whose provisions may not apply elsewhere:

Finally, there is a clergy privilege, which is very tightly defined by the law. It applies only to those clergy whose church rules specify that they have a duty to keep information secret and that there be no third party present when the information is given. Within those constraints, the privilege is controlled by the "penitent" (equivalent to the client or patient), but it may also be held independently by the clergy. An important distinction which pertains here is that while the penitent can bind the clergy, the penitent is not bound by the clergy's privilege. Thus, if the penitent claims the privilege, the information cannot be revealed by the clergy; but if the penitent waives the privilege and the clergy claims it, the clergy can remain silent even though the penitent reveals the information.

A clergy's independently held privilege is established for the benefit of the clergy's personal sense of conscience. There are no exceptions to this privilege arrangement. It cannot be breached for any legal reason whatsoever. It is absolute (Everstine et al.,
The foregoing suggests that clergy may be accorded greater confidentiality under the law than other counsellors or therapists. But they do not have immunity from lawsuits. Professor Ralph Slovenko gives this account:

In a case (arising in Texas), a minister advised the wife to seek separation from the husband, due to their marital problems. She followed this advice. The husband, later, in a state of rage, shot her, seriously injuring her. The couple later reconciled and then jointly sued the minister for his counsel and advice. They prevailed. The case sent clergymen scurrying to insurance companies. Following the Texas case, a number of alienation of affection suits were filed against ministers, and there have been other types of cases. In one, it was alleged that a young man who killed himself went to church officials for counseling for about 5 years instead of going to a psychiatrist (which presumably would have made a difference.) Church officials allegedly discouraged the deceased from seeking psychiatric care although they knew he had attempted suicide before. The suit charged that the minister told the deceased 'to engage in prayer, read scriptures and listen to tape recordings of sermons.' There is now a new crop of insurance policies to guarantee that, when doling out advice, men of God have
more than God on their side (Slovenko, 1981).

There is one article which ought to be mentioned in this paper concerning violent, dangerous patients, even though it does not involve the element of confidentiality. It does have important things to say about making dangerous patients less dangerous. Bruce L. Danto has published an article with the arresting title of "Patients Who Murder Their Psychiatrists" (Danto, 1982). Dr. Danto is a person with impressive credentials for discussing dangerous patients. He is a psychiatrist with experience as a police officer, an expert on barricaded gunman situations and hostage negotiations as supervisor on a SWAT team. His experience is more than academic; his own children were once held hostage in his own home during a robbery. In addition, he has had close personal brushes with death, described in this article. Perhaps surprisingly, it was his communications skills, and not skills at physical combat, that saved his life. He has examined the research literature and finds little to help clinicians learn the art of survival from a threatened homicide. He echoes the suggestion advanced by Wexler, discussed in an earlier portion of this paper, that victims can contribute to their own demise. He describes two cases where patients murdered their psychiatrist. He knows these cases well because he testified as a medical witness in the murder trials of each of the killers. In one of these cases there is a strong
suggestion that the psychiatrist victim might have ignored some rather blatant danger signals and that the murder might even have been averted by some prudent common-sense measures. The other case reminds us once again how difficult it is to assess dangerousness. "It is apparent that the psychiatrist did not see from the records how dangerous Bill actually was." Dr. Danto proposes a model speech that a psychiatrist might give when his patient is holding a gun on him in his office. It should be delivered in a quiet voice:

You have the power. I respect that in the gun you are holding on me. I know you're upset and so am I. I think it would be easier for me to help you if I didn't have to stare at that gun. Could we make a deal? Would you mind just letting it rest on the seat or table next to you while we talk? When I don't have to worry about it going off, something I feel you don't want either, we can relax a little more and find a way of helping you. I will make no effort to reach for your gun. I think we'd both feel better talking this out and finding an easier and more comfortable way of helping you deal with your situation (Danto, 1982).

We will end this literature review with another quote from Dr. Paul S. Appelbaum. In a recent article (Appelbaum 1984b) he reflects on what he sees as a trend in court decisions toward "a standard that approaches strict
liability." The legal term "strict liability" suggests that the therapist may be held liable for the damage done by the patient, regardless of what the therapist might have done or not done. No court has ever said that, but that is the direction Dr. Appelbaum fears we are going. But he does not just deplore the trend, he has some thoughts about how mental health professionals ought to deal with it:

Anguished cries and protests, and even amicus curiae briefs attempting to fight the trend on a case-by-case basis, are no longer enough. Rather, the mental health professions, led by psychiatry, need to formulate a coherent standard of care for dealing with violent patients, instead of allowing the courts to do it for them. . . . Whether professional efforts to formulate appropriate standards of behavior will stop the courts from their swing toward strict liability is uncertain. Such efforts, however, may represent the most positive approach to the problem (Appelbaum, 1984b).

These quoted words from Dr. Appelbaum come closer than anything we have found in the published literature to expressing the basic underlying conviction that impels this dissertation. However, this observer would contend that formulation of coherent standards could be led by any of the mental health professions, certainly including psychology.

The American Psychological Association

An ad hoc committee of the American Psychological Association
Association has developed a background paper to address the issue of the therapist's duty to protect the public from the dangerous acts of violent mental patients. It has been referred to as a "white paper." In response to this author's request, the APA sent a copy of the white paper, accompanied by a memorandum from Leonard D. Goodstein, Executive Officer, bearing date of November 1985, addressed to "Interested Parties." This collection of papers contains about 21 pages and includes a legislative alert, a model bill, an explanation of the duty to protect and the need for legislative redress, an annotated bibliography of research on the prediction of violence, an annotated bibliography of research on the dangerousness of mental patients, and a chronological listing and brief description of case law in this area.

The executive officer's memorandum pointed out that these papers are not statements of policy by the American Psychological Association. This same caveat is repeated immediately following the model bill to limit psychotherapists' civil liability for the violent acts of mental patients. The memorandum acknowledges the major work done on this white paper by Anne Marie O'Keefe, an attorney and clinical psychologist of the APA staff, and invites calls to Ms. O'Keefe at the Office of National Policy Studies (202/955-7742).

The model bill set out in the white paper is very
similar to the new California legislation mentioned earlier in this dissertation. The major difference is that the model bill is concerned with an "actual" threat of violence, whereas the California law is concerned with a "serious" threat. Further comparison of the model bill to the new California law is given in Appendix G to this dissertation.

The final chapter of this dissertation contains this student's own model bill, proposed for consideration as legislation for Texas. It represents this student's effort to fashion a more adequate bill than either the white paper's model bill or the California legislation.

Having completed the literature review, we turn now to a description of the hypotheses which were tested by the attitude survey.

Hypotheses

**Hypothesis 1**

The primary theme of this dissertation is that there is a lack of consensus at present among Texas psychologist therapists. The vignette and questionnaire, with the array of 28 answer choices, was designed to show the extent to which consensus exists, both under real world conditions, and under conditions of an ideal world in which laws and ethical guidelines coincide with what the therapist thinks they ought to be. Hypothesis 1, then, was that there is no such consensus, either for real world conditions or for ideal world conditions.
Hypothesis 2

Our second hypothesis was that both psychologists and judges would view the problem as calling for a different answer in ideal world conditions from the answer given for real world conditions. Accordingly, our hypothesis was that the frequencies of answer choices selected would differ from real world conditions (Question I) to ideal world conditions (Question II), and that the differences would be significant. Significant differences, if any, would throw light on attitudes of psychologists and/or attitudes of judges as to what changes in the law might be regarded as desirable.

Hypothesis 3

Our third hypothesis was that psychologists would tend to take different views of these issues from the views judges take, and accordingly that psychologists would tend to select answer choices different from those chosen by judges, both as to real world conditions and ideal world conditions, and that these differences would be significant.

