

The *Tarasoff* Raid: A New Extension of the Duty to Protect

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The authors discuss the general outlines of the *Tarasoff* duty of psychotherapists to protect potential victims of their violent patients. They describe the flexible range of clinical responses that therapists have utilized, as well as their professional concerns about preserving patient confidentiality (or at least strictly circumscribing the scope of disclosure when confidentiality must be breached). A recent case is reported that illustrates a striking new extension of *Tarasoff*, involving a police search and seizure of a psychotherapist's confidential treatment records and tapes, in response to a third-party complaint that the records contained evidence of his patients' violent acts and propensities. The implications of this case are that the therapist's discretion in the assessment of his duty to protect, the selection of a proper course of action, and the implementation of specific responses may be taken out of his hands, for all intents and purposes, and expropriated by law and order officials. Moreover, regardless of whatever clinical approach he adopts and whether or not he issues a warning, his attempts to preserve patient confidentiality are bound to prove unsuccessful in any future legal proceedings. Patient communications are likely to lose their confidential status on the grounds that they caused or triggered the *Tarasoff* warning (or that they should have triggered it). If the patient directed serious threats against the therapist himself, the court may find that, as a consequence, a "genuine therapeutic relationship" ceased to exist and thereafter all patient disclosures were no longer confidential on that basis. The patient disclosures (which otherwise would likely have remained confidential) may then be admitted into evidence in future criminal proceedings against the patient.

The *Tarasoff*¹ case has become perhaps the most well-known case in the annals of modern psychiatry. It is by now familiar to all psychiatrists as the landmark case that broke new legal ground by imposing a judicially created legal duty on psychotherapists to protect potential victims from their violent pa-

tients. There is no need to restate the underlying facts of the *Tarasoff* case itself, which have been recounted in detail by a number of commentators.^{2,3} It should be noted, however, that the original *Tarasoff* decision in 1974 (describing the psychotherapist's "duty to warn") resulted in vigorous efforts by the defendants and several *amici curiae* to reargue the case. In an unusual move, the court granted their petition and a new decision (*Tarasoff-II*⁴) was issued in 1976, which formulated the psychotherapist's duty more broadly as a "duty to protect":

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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 intended victim of danger, to notify the police, or take whatever steps are reasonably necessary under the circumstances.⁴

By remaining somewhat vague about how this novel "duty to protect" could best be discharged, the court left it to the sound discretion of the psychotherapist to employ a wide range of available clinical interventions that would conventionally be employed with violent patients. A case-by-case approach allows for flexibility and the exercise of clinical judgment, rather than imposing a rigidly mechanical formula, which would discharge the mandated duty to protect in each and every case alike.

Psychiatrists' concerns regarding maintenance of confidentiality of treatment and acting to safeguard the patient's best interests seemed to be most favorably addressed by keeping open a broad range of multiple possible options that might serve to achieve "the therapist's primary aim . . . [i.e.,] to maximize both the patient's controls and the potential victim's safety within the context of each individual's rights."⁵ Thus, for some patients, interventions such as increasing the frequency of treatment or starting psychotropic medication might serve to reduce the patient's dangerousness without any need to compromise confidentiality.⁶ In other situations,

warnings might be unavoidable, but could be integrated into the treatment as therapeutic maneuvers to set limits or offer the patient a corrective ego experience.^{5,7} Finally, situations calling for maximal control might require involuntary commitment or summoning the police.⁵

Stone² prophetically noted in 1976 that "*Tarasoff* has set off a legal imbroglio in the civil courts that may long be with us." Indeed, no area of litigation involving the practice of psychotherapy has been more active than lawsuits drawing on *Tarasoff*.⁸ A steady stream of appellate decisions involving cases arising from *Tarasoff* has served to expand the duty to protect third parties from patients' violent acts and, in retrospect, has made "the decision of the California court seem conservative by comparison."⁹ According to Appelbaum,⁹ the expansion of liability reflected in the progeny of *Tarasoff* has approached a standard of *strict liability*, by which psychotherapists may be held liable for the violence of their patients even in the absence of a clear finding of negligence on their part.

In addition to the expansion of malpractice liability for patient violence, psychiatrists are concerned as well about recent court rulings that involve the *Tarasoff* doctrine in criminal cases. For example, in *People of the State of California v. Wharton*,¹⁰ the Supreme Court of California ruled that psychotherapists had to reveal the specific details of patient disclosures that caused or triggered the *Tarasoff* warning to the intended victim. In *Wharton*, the specific content

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of patient communications to the therapists (which had triggered their decision to warn the homicide victim) was then used to prove premeditation at the murder trial, in order to have the death penalty imposed. Decisions like *Wharton* threaten to broaden the *Tarasoff* doctrine beyond recognition and confirm some of the worst fears of psychiatrists in regard to the potential for encroachment on the integrity of psychotherapy.

