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TARASOFF AND THE DILEMMA OF THE DANGEROUS PATIENT: NEW DIRECTIONS FOR THE 1990'S

Michael L. Perlin*

I. INTRODUCTION

One of the most controversial aspects of the legal regulation of mental disability practice is the so-called "duty to protect" that stems from caselaw construing the California Supreme Court's 1976 decision in Tarasoff v. Regents of University of California.1 Tarasoff held that, in certain limited circumstances, when a therapist determines (or should have determined) that her patient presents a "serious danger of violence to another, [she] incurs a duty to use reasonable care to protect the intended victim against such danger."2 If she fails to do this, she may be liable for tort damages.3

Over the past fifteen years, the legend of the Tarasoff case has grown to mythic proportions. The case has spawned a cottage industry of commentary: mental health professionals have attacked it as a prime example of unwarranted "judicial intrusion" into psychotherapeutic practice; legal commentators have predicted that it marked "the decline of effective psychotherapy;" and empirical surveyors have found that it has had a profound impact on mental

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3. Id. at 340-42.


health practice even in jurisdictions where it is inapplicable.\textsuperscript{7} Widely misunderstood,\textsuperscript{8} it remains the benchmark against which all other litigation and statutory reform in this area is measured,\textsuperscript{9} as well as the subject of the most common questions directed to the American Psychiatric Association's legal consultation service.\textsuperscript{10} According to the most comprehensive empirical survey done on Tarasoff awareness among mental health professionals, "it is a fair guess that there is no other legal decision, with the possible exception of controversial cases such as \textit{Brown v. Board of Education}, which could command this level of recognition among a subgroup of laypersons."\textsuperscript{11}

\textit{Tarasoff} has become shorthand for a variety of fact situations and issues that transcend both the unique situation presented in that case and the broader question of how liability should be imposed in cases where mentally disabled persons are litigational "third parties," that is, where they are neither plaintiffs nor defendants but where it is alleged that their violent actions caused the injury that led to the victim's suit against the therapist.\textsuperscript{12} Issues of confidentiality, informed consent, scope of insurability, patients' rights, predictivity of dangerousness, and limits on governmental intervention in psychotherapeutic practice have all been considered through the \textit{Tarasoff} filter in ways that should eventually help illuminate the core underlying issue: what must a therapist do when she believes that her patient or client is potentially dangerous to a third party, and what implications does the resolution of this issue have for malpractice jurisprudence?

In the course of this article, I will consider this question in the following way. First, I will briefly summarize \textit{Tarasoff} and its progeny, try to articulate the direction in which post-\textit{Tarasoff} cases appear to be headed, highlight some of the key questions that must be asked in any potential \textit{Tarasoff} setting, and review the scholarly

\begin{itemize}
    \item \textsuperscript{7} See Givelber, supra note 5, at 39-54.
    \item \textsuperscript{9} See 3 PERLIN, supra note 1, § 13.05, at 135.
    \item \textsuperscript{10} James C. Beck, \textit{The Psychotherapist's Duty to Protect Third Parties From Harm}, 11 MENT. & PHYS. DIS. L. RPTR. 141, 147 (1987).
    \item \textsuperscript{11} Givelber, supra note 8, at 457-58.
    \item \textsuperscript{12} This use of the term is explained in 3 PERLIN, supra note 1, § 13.05, at 134 n.70.
\end{itemize}
and practice-based critiques of the decisions.\textsuperscript{13} Second, I will look at the subject matter from the important—but rarely discussed—perspective of the forensic evaluator, will say a brief word about the impact of \textit{Tarasoff} on cases involving persons with AIDS, and will consider how the \textit{Tarasoff} doctrine fits (or does not fit) with other important mental disability constructs such as the right to treatment, the application of procedural and substantive due process to the involuntary civil commitment setting, the application of the least restrictive alternative, the right to refuse treatment, and the bundle of civil rights surrounding outpatient commitment.\textsuperscript{14} Third, I will try to look at “new directions” in \textit{Tarasoff} developments in light of two important constructs: those cognitive psychology devices (such as heuristics) through which we attempt to simplify complicated information-processing tasks, and “therapeutic jurisprudence” (the investigation into the question of whether legal rules impair or improve the functioning of the mental disability system). In this context, I will focus specifically on the relationships between \textit{Tarasoff}, public perceptions of \textit{Tarasoff}, and malpractice litigation. Finally, I will conclude by suggesting that, in order to “solve” the dilemma of the clinician’s obligation in dealing with the dangerous patient, we must look at these latter concepts: the integration of \textit{Tarasoff} with other jurisprudential doctrines; and the application of cognitive psychology/therapeutic jurisprudence constructs.\textsuperscript{15}

\section{\textit{Tarasoff}, Its Progeny, and Its Critiques}

\subsection{The Tarasoff Case}

The facts of \textit{Tarasoff} are well-known. A University of California graduate student (Poddar) told his therapist that he intended to kill Tatiana Tarasoff, a young woman whom he had previously dated.\textsuperscript{16} The therapist consulted with his supervisor and then contacted the campus police who questioned Poddar and then released him once he promised to stay away from Ms. Tarasoff.\textsuperscript{17} Two months later, Poddar went to Ms. Tarasoff’s home, and killed

13. See infra text accompanying notes 16-72.
14. See infra text accompanying notes 73-141.
15. See infra text accompanying notes 142-96.
17. Id. at 339-40.
her. Subsequently, her parents filed suit on a variety of tort theories, including the failure on the part of Poddar’s therapists to warn them that Poddar was a “grave danger” to their daughter.

In its rehearing in the case, the California Supreme Court found a “duty to protect” (rather than a “duty to warn”), and held:

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 discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.

In answering the question of whether a plaintiff would be entitled to legal protection against a defendant’s conduct in such a case, the court sought to balance the foreseeability of harm to the plaintiff, the degree of certainty that she would suffer injury, the closeness of the connection between defendant’s conduct and the plaintiff’s injury, the moral blameworthiness attached to the defendant’s conduct, and the potential consequences to the commu-

20. In its initial decision, the California Supreme Court had found that a psychotherapist was under a duty to warn when, “in the exercise of his professional skill and knowledge, [he] determines, or should determine, that a warning is essential to avert danger arising from the medical or psychological condition of his patient.” Tarasoff v. Regents of Univ. of Cal., 529 P.2d 553, 555 (1974), modified, 551 P.2d 334 (1976). The Court reheard the case at the request of the American Psychiatric Association and other professional organizations. Mark J. Mills & James Beck, The Tarasoff Case, in The Potentially Violent Patient and the Tarasoff Decision in Psychiatric Practice 1, 4-5 (James Beck ed. 1985); see also Vanessa Merton, Confidentiality and the “Dangerous” Patient: Implications of Tarasoff for Psychiatrists and Lawyers, 31 EMORY L.J. 263, 294 n.70 (1982).
21. The decision was a split one. Justice Mosk concurred in part and dissented in part, stressing that his partial concurrence was premised on the fact that the defendant therapist did predict that Poddar would kill Tatiana. Tarasoff, 551 P.2d at 353. Justice Clark dissented, warning that the majority’s rule “is certain to result in a net increase in violence.” Id. at 355. See also infra text accompanying notes 100-01.
In such cases, liability will only lie where the defendant bears a "special relationship" to the dangerous person. The therapist-patient relationship satisfies this test.

The court rejected the argument that mental health professionals' inability to accurately predict dangerousness should insulate them from liability, and stressed that the alleged failure here was not in the accuracy of prediction (as the therapist did contact the campus police) but in the failure to warn once the prediction was made. While it was possible that unnecessary warnings might be given, that risk was "a reasonable price to pay for the lives of possible victims that may be saved." Finally, the court rejected defendants' argument that confidentiality concerns barred the issuance of warnings. Looking both at the patient's interest in privacy and the public's interest in safety, the court concluded that "the public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins."