Hypothesis 4

The fourth and final hypothesis related to psychologists only, since it involved data gathered from psychologists but not from judges. The hypothesis was that a systematic association exists between the therapist's attitude toward the issues with which this study is concerned and at least some of the demographic variables and/or the practice
variables as to which we gathered information from the therapists who answered our questionnaire. In this regard the therapist's attitude was regarded as a point on a continuum. At one end of the continuum the therapist tends to be reluctant to breach the privacy of the therapeutic alliance, and at the other end the therapist has a greater readiness to warn a person threatened by the patient.
Subjects

The persons whose attitudes were of interest for the proposed survey include every psychologist in Texas. By choosing Texas psychologists instead of psychologists in general, we were able to control for differences in state law. Previous studies which directed a given question to therapists in differing legal environments are instructive, but they fall short of dealing with what the individual therapist must deal with, which is the exact legal setting of the particular state in which the individual therapist is practicing. Our subject matter involves the interplay between rules of law laid down by legislatures and judges, and professional standards as perceived by psychologists. This particular dynamic, of course, will differ from state to state.

Within the general category of psychologists practicing in Texas, we selected a particular population, health service providers in psychology. Of the approximately two thousand licensed psychologists in Texas, slightly over half are listed as health service providers in psychology (Texas State Board of Examiners of Psychologists, 1985). We sent a
mail packet including the vignette and questionnaire to every person listed as a health service provider in psychology in the current roster. It was believed that the attitudes of this population toward the issues we were exploring were likely to be generally representative of those of Texas psychologists as a whole.

Psychologists, of course, are better informed about the therapy they provide than anyone else. But another dimension was added to our attitude survey by including in the survey population a group with interests that are somewhat similar, but who are concerned about the interests of the community as a whole from a somewhat different perspective than psychologists. A group that fits these criteria very well are the judges in Texas who preside over the civil proceedings by which confinement for involuntary mental health care is sought for mentally ill persons—in short, mental illness commitment judges.

Who are the judges who hear commitment proceedings? Most of the 256 counties of Texas have a county judge who presides over commitment proceedings for that county. In some cases, especially in rural counties, this is the same county judge who presides over the commissioners' court, which is the governing body of the county. In some more densely populated counties, the judge of a county court at law customarily hears the commitment cases. In several metropolitan counties, the legislature has established
statutory probate courts, and the judges of these also constitute mental illness courts, to hear the commitment cases. Probate courts deal with such matters as estates of decedents, wills, and guardianships, dealing with persons under some legal disability, such as minors, and persons of unsound mind.

An organization has been established which provides a well-defined channel of communication with and among all these various judges who hear commitment cases in Texas, called the Texas College of Probate Judges. It has been the extremely good fortune of this researcher to receive gracious encouragement and assistance from Hon. Joseph E. Ashmore Jr., Judge of Probate Court of Dallas County, Texas, No. 3, and one of the leaders of the Texas College of Probate Judges. Through his assistance this researcher has been privileged to appear before two groups, one consisting of probate judges from a number of different counties in the South Texas area; the other a statewide group which convened in October of 1985, all in an effort to stimulate interest in this research project.

The same vignette and the same vignette questions submitted to the Texas psychologists were also submitted to the entire membership of the Texas College of Probate Judges. The vignette questions were modified slightly. Instead of being asked "what would you do?," the judges were asked "what should the psychologist therapist do?"
Individual data about the judges and their personal background were not requested. The time and effort required for judges' responses was kept at a minimum, in order to get a higher number of responses.

Materials

The materials used were the following: The vignette, Appendix A; the questionnaire directed to psychologists, Appendix B; a letter of transmittal which accompanied the vignette and questionnaire sent to psychologists, Appendix C; and a letter of transmittal sent to the judges, Appendix D. The questionnaire sent to the judges was the same as the vignette questions sent to psychologists, with appropriate modifications as indicated earlier. The mail packets for psychologists and for judges each included a self-addressed envelope for returning the responses. A permit was obtained from the postal service for payment of return mail on receipt. A North Texas State University return address was used.

Procedure

The materials set out in Appendices A, B, C and D were duplicated. One thousand copies of each item for the psychologist packet were prepared, and four hundred copies of each item for the judges' packet. The researcher assembled the mailing packets and addressed them, using the current Roster for the psychologists and addresses for the judges furnished by the Texas College of Probate Judges.
Judges' packets were presented in person by the researcher at the October meeting mentioned previously. Judges were asked to answer the questionnaires and return them on the spot, and 38 judges did so. Packets were sent by mail to all other judges on the mailing list.
CHAPTER III

RESULTS

A substantial response to the questionnaires was received, both from psychologists and from judges. The numbers and percentages of questionnaires answered and returned are set out in Table 1, Appendix H.

From the array of 28 answer choices offered, 5 of the possible answers accounted for 58% of the choices made by psychologists for Question I (real world). For Question II 5 answers (almost the same 5 as for Question I, but not quite) accounted for 55.5% of psychologists' choices. The situation was similar with the judges. For Question I, the 5 most popular choices accounted for 59.8% of the total. For Question II, the 5 most popular choices accounted for 54.7% of the total. These most popular answer choices, for psychologists and for judges, for Question I and Question II, together with the frequency percentage for each choice, are set out in Table 2, Appendix I. The frequency percentages for all 28 answer choices for psychologists and judges, Questions I and II, are set out in descending order in Table 3, Appendix J. The frequencies are set out in numerical order in Table 4, Appendix K. A few of the choices offered were not selected by any of the
psychologists, and a few were not selected by any of the judges. Only one, No. 26, was not chosen by anyone, psychologist or judge, for Question I or Question II. It reads: "Call Joseph and tell him you will try to have him sent to the penitentiary if he harms Phyllis. Also call the police." It fails to mention a warning to Phyllis.

A chi-square computation was made to compare frequency of choices by psychologists from the array of 28 choices for Question I (real world, N = 195) to their choices for Question II (ideal world, N = 180). Degrees of freedom = 27. The calculated chi-square of 23.835 was well below the critical point of the theoretical chi-square distribution for 27 degrees of freedom at the .05 level, which is 40.113. Even had we ignored the 4 zero-frequency choices and used 23 as the degrees of freedom, we would have found a critical point of 35.172 at the .05 level, well above the calculated chi-square of 23.835.

A similar computation of chi-square was made to compare frequency of choices by judges for Question I (real world, N = 92) to their choices for Question II (ideal world, N=95). Degrees of freedom = 27. The calculated chi-square of 21.795 was well below the critical point of the theoretical chi-square distribution for 27 degrees of freedom at the .05 level, which is 40.113. For the judges there were only 2 zero-frequency choices, so it is readily apparent that the calculated chi-square would have been well
below the critical point of the theoretical distribution had the zero-frequency choices been omitted from the computation.

Also, a computation of chi-square was made to compare frequency of choices by psychologists (N = 195) to frequency of choices by judges (N = 92), both for Question I, (real world). Degrees of freedom = 27. The calculated chi-square of 82.669 was well above the critical point of the theoretical chi-square distribution for 27 degrees of freedom at the .01 level, which is 46.963.

Similarly, a computation of chi-square was made to compare frequency of choices by psychologists (N = 180) to frequency of choices by judges (N = 95), both for Question II (ideal world). Degrees of freedom = 27. The calculated chi-square of 57.955 was above the critical point of the theoretical chi-square distribution for 27 degrees of freedom at the .01 level, which is 46.963.

Correlation coefficients were computed between the answers chosen by psychologists and the various demographic variables and practice variables as to which information was elicited from the psychologists on the questionnaire. For this computation, the array of 28 choices was arranged in three lists. These lists will be referred to in this paper as list red, list white and list blue. List red contains choices which indicated a readiness on the part of the therapist to warn Phyllis of the threat made by Joseph.
List blue contains choices which indicated less readiness to warn Phyllis, and more inclination to maintain confidentiality. List white contains the choices which are more neutral, and were not included on list red or list blue. The lists contain all of the 26 choices selected by psychologists. These lists, with the answer choices included on each, are set out in Table 5, Appendix L.

