

# Psychotherapy as Law Enforcement

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Legal doctrines do not stand still, but instead evolve and tend to grow and to spawn what law school academicians fondly term