B. Subsequent Decisions

Subsequent decisions from other jurisdictions have been far from unanimous in their interpretation of Tarasoff. Some have adopted its holding, some have extended its reach, others have limited it, while yet others have simply declined to follow it. Courts have extended the Tarasoff duty where the victim was the young child of a threatened victim, where the foreseeable violence might involve a "class of persons at risk," and, in one case,
to anyone who might foreseeably be endangered by the patient in question. In the broadest extensions, one case extended the potential class of defendants (to include all "mental health professionals," not simply psychiatrists and psychologists) as well as the type of injury involved (to include property damages where the patient burned down his parents' barn). Another case held that a doctor might be liable for failing to warn of medication side-effects if those side-effects should have led him to caution the patient against driving where it was foreseeable that an accident could result.

Courts have distinguished Tarasoff in a variety of cases. Most have involved fact settings where the victim was neither identified nor identifiable. Similar results were reached where: the therapist lacked sufficient control over the patient in question; the therapist could have reasonably believed that the patient's fantasies did not pose a danger to an identifiable victim; the foreseeable victim had pre-existing knowledge of the patient's potential danger; a separate statutorily-created privilege protected the therapist from disclosing the patient's actual confidential communication; by the time of the disclosure, the communication was no longer confiden-


40. See, e.g., Thompson v. County of Alameda, 614 P.2d 728 (1980), and see generally 3 Perlin, supra note 1, § 13.14, at 164-65 (listing cases).


42. White v. United States, 780 F.2d 97, 102 (D.C. Cir. 1986).


tial; and where it was unsuccessfully alleged by plaintiffs that a mentally ill adult's parents had undertaken a custodial relationship with their son when they allowed him to live with them after his release from a psychiatric hospital.

In spite of the inconsistent treatment (including cases litigated in several jurisdictions that either severely limit the Tarasoff duty or flatly reject its holding), the symbolic value of Tarasoff remains compelling. So compelling that no one has seriously questioned either Dr. James Beck's conclusion that the duty to protect is now "a national standard of practice" or his admonition that mental health professionals should practice "as if the Tarasoff duty to protect is the law."

C. Critical Commentary

Both Tarasoff and its supportive progeny were greeted initially with an "avalanche" of largely critical academic commentary. Commentators trained in the mental health professions initially criticized it for three main reasons: it was purportedly

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49. 3 PERLIN, supra note 1, § 13.09, at 151.
50. James Beck, The Psychotherapist and the Violent Patient, in THE TARASOFF DECISION, supra note 5, at 9, 33; see also Menninger, The Impact of Litigation and Court Decisions on Clinical Practice, 53 BULL. MENNINGER CLINIC 203, 207 (1989) (same); cf. Givelber, supra note 5, at 474 (Tarasoff "potentially the law everywhere").
51. Id. Cf. Michael D. Roth & Laurie J. Levin, Dilemma of Tarasoff: Must Physicians Protect the Public or Their Patients? 11 LAW, MED. & HEALTH CARE 104, 110 (1983) (Tarasoff has been adopted "from coast to coast").
premised on the "false view" that valid professional standards enabling psychotherapists to accurately predict future violence did exist;\textsuperscript{53} it allegedly compromised confidentiality that was essential to successful psychotherapy;\textsuperscript{54} and, by raising the therapist's obligation to the public over her obligation to the individual patient, it supposedly compromised "central professional ethical precepts."\textsuperscript{55} Critical legal commentators looked primarily at confidentiality issues, predicting that the decision would reduce the success of therapy by decreasing patients' trust in their therapists, by discouraging patients from communicating sensitive information because of fear of subsequent disclosure, and by causing patients to prematurely terminate therapy when they might learn of the potential (or actual) breach of confidentiality.\textsuperscript{56} Others expressed concern that \textit{Tarasoff} might lead to the overcommitment of patients as a means of attempting to insure the potential victim's safety,\textsuperscript{57} that


\textsuperscript{55} Givelber, supra note 5, at 37.


\textsuperscript{57} Theodore A. Olsen, Note, \textit{Imposing a Duty to Warn on Psychiatrists—A Judicial Threat to the Psychiatric Profession}, 48 \textit{U. Colo. L. Rev.} 283, 297 (1977); McCarty, supra note 53, at 133; \textit{Tarasoff}, 551 P.2d at 360 (Clark, J., dissenting); cf. McIntosh v. Milano, 403 A.2d 500, 514 (1979) ("If psychiatrists now say . . . that therapists are no more accurate than the average layman, serious questions would arise as to the entire present basis for commitment procedures"). See generally infra text accompanying notes 76-79.
the warnings themselves might cause the putative victim unnecessary emotional distress or lead to preemptive retaliatory violence on the part of the warned victim, or that the requirement of giving warnings might drive therapists away from treating potentially violent patients.

More recent literature has considered the case from a variety of other perspectives. First, influential professional associations and commentators have urged state legislatures to adopt statutes to limit potential liability for patients’ future violent acts, arguing, in part, that such measures are a necessary step if any order is to be made out of the “disharmony” caused by the “incoherent” case law. Second, other commentators have “unpacked” the rea-

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59. Personal communication, Dr. Robert L. Sadoff (July 12, 1991).
62. See Alan Felthous, The Ever Confusing Jurisprudence of the Psychotherapist’s Duty to Protect, 17 J. PSYCHIATRY & L. 575, 576, 590 (1989); see also Joseph Bloom, The Tarasoff Decision: Dangerousness and Mandated Outpatient Treatment, 30 INT’L J. OFFENDER THER. & COMPAR. CRIMINOL. vii, viii (1986) (statutes reflect “orderly progression in the attempt to more narrowly define the situations in which the Tarasoff requirement will apply, and provide clarity in the law”). California is among the states that has adopted such a law. See CAL. CIV. CODE § 43.92 (1991); see e.g., Juliet Virtue, Note, Tort Liability for California Public Psychiatric Facilities: Time for a Change, 29 SANTA CLARA L. REV. 459 (1989).
63. See Perlin, supra note 48, at 603-04; Michael L. Perlin, Power Imbalances in Therapeutic and Forensic Relationships, 9 BEHAV. SCI. & L. 111, 128
soning supporting Tarasoff-esque decisions to focus on the implicit expectations of "clairvoyance" on the part of mental health professionals. 64 Third, commentators are now beginning to explore, carefully and sensitively, the linkage between Tarasoff-type duties, preventive detention and requirements that the therapist engage in social control, 65 a question that has troubling implications when the therapist and patient are from different cultural backgrounds. 66 As I will explore later, the fear that Tarasoff concerns

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66. Griffith & Griffith, supra note 54, at 258 ("There is a tendency in such situations for aggressive behavior to be misinterpreted as a sign of dangerousness"). On the impact of socioeconomic variables such as status, race and sex, and such interpersonal variables as physical attractiveness and social likability on mental health professionals' attitudes, see Richard Rogers, Ethical Dilemmas in Forensic Evaluations, 5 Behav. Sci. & L. 149, 152 (1987), discussing Robert J. Menzies et al., Dimensions of Dangerousness: Evaluating the Accuracy of Psychometric Predictors of Violence Among Forensic Patients, 9 Law & Hum. Behav. 49 (1985), and Michael Saks & Reid Hastie, Social Psychology in Court (1985).
distorted psychiatric hospital admission and release decisions and led to the improper use of psychiatric facilities is critical to the underlying inquiries.67

On the other hand, others have begun to react positively to the Tarasoff duty,68 reasoning it could result in more proper treatment and rehabilitation for patients, thus avoiding criminal and civil proceedings that might otherwise have resulted.69 Others have reported instances where warnings have furthered the therapeutic alliance and contributed to a patient’s progress in therapy.70 We must assess these findings if we are to determine the ultimate therapeutic (or anti-therapeutic) impact of Tarasoff-type cases.71

III. ALTERNATIVE PERSPECTIVES

A. Introduction

There is little left to add to this orthodox doctrinal dissection of Tarasoff. The decision and its supportive progeny reflect the judicial attitudes that confidentiality is “trumpable,”72 that certain kinds of dangerousness are predictable, and that warnings and/or

67. See Appelbaum, supra note 65, at 783; see also Paul S. Appelbaum, Hospitalization of the Dangerous Patient: Legal Pressures and Clinical Responses, 12 BULL. AM. ACAD. PSYCHIATRY & L. 323, 325 (1984) (“The natural response on the part of clinicians has been to feel compelled to commit (or admit involuntarily) all dangerous patients, regardless of their suitability for hospitalization”) (emphasis in original)).


