The Duty to Warn/Protect: Issues in Clinical Practice

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The duty of therapists to warn or protect third parties when a patient expresses a threat was established by the court in the *Tarasoff* decision. Confidentiality, disclosure, and prediction of violence are clinical, ethical, and legal issues that the therapist must address in the context of a therapeutic relationship. Clinical case material from the literature, as well as cases from the authors' experiences, indicate that when confidentiality is breached and a potential victim is warned, the therapeutic results may be positive, especially if the patient participated in the process. Other methods of protection, such as commitment, use of medications, police involvement, and confiscation of a weapon, may be necessary. Each case deserves individual consideration as to what appropriate and necessary steps should be taken. Through careful assessment of a patient's threats, concern for the patient and victim, adherence to ethical standards of care, and knowledge of the law, one can often protect a victim as well as engage the patient in an ongoing therapeutic relationship.

The duty to warn or protect third parties when a patient has made violent threats is one of the issues faced by mental health professionals in the context of therapy. For the therapist it involves confidentiality in the therapist-patient relationship, ability to predict violent behavior, and steps that can be taken to deal with this situation. In addition to the basic tenets of psychotherapy and the doctor-patient relationship, there is an issue of protection of society from a potentially violent individual. The last decade has witnessed changes in what courts expect when therapists become aware that others' lives are endangered by their patients.

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The *Tarasoff* Decision

Before the *Tarasoff* decision, only custodial persons were responsible for the actions of individuals under their control.[1] Psychiatrists were held liable for the violent acts of patients who were negligently released.[2,3] The first *Tarasoff* decision,[4] in 1974, placed a duty on psychotherapists treating potentially dangerous individuals to warn possible victims when specific threats had been made. The court recognized a "compelling interest" in the protection of human

life. It held that a psychotherapist must take action, including the breach of confidentiality, in order to protect potential victims if it has been determined that the patient is making a serious threat on the life of another individual.[5] Because of the protest on the part of psychotherapists, the California Supreme Court granted a petition for rehearing and an *amicus curiae* brief was presented. In 1976, the Supreme Court rendered its second opinion, commonly referred to as *Tarasoff II*.[6] It stated that the therapist has an obligation to protect the intended victim against danger. Depending upon the nature of the case, this may be accomplished in a variety of ways. The therapist, however, has an affirmative responsibility to take whatever steps are reasonably necessary under the circumstances. This second decision, then, emphasized the duty on the part of the therapist to protect the third party in addition to simply warning and provided some flexibility as to the methods that could be used in order to accomplish such protection.

Confidentiality in Therapy

One of the serious challenges that *Tarasoff* presents to therapists is the matter of confidentiality, considered to be the cornerstone of psychotherapy and the therapist-patient relationship. Smith[7] suggests that the constitutional right of privacy should include the protection of the confidential communications in psychotherapy. The right to privacy is part of the Fourteenth Amendment. In re *Lifschutz,*[8] one court held that the constitutional right of privacy protects the communication between a therapist and a patient. Another court stated that the constitutional right of privacy does not encompass a privilege in this relationship.[9] It appears that the privacy right for the preservation of confidentiality will depend upon the state's "compelling interest" in a particular matter. Smith[10] pointed out that the courts have not classified this right to privacy as an "essential interest." Slovenko[11] stated that trust—not confidentiality—is the important issue, although confidentiality has been viewed as essential to psychotherapy. Without it, a patient may decide not to enter therapy and may not be inclined to disclose personal information; therefore, successful treatment may not be accomplished, and trust between a patient and therapist may be eroded.[12]

Prediction of Violence

Another clinical issue of immense proportion presented to clinicians by way of the *Tarasoff* decision is the prediction of dangerousness. Monahan's[13] treatise on the prediction of violent behavior showed that mental health professionals do not accurately predict future dangerousness. In spite of this, Dix[14] stated that mental health professionals are being called on to predict dangerousness now more than ever. Ironically, just before the first *Tarasoff* decision, a task force of the American Psychiatric Association found that psychiatrists had not reliably demonstrated any ability to predict future violence and that no psychiatric expertise has been established in that area.[15]

Some data indicate that psychiatrists can predict future violence based on a

past history of repeatedly violent behavior.[16] Some studies have attempted to examine the prediction of dangerous behavior. One survey of California psychotherapists taken after the *Tarasoff* decisions found that they made attempts to assess violent potential in individuals and warned more potential victims.[17] Barnard and coworkers[18] reported in 1984 that one fourth of dangerous mentally disturbed offenders in a maximum security treatment facility were involved in aggressive incidents during a four-month period. The fact that they were labeled dangerous did not seem to be enough to predict future dangerousness. They emphasized certain features of the patients' environment and previous aggressive behavior related to continuing dangerous behavior. The work of Spodak and associates,[19] also reported in late 1984, is highly interesting. They studied a group of insanity acquittees after discharge from the hospital over a period of from five to fifteen years. Forty-four percent of this group were never again rearrested. They felt that this group did not represent a substantial danger to society when discharged and that they, even though previously violent and highly suspect for future violence, were much less violent than anticipated.