A value of 1 was assigned to the choices on list red, 2 to the choices on list white, and 3 to those on list blue. Accordingly, a score was assigned to each therapist's choice in answer to Question I (real world) and to Question II (ideal world). These scores were used in computing the Pearson correlation coefficients. Only in very limited instances were significant correlations found. Two of these are of interest here: A positive correlation is indicated between number of years in fulltime practice of psychology and tendency to choose a list blue choice in real world conditions. Coefficient = .176, probability = .016.

A negative correlation is indicated between number of new patients seen each week and tendency to choose a list blue choice in real world conditions. Coefficient = -.221, probability = .002.

Therapists were asked on the questionnaire to list writers on psychology or related topics whose teachings had most influenced their own approach to therapy. The writers who proved to be most popular with the therapists who
responded are Carl Rogers, Sigmund Freud and Albert Ellis. Data on how these and 34 others fared as first, second and/or third choices is set out in Table 6, Appendix M.

Data gathered in the follow-up interviews cannot be described meaningfully in quantitative terms, other than to report that 30 such interviews were held with psychologists who had given consent on the questionnaires. The same is true of free-form comments written onto the questionnaires. But both these sources will be referred to in the discussion chapter.
CHAPTER IV

DISCUSSION

The discussion is in two major parts. First, each hypothesis is examined in the light of the quantitative data. Second, the need for new legislation for Texas is explored, and a proposed legislative enactment is set out at the end of the chapter.

The Quantitative Data

Hypothesis 1

The hypothesis that no consensus exists at present among Texas psychologist therapists as to how the problem under study should best be dealt with appears to find logical support in examination of the frequencies set out in the beginning portion of the results chapter. For real world conditions, a majority chose from just 5 choices. Four of these 5 choices were also among the 5 most frequent choices for ideal world conditions. But these 4 choices reflect widely differing attitudes toward the problem. "Consult a colleague but otherwise make no disclosure" is in rather sharp contrast with "warn Phyllis and call the police yourself." The greatest percentage that any one of these received is 17.4%. The data provide at least some evidence in support of the conclusion that there is no present
The judges do not come materially closer than the psychologists to agreeing on a particular answer choice. Their most popular choice received 18.5%. The same choice, No. 12, "Report the case in full detail to law enforcement personnel. Explain that the therapist cannot legally warn Phyllis, but they can, and they should do so," was also most popular with the judges for the ideal world, at about the same percentage, 18.9%. But the judges come much closer to a consensus. Among the 5 most popular choices for both real world and ideal world, chosen by a majority of the judges, there is not one choice that calls for the therapist to warn Phyllis directly. That task, if it is to be undertaken at all, is to be left to law enforcement personnel or medical personnel. One possible explanation for this may be that the judges may be more familiar with the applicable law than the psychologists are. All of these more popular choices selected by the judges are in keeping with the confidentiality statute and suggest an intention that the therapist stay within that statute and not risk liability to the patient for unauthorized disclosure.

Hypothesis 2

Our second hypothesis is that there are significant differences between frequencies for answer choices for real world conditions and those for ideal world conditions. Had such differences been found it might have led to some
insight on how therapists and/or judges would like for the law to be different than it is. But as the chi-square statistics recited in the results chapter reflect, no significant differences are found in this data, either as to psychologists or judges. It cannot be said that this data shows that psychologists and/or judges would like for the law to remain as it is. The data fails to throw much light either way.

Hypothesis 3

Our third hypothesis is that there are significant differences between attitudes of psychologists and those of judges toward the problem under study. The chi-square statistics recited in the results chapter support this hypothesis. As to the nature of the differences in attitudes, it may be revealing to examine the particular answer choices which contribute most to the strength of the chi-square statistic. No. 12 is by far the leading choice in this regard, both real world and ideal. In the real world case, the total of the two cell chi-squares for this choice is 23.063, more than one-fourth the total chi-square for the entire array. In the ideal world case it is 10.961, almost one-fifth the total. It reads "Report the case in full detail to law enforcement personnel. Explain that the therapist cannot legally warn Phyllis, but they can, and they should do so". In both realms, this choice is far more popular with judges than with psychologists. One possible
explanation for this is that judges may be more likely to regard this as an accurate statement of the law than psychologists are. The free-form comments and the follow-up interviews give impression that many psychologists believe that, under Texas law, there is not only a right to warn but a duty to warn, and many are surprised to learn at Art. 556lh seriously affects the therapist's right to warn a threatened person. Another heavy contributor to the difference in the real world case is No. 20, "Warn Phyllis. Call the police yourself." While 34 of the psychologists select this as their first choice, only two judges do so. The same influence may be at work here as noted above with respect to choice No. 12.

**Hypothesis 4**

Our final hypothesis is that there is a systematic association between a therapist's readiness to warn (or, to state the matter conversely, the therapist's reluctance to breach the privacy of the therapeutic alliance), and at least some of the demographic variables and/or practice variables dealt with by the data. One correlation coefficient mentioned in the results chapter is suggestive of the possibility that senior therapists may have a greater tendency to maintain confidentiality than their junior colleagues. Whether this is true, and if so, why, may provide an interesting item for future inquiry. Another correlation coefficient mentioned in the results chapter is
suggestive of the possibility that those who see more new patients in a given time may have more readiness to warn and less tendency to maintain confidentiality that other therapists. It may be that among the therapists who see the most new patients are those in a consulting type practice, such as those who make hospital rounds. This type practice is likely to involve sharing information and findings with other health care providers on a regular basis. Whether there is something about this situation that tends to lead to therapists acquiring a greater readiness to warn is an interesting speculation not fully resolved by the present data.

A Diverse Group

Although all are health service providers, the psychologists who participated are a very diverse group in several ways. The proportion of women to men is about the same for participants as it is for health service providers in psychology, judging from a search for feminine sounding names and masculine sounding names in the Texas Roster. Ages range from between 30 and 39, (26.9%) to over 59 (6.7). The number of years in clinical or counselling practice ranges from none (1.9%) to 37 (1.0%). The modal length of practice is 10 years (13.0%). Roughly half the participants (51.7%) have 10 years practice or less; the others have 11 years or more. The majority (61.7%) practice in cities with population over a quarter-million. About one-fifth practice
in communities of less than 100,000, a very few (1.0%) less than 10,000. The number of new patients seen each month ranges from less than 5 (32.5%) to over 20 (17.2%). About 80% have testified as a psychologist expert witness in one or more cases, some over 100 cases. About 89% have seen patients they considered dangerous, some over 100. The therapists having patients who have killed one or more persons comprise 61.2%. Almost the same proportion (61.7%) have had one or more patients threaten to kill someone. These quantities may not be representative of all health service provider psychologists in Texas, since encounter with dangerous patients may have been a factor in the decision of the participants to take part in this study.

The participants were asked, "What percentage of your therapy patients do you ask for consent, at the outset of therapy, to make any disclosure . . . which you may deem necessary to prevent harm to the patient or to anyone else?" About half the participants reported that they make no such request of any patients. The remainder report requesting such consent verbally, in writing, or both, from at least some of their patients. It is difficult to draw firm conclusions from this data because therapists are often heard to say, "I don't ask for their consent, I tell them that that is how it is going to be." When this admonishment is given and the patient continues therapy, it can be argued that the patient has given consent, by deed if not by word.
It is not clear how a therapist who gives this admonishment would answer the question quoted above. The therapists were also asked whether seeking such consent would be a positive introduction to therapy or an impediment to therapy. Of those who answered this question, 41.9% regarded it as a positive introduction to therapy; 58.1% as an impediment. In discussing this issue with therapists, those who regard it as an impediment seem to be fairly flexible on the point, with some willingness to consider further the implications of it.

The diversity of outlook of the psychologists who participated is indicated by the names they gave when asked to list the writers whose published teachings have the greatest influence on their approach to therapy, first, second and third choice. No less than 130 different names were given. Examination of these frequencies reveals that most of these choices went to 37 of the writers named. In analyzing the data, names were selected for special attention who were chosen by more than one participant as a first or second choice. This process yielded the 37 names which appear in Table 6, Appendix M. Names on this list of 37 were selected in approximately 78% of all the choices made. The other 93 names accounted for the other 22% of the choices for first, second or third choice.