69. See, e.g., McCarty, supra note 52, at 121-22.


72. The word “trump” in this context denotes the supremacy of one right or duty over another right or duty. See generally Perlin, supra note 63, at 113 n.28.
other prophylactic measures do work. While the arguments as to predictivity and utility should be subject to empirical rebuttal, courts have, as of yet, been singularly unimpressed.

Two inferences can be drawn. First, judges who see psychiatrists regularly predicting dangerousness in involuntary civil commitment cases and who see renegade psychiatrists predicting long-term future dangerousness in death penalty cases (in cases where such predictions typically implicate no liability exposure) simply

73. See, e.g., Richard J. Bonnie, Professional Liability and the Quality of Mental Health Care, 16 LAW, MED. & HEALTH CARE 229, 230 (1988); Statutory Approaches, supra note 61, at 821.

While the legal conclusion that confidentiality is not an absolute value, see, e.g., United States v. Lindstrom, 698 F.2d 1154, 1167 (11th Cir. 1983); In re Zuniga, 714 F.2d 632, 641 (6th Cir. 1983), and is not similarly measurable, it is possible to study the impact of less-than-total confidentiality in the therapist-patient relationship. See, e.g., Shuman & Weiner, supra note 68, at 928 (existence of psychotherapist-patient privilege had a "marked bearing" on only a small percentage of individuals surveyed).

74. Empirical issues are discussed in Lipari, 497 F. Supp. at 191, and in Schuster, 424 N.W.2d at 168; see also infra text accompanying notes 181-83. Most empirical studies suggest that the current data base does not yield enough information so that reasonably accurate predictions can be made as to the likelihood of a specifically targeted person becoming an actual victim. See Gregory B. Leong et al., The Tarasoff Dilemma in Criminal Court, 36 J. FORENS. SCI. 728, 734 (1991), discussing Park Dietz, "Assessment of Violent Threats," (paper presented at meeting of the Southern California chapter of the American Academy of Psychiatry and Law, Long Beach, CA, June 1990).

75. On involuntary civil commitment issues in this context, see generally Perlin, supra note 63, at 117. On death penalty issues, see Barefoot v. Estelle, 463 U.S. 880 (1983); 3 PERLIN, supra note 1, § 17.13, at 529 n.270 (discussing testimony of Dr. James Grigson), and id. (citing sources criticizing Dr. Grigson's testimony).

Interestingly, the majority of therapists responding to a major Tarasoff survey indicated (1) that they were "quite confident" in their abilities to predict future violence, and (2) that they believed that almost all of their colleagues would agree with these predictions. See Givelber et al., supra note 5, at 463-64. Compare JOHN MONAHAN, PREDICTING VIOLENT BEHAVIOR: AN ASSESSMENT OF CLINICAL TECHNIQUES 92 (1981) (two out of three predictions of dangerousness by psychiatrists and psychologists are inaccurate).

76. Improper civil commitment cases are rarely successful. See, e.g., Laurence R. Tancredi, Psychiatric Malpractice, in 3 PSYCHIATRY, ch. 29, at 1, 7 (Jesse O. Cavenar ed. rev. ed. 1986); 3 PERLIN, supra note 1, § 12.25, at 70-71 (discussing cases in which verdicts have been upheld or in which cases have been allowed to proceed to trial based on improper civil commitment theories). Compare Zinermon v. Burch, 494 U.S. 113 (1990) (failure to inquire into patient's competency to consent to voluntary hospitalization may trigger §1983 civil rights claim),
do not buy the argument that predictions here are any murkier, especially where so many of the litigated cases (including Tarasoff itself) include a specifically-identified victim. Recent literature urging a "context-bound" or "interactionist" perspective on dangerousness has simply not been considered by legal fact-finders weighing these cases. Second, while the literature raises arguments suggesting that warnings may be either useless or counter-productive, it does not appear that these arguments have been made convincingly in the litigated cases.


77. See Robert D. Miller et al., Emerging Problems for Staff Associated with the Release of Potentially Dangerous Forensic Patients, 16 BULL. AM. ACAD. PSYCHIATRY & L. 309, 314 (1988):

The psychiatric profession, which had demonstrated its willingness to predict future dangerousness when such predictions were required in order to effect the involuntary commitment of patients who appeared to need it clinically, or to facilitate the release of forensic patients who were perceived not to require further hospitalization, is now surprised to find that other courts are holding them accountable for that claim of expertise in areas where they had not chosen to assert it.

See also Leonard S. Rubenstein, The Paradoxes of Professional Liability, 39 HOSP. & COMMUN. PSYCHIATRY 815 (1988) (courts' perception that psychiatrists have significant predictive expertise "encouraged, indeed fostered" by clinicians' assertions).

78. Cf. Tarasoff, 551 P.2d at 354 (Mosk, J., concurring & dissenting) (stressing significance of allegation in complaint that "defendant therapists did in fact predict that Poddar would kill") (emphasis added). For a survey of cases declining to apply Tarasoff where the victims were either not foreseeable nor identifiable, see 3 PERLIN, supra note 1, § 13.14, at 165 nn.306-309.6.


80. See, e.g., Appelbaum, supra note 65, at 783-85; see supra text accompanying notes 59-61, and sources cited. But compare supra text accompanying notes 69-71 (reporting positive outcomes of Tarasoff compliance). While we know that there is little reliable data as to either the prophylactic value of Tarasoff warnings or the case’s actual impact on all aspects of clinical practice, see infra text accompanying note 185, it is still somewhat surprising that these arguments have not been raised more frequently and more forcefully in cases already litigated.

Compare White v. United States, 780 F.2d 97, 105 n.25 (D.C. Cir. 1986). In
Thus, while the characterization of Tarasoff as a "national standard" may be somewhat overblown, it is clear that most courts are comfortable with some sort of protective duty, and it is likely that courts in "new" jurisdictions will generally agree with this principle of law. The harder question is this: what are Tarasoff's implications for cases arising in other settings? Specifically, how should we read Tarasoff in light of (1) the responsibilities that stem from forensic relationships, (2) cases involving persons with AIDS, and (3) recently-developed bodies of constitutional law that set out the rights of mentally disabled persons subject to institutionalization?

B. Other Settings

1. Forensic cases.—The forensic relationship, by its very nature, is an unbalanced one.\(^8\) The forensic mental health professional does not profess to "see a patient" for therapeutic reasons (although forensic interactions may have a therapeutic component); rather, she intervenes on behalf of the litigation, administrative or economic needs of one of a series of third parties (e.g., an attorney, a court, a prosecuting agency, an insurance company). Without these external actors, the forensic relationship could not exist.\(^8\) Thus, there is no expectation of absolute confidentiality at the forensic interview.\(^8\)

White, the court expressed no surprise that a hospital was unaware that a patient would elope since the patient's therapist had told the subsequently-violent patient that he could not promise him full confidentiality in his disclosures. The White court, however, affirmed a trial court decision declining to apply Tarasoff as it found "reasonable" the therapist's assessment that a patient's single fantasy of doing harm to his wife did not reflect a danger to her. Id. at 102; see generally 3 Perlin, supra note 1, § 13.16, at 167-68 (discussing White).


Should Tarasoff be extended to include claims made against forensic mental health professionals? While this question has been the topic of little legal scholarly consideration as of yet, academic psychiatrists have begun to consider the contours of the Tarasoff/forensic relationship. Also, forensic mental health professionals now self-report concerns about the application of the Tarasoff duty to situations where they evaluate the "threat" as a mere "expression of anger" with no imminent danger to a victim, and see ethical problems with the imposition of such a duty.

A recent California Supreme Court case has held that, once a mental health professional retained by defense counsel to testify at a criminal trial warns potential victims (based upon a threat made by the defendant), expectations of further confidentiality are terminated, and the fact of the threats may be introduced at trial. This case raises the important and difficult question of the interplay between Tarasoff and cases such as Estelle v. Smith on the question of a forensic examiner's duty to inform a criminal defendant of potential disclosure of information shared during a forensic interview. It is reasonable to expect that these issues will surface again in other jurisdictions, leading to a more careful exploration of the Tarasoff forensic setting intersection.