Even those psychiatrists who had learned to live with the *Tarasoff* doctrine and come to accept its narrow rationale for disclosure, to avert danger to others, are troubled by this further threat to confidentiality. Rather than mandating strict circumscription of the scope of the disclosure, it appears that once the therapist invokes *Tarasoff* and issues even the most discrete "generic" warning (e.g., merely telling the victim that he or she is in danger), "by that act the therapist has destroyed the[patient's] privilege as to all communications which led to the conclusion that [he or she] was dangerous, and that a warning was necessary."¹⁰ In this context, we would like to expand on an earlier brief preliminary report of a striking new extension of the *Tarasoff* doctrine,¹¹ which removed the initiative from the psychotherapist to control the implementation of the duty to protect and involved a police raid on the therapist's confidential treatment files (including audiotapes). The search and seizure of the therapist's records (and their ultimate admissibility into evidence to be used against the patients) was predicated on the *Tarasoff* excep-

tion to confidentiality, which enabled the prosecution to pierce the psychotherapist-patient privilege in order to reveal the patients' self-incriminating disclosures. This "*Tarasoff* raid" was not triggered by the therapist, who was bypassed, but by a third-party tip to the police.

Case Report

Two brothers, ages 19 and 22, respectively, became suspects soon after they reported finding their parents shot to death in their Beverly Hills mansion. The brothers were suspected of murdering their parents in order to acquire a \$14 million dollar inheritance. For a period of time, both prior to and following the murders, both brothers were patients in psychotherapy with Dr. O, a clinical psychologist. After a tip from a third party* that the therapist's records contained incriminating evidence about the murders and the brothers' violent propensities, the authorities acting pursuant to a search warrant seized Dr. O's treatment notes and audiotapes relating to their therapy. During therapy sessions, the brothers had confessed to the murder of their parents and one of them had explicitly threatened to kill Dr. O and anyone associated with him, who might learn their secret and turn them in. Perceiving that such threats posed a "mortal danger" to himself, his family and his business associate, Dr. O undertook a number of measures, including consulting other therapists (and attorneys) for advice about risk management

*The tip came from Dr. O's business associate, who was one of the potential victims of his patients.

and dealing with his “countertransference” reaction, moving into a hotel with his family, purchasing guns for self-defense, repairing his home security system, and inquiring about hiring a bodyguard. He reasonably concluded that it was necessary to disclose the threats in order to prevent the threatened danger and he therefore “warned” his wife and business associate about the brothers’ confession and threats. [It should be emphasized however that Dr. O specifically testified that he did not believe at the time he was breaching patient confidentiality, because he considered his wife, a fellow psychotherapist who shared his office space, and his business associate to be within his “zone of confidentiality,” especially because they had previously both signed explicit confidentiality agreements with him. The court rejected this contention.]

Dr. O concluded that the best approach was to continue to treat the brothers, convince them that he was their ally and that it was in their best interests to stay in treatment, if only to let him help them to develop a psychiatric defense, in the event they ever were arrested and brought to trial.† On this basis, he saw them for a number of ongoing sessions before the search and seizure occurred. Afterward, the brothers were arrested for the murders of their parents.

†Dr. O also cautioned the brothers that his notes and tapes of the sessions were in a safety deposit box and would be turned over to the police if anything happened to him or to those close to him. He clearly wanted to avert the danger posed by the patients; yet, at the same time, he appeared to want to help them, to comport himself as their therapist and to meet his ethical obligations to preserve patient confidentiality.

Pretrial Legal Developments

At pretrial hearings, held *in camera*, the defendants claimed that Dr. O’s notes and tapes were protected by the psychotherapist-patient privilege. As the holders of the privilege, they contended that they had the right to refuse to disclose (and to prevent disclosure by others of) their confidential communications. The trial court concluded

There is no logical, legal, or public policy rationale for there to exist a privileged, confidential relationship between a psychotherapist and patients who, having confessed to two recent, impulsive and brutal murders, seriously threaten the psychotherapist’s life.¹²

Under the so-called “dangerous patient” exception‡ to psychotherapist-patient privilege, the moment the therapist reasonably concluded that the brothers posed a threat to him and those close to him, triggering his disclosure of their communications in order to prevent the perceived danger, those communications (which had caused him to issue the warning) lost their confidential status. Once he invoked *Tarasoff* and issued the warnings to his wife and business associate, the patient disclosures ceased to be shielded by the psychotherapist-patient privilege. [The court noted that *actual* disclosure by the therapist was not required for the exception to prevail over the privilege, once he should have known that he was ethically and legally required to make disclosure to a threat-

‡The relevant statute¹³ states: “there is no privilege under this article if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger.”