Clinical Applications of *Tarasoff*

Surely, mental health professionals are in a serious dilemma. On one hand, they are required in some jurisdictions to warn and protect potential victims of foreseeable violence and to take all the appropriate and necessary measures they have in their means to protect such individuals. On the other hand, they are faced with issues of confidentiality and trust in psychotherapy with their patient. It is, perhaps, by the nature of therapy itself with expectations of confidentiality that the patient is able to confide violent feelings toward an identifiable victim. By insisting upon the disclosure of confidential information, the courts may stifle the confidences of patients. Therapists are also faced with the problem of accurately predicting dangerousness, even on a short-term basis. The expansion of liability beyond the original *Tarasoff* decision now means that, at least in some jurisdictions, and possibly in others in the future, therapists must act to protect a potential victim even when that victim has not been positively identified or only when there is slight suspicion that the patient may be dangerous.[20] According to Monahan,[21] this will not destroy the essential "helping role" of mental health professionals. He indicated that they may be thrown into a social control function through the nature of their work but stressed that the community protection role of these professionals should be minimal.

Clinical Experiences Beck[22] discussed several cases in which both positive and negative aspects of warning an intended victim were illustrated. In a survey of psychiatrists in clinical practice, he found that 40 percent had been involved in a case in which a warning was given to a potential victim. It was felt that, in itself, this seldom had an adverse effect on the therapeutic relationship. Warnings that were not initially discussed with the patient were found to have a harmful therapeutic effect. He concluded that the important

factor of these warnings is their integration into the therapy, which may serve as a limit-setting function and decrease potential violence.

Finney[23] reported on a case in which there was a positive therapeutic aspect in the warning of a potential victim. He raised the question of violation of confidentiality as a psychotherapist but emphasized the positive outcome of informing the patient about warning the other party. Wulsin and associates[24] presented a case in which they enlisted the alliance of the patient in warning the potential victim. They emphasized the maintenance of trust in the relationship with the patient and exploration of the ambivalence toward the intended victim. Wechsler[25] discussed the use of *Tarasoff* when necessary as a pragmatic therapeutic tool, and Roth and Meisel[26] outlined the importance of involving the patient in the breach of confidence in order to promote positive therapeutic goals.

Clinical Case Illustrations The following are examples of the clinical applicability of enlisting the patient in warning an intended victim in the course of treatment.

Case 1 A 25-year-old man came to the emergency department requesting help because he was afraid that he might kill someone. He stated he wanted to kill his girlfriend's gynecologist because he was concerned that the doctor was molesting her during the examinations. On the preceding day, before his girlfriend's appointment, he saw the doctor drive into the parking lot. The patient got a tire iron, was going to stalk the doctor into his office and strike him, but changed his mind.

The patient had no previous psychiatric history and denied drug and alcohol abuse, but did have a history of frequent fighting. There were no delusions, hallucinations, or other signs of psychosis. He was morbidly preoccupied with what the doctor was doing to his girlfriend and he did not believe her when she tried to reassure him that nothing unusual was occurring. There was evidence of generalized suspiciousness and mistrust of people throughout his history. He was diagnosed as having paranoid personality.

After discussing the situation with the patient and capitalizing on his ambivalence about killing, he agreed to allow me to telephone the physician, advise him of the patient's threats, and make some suggestions regarding management of the girlfriend. With the patient and his girlfriend present in the office, the doctor was telephoned and was grateful to be advised of the situation. I suggested that the doctor sit down with the couple, explain what he was doing in checking her for ovarian cysts, and have the patient in the room during the examination of his girlfriend. The patient felt relieved and agreed to take perphenazine, prescribed for his agitation and paranoia. He agreed to therapy in the outpatient department and attended regularly. His therapist reported a good working relationship with him.

Discussion of Case This patient illustrates a situation in which violence could be fairly reliably predicted because of the past history of violence, a para-

noid personality with misinterpretation of events, an explicit interest to kill, a weapon, and a near-completion of the act. The patient was ambivalent and requested psychiatric help, both of which were used therapeutically. Therefore, it was decided to warn the intended victim for his immediate protection, with the patient's cooperation in process. This opened up other alternatives, such as involving the patient in the treatment of his girlfriend and offering medication and psychotherapy to him. There seemed to be no need to involve the police because the situation was resolved promptly. Commitment or voluntary admission did not appear to offer any treatment advantages because of his personality disorder, the absence of psychosis, and the fact that the situation would likely continue after discharge.

Case 2 A 32-year-old single woman presented to the outpatient clinic stating that she had been angry and depressed since her common-law husband left her for another woman. Her initial complaints included decreased sleep and appetite, crying spells, and weight loss. She further reported that people were out to harm her and that someone was putting holes in her walls and underlining different scriptures in her Bible. She had made several suicide attempts during the previous two weeks (overdoses of pills and turning on gas jet) and had thought about killing her boyfriend but denied any plans. She was prescribed thioridazine 200 mg/day and was instructed to return in one week. Based on her past 12-year psychiatric history (which included such symptoms as auditory and visual hallucinations, paranoid delusional ideation, and thought insertion and withdrawal) and her current symptomatology, she was diagnosed as schizophrenic, paranoid type.