2. Persons with AIDS.—Scholars have begun to consider the implication of Tarasoff warnings in cases of persons with AIDS.


89. Clark is discussed carefully in this context in Leong, supra note 74.


One commentator has argued that "[n]o single concept typifies the dilemma" facing health care providers more than the existence of a Tarasoff duty, predicting that cases expanding on Tarasoff's core concepts imply that AIDS cases will also be read in a similarly expansive manner. Recent research suggests that a patient's sex, race, and sexual orientation may significantly control whether a physician decides to reveal that such person carries the AIDS virus, making careful weighing of potential Tarasoff issues in this context even more essential. The recent increase in AIDS-related litigation should bring about closer scrutiny of the application of Tarasoff in the context of cases involving persons with AIDS.

C. Tarasoff and the Constitutional Rights of Mental Patients

1. Introduction.—Paul Appelbaum's Tarasoff critique makes


92. Labowitz, supra note 91, at 500, 503. See also Waldron, supra note 91 (concluding that the right of society to be free from the risk of AIDS outweighs a patient's right to privacy); accord Judith L. Enjon, Comment, Doctor-Patient Confidentiality Versus Duty to Warn in the Context of AIDS Patients and Their Partners, 47 MD. L. REV. 675 (1988). Compare, e.g., Curran et al., supra note 91, at 29 (urging the adoption of statutes to protect physicians for liability) to Weiss, supra note 92, at 308 (arguing against extending Tarasoff duty).


95. Beyond the scope of this paper is the interrelationship (or lack of interrelationship) between Tarasoff cases (imposing a special tort duty) and the United States Supreme Court's recent decision in DeShaney v. Winnebago County Dept. of Social Serv., 489 U.S. 189, 201-02 (1989), holding that the State had no such "special duty" to protect under federal civil rights law or the Due Process clause (mother of child beaten by child's father sued local social service officials and
two important points relevant to the doctrine's interplay with the bundle of constitutional rights of individuals institutionalized in facilities for the mentally disabled. First, *Tarasoff* may increase the use of preventive detention (as a means of avoiding liability on the part of mental health professionals fearful of exposure to civil suits), and second, it may serve to lessen the likelihood that individuals legitimately institutionalized in psychiatric hospitals will receive adequate treatment.\(^9\)\(^6\) Appelbaum's argument is a compelling one and forces us to read *Tarasoff* in the context of a variety of substantive constitutional mental disability law doctrines—involuntary civil commitment, outpatient commitment, the right to the least restrictive alternative, the right to treatment, and the right to refuse treatment—if we are to understand fully *Tarasoff*'s ultimate potential impact.

2. *Involuntary civil commitment.*\(^9\)\(^7\)—Early critics of *Tarasoff* charged that it would lead to inappropriate civil commitment as a means by which mental health professionals could eliminate their potential liability.\(^9\)\(^8\) Dissenting in *Tarasoff*, Judge Clark had predicted that the duty to warn was likely to greatly increase the risk of civil commitment—"the total deprivation of liberty . . . of those who should not be confined."\(^9\)\(^9\) Appelbaum has warned of the "distorting influence" that liability concerns can have on admission de-

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employees, charging that they had failed to adequately protect the child by removing him from his father's custody.

I wish to thank Professor Peter Margulies for calling my attention to this issue.

96. Appelbaum, *supra* note 65, at 783-86.

97. On the involuntary civil commitment process in general, see 1 *Perlin*, *supra* note 1, Chapters 2 & 3.


99. *Tarasoff*, 551 P.2d at 360 (Clark, J., dissenting). *But see* McCarty, *supra* note 53, at 122-23 (benefits of *Tarasoff* outweigh costs, including patient's potential lost liberty). *Cf.* Robert A. Miller, *Outpatient Civil Commitment of the Mentally Ill: An Overview and an Update*, 6 *Behav. Sci. & L* 99, 111 (1988) ("There have been, to my knowledge, no published cases to date involving liability of therapists for the actions of civilly committed outpatients"). *But see* Cain v. Rijken, 700 P.2d 1061 (Cr. Ct. App. 1985) (community day treatment program providing aftercare services to insanity acquittee had assumed responsibility to exercise reasonable care to control the "dangerous propensities of the patient"); *compare* Halverson v. Pike's Peak Fam. Counseling, 795 P.2d 1352 (Colo. Ct. App. 1990) (statutory immunity would apply equally in duty to warn cases involving inpatients and outpatients) (third-party patient in *Halverson* was inpatient).
Other commentators have begun to consider the many underlying policy questions encrusted in the civil commitment decision in the context of Tarasoff: e.g., the appropriate balancing that must be struck between clinical choice and legal duty; the risk factors associated with inappropriate commitment; and the linkage between commitment, deprivation of liberty, and the "least restrictive alternative" doctrine.

Yet, Tarasoff's full range of potential implications for involuntary civil commitment policy have not been seriously addressed. Given what we now know about the way that a single vivid or "outrageous" case can dramatically increase commitment rates, we must reevaluate Tarasoff's implicit endorsement of commitment as

100. Appelbaum, supra note 65, at 783. See also Mills, supra note 70, at 72: "We suggest that when possible, the clinician shift to the courts the burden of the decision making regarding release from the hospital and long-term treatment of potentially violent patients." This issue is confounded further by research that suggests that clinicians' predictions of future violence become more conservative "[a]s the consequences of incorrectly predicting nonviolence become more severe." Stanley L. Brodsky, Fear of Litigation in Mental Health Professionals, 15 CRIM. JUST. & BEHAV. 492, 496 (1988) (discussing MONAHAN, supra note 75).

101. See Bednar, supra note 39, at 273-78; Bernard M. Dickens, Legal Issues in Medical Management of Violent and Threatening Patients, 31 CANAD. J. PSYCHIATRY 772, 773-76 (1986). In most jurisdictions, a person can not be involuntarily committed unless there is clear and convincing evidence that she is mentally ill, and, as a result of that mental illness, dangerous to herself or others. See, e.g., 1 PERLIN, supra note 1, §§ 2.06-.16; §§ 3.40-.42; State v. Krol, 344 A.2d 289 (N.J. 1975); Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972) (subsequent citations omitted); Addington v. Texas, 441 U.S. 418 (1979). On the question of the applicability of the least restrictive alternative in the commitment context, see infra text accompanying note 108.

102. On the other hand, we know that many clinicians misunderstand the relationship between Tarasoff and involuntary civil commitment. See Givelber, supra note 5, at 467 (over 10% of all therapists surveyed believed Tarasoff required them to seek emergency involuntary commitment to comply with case's mandate), and id. at 477-78 (about one-third of all therapists surveyed were more willing to initiate involuntary hospitalization after Tarasoff).

an alternate means of remediating liability potential. At least one commentator has already recommended that psychiatrists lower their dangerousness threshold so as to avoid liability in Tarasoff-type cases if this position becomes a popular one, the dilemma for mental health professionals will become even starker.

3. Least restrictive alternative.—Over the past two decades, a substantial body of statutory and constitutional law has developed holding that involuntarily committed mental patients have either a right to the “least restrictive alternative” or to a “reasonably nonrestrictive” setting for treatment. I have previously noted the inherent conflict between this body of case law and tort cases that seek to impose liability on institutional psychiatrists for developing “open door” policies that may carry risks to both the patient, as well as to the general public. While courts have generally rejected liability claims in “open door” cases, the policy is still characterized as a “calculated risk.”

104. See Tarasoff, 551 P.2d at 340 (“discharge of this duty may require the therapist . . . to warn the intended victim . . ., to notify the police, or to take whatever other steps are reasonably necessary under the circumstances”) (emphasis added). But compare supra note 102 (extent to which therapists believe Tarasoff requires initiation of commitment proceedings).

105. See Greenberg, supra note 65.

106. See Johnson, Note, supra note 61, at 254-57 (setting out alternatives). Several of the statutory reforms enacted in the wake of Tarasoff explicitly permit efforts at involuntary hospitalization as a means of effectuating the Tarasoff duty. See Statutory Approaches, supra note 61, at 825-26.