Proposed Legislation

What has been learned in the preparation for this
research project, and in the process of carrying it out, may have some practical usefulness to those who are interested in possible changes in the laws which are presently in force in Texas. One question set out on the questionnaire asked consent for a follow-up interview. A number of therapists entered their names, giving consent to such an interview. Of those who did so, thirty were selected on the basis of their experience with dangerous patients, as reflected in other answers to the questionnaire. These were interviewed, mostly by telephone. No statistical studies were attempted from the data thus acquired. But these interviews provide a major basis for the proposed legislation set out at the end of this chapter. The interviews were largely directed toward a description of what the therapists do when confronted with the patient's threat to kill or harm someone. These therapists practice in many different parts of the state, and represent a great variety of types of practice. Many varied opinions were expressed on various issues. This series of interviews was an altogether necessary preparation for this effort to formulate a coherent proposal for legislative enactment. Since anonymity was promised to all participants in the original questionnaire, the names of the thirty therapists consulted will not be mentioned. Only two exceptions will be made to that rule, and that only because it seems appropriate to point out that the chairman and vice chairman of the Texas
Psychological Association's Committee on Legislation were consulted in the course of this project. Both Dr. Thomas Cook, chairman of that committee, and Dr. Kevin Karlson, vice-chairman, have taken an active interest in this work and have expressly agreed that their interest in this work be made known in the text of this paper. While the author is solely responsible for the proposals here set forth, profound gratitude is expressed to these two gentlemen for their highly informative and greatly valued assistance and encouragement. Indeed, one would be remiss not to express gratitude to all the psychologists who cannot be named here, but who participated and assisted in this work.

The one thing that most of these therapists seem to agree on is that the therapy itself is often the best protection the threatened person has, and that in grand sum the efforts of psychologist therapists of Texas make an important contribution to the public safety. They seem to agree that if therapy continues after the threat is uttered, the danger to the threatened person is likely to be lessened by the therapy.

The one other point on which most therapists seem to agree is that no methodology exists whereby predictions can be made with reasonable certainty as to whether the threat, once uttered, will be carried out. Some think that a fairly high level of accuracy in predicting that the threat will not be carried out is attainable by predicting, in doubtful
cases, that it will be carried out. But even in this respect no one believes that anything like certainty is attainable.

The most important difference of opinion among the therapists consulted centers on the question of what should be said to the patient at the beginning of therapy about the possibility that the patient will, in the privacy of the therapy encounter, express an intention to harm someone. Many differing shades of opinion were expressed, but they can be generally grouped into two basic, divergent approaches to the problem. It may be helpful to refer to these as Approach A and Approach B. (As a mnemonic device, we might say that, as will be apparent in due course, the letter A can be associated with the word "airport", and the letter B can be associated with the terms "bluster", "bravado" and "blowing off steam".)

Approach A holds that, at the beginning of therapy, the therapist makes an active effort to discourage the patient from making any threat in the therapist's hearing to harm someone. We have all seen the signs at airport passenger loading areas announcing that jokes about guns and bombs are forbidden. In a similar manner, the patient is informed that if he makes any threat to harm anyone, he can expect the therapist to promptly inform the threatened person and the police that such a threat has been made. Such an initial statement has been referred to as the "psychological
Miranda." The desired effect of this, according to Approach A, is to eliminate many threats that would otherwise be made. The threats that are thus screened out, according to this view, are not threats that are important to therapy, and their omission does not hamper therapy. In fact it helps, because the therapist does not have to struggle with the problem of how to deal with such threats. But, surprisingly, the advocates of this approach report that a fair number of threats are made in spite of the admonishment. One therapist reports roughly one a week on the average, over a period of some years. These threats that come out in spite of the screening are important to therapy. But again, the therapist does not struggle much with how to deal with it. He or she simply does what was promised at the outset—inform the threatened person and the police. But a great deal of care and skill is involved in exactly how this is done. In some cases the patient is asked to be the one who informs the threatened person. And the remarkable thing is that these therapists report that they are generally able to "go public" and still maintain strong rapport with the patient, and continue therapy. Therapists who question Approach A believe that the initial admonishment, the psychological Miranda, will discourage some of the patients who need therapy most from pursuing therapy. One therapist mentioned the case of a Viet Nam combat veteran. If such an admonishment had been made to
that patient, so the therapist believes, the patient would have rejected therapy, and might have refused to pursue it even from another therapist. But one therapist who advocates Approach A reports that, in six years during which such an admonishment has been given to all patients, a grand total of three persons have refused therapy because of it. In summary, those who reject Approach A see two major problems with it: first, it may deprive some people of therapy who need it most, and, second, that "going public" will sometimes increase the danger, not reduce it, because the protection that therapy affords to the threatened person will have been lost, in exchange for the dubious protection afforded by warnings.

Therapists who prefer Approach B make no effort to discourage the patient from making threats, or from expressing any other thoughts they may have. It is assumed that a great portion of the threats will not be carried out, and, moreover, no attempt will be made to carry out such threats. Such threats, then, can be called bluster, or bravado, or blowing off steam. The therapist, then, is called upon to assess the threats that are heard, and sort out the bluster from the rest. The difficulty, as everyone recognizes, is that there is no reliable method for making this assessment with certainty, and the most skilled professional, acting with the utmost care, can be wrong. But the proponents of Approach B answer this by saying that
reliance upon a warning to guarantee the safety of the threatened person is equally vulnerable to error, especially if the effect of the warning is to take away the protective effect of continuing therapy. Continuing therapy is a protective measure that may or may not be sufficient; warning is a protective measure that may or may not be sufficient. There is risk either way. The Approach B therapist does her or his good faith best to select the safest of these two risky routes. The moment the therapist concludes that warning is the least risky of these two routes, the therapist warns. Typically, the Approach B therapist does not decide never to warn; rather, he or she decides to postpone warning unless and until it appears to be the safer course. Warning is an option that is always kept under consideration, but it may be deferred at a given point in time. To the Approach B therapist this is a logical method if a warning would shatter the rapport which is the essential element that makes continuing therapy an act of protection toward the threatened person. The therapist defers warning, not out of any certainty that the threat will not be carried out, but out of the belief that therapy, which seems to be working as a protective strategy, is more reliable than the available alternative. As one therapist put it, "I would rather depend on what I am doing, which seems to be working well, than to assume that my patient's wife will flee from her home if I tell her of the
threat, since that is the only way she could really protect herself, or than to depend on help from the police."

The police, of course, can do nothing until after the threat is carried out. The benefit of warning the police is that they may help in locating the threatened person; their participation may make the threatened person take the warning more seriously; and, of course, the fact that the police might look to him as the prime suspect may deter the patient from carrying out the attack. If the patient is commitable, then the police can take him into custody. But commitment is not always a satisfactory solution to the problem under study.

It has been said here several times, and repeated many times in the published commentary, that there is no reliable method to predict with certainty whether the threat will be carried out. Approach A therapists tend to hold that attempts to make such predictions should be avoided. But Approach B therapists, while acknowledging that some element of uncertainty will always be present, tend to hold that the attempt must be made, and the therapist must do the best that can be done. And they tend to believe that, uncertain as it is, the assessment is better than pure guesswork. And they also tend to believe that, while no method assures success, there are certain guidelines that will make successful prediction more likely, and ought to be followed. These guidelines consist of a set of indicators, as follows:
1. Whether the patient's history includes, or does not include, violent behavior, and the nature and extent of such violent behavior if any, are important factors in predicting violent behavior.

2. Apart from history of violence, the most important indicator has to do with the manner in which the patient responds to the therapist's efforts to defuse the danger. Therapy, generally speaking, is a joint enterprise, and how well the patient does his part in this particular aspect of therapy is a crucial indicator. Another way of saying this is that, in order to assess the threat, the therapist-patient relationship must be carefully assessed.

3. How clearly the patient is thinking is important. An irrational, thought-disordered patient may be more dangerous.

4. But, on the other hand, a clear-thinking patient who has worked out an elaborate, detailed plan for the attack, based on carefully assembled facts, such as information about the routine movements of the threatened person, may be even more dangerous.