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ened third party. In other words, whether the therapist chooses to warn or not to warn, to preserve patient confidentiality or not to do so, at any later legal proceedings, in retrospect, confidentiality is already destroyed, regardless of what course of action the therapist elected to follow at the time.] The patient disclosures at issue here included the confession to the murder of their parents and their threats against Dr. O and anyone associated with him. The defendants appealed.

The intermediate appellate court, the Court of Appeal for the Second District of California, agreed that Dr. O's disclosures to his wife and business associate were permissible under the dangerous patient exception, because he reasonably concluded that the threats posed a danger and that disclosure was necessary to assure their safety. The court rejected the defendants' contention that a narrow "generic" warning would have sufficed and that there was no need to include specific references to a confession about the murders. The court explained that Dr. O "would have been hard pressed to convince anyone of the seriousness of the threat without including specific information about the crime."¹² [At the time, the brothers were publicly perceived as the bereaved sons of a close, loving family, not as suspects in a brutal crime.] Thus, the court rejected the argument that if confidentiality must be broken in order to avert imminent danger, it should be broken by the narrowest of means, requiring a strict circumscription of the scope of disclosure.

The court went on to hold that once

the patients seriously threatened Dr. O, there ceased to be any "genuine therapeutic relationship" and thereafter, communications on their part ceased to be confidential. § This purported therapy was characterized as a "charade" in which Dr. O "was motivated by self-preservation" and the brothers "were motivated by self-interest" in the hope of "provid[ing] themselves with a possible psychiatric defense."

Discussion

Flemming and Maximov¹⁴ recommended a case-by-case selection of "the form of intervention with the least harmful impact upon the patient's interests" when dealing with potentially dangerous patients. Others have discussed a wide range of clinical interventions that are available to the therapist, which are often effective in reducing patient dangerousness without necessitating warning the intended victim or otherwise compromising confidentiality.^{5,6} Such measures might include increasing the frequency of treatment, starting medication, increasing the dosage of medication, agreeing on a brief involuntary hospitalization, and others. Quinn⁵ recommends that therapists "consider all possible therapeutic, social or environmental manipulations that can be mutually agreed upon by the therapist and patient without compromising confidentiality." The therapist utilizes his discretion and clinical judgment in deciding which forks of the "decision tree" to follow and when. (For example, deciding

§This part of the holding applied to the last few sessions between Dr. O and the brothers.

to issue a warning or invoke police action when the danger is imminent and the need for maximal control is indicated.) Psychiatrists feel they can best carry out their clinical duty to their patients *and* their legal duty to protect potential victims, if they can independently exercise their clinical judgment as to the selection of a proper course of action and the implementation of appropriate responses.

The case reported here raises a number of troubling issues relating to the therapist's ability to control the management of the dangerous patient's clinical care and to implement the duty to protect without compromising patient confidentiality (or if confidentiality must be broken, doing so by the narrowest means possible.) Dr. O was realistically concerned about protecting the safety of his family, his associate, and himself, but he also simultaneously maintained a high level of concern about the ethical implications of revealing his patients' threats. (Otherwise, he could have gone to the police immediately.) In sharing his concerns with his wife and business associate, he sincerely believed he was still maintaining confidentiality (in view of the signed confidentiality agreements he had with them). He took a number of reality-based measures to maximize safety and to continue the process of ongoing risk assessment, including consultation with colleagues. Meanwhile, by a variety of means, he persuaded the patients to continue in treatment, in an ongoing attempt to maximize their controls and to deal therapeutically with the psychological consequences of their con-

duct. Although it is easy to second-guess his approach (certainly others may have handled the situation differently),^{||} he appears to have followed Quinn's⁵ recommendation to "consider all possible therapeutic, social or environmental manipulations that can be mutually agreed upon by the therapist and patient without compromising confidentiality."