109. See 3 PERLIN, supra note 1, § 12.18, at 54.


111. M.W. v. Jewish Hosp. Ass'n of St. Louis, 637 S.W.2d 74, 76 (Mo. Ct. App. 1982); see also Eanes v. United States, 407 F.2d 823, 824 (4th Cir. 1969) (while court refuses to “condemn, per se, the open door policy,” it suggests that “great care and caution” be undertaken so as to assure that the risks involved not be “underestimated or miscalculated”).
At least one post-Tarasoff case that imposes a duty to protect has noted that, while state statutes did mandate less restrictive alternatives in commitment and release decision-making, those statutory schemes did not "contemplate that the decision to release an involuntarily committed patient [might] be made without regard to the safety of others." As state legislators continue to become more receptive to pleas to broaden civil commitment criteria, and as they consider whether courts should be involved in release decision-making in the cases of all patients involuntarily committed pursuant to a dangerousness finding is placed on the debate agenda, the relationship between Tarasoff and restrictiveness of institutional conditions will likely attract more judicial, legislative and scholarly scrutiny.

4. Right to treatment.—If hospitals are being used to detain potentially dangerous individuals because of fear of liability, we must consider the implications of the right to treatment doctrine for this population. Institutionalized patients are constitutionally and statutorily entitled to adequate treatment, and, in many jurisdictions, such treatment must be designed so as to give each patient "a realistic opportunity to be cured or to improve his or her mental condition." How can this right to meaningful treatment

113. See Perlin, supra note 103, at 128-29.
115. Recent criticisms of deinstitutionalization policy, see generally Perlin, supra note 103, will also likely spur this debate. On the ethical issues raised for mental health professionals by deinstitutionalization decisionmaking, see, e.g., J. Richard Ciccone & Colleen D. Clements, The Ethical Practice of Forensic Psychiatry: A View From the Trenches, 12 BULL. AM. ACAD. PSYCHIATRY & L. 263, 268-69 (1984).
116. See Appelbaum, supra note 65, at 783.
117. Wyatt v. Stickney, 325 F. Supp. 781, 784 (M.D. Ala. 1971) (subsequent citations omitted); see generally 2 PERLIN, supra note 1, §§ 4.07-.19. For state statutes following Wyatt and its progeny, see id. §§ 11.03-.07; Michael L. Perlin, State Constitutions and Statutes As Sources of Rights for the Mentally Disabled: The Last Frontier? 20 LOY. L. REV. 1249, 1296-1317 (1987). In Youngberg v. Romeo, 457 U.S. 307, 319 (1982), the Supreme Court found that institutionalized mentally retarded individuals had a constitutional right to "minimally adequate or reasonable training to ensure safety and freedom from undue restraint."
be effectuated\textsuperscript{118} if patients, unlikely to benefit from hospitalization, are admitted due to \textit{Tarasoff} fears?\textsuperscript{119}

The United States Supreme Court has recently granted \textit{certiorari} on a case whose disposition may have ominous implications for the answer to this question. In \textit{State v. Foucha}, the Louisiana Supreme Court held that it was appropriate to continue a patient’s commitment where he was found to be no longer mentally ill, but was still dangerous to others.\textsuperscript{120} Although \textit{Foucha} involves an insanity acquittee, if the Supreme Court’s ultimate decision suggests that mental illness is \textit{not a sine qua non} for institutionalization in a mental hospital, the right to treatment and \textit{Tarasoff} may be placed on a new collision course.\textsuperscript{121}

5. \textit{Treatment in community settings}.—Because of perceptions that deinstitutionalization has been responsible for the inappropriate release of patients unable to care for themselves, commentators have urged the adoption of outpatient commitment

118. See also Michael A. Norko et al., \textit{Prosecuting Assaultive Psychiatric Inpatients}, 42 \textit{Hosp. & Commun. Psychiatry} 193 (1991) (listing factors, including \textit{Tarasoff}, that result in an increase in violent patients being treated at mental health centers, which increases the danger to other patients and staff members).

119. Appelbaum, supra note 65, at 783.


121. That is, if the Supreme Court rules that the Louisiana statute under which Foucha’s institutionalization continues is constitutional, courts will quickly be confronted with new questions as to the rights of such patients—dangerous but not as a result of mental illness—to refuse treatment. Although the direct precedential weight of such a decision in \textit{Foucha} would initially necessarily be limited to other cases involving insanity acquittees, it is certainly within the realm of possibility that such a hypothetical decision could be looked at as authoritative to buttress commitment of individuals who are seen as potentially dangerous under \textit{Tarasoff}. Courts would \textit{then} have to consider the scope of the right to refuse treatment for such a population. Compare Appelbaum, supra note 65, at 781:

\begin{quote}
When the potential for violence is long-term and dissociated from any acute disorder that might exist, the current system provides powerful incentives for psychiatrists to prolong hospitalization beyond the term of useful treatment. Persons thought to be dangerous are deprived of freedom for a time but without therapeutic gain. Meanwhile, the long-term threat inevitably remains whenever the patient is discharged.
\end{quote}

(OPC) as a potential solution.\textsuperscript{122} Supporters of OPC statutes argue that such laws would insure that such individuals would have access to "protective liberty" through broad-based treatment mechanisms in community settings.\textsuperscript{123} Opponents have responded that OPC will subvert the dangerousness standard, lead to quality control problems, and defeat the right to refuse treatment.\textsuperscript{124} While early empirical studies have been mixed,\textsuperscript{125} most suggest that the ultimate success of OPC will depend on the dedication of community mental health center staff members "to making [it] work"; where centers pay only "lip service" to OPC, the law becomes undermined.\textsuperscript{126}

Three separate Tarasoff concerns are raised here. First, we must consider the effect that Tarasoff may have on a patient's unwillingness to participate in such treatment,\textsuperscript{127} as well as the implications for subsequent institutional treatment if a patient's outpatient status is terminated as a result of such refusal.\textsuperscript{128} Second, as there is already some strong evidence that community centers "have historically turned their back on precisely the population

\begin{footnotesize}
\textsuperscript{122} See Perlin, supra note 103, at 119-26.


\textsuperscript{125} See Perlin, supra note 103, at 122 n.343 (comparing studies).

\textsuperscript{126} Hiday & Scheid-Cook, supra note 123, at 229-31.

\textsuperscript{127} See Johnson, Note, supra note 61, at 254-55.

\textsuperscript{128} Perlin, supra note 124, manuscript at 50-51. See, e.g., WIS. STAT. ANN. § 51.20(13)(dm) (OPC permissible if court finds patient's dangerousness "is likely to be controlled with appropriate medication administered on an outpatient basis"); TENN. CODE ANN. § 33-6-201(b)(2) (allowing OPC where patient is subject to the "obligation to participate in any medically appropriate outpatient treatment, including . . . medication"); In re Anderson, 140 Cal. Rptr. 546, 550 (1977) (medication an appropriate condition of outpatient treatment). Compare In re Richardson, 481 A.2d 473, 479 n.5 (D.C. 1984) ("Not every instance of the outpatient's failure to take prescribed medication or attend therapy sessions justifies the conclusion that he is not cooperating with the treatment program").
\end{footnotesize}
that OPC was designed to serve," it should not surprise us if potential liability serves to increase community clinicians' resistance to becoming involved with patients subject to OPC statutes. Third, if individuals in outpatient settings are deemed capable of generating Tarasoff liability, such characterizations "would certainly temper the interest to treat them in the community."

6. Right to refuse treatment.—No aspect of institutionalization is more controversial than the right of involuntarily committed patients to refuse the administration of antipsychotic medications. In honoring a limited or qualified right to refuse, courts have clearly admonished psychiatric facilities not to use medications as a substitute for treatment or as a means of social control. While the Supreme Court, in Washington v. Harper, has subsequently sharply limited the right of convicted prisoners to refuse medication it nevertheless cautioned against the arbitrary use of drugs, noting that involuntary medication "represents a substantial interference with [a] person's liberty." Also, there is no indication that Harper will cause significant cutbacks in the right to refuse doctrine as it applies to other populations.