5. The nature of the pathology is a factor to be considered. A severely depressing patient who is doing very little by way of physical activity may, for the moment, be less dangerous than a manicking patient engaged in a great deal of activity. Other aspects of the patient's pathology may bear on the assessment.
6. Age of the patient is a factor. Young people are more likely to make threats for the pure pleasure of it than older people. But this factor is by no means conclusive.

7. The effect of medication is a factor, as is the patient's habit of substance abuse, if any.

8. Information about the threatened person, and the likelihood of provocative behavior by the threatened person, can be indicators.

9. The frequency and persistency of the threat, and the time period involved, can be indicators.

10. The patient's display of impulse control or lack of it, as well as the patient's habit of compliance with societal restrictions, are indicators.

11. Doubtless there are other indicators used by various therapists. And none of these, in isolation, provide a sufficient basis for decision. The entire gestalt, as it develops from moment to moment in the course of therapy, must be taken into account. Whatever affects therapy can have some effect on the assessment of likelihood that the threat will, or will not, be carried out.

12. There are other guidelines apart from these indicators mentioned above. One is that consultation with colleagues is very nearly essential in the more difficult cases, and helpful in any case.

13. Another is that it promotes clarity of thinking to make a written analysis of the problem when a threat is
uttered. And this writing may prove to be very useful evidence that the matter was carefully considered.

One or two other impressions, gained from the conversations with the therapists, are noteworthy:

Many therapists do not have a clear, detailed grasp of the provisions of the Texas confidentiality statute. Therapists are often surprised to learn that, according to its terms, a therapist could be held liable in damages to the patient for disclosing a threat to the threatened person without the patient's consent, if the patient can show damage by the disclosure. Some therapists seem to have a great faith that their own good faith is all the legal protection they need. From a lawyer's perspective, this is a naive attitude. A proposal for change in this feature of the law will be offered in this chapter.

But there is a corollary to this that has important implications for legislation. As this is written, therapists in Texas, whether we are talking about Approach A therapists or Approach B therapists, are doing what they believe, in all good faith, is most likely to protect anyone who is in danger of harm at the hands of their patients. And they do remarkably little worrying about the legal consequences to themselves when they do the best they can in good faith and in fairness to all. They make decisions from a list of choices, all of which are fraught with unavoidable risks, and they make these decisions courageously. At every
turn they are faced with the danger that the choice they made will prove to be catastrophically wrong, in spite of their best efforts, no matter how carefully and skillfully applied. If this happens, they will face the glare of publicity, and some will judge them to have been somehow at fault. However unfair this judgment is, it will bring pain for the therapist. And in the courtroom, far from the reality of what the therapists was actually up against and what the therapist actually had to work with, various people, even including other therapists, will discourse learnedly about what the therapist should have done. And in the face of these hazards, they are at their posts now, doing work that the community urgently needs for them to be doing. Some of them do not know it, but they are in a position analogous to Daniel in the lion's den. If they stumble in one direction, their patient can leap upon them for an unauthorized disclosure. If they stumble in the other, someone killed or injured by their patient can leap upon them. The providential intervention that rescued Daniel may or may not be available to these therapists. The hope is expressed here that the legislature will assume the role of their rescuers, because it is in the public interest for the legislature to do so. Although the tidal wave has not yet reached the appellate courts of Texas, courts in other states have created a serious dilemma for therapists. Therapists are subject to the same human needs and pressures
that everyone else is. They need some expression of support and encouragement from the community, in the form of legislative changes. And the public interest requires that they have it. Whether they have it or not they will probably keep doing their jobs the best they can. But if they have the legislative help they need, they can and will do this work with a great deal more confidence, more clear understanding of what is expected of them and how they can protect themselves by doing what ought to be done in the interest of public safety, more conviction of the real worth of what they are doing, more enthusiasm, more heart. Therapists need this, and everyone who faces the rising tide of violence in our communities needs for them to have it.

The work that the therapists who face these threats are doing is comparable in some ways to the work done by police negotiators when someone takes someone hostage, barricades himself and the hostages in some sheltered place, and threatens to kill anyone who comes within weapon range. Typically the SWAT team surrounds the place, an armed standoff lasts for hours, and the negotiator tries to talk to the armed man. Often there is a happy ending, often not. It is probably a safe guess that some methods have been found to work better for the negotiators than others. But it is probably true that there is no technology that will assure a favorable outcome, however skillfully applied, with whatever level of diligence and care. But there are some
differences. If the outcome is bad and the innocent hostages are killed, there does not seem to be much public impulse to blame the police negotiator for not somehow bringing about a better outcome. And if the outcome is good, and no one is injured, applause for the police negotiator. And well there should be. A very dangerous job has been done, requiring a great deal of courage, infinite patience, and probably some kind of indefinable knack. But if the therapist faces a situation where someone's life is in danger, and manages, by the exercise of courage, patience and some indefinable knack, to work through it with no one hurt, where is the applause? There can be none, because there can be no public knowledge of it. Confidentiality requires that. The therapist must savor this victory in private. It is only when catastrophe strikes that the TV cameras show up. It would seem just, fair, and in the public interest, that if anyone ever seeks to hold the police negotiator liable because she or he did not somehow avoid anyone being hurt, that the controlling issue would be simply the good faith of the police negotiator. It also seems just, fair, and in the public interest that when someone seeks to hold the therapist liable because he or she did not somehow avoid anyone being hurt, that the controlling issue would be the good faith of the therapist.

One more thought should be examined before we set out the terms of the proposed legislation. If psychologists are
going to ask the legislature to make good faith the test, it would probably increase the chances of legislative approval if psychology as a profession would demonstrate its own good faith by taking steps to demonstrate that public safety is indeed a major concern of working psychologists. Among such steps the following might be considered.

1. The Texas Psychological Association should adopt proposed legislation dealing with the issues here under study. The Association's proposed statute should then be placed in the hands of every psychologist practising in Texas.

2. Through action of the Texas Psychological Association or otherwise, frequent and regular written reports should be made available to the psychologists of Texas, emanating from a blue-ribbon panel of distinguished psychologists representing various areas of the state and various points of view concerning the practice of psychotherapy. These reports should articulate the panel's best efforts to describe a consensus of Texas psychologists' views relating to the issues dealt with by the Association's model statute, and, in particular, a definition of good faith behavior on the part of therapists.

3. One of the specific items dealt with in the reports of the blue ribbon panel should be an effort to arrive at the clearest, most accurate and best statement possible of factors that should be kept in mind by therapists in Texas
as they attempt to assess the likelihood that threats made by patients will be carried out.

4. A vigorous and structured dialogue should be begun in which the most experienced therapists who adhere to Approach A and the most experienced who adhere to Approach B would explain their own position thoroughly and in great detail and would come to understand as fully as possible the opposing position. This should not be viewed as a debate, because the object is not to show that someone is right and someone is wrong. Rather, the object is for all concerned to see how much that is useful can be gleaned from understanding a divergent position, and how much can be said that represents a consensus of all participants. The content of this dialogue should be made known to, and available for study by, every psychologist therapist in Texas.

5. Some therapists are more experienced than others in dealing with threats by patients. The benefit of that experience should be made available to all psychologists engaged in therapy in Texas. A structured series of seminars to be held in all areas of the state should be initiated to accomplish this end. The cooperation of universities in the state which offer graduate programs in clinical and/or counselling psychology could be enlisted to facilitate this work.

A proposed statute is hereby offered:
CIVIL LIABILITY OF MENTAL HEALTH PROFESSIONALS
FOR THE VIOLENT ACTS OF PATIENTS/CLIENTS

This Act shall apply to all persons defined as "professionals" under the provisions of Article 5561h [Confidentiality of Mental Health Information Act], and the said definition shall apply to the provisions of this Act. The term "threat" as used herein shall mean a clear expression of present intent to commit or cause to be committed serious physical violence against a clearly identified or reasonably identifiable victim or victims.