When the patient returned for follow-up, she was extremely angry and suspicious and reported that she had tried to kill her boyfriend by sprinkling rat poison on his food. Because she was not successful in her attempt, she then proceeded to crush her pills and put them in his food. She continued to verbalize homicidal thoughts and plans toward her boyfriend. She also expressed a wish to die.

Upon further questioning, she reported that she had threatened her boyfriend with a knife on several occasions during their chaotic seven-year relationship. We initially tried to dissuade her from her homicidal plans and encouraged hospitalization, which she refused. She agreed to an injection of fluphenazine decanoate. We informed her that we would have to take steps to locate her boyfriend and warn him of her plans to kill him. We then called the patient's mother and recommended commitment. For a variety of reasons, the mother did not wish to proceed with commitment. At this point we proceeded to call the police, informing them of the situation and asking them to locate the boyfriend to warn him. They were able to do this successfully. The boyfriend and the patient were able to discuss their situation and began taking steps to resolve their problems. The patient did not make any further threats or attempts on the boyfriend's life. She

continued in psychotherapy on medication, achieving a positive therapeutic relationship and resolution of her psychotic symptoms.

Discussion of Case This patient expressed homicidal/suicidal ideas, reported poisoning her boyfriend, and was psychotic. Therefore, several approaches were taken, including placing her on a depot medication, informing a relative and the police so that the victim could be warned, and consideration of hospital commitment. As it turned out, warning the boyfriend that his life was endangered was adequate for preventing further harm. The psychosis also was treated vigorously. Psychotherapy was useful for further exploration of her self-destructive and violent impulses.

Commitment to the hospital would have been necessary if the boyfriend had not been located or if the psychosis could not have been treated on an outpatient basis. In any case, it was necessary to warn the victim because the patient reported having already poisoned him. In this case, warning was an integral part of protection.

Clinical Approaches and Alternatives

Protection of the lives of threatened third parties has been viewed as one of the duties of therapists by the legal system. From our experience and reported experiences of other investigators, it appears that warning intended victims may have beneficial consequences. First of all, the life of an individual may be saved. Secondly, the potential perpetrator of the crime, the patient, may be diverted from committing an act for which there would be serious consequences and penalties. Third, involvement of the patient is extremely important and serves the purpose of limit setting for which the patient may be grateful. It also introduces new material into the therapy that can be explored. In this fashion the therapist attempts to deal with a potentially serious problem as effectively as possible under the circumstances.

There are, of course, other alternatives besides warning the threatened party. Naturally, one must assess the clinical situation closely and decide upon which method or methods are to be used. The cases presented here serve as some useful guidelines. Alternative approaches include: the use of medications to control behavior; increase in medication the patient is already taking or the use of a depot/long-acting medication; other intensification of treatment, such as increasing frequency of therapeutic sessions; notification of law enforcement agencies; civil commitment to an inpatient facility; and making direct attempts to control the situation, such as gaining possession of a weapon. *Tarasoff II* called attention to the use of other reasonable means to protect the potential victim besides warning. It should be noted, however, that almost every one of these alternative procedures involves breach of confidentiality or treatment in the least restrictive setting. Having properly assessed the situation, the therapist, given the circumstances of a potential death, may choose one or more of these means to gain control of a potentially dangerous situation.

Is the therapist a guardian of society?

The answer to this question must be "no." Having been told by a patient that there is a definite intent to seriously harm another individual, however, it is felt that the therapist incurs a responsibility as a professional to take all reasonable and necessary precautions to warn and protect that person or to use other treatment approaches as indicated. When a patient threatens but does not identify an individual and the therapist feels that there is a definite potential for violence, it is felt that reasonable care must be taken to protect as yet unnamed victims from the patient. This may involve civil commitment and any of the other treatment approaches noted above. In some instances, the potential threat is not seen as a particularly serious one. Appropriate steps should be taken in therapy with the individual to deal with that issue. One may need to alert third parties or law enforcement agencies or use other steps when more serious harm could be surmised. In any case, whether someone has been warned of intended violence or there has been an idle threat on someone's life, these issues must be effectively dealt with in the therapy of the patient. Our cases, and those of others,[27-30] demonstrate that this can be accomplished effectively.

Conclusion

In a therapeutic setting in which a patient threatens the life of another individual, there are several options that can be taken to warn and protect the threatened party and to treat and control the patient. Even after taking what are considered to be appropriate actions, a therapist still may be found liable for the action of a patient. This is likely to continue with the expanding interpretation of liability by the legal system. Nevertheless, common experiences of therapists and their consequent actions and recommendations in dealing with patients who threaten the lives of others will, hopefully, serve as guidelines for a broadened standard of practice of mental health professionals. Only through prudent decision making involving the patient, ethical adherence to standards of practice, and careful regard for the legal precedents in such matters can a therapist hope to solve some of the dilemmas of confidentiality and disclosure when another's life has been threatened by a patient.

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