The implications of this case are that control and discretion may be, for all practical purposes, taken away from the therapist. Regardless of what clinical approach the therapist elects to follow, no matter how scrupulously careful he tries to be to protect patient confidentiality, his efforts will avail little in the event there are future legal proceedings. In such an event, the foreseeable evidentiary consequences are as follows: once the therapist realized the patient was dangerous, all confidentiality is destroyed relating to patient communications and disclosures leading up to that realization. And, in retrospect, if the therapist should have realized that the patient was dangerous, but didn't, the same considerations apply. If the therapist decided to issue a warning to those endangered by the patient, not just the narrow "generic" warning, but all of those patient communications and disclosures that triggered the warning also lose their confidential status. If the ther-

^{||}The authors would have terminated treatment under the circumstances of this case, concluding we would be unable to maintain an effective therapeutic relationship with a patient expressing deadly earnest threats to kill the therapist and anyone associated with him. We might also, after due deliberation, have notified the authorities in regard to the threats. We do not mean to suggest that ours is the only, the best or the "correct" response to this unique case. Others may certainly differ.

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apist elected not to issue an actual warning (in order not to compromise confidentiality), nonetheless confidentiality is still destroyed because, in hindsight, he arguably should have issued one. Thus, the *Tarasoff* doctrine, originally intended as a strictly circumscribed exception to patient confidentiality for the limited purpose of averting danger to others, can now be used as a vehicle to carve out a much broader exception to confidentiality, in order to acquire otherwise unobtainable evidence to use against the patient at a criminal trial.[¶]

The court also held that once the patient seriously threatened the therapist, a “genuine therapeutic relationship” ceased to exist. Thereafter, Dr. O’s “primary objective was not to provide treatment . . . but justifiably to protect his own life” and the lives of those close to him. Therefore, according to the court’s rationale, there was no confidentiality in the later sessions, because the psychotherapist-patient relationship had ceased to exist.

It seems to us that the court is setting an unfortunate precedent by arbitrarily deciding that treatment had ceased to exist under the circumstances. The relationship between Dr. O and his patients continued to demonstrate many of the indicia of treatment: he continued to schedule regular appointments for them, to conduct sessions in his office

and to charge a fee; he attempted to help them to express and work out their feelings about the evolving situation, in order to avert any future violence; in short, he did those things that therapists try to do in their management of dangerous patients: to maximize the patient’s controls and to strive to protect potential victims, while working to preserve confidentiality, if possible. Even if some of his interventions were unorthodox or ill considered, nonetheless, we question the wisdom and validity of the court’s determination that there was no treatment.

The court seems to suggest that anytime serious threats by a patient are directed against the therapist, this will automatically result in a) the demise of the treatment and b) the loss of confidentiality. Such a legal rule might lead to unintended and undesirable consequences. For example, once a patient seriously threatens his therapist, thereby causing the treatment to cease to exist, do all of the therapist’s obligations also come to an end (e.g., his duty to protect others from his dangerous patient), because there is no longer any psychotherapist-patient relationship?

Conclusion

It is generally agreed that the therapist should exercise good clinical judgment in deciding how best to implement the duty to protect under *Tarasoff*. The implications of the case reported here, however, suggest that even the best efforts of the therapist to preserve patient confidentiality will be doomed to failure. If a therapist fails to take action when a patient poses a threat to others (or to the

[¶]In this case, invocation of *Tarasoff* served to allow the prosecution to obtain (and introduce into evidence) disclosures about a crime (the murder of the parents) that otherwise would likely have been protected by the psychotherapist-patient privilege. Likewise, in *Wharton*, proof in the therapists’ notes of premeditation came into evidence on the coattails, as it were, of the *Tarasoff* warning.

therapist himself), if he decides that under the circumstances disclosure is unwarranted, or that measures other than issuing a warning or contacting the police will suffice, a third-party complaint may still trigger a search and seizure of the therapist's files.[#] Afterward, *post hoc* invocation of *Tarasoff* or related statutory authority may then serve to pierce the psychotherapist-patient privilege for all related patient disclosures. Alternatively, the court may decide that both treatment and confidentiality had ceased to exist, as a result of the patient's serious threats against the therapist.

The implication of the "*Tarasoff* raid" case for psychiatrists is that 1) clinical discretion in the assessment of the duty to protect, the selection of a proper course of action, and the implementation of specific responses may be taken out of their hands under certain circumstances and expropriated by law and order officials (as in this case), or in any event 2) their efforts to preserve patient confidentiality are unlikely to prove successful. Henceforth, psychiatrists should keep in mind that patients who are al-

[#]Such *Tarasoff* raids might be utilized by police and prosecutors to go on "fishing expeditions," seize evidence, and, under cover of the "dangerous patient" exception, admit otherwise confidential disclosures into evidence against the patient (disclosures that might be only tangentially related to the patient's immediate dangerousness.)

leged to be dangerous run the risk of a broadly construed loss of their right to confidentiality. Patient communications to the therapist that bear on the patient's dangerousness at the time are unlikely to be protected by confidentiality in any future legal proceedings and may be used against the patient's interests.

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