If Tarasoff leads to the hospitalization of disruptive individu-
als who are unlikely to benefit from psychiatric treatment, serious constitutional questions about the right of such individuals to refuse antipsychotic drug treatment are raised. In addition, important ethical considerations—centering on the motivation of the institutional treaters—are implicated as well.

IV. NEW DIRECTIONS FOR THE '90s?

A. Introduction

If Tarasoff is to be truly understood, it is necessary to consider these issues in light of yet another set of concerns. First, we need to consider recent developments from the perspective of cognitive psychology, and look at the way heuristic reasoning shapes both Tarasoff decision-making, as well as mental health professionals’ responses to Tarasoff-type cases. Then, we must turn to “therapeutic jurisprudence” as a means of identifying and examining the extent of the relationship between “legal arrangements and therapeutic outcomes.” Finally, I will draw on these inquiries, and try to offer some predictions for future judicial and legislative behavior in this area in an effort to determine the ultimate impact of Tarasoff on our malpractice jurisprudence.

B. Cognitive Psychology

Interest has recently been kindled in the use of cognitive psychology in the legal process. Focusing primarily on concepts that describe and explain heuristic reasoning and thinking, cognitive psychology serves as a means of explaining judicial, legislative and lay decisionmaking, and as a vehicle by which to interpret developments in mental disability law.


Simply put, "heuristics" refers to the implicit devices that individuals use to simplify complex information-processing tasks, leading to distorted and systematically erroneous decisions, and causing decision-makers to "ignore or misuse items of rationally useful information." The vivid, "outrageous" case overwhelms reams of abstract data upon which rational choices should be made; mental health professionals are as susceptible to these devices as are judges, jurors, legislators or other lay persons.

In a series of papers, I have considered the power of heuristics in establishing mental health law policy in such areas as the insanity defense, the relationship between deinstitutionalization and homelessness, and the right to refuse treatment. Such heuristic devices as the vividness effect, availability, typification, and attribution theory can be powerful animators of legislative


144. David L. Rosenhan, Psychological Realities and Judicial Policy, 19 STAN. L. REV. 10 (1984). Thus, one instance in which an ex-patient (or an individual denied admission to a mental hospital) commits a crime of violence may have the effect of dramatically increasing civil commitment rates in a jurisdiction in spite of whether or not the commitment criteria are amended in response to the violent incident. See, e.g., Bagby & Atkinson, supra note 103, at 46; Fischer, supra note 103, at 712. On the way that such a vivid case affects legislative policy in criminal law, see People v. Seefeld, 290 N.W.2d 123, 124 (Mich. Ct. App. 1980) (discussing the adoption of the guilty but mentally ill verdict).


147. Perlin, supra note 103.

148. Perlin, supra note 126; Perlin, supra note 146.

149. "Availability" refers to the way that we tend to judge the probability or frequency of an event based upon the ease with which we recall occurrences of the event; "typification" involves the characterization of a current experience as one which is familiar to an individual through reference to past stereotypic behaviors; under "attribution theory," once we adopt a stereotype, we interpret a wide variety of additional information so as to reinforce that stereotype. See generally Per-
amendment, judicial decisionmaking, jury deliberation, and professional response in Tarasoff-type cases.

Some of the empirical research and commentary to which I have already referred reflects this phenomenon. Thus, more than three-quarters of the clinicians surveyed reported that the issuance of warnings was the sole acceptable means of protecting potential victims. Also, commentators have significantly overstated the precedential effect of Tarasoff in all federal and state jurisdictions. Beyond this, we can be fairly confident in predicting that the distortions inherent in the heuristic reasoning style will have an important impact on an area of mental disability jurisprudence as volatile, demanding and contentious as the duty to warn. If we ignore the power of heuristics here, we proceed at our own peril.

C. Therapeutic Jurisprudence

We must also turn our attention to the construct of “therapeutic jurisprudence” as a model by which to assess the ultimate impact of case law and legislation that affects mentally disabled individuals. “Therapeutic jurisprudence” studies the role of the law as a therapeutic agent. This perspective recognizes that substantive rules, legal procedures, and lawyers’ roles may have either therapeutic or anti-therapeutic consequences, and questions whether such rules, procedures, and roles can or should be reshaped so as to


150. See Givelber, supra note 8, at 465.
151. See, e.g., Roth & Levin, supra note 51.
152. See David B. Wexler, Therapeutic Jurisprudence: The Law as a Therapeutic Agent (1990); Wexler, supra note 141.
enhance their therapeutic potential, while not subordinating due process principles.153

Thus, authors have recently considered the therapeutic jurisprudential issues inherent in such mental disability law issues as the insanity acquittee conditional release hearing,154 juror decision-making in malpractice and negligent release litigation,155 competency to consent to treatment,156 standards of psychotherapeutic tort liability,157 the impact of scientific discovery on substantive criminal law doctrine,158 and the relationship between voluntary and involuntary commitment.159

Tarasoff, therefore, should be the source of a variety of therapeutic jurisprudential inquiries. First, what impact will the need to comply with Tarasoff have on clinical practice? Second, will courts’ construction of empirical evidence that is developed about such impact take into consideration therapeutic jurisprudential values? Third, what impact will Tarasoff litigation have on clinical practice?

Much of the first wave of Tarasoff commentary spoke, sub

159. See Winick, supra note 76. There has also been a heightened call for further investigations into such other areas as the due process involuntary civil commitment hearing, the juvenile commitment process, the implications of the extension of right to refuse treatment doctrine to “new populations,” power imbalances in forensic relationships, and the ways in which counsel are appointed to represent the mentally disabled. See 1 PERLIN, supra note 1, § 1.05A, nn.156.12-156.17, at 6 (1991 pocket part) (citing sources).
silentio, to the first of these concerns.\textsuperscript{160} Thus, after Alan Stone initially assailed Tarasoff, warning that it would “destroy the patient’s expectation of confidentiality,”\textsuperscript{161} the first wave of empirical studies seemed to belie this prediction.\textsuperscript{162} While warnings not discussed with patients were interpreted to be therapeutically harmful, warnings that were discussed were interpreted to have positive therapeutic effects.\textsuperscript{163} Other empirical inquiries have focused on the ways that clinician awareness of Tarasoff has altered the therapeutic relationship, suggesting that the increased awareness of and concern about possible violence may lead to “heightened anxiety .. . in any clinical situation in which the potential violence of a patient becomes an issue, or in which the prospect of a duty to warn arises.”\textsuperscript{164}

\textsuperscript{160} Some also spoke to it openly. See Wexler, \textit{supra} note 54, at 4 (“Tarasoff ... has the clear-cut potential of prompting and prodding practicing therapists to terminate their continued clinging to an outmoded ‘individual pathology’ model of violence, and to accept the paradigm of ‘interactional’ or ‘couple’ violence already endorsed by the professional literature.”). Wexler’s insights are discussed in 3 \textit{Perlín}, \textit{supra} note 1, § 13.21, at 182-84.

\textsuperscript{161} Stone, \textit{supra} note 54.

\textsuperscript{162} See Mills et al., \textit{supra} note 70, at 70, discussing findings reported in del Rio, \textit{Ellsberg Psychoanalytic Situation}, 5 \textit{Int’l J. Psychoanalytic Psychotherapy} 349 (1976); Donald Schmid et al., \textit{Confidentiality in Psychiatry: A Study of the Patient’s View}, 34 \textit{Hosp. & Community Psychiatry} 353 (1983). On Stone’s recession from his initial position, see Stone, \textit{supra} note 55.

\textsuperscript{163} Richard J. Carlson et al., \textit{The Duty to Warn/Protect: Issues in Clinical Practice}, 15 \textit{Bull. Am. Acad. Psychiatry & L.} 179, 181-84 (1987), discussing, in part, Beck, \textit{supra} note 10; Joseph C. Finney, \textit{Breaking Confidences: An Application of the Tarasoff Rule}, 3 \textit{Am. J. Forens. Psychiatry} 135 (1982-83). See also Judith Treadway, \textit{Tarasoff in the Therapeutic Setting}, 41 \textit{Hosp. & Commun. Psychiatry} 88, 89 (1990) (Fulfilling Tarasoff’s duty “encourages patients to make choices, to be involved in decisionmaking, and to accept that they, not the therapist, have the ultimate responsibility for impulse control.”). If, as has been reported, patients most knowledgeable about the work of health professionals are the least likely to sue, see May & Stengel, \textit{supra} note 64, at 117, it would seem worth asking whether the involvement of the patient in this sort of decisionmaking might have some subsequent reductive effect on litigation.