(1) No monetary liability and no cause of action may arise against any professional for failing to take action to minimize the possibility of harm to any person from a patient/client's unlawful violent behavior unless the patient/client has communicated to the professional a threat.

(2) The duty to take action to minimize the possibility of harm to any person shall be discharged by the professional if reasonable efforts are made to accomplish one or more of the following protective measures:

(a) continued, ongoing psychotherapy conducted after the threat is uttered, calculated to minimize the possibility that such threat will be carried out, and which the therapist believes, in good faith, is having such effect.

(b) seek to bring about civil commitment of the
patient/client under the provisions of the Mental Health Code.

(c) communicate the threat to the victim or victims

(d) notify the police agency having jurisdiction of the area where violence appears likely to occur.

Which of the foregoing measures, or what combination of more than one of the foregoing measures, is most likely to minimize the possibility of harm to any person shall be decided by the professional in the good faith exercise of professional judgment, and such professional shall not be held liable for such good faith decision so long as diligent efforts shall be made in good faith to carry out such decision; PROVIDED, HOWEVER, that if at any time such professional shall conclude that the protective measures set out in sub-paragraph (a) above no longer provide in themselves the most promising measures for the prevention of unlawful violence, such professional shall, as soon as reasonably possible, proceed with reasonable efforts to carry out one or more of the other protective measures set out herein.

(4) No monetary liability and no cause of action may arise under Article 5561h [Confidentiality of Mental Health Information Act] nor otherwise against any professional for disclosure to third parties of confidential communications where such disclosure was made in a good faith effort by
such professional to discharge such professional's duty to take action to minimize the possibility of harm to any person pursuant to the provisions of this act.

(5) This Act repeals Section 4(b)(2) of Article 5561h [Confidentiality of Mental Health Information Act].
Appendix A

THE VIGNETTE

Your patient, Joseph, a thirty year old single male, is infatuated with Phyllis, a twenty-seven year old single woman, who rejects his advances, causing him extreme distress. In a private therapy session he has just told you that if he cannot have her he will kill her, and that he has purchased a switchblade knife for this purpose. You counselled to defuse the situation. He made an appointment with you for therapy, and left your office. He comes to you voluntarily, and is not under any court order, confinement or restraint. Your impressions are as follows:

1. He made this statement to you in strict confidence, and would feel betrayed and outraged if you disclosed it to anyone.

2. Phyllis is not aware of any danger she may be in.

3. Joseph is mentally ill and in need of therapy. Therapy is progressing well, and you expect continued progress.

4. Joseph will continue therapy so long as the present rapport remains intact. Disclosure of the threat would likely destroy his trust in you, and put an end to therapy.

5. Without continued therapy he may be a threat, not just to Phyllis, but to others whom he might perceive as causing him severe frustration, even into the distant future.
6. It seems unlikely that he would be committed to involuntary confinement and treatment in a civil proceeding in Mental Illness Court. He is not psychotic and is generally unlike the typical patient who is committed.

7. After he left the office you review the case carefully. You tend to feel that it is not likely that he will actually carry out the threat to Phyllis, but the possibility that he might makes you feel extremely uneasy. You consider referring the case, but realize that that would not solve your immediate problem.
Appendix B

THE QUESTIONNAIRE

Part A: The vignette questionnaire:

I. With respect to the situation described in the vignette you have just read, what would you do? Which of the following responses comes closest to describing what you would do? Please circle the appropriate number to indicate your choice. Even if none of these is exactly what you would do, please select the one you feel is closest to what you would do. Please answer on the basis of your own present impressions as to legal and ethical guidelines. Please do not consult anyone, and do not look up anything. Please select one answer only.

Enter the number here for the answer you select: ________

1. Honor your patient's expectations about the confidential nature of the disclosure he has made to you, and disclose the threat to no one. Continue therapy as before.

2. Disclose to no one the threat to Phyllis's safety. Change the emphasis of therapy, putting first priority on discouraging him from injuring Phyllis.

3. Disclose the threat to no one except to seek advice from a colleague.

4. Change the therapeutic emphasis toward protection
of Phyllis, but seek advice from a colleague, otherwise disclosing the threat to no one.

5. Report the case in full detail to medical personnel. Give facts only, making no suggestions.

6. Report the case in full detail to law enforcement personnel. Give facts only, making no suggestions.

7. Report the case in full detail to medical personnel. Explain that I cannot legally warn Phyllis.

8. Report the case in full detail to law enforcement personnel. Explain that I cannot legally warn Phyllis.

9. Report the case in full detail to medical personnel. Explain that I cannot legally warn Phyllis, and neither can they, legally.

10. Report the case in full detail to law enforcement personnel. Explain that I cannot legally warn Phyllis, nor can they, legally.

11. Report the case in full detail to medical personnel. Explain that I cannot legally warn Phyllis, but they can, and they should do so.

12. Report the case in full detail to law enforcement personnel. Explain that I cannot legally warn Phyllis, but they can, and they should do so.


14. Warn Phyllis. Urge her to not let Joseph, the police, or anyone else know she knows.
TURN THE PAGE. THE QUESTIONNAIRE CONTINUES OVERLEAF.

15. Warn Phyllis. Urge her not to call the police.

16. Warn Phyllis. Ask her to meet with you and Joseph for therapy.

17. Urge Phyllis to meet with you and Joseph for therapy, but do not tell her about the threat.

18. Call Phyllis. Do not tell her about the threat, but tell her you are concerned about Joseph, and ask her to be careful.

19. Warn Phyllis. Urge her to call the police.

20. Warn Phyllis. Call the police yourself.


22. Call Joseph. Ask him to meet with you and Phyllis in therapy.

23. Call Joseph. Ask him to meet with you more frequently for therapy.

24. Call Joseph. Urge him not to harm Phyllis. Tell him you will try to have him sent to the penitentiary if he does.

25. Call Joseph and tell him you will try to have him sent to the penitentiary if he harms Phyllis. Also warn Phyllis.

26. Call Joseph and tell him you will try to have him sent to the penitentiary if he harms Phyllis. Also call the police.

27. Call Joseph and tell him you will try to have him
sent to the penitentiary if he harms Phyllis. Also warn Phyllis and call the police.

28. Call Joseph and make an effort to have him consent to voluntary hospitalization.

The next question is related to the above question. It is as follows:

II. Which of these choices would you make in the best of all possible worlds, i.e., one in which the law and the published ethical standards were as you would wish them to be? Choose one of the answers listed above. Again, select only one, the one closest to your choice.

Please enter the number of the answer you select here: ___

Part B: Information about yourself: Please circle the appropriate choice, or enter the information requested in the blank provided:

Age: 1) less than 30; 2) 30-39; 3) 40-49; 4) 50-59; 5) over 59

Sex: 1) male 2) female

What year licensed as a psychologist in Texas: 19___

Number of years in fulltime practice of psychology: ___

Number of years in clinical or counselling practice: ___

Percentage of time devoted to therapy during current year: ___% 

Percentage of time devoted to therapy over past five years: ___% 

Approximate population of the community in which you
Appendix B—Continued

practiced:
1) less than 10,000 2) 10,000 -- 49,999 3) 50,000 -- 99,999 
4) 100,000 -- 249,999 5) More than 249,999

How many new patients you see each month:
1) less than 5; 2) 5 to 9; 3) 10 to 19; 4) 20 or more

Approximate number of cases in which you, as a psychologist, testified as an expert witness. ______________________

Before each of the following items, enter approximately how many patients you have had as to whom the following statements would apply? (Some patients might be in more than one category):

The patient —

_____ was considered by you to be a dangerous person:

_____ had killed someone:

_____ killed someone after treatment began:

_____ threatened to kill someone:

_____ threatened to kill someone and did so:

_____ threatened to kill someone and attacked the intended victim:

_____ threatened to harm someone:

_____ threatened to harm someone and attacked the intended victim:

_____ was not mentally ill but threatened to kill someone:
was not mentally ill but threatened to kill someone and did:

Do you usually obtain a signed advised consent for treatment from your patients which directly covers the practice of psychology?