For a recent inquiry into the impact of the psychotherapist-patient privilege from a therapeutic jurisprudence perspective, see Klotz, \textit{supra} note 71 (arguing that the absence of an absolute privilege might better prevent harmful behavior).

\textsuperscript{164} Wise, \textit{supra} note 56, at 186-88. In response to such concerns, thoughtful commentators have crafted a series of guidelines to therapists to help them deal with the Tarasoff “paradox.” See Loren H. Roth & Alan Meisel, \textit{Dangerousness, Confidentiality, and the Duty to Warn}, 134 \textit{Am. J. Psychiatry} 508, 509-11 (1977); see also Paul S. Appelbaum, \textit{Tarasoff and the Clinician: Problems in Fulfilling
These findings lead to other inquiries. First, to what extent does therapist misinformation about the scope of Tarasoff negatively affect therapist-patient relationships? Surveys suggest that therapists have overstated both the Tarasoff prescription (as to ways of effectuating the duty) as well as its national precedential applicability. Furthermore, they frequently misstate its holding,\textsuperscript{165} construe it to require accurate predictions,\textsuperscript{166} and, others believe the duty to be triggered by utterance of any threat.\textsuperscript{167} Also, it has been argued that professionals have been misled by associational newsletters that have distorted or misstated the holdings of Tarasoff's progeny, and that these misunderstandings serve to further alienate law and psychotherapy.\textsuperscript{168}

These inquiries raise yet another concern: have therapists responded to Tarasoff by adopting a passive-aggressive style of behavior?\textsuperscript{169} Commentators have speculated that the motivations of some of the clinicians who have responded to Tarasoff by over-predicting violence and over-issuing warnings\textsuperscript{170} may be simply...
their concern to escape legal liability. Others have reported that some clinicians have become reluctant to probe into areas of their patients' lives dealing with violence, while others have altered their record-keeping (either by obscuring information that might suggest violence or by "padding" a record with information so as to support a decision not to warn). Still others have argued that clinicians in hospitals should decline to assume final responsibility for releasing violent patients, and should require court interventions in all such cases. Thus, Professors Schopp and Wexler have concluded:

If the clinician is sufficiently concerned about tort liability to conduct the therapeutic relationship with a wary eye toward protecting his own interests regarding liability, that attitude may be sufficient to dilute the therapist's apparent trustworthiness and concern for the patient's welfare and thus to undermine the therapeutic relationship.

Further, this must be all weighed in light of yet another body of data that has found that doctors sued for malpractice reported significantly more emotional and psychological distress than nonsued physicians, that significantly more of the sued group were likely to stop seeing certain kinds of patients, to discourage their children from entering medicine, and to think about early retirement.

172. Compare Perlin, supra note 146, at 35-36 (discussing reluctance of judges and insanity defense policymakers to "'go deeper' when we unconsciously fear what we may learn at a deeper level of exploration").
173. Wise, supra note 56, at 188-89.
174. Mills et al., supra note 70, at 72; see also supra note 117.
175. Schopp & Wexler, supra note 157, at 184.
176. Sara C. Charles et al., Sued and Nonsued Physicians' Self-Reported Reactions to Malpractice Litigation, 142 AM. J. PSYCHIATRY 437 (1985); cf. Stephen M. Rosoff, Physicians as Criminal Defendants: Specialty, Sanctions, and Status Liability, 13 LAW & HUM. BEHAV. 231, 235 (1989) (questioning whether "status liability"—the positive relationship found between punishment and status when a high occupational status defendant commits a serious criminal offense—operates in the context of medical malpractice cases as well): see also Ellen G. McDaniel, Book Review of Robert Simon, Clinical Psychiatry and the Law (1987), 39 HOSP. & COMMUN. PSYCHIATRY 999 (1988) ("My problem, on completion of this text, was the gripping realization of how endless were the possibilities of being a defendant, regardless of the outcome. I had a momentary impulse
Others have concluded that it is not simply the reality, but the possibility of malpractice litigation that is the source of "marked anxiety" in many mental health professionals and what Robert Simon has called "iatrogenic liability neurosis" can capture a therapist's professional judgment. If clinicians believe—accurately or inaccurately—that adopting the sort of behavior just described will minimize their malpractice exposure, it is not unreasonable for us to conclude that more will follow that approach. This conclusion must be read in the context of evidence suggesting that many clinicians believe that if they were to release a patient who subsequently commits a violent act, their liability exposure (both as to likelihood of being sued and to the extent of potential monetary damages) would be much greater than in a case in which they were to improperly civilly commit an individual who does not meet statutory commitment criteria.

Next, we need turn our attention to the ways that courts construe empirical evidence in Tarasoff cases. The few courts that have considered the issue have not responded in any uniform or coherent way. Two cases, including Tarasoff, have simply concluded that there was little empirical evidence to support the prediction that imposing a duty would lead to overcommitment. One of the courts that has distinguished Tarasoff relied on Stone's prediction that the duty would deter treatment. On the other

177. Brodsky, supra note 100, at 493; see also Appelbaum, supra note 166, at 429.


180. See Johnson, supra note 61, at 255-56, discussing, inter alia, Tarasoff, 551 P.2d at 346 n.12; Currie v. United States, 644 F. Supp. 1074, 1082 (M.D.N.C. 1986), aff'd 836 F.2d 209 (4th Cir. 1987); see also Thomas A. Goodman, From Tarasoff to Hopper: The Evolution of the Therapist's Duty to Protect Third Parties, 3 BEHAV. SCI. & L. 195, 219 (1985) ("There has been creditable evidence either that the practice of psychotherapy has suffered or that violence within our society has increased because of the imposition of the duty to protect others upon the mental health professions").

181. See Littleton v. Good Samaritan Hosp. & Health Center, 529 N.E.2d 449, 459 n.20 (Ohio 1988) (discussing Stone, supra note 54). The patient in Lit-
hand, one of the most expansive readings of Tarasoff buttressed its holding by relying upon survey results in which psychotherapists self-reported that they could accurately predict dangerousness,\textsuperscript{182} notwithstanding the "overwhelming academic and empirical evidence to the contrary."\textsuperscript{183} The fact remains that there is no reliable database of empirical evidence as to the therapeutic value of Tarasoff warnings or of the case's ultimate "real life" impact.\textsuperscript{184}

Finally, this commentary must be read in the context of other literature that has looked broadly at malpractice litigation (and in a more focused manner at suits brought against psychotherapists) in an effort to determine their impact on the quality of therapy provided to patients,\textsuperscript{185} and that has begun to question whether the so-called "explosion" in malpractice litigation is myth or reality.\textsuperscript{186} Thus, we need to carefully consider Richard Bonnie's con-

tleton was a voluntary in-patient who "did not manifest violent propensities while being hospitalized." Id. at 460.

\textsuperscript{182} Schuster v. Altenberg, 424 N.W.2d 159, 169 (Wis. 1988).

\textsuperscript{183} Note, supra note 39, at 279. See also Rubenstein, supra note 77, at 815 (Clinicians have regularly persuaded courts to defer to their predictive judgments); see supra note 77.

\textsuperscript{184} See, e.g., Appelbaum, supra note 164, at 425; Leong et al., supra note 74, at 734.

\textsuperscript{185} On the impact of malpractice litigation in general, see, e.g., David S. Starr, Does Malpractice Litigation Deter Substandard Care?, 37 Med. Trial Tech. Q. 360, 379 (1991) (study indicates that threat of malpractice litigation is "less instrumental" in preventing negligent care than had been supposed). On the impact of malpractice litigation against mental health professionals, see Bonnie, supra note 73, at 234-36 ("[T]hreat of liability [likely] does exert a significant behavioral effect in those situations where the standard of care is ambiguous, or is subject to professional disagreement" litigation may have substantial educational value because it attracts attention to issues of clinical practice that might otherwise have not been noted). Cf. Schopp & Wexler, supra note 157, at 184: "{[C]oncern about tort liability can undermine the ordinary clinician's devotion to both the fiduciary duty and the therapeutic project when conflicts occur between the standard of care for tort liability and the conduct likely to promote effective therapy."

\textsuperscript{186} See Perlin, supra note 63, at 122-24 (The general perception of a litigation explosion is "deeply flawed" on a variety of important bases); see also sources cited id. at 122-23 nn.90, 94. For an overview of recent issues, see Peter E. Herzog, The Reform of Medical Liability: Tort Law or Insurance, 38 Am. J. Comp. L. 99 (Supp. 1990). On recent empirical surveys suggesting low rates of malpractice filings, see Winsor C. Schmidt et al., Factors Associated With Medical Malpractice: Results From A Pilot Study, 7 J. Contemp. Health L. & Pol. 157, 160 nn.17-20 (1991) (citing studies); Randy Otto & Winsor Schmidt, Malpractice in
clusion that, "To the extent that Tarasoff litigation has spurred mental health professionals to think systematically about these clinical problems, it has made a beneficial contribution to the quality of care received by these patients."\textsuperscript{187}

There is truly a broad array of topics here for scholars to examine carefully:\textsuperscript{188} the impact of "litigaphobia"\textsuperscript{189} (and what may

\textit{Verbal Psychotherapy: Problems and Potential Solutions,} 4 \textit{FORENSIC REPORTS} 309, 314 (1991) (same), and \textit{id.} (psychologists appear to be at lower risk than psychiatrists for malpractice suits). At least one commentator, however, has asserted an explicit causal relationship between an "upsurge" of litigation against psychiatrists and the Tarasoff decision. \textit{See} Menninger, \textit{supra} note 50, at 205. Another has speculated as to the relationship between Tarasoff liability and clinicians' increased difficulties in obtaining professional malpractice insurance. \textit{See Geske, supra} note 61, at 401 n.59 (discussing Martha King, \textit{Are Therapists Liable for Their Patients' Violence? STATE LEGISLATURES,} Feb. 1988, at 19).


\textsuperscript{187} Bonnie, \textit{supra} note 73, at 236. \textit{See also id.} at 238 ("[T]he increased risk of iatrogenic injury, and therefore of a lawsuit, is perhaps a necessary side effect of highly beneficial advances in the quality of care, no less in mental health care than in other areas of health care."). \textit{But see} Robert D. Miller et al., \textit{Psycho Therapists' Duty to Prevent Foreseeable Harm: Schuster v. Altenberg, (In Opposition to Schuster: A Call for Legislative Action)}, 62 \textit{Wis. LAW} 10, 68 (May 1989) (criticizing courts for "ignor[ing] the considerable emotional trauma and loss of professional time and reputation suffered by defendants" in Tarasoff-type suits).

\textsuperscript{188} \textit{Compare} Perlin, \textit{supra} note 124, at 54 (making similar suggestion in context of right to refuse treatment law).

\textsuperscript{189} \textit{See} Brodsky, \textit{supra} note 100, at 497; Francis A. Breslin et al., \textit{Developments of a Litigaphobia Scale: Measurement of Excessive Fear of Litigation}, 58 \textit{PSYCHOLOG. REPORTS} 547 (1986); Stanley L. Brodsky, \textit{Litigaphobia: A Professional Disease}, 28 \textit{CONTEMP. PSYCHOL.} 204 (1983). Elsewhere, Brodsky defines "litigaphobia" as the "excessive and irrational fear of litigation." Brodsky, \textit{supra} note 100, at 497 (discussing Stanley L. Brodsky, \textit{A Case Report of Litigaphobic Release From an Involuntary Commitment,} 2 \textit{PUB. SERV. PSYCHOL.} 11 (1983)). \textit{See also Simon, supra} note 178, at xxiv-xxv (discussing "iatrogenic liability neurosis").

Decisions of therapists to not ask patients certain questions (for fear of the answers that might be provided), \textit{see} Wise, \textit{supra} note 56, at 186-88, or to not treat certain types of patients, \textit{see} Appelbaum, \textit{supra} note 61, at 821, certainly fit into this paradigm. \textit{See also} Appelbaum, \textit{supra} note 65, at 785 (fear of being sued can "incapacitate" clinicians). As to the degree of fear felt in this context, there is little doubt. \textit{See Appelbaum, supra} note 61, at 821 ("[I]t appears clear that no court decision in the last generation has succeeded in so raising the anxieties of mental health professionals.").
again simply be a rarified form of passive-aggressive behavior)\(^{190}\) on mental health professionals caused by decisions imposing \textit{Tarasoff} liability;\(^{191}\) the implications of "critogenesis" (meaning the "inherent risks of legal intervention in medical decisionmaking")\(^{192}\) in \textit{Tarasoff} litigation; the degree to which some clinicians may be "willfully blinding"\(^{193}\) themselves to information about their patients in an effort to avoid liability; and the extent to which courts are even willing to consider the underlying social science data.\(^{194}\) We have not even skimmed the surface of these important investigations. If we take the notion of "therapeutic jurisprudence" seriously and begin to turn our attention to these and other similar questions, it would illuminate the underlying issues for judicial decisionmakers, clinicians and other scholars alike.

\section*{V. Conclusion\(^{195}\)}

There is no dispute as to the controversy or confusion spawned by the \textit{Tarasoff} decision and its progeny. Its very existence has reshaped the configurations of mental health practice, and has altered the relationship between clinicians and public authorities. It has been responsible for legislative debate and statu-

\begin{footnotesize}

\footnotetext[190]{See, e.g., Julie Magna Zito et al., \textit{One Year Under Rivers: Drug Refusal in a New York State Psychiatric Facility}, 12 INT'L J. L. \& PSYCHIATRY 295 (1989).}

\footnotetext[191]{In at least one case, a court has spoken to this fear, and has dismissed the concern, indicating that the fear misinterprets the therapist's duty. See Lipari v. Sears, Roebuck \& Co., 497 F. Supp. 185, 192 (D. Neb. 1980), discussed in John-son, supra note 61, at 256. The extent to which this type of court statement can assuage such fears is far from clear.}

\footnotetext[192]{Thomas G. Gutheil et al., \textit{Participation in Competency Assessment and Treatment Decisions: The Role of the Psychiatrist-Attorney Team}, 11 MENT. \& PHYSICAL DISABILITY L. REP. 446, 449 (1987).}

\footnotetext[193]{See Perlin, supra note 146, at 35-36; see Joel J. Finer, Gates, Leon, and the Compromise of Adjudicative Fairness (Part II): Of Aggressive Majoritarianism, Willful Deafness and the New Exception to the Exclusionary Rule, 34 CLEV. ST. L. REV. 199, 205 (1986).}


\footnotetext[195]{For an excellent and thoughtful analysis of the ways that therapists can ethically (and therepeutically) reduce their \textit{Tarasoff} exposure, see John Monahan, \textit{Limiting Therapist Exposure to Tarasoff Liability: Guidelines for Risk Contain-ment}, 47 AM. PSYCHOLOGIST (forthcoming 1992).}

\end{footnotesize}
tory amendment in a significant number of states, including some in which Tarasoff-type issues have never been litigated. The extent to which it is both known and materially misunderstood assured maintenance and continuation of its symbolic, shaman-like status. The fact that clinicians self-report changes in their therapeutic approach (because of fear, real or imagined, of Tarasoff-inspired legal liability) attests to the dominance of its image.

While other courts will doubtlessly tinker with its boundaries, extending or narrowing its holding based on the fact-specific circumstances, these new decisions will not add that much to the dilemma facing mental health professionals (save for adding an extra level of confusion as more state-by-state variations occur). We can also be confident that each of these decisions will be the subject of careful and meticulous doctrinal analysis.

In summary, many of the important issues in Tarasoff have been the subject of far too little academic scrutiny. The impact of heuristic thinking on Tarasoff decisionmaking (and on clinician response to Tarasoff), the complex therapeutic jurisprudential implications of the decision, the paucity of empirical data bases upon which litigators, lawmakers, and judges can draw: these are areas crying out for new research, new ideas, and new reforms. It is to these questions that our attention must now turn.