1) Yes  2) No

For what percentage of patients do you obtain such a consent? __%

For what percentage of your patients do you or someone for you obtain signed consent for "medical" or "health" treatment in general (e.g. hospital consent for treatment of inpatients)? __%

TURN THE PAGE. THE QUESTIONNAIRE CONTINUES OVERLEAF.

For what percentage of your patients do you give information about the issue of confidentiality?

Verbally only? __%
Written only? __%
Both written and verbally? __%
None given? __%

These should sum to 100 %

What percentage of your therapy patients do you ask for consent, at the outset of therapy, to make any disclosure to anyone of anything the patient tells you which you may deem necessary to prevent harm to the patient or to anyone else?

Verbally only? __%
Written only? __%
Appendix B--Continued

Both written and verbally? ______ %

None requested? ______ %

These should sum to 100 %

With respect to seeking such consent, which of the following is closest to your opinion?

1) It would be a very positive introduction to therapy.

2) It would be an impediment to therapy.

During the past year how many times have you declined to give information requested about one of your patients? (For example, to a family member or an insurance adjuster.)

1) None at all 4) 6 to 9 times
2) Only once 5) Ten times or more
3) 2 to 5 times

Please list one or more (but no more than three) well known writers on psychology or related topics whose published teachings have had the greatest influence on your own approach to therapy:

1. __________________ 2. __________________ 3. __________________

Part C. Your comments: Please enter, on a separate sheet, any comments you wish to make that are brought to mind by this vignette and this questionnaire. Label them "added comments".
Part D. Will you consent to a follow-up interview by the researcher?

If so, please enter your name here: ________________________

(Names are strictly confidential, and will be disclosed to no one.)

THIS IS THE END. WHEN YOU HAVE COMPLETED YOUR RESPONSE, PLEASE MAIL THIS FOLDER, USING THE ENCLOSED SELF-ADDRESSED ENVELOPE. YOUR RETURN POSTAGE IS PREPAID. THANK YOU VERY MUCH FOR YOUR PARTICIPATION.
Appendix C

TO THE HEALTH SERVICE PROVIDERS IN PSYCHOLOGY OF TEXAS:

Dear Fellow Psychologist:

What is the duty of a psychologist who has confidential knowledge that someone is in danger? That question is involved in one of our doctoral dissertation studies now in progress.

The study is based on a vignette of a hypothetical case. The vignette is on the reverse side of this letter. I urge that you read it. You will find it interesting, and very relevant to our work.

If this were your case, what would you do?

Does this vignette raise issues that are fundamental to our profession? If you believe that it does, we ask for your help. This study is an attitude survey, and your response is needed. This letter, with the enclosures, is being sent to all Health Service Providers in Psychology in Texas. Identity of participants will be kept in strict confidence. Published findings will give statistics, not names. The report will say that the participants are Health Service Providers in Psychology in Texas, with no other clues to identity.

We sincerely hope that your views will be reflected in the findings of this study. Those who respond will, in a sense, speak for the psychologists of Texas. Please be sure
that your response is mailed within thirty days, so that tabulation can begin.

Please read the vignette, then answer the questionnaire. Mail, using the enclosed self-addressed envelope. Your postage is prepaid.

Your views will enlighten us all, for which we thank you most sincerely.

Respectfully,

(signed)

Leon A. Peek, Ph.D.
Faculty Advisor

(signed)

Minor L. Morgan, Ll.B., M.A.
Student Researcher

SEE VIGNETTE ON REVERSE SIDE OF THIS PAGE
Appendix D

To Members of the Texas College of Probate Judges:

Dear Judge:

I am writing you on a matter of special interest to all Texas judges who hear mental illness commitment cases. What do you believe to be the duty of a psychologist, or other mental health therapist, who has confidential knowledge that someone may be in danger? That question is involved in an attitude survey now being directed to all the Health Service Providers in Psychology in Texas. This survey is a part of psychological research being conducted under the supervision of the psychology faculty of North Texas State University at Denton. The student researcher is Mr. Minor L. Morgan of Dallas, an attorney whom I have known for a number of years, with substantial experience in the Probate Courts and Mental Illness Court of Dallas County. The report of this attitude survey will be Mr. Morgan's doctoral dissertation which, when given faculty approval, will complete his requirements for a doctoral degree in clinical forensic psychology.

Mr. Morgan and his psychology faculty committee feel that this attitude survey will be far more useful if it is participated in by Texas judges who hear mental illness cases. Psychologists can address the concerns of their own
profession: judges will be more inclined to address the concerns of the community at large. I agree, and I ask that each of you take part. Please read the attached vignette of a hypothetical case. (This is not based on a pending case, either in my court or any other that I know of.) I believe you will find it interesting, and relevant to important issues. Then respond in your own way to the brief questionnaire, and return your response, using the enclosed postage-paid envelope.

Your participation will be completely anonymous. The report will give statistics, not names. The report will state that the participants are judges who hear commitment cases in Texas. Beyond that, no clues to identity will be given. In a sense, those of you who do respond will speak for the judges of Texas who hear mental illness cases. I hope each of you will respond. Please mail your response within thirty days, so that tabulation can begin.

One possible result of this study is that Texas psychologists may be able to articulate the professional standards that should govern cases of this sort in a more clear and comprehensive statement than is now available. That would enhance their efforts to do their work in a responsible way. This would surely benefit the community as a whole. Those of you who were at the meeting in Corpus Christi in July of this year will remember that Mr. Morgan made a brief statement there about this project. This is
the questionnaire he mentioned.

Thank you very much.

Respectfully,

(signed)

Joseph E. Ashmore, Jr.
Judge, Probate Court No. 3
Dallas County, Texas

PLEASE TURN THE PAGE FOR THE VIGNETTE AND QUESTIONNAIRE
An act to add Section 43.92 to the Civil Code, relating to personal rights.

LEGISLATIVE COUNSEL'S DIGEST
AB 1133, as amended, McAlister. Damages against certain professionals.
Existing law provides that certain professionals are immune from monetary liability or a cause of action for damages suffered by a person as a result of specified actions performed in the course of the professional’s duties. However, case law has held that a psychiatrist may be liable for negligently failing to protect a person when a patient presents a serious danger to that person.
This bill would provide for immunity from liability for a psychotherapist who fails to warn of and protect from, or predict and warn of and protect from a patient’s threatened violent behavior, except where the patient has communicated to the psychotherapist an actual a serious threat of violence against a reasonably identifiable victim. This bill would further provide that if a duty to warn and protect does exist, it would be discharged by the psychotherapist making reasonable efforts to communicate the threat to the victim and to a law enforcement agency.
The people of the State of California do enact as follows:

SECTION 1. Section 43.92 is added to the Civil Code, to read:

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

(b) If there is a duty to warn and protect under the limited circumstances specified above, the duty shall be discharged by the psychotherapist making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.
September 20, 1985

Mr. Minor Morgan
5123 Ravine Drive
Dallas, TX 75220

Dear Mr. Morgan:

Today the Governor signed the bill which deals with the 'duty to warn' of potential violent behavior when such information has been communicated to a psychotherapist.

Enclosed is a copy of the bill in the final form which was signed.

Sincerely,

Anita M. Miller
Director Governmental Affairs

Affiliated with the American Psychological Association
Appendix G

Comparison of the APA Ad Hoc Committee Model Bill to the Recent California Legislation

As noted in the text at pp. 117-118, the Model Bill to Limit Psychotherapists' Civil Liability for the Violent Acts of Mental Patients included as a part of the White Paper recently issued by an ad hoc committee of the American Psychological Association is very similar to the recent California legislation referred to at p. 32 of the text and set out in full as Appendix E, pp. 171-172. Both bills relieve the therapist of monetary liability for the patient's violent behavior unless a threat has been communicated to the therapist. In the California bill the threat must be a "serious" one. In the ad hoc committee's model bill it must be an "actual" one.

Under the California bill the therapist must take two actions to escape liability, that is, make a reasonable effort to notify the victim and a law enforcement agency. Under the ad hoc committee's bill, the therapist must do one or the other, or seek civil commitment of the patient.

The ad hoc committee's bill expressly relieves the therapist of liability to the patient for making disclosures of confidential information in an effort to discharge a duty of protection of the potential victim. The California bill does not expressly deal with this point, but other California legislation or case law may do so.
Appendix H

Table 1

Numbers and Percentages of Responses to Questionnaires

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Appendix I

Table 2

Answer Choice Frequency Percentages, Most Popular Choices

Psychologists, Question I (What would you do, real world):

Choice number: Frequency percentage:

20 17.4%
"Warn Phyllis. Call the police yourself."

4 14.4%
"Change the therapeutic emphasis toward protection of Phyllis, but seek advice from a colleague, otherwise disclosing the threat to no one."

13 11.8%
"Warn Phyllis. Report the facts only, making no suggestions."

21 7.2%
"Call Joseph. Seek his consent to warn Phyllis."

28 7.2%
"Call Joseph and make an effort to have him consent to voluntary hospitalization."

Psychologists, Question II (What would you do, ideal world):

Choice number: Frequency percentage:

20 13.3%
"Warn Phyllis. Call the police yourself."
Choice Number: Frequency Percentage:

4 12.2%

"Change the therapeutic emphasis toward protection of Phyllis, but seek advice from a colleague, otherwise disclosing the threat to no one."

28 10.6%

"Call Joseph and make an effort to have him consent to voluntary hospitalization."

13 10.0%

"Warn Phyllis. Report the facts only, making no suggestions."

16 9.4%

"Warn Phyllis. Ask her to meet with you and Joseph for therapy."

Judges, Question I (What should therapist do, real world): Choice number: Frequency percentage:

12 18.5%

"Report the case in full detail to law enforcement personnel. Explain that the therapist cannot legally warn Phyllis, but they can, and they should do so."

28 13.0%

"Call Joseph and make an effort to have him consent to voluntary hospitalization."
Choice Number: | Frequency Percentage: |
---|---|
2 | 12.0% |

"Disclose to no one the threat to Phyllis' safety. Change the emphasis of therapy, putting first priority on discouraging him from injuring Phyllis."

4 | 8.7% |

"Change the therapeutic emphasis toward protection of Phyllis, but seek advice from a colleague, otherwise disclosing the threat to no one."

1 | 7.6% |

"Honor the patient's expectations about the confidential nature of the disclosure he has made, and disclose the threat to no one. Continue therapy as before."

Judges, Question II (What should therapist do, ideal world):

Choice number: | Frequency percentage: |
---|---|
12 | 18.9% |

"Report the case in full detail to law enforcement personnel. Explain that the therapist cannot legally warn Phyllis, but they can, and they should do so."

28 | 14.7% |

"Call Joseph and make an effort to have him consent to voluntary hospitalization."

4 | 7.4% |

"Change the therapeutic emphasis toward protection of Phyllis, but seek advice from a colleague, otherwise disclosing the threat to no one."
Appendix I—Continued

Choice Number:  
6 7.4%

"Report the case in full detail to law enforcement personnel. Give facts only, making no suggestions.

11 6.3%

"Report the case in full detail to medical personnel. Explain that the therapist cannot legally warn Phyllis, but they can, and they should do so."
Appendix J

Table 3
Answer Choice Frequency Percentages, Descending Order

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Table 4

Answer Choice Frequencies, Numerical Order

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Appendix L

Table 5

Answer Choices, Lists Red, White, and Blue

List Red (Readiness to Warn):

11. Report the case in full detail to medical personnel. Explain that I cannot legally warn Phyllis, but they can, and they should do so.

12. Report the case in full detail to law enforcement personnel. Explain that I cannot legally warn Phyllis, but they can, and they should do so.


14. Warn Phyllis. Urge her to not let Joseph, the police, or anyone else know she knows.

15. Warn Phyllis. Urge her not to call the police.

16. Warn Phyllis. Ask her to meet with you and Joseph for therapy.

19. Warn Phyllis. Urge her to call the police.

20. Warn Phyllis. Call the police yourself.

25. Call Joseph and tell him you will try to have him sent to the penitentiary if he harms Phyllis. Also warn Phyllis.

27. Call Joseph and tell him you will try to have him sent to the penitentiary if he harms Phyllis. Also warn Phyllis and call the police.
List White (Neutral):

5. Report the case in full detail to medical personnel. Give facts only, making no suggestions.

6. Report the case in full detail to law enforcement personnel. Give facts only, making no suggestions.

7. Report the case in full detail to medical personnel. Explain that I cannot legally warn Phyllis.

8. Report the case in full detail to law enforcement personnel. Explain that I cannot legally warn Phyllis.

9. Report the case in full detail to medical personnel. Explain that I cannot legally warn Phyllis, and neither can they, legally.

10. Report the case in full detail to law enforcement personnel. Explain that I cannot legally warn Phyllis, nor can they, legally.

17. Urge Phyllis to meet with you and Joseph for therapy, but do not tell her about the threat.


22. Call Joseph. Ask him to meet with you and Phyllis in therapy.

24. Call Joseph. Urge him not to harm Phyllis. Tell him you will try to have him sent to the penitentiary if he does.
Appendix L—Continued

List Blue (Less Readiness to Warn):

1. Honor your patient's expectations about the confidential nature of the disclosure he has made to you, disclose the threat to no one. Continue therapy as before.

2. Disclose to no one the threat to Phyllis's safety. Change the emphasis of therapy, putting first priority on discouraging him from injuring Phyllis.

3. Disclose the threat to no one except to seek advice from a colleague.

4. Change the therapeutic emphasis toward protection of Phyllis, but seek advice from a colleague, otherwise disclosing the threat to no one.

23. Call Joseph. Ask him to meet with you more frequently for therapy.

28. Call Joseph and make an effort to have him consent to voluntary hospitalization.
Appendix M

Table 6
Writers Who Influenced Therapist Participants

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* Several persons named Keeney have published writings on psychology-related topics. It is undetermined which of these the participants had in mind.
References

(Judicial opinions in court cases, e.g. Tarasoff I, Tarasoff II, Brady v. Hopper, etc. are listed in a separate section following this list of references).


Each of the opinions cited is published in a volume of one of the units of the National Reporter System, all published by West Publishing Company, St. Paul, Minn. Each unit of the National Reporter System consists of a number of volumes, and new volumes are published as new cases are reported. The units whose volumes are cited in this dissertation are listed here, with standard abbreviations. The volume number precedes the unit abbreviation; the page number of the beginning of the case report comes immediately after the unit abbreviation.

A2d: Atlantic Reporter, second series.
Cal. Rptr.: California Reporter.
NE2d: North Eastern Reporter, second series.
NW2d: North Western Reporter, second series.
P2d: Pacific Reporter, second series.
SE2d: South Eastern Reporter, second series.
SW2d: South Western Reporter, second series.
S.Ct.: United States Supreme Court Reporter.

The cited opinions are listed on the next page, et seq.


Bradley Center Inc. v. Wessner, 296 SE2d 693, Supreme Court of Georgia, 1982.


Cairl v. State, 323 NW2d 20, Supreme Court of Minnesota, 1982.


Davis v. Lhim, 335 NW2d 481, Court of Appeals of Michigan, 1983.


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Estate of Mathis v. Ireland, 419 NE2d 782, Court of Appeals of Indiana, Third District, 1981.

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McIntosh v. Milano, 403 A2d 500, Superior Court of New Jersey, Law Division, 1979.


People v. Murtishaw, 175 Cal. Rptr. 738, Supreme Court of California, 1981.

People v. Poddar, 111 Cal. Rptr. 910, Supreme Court of California, 1974.


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Tarasoff I: Tarasoff v. Regents of the University of California, 118 Cal. Rptr. 129, Supreme Court of California, 1974.

Tarasoff II: Tarasoff v. Regents of the University of California, 131 Cal. Rptr. 14, Supreme Court of California, 1976.

Thompson v. County of Alameda, 614 P2d 728, Supreme Court of California, 1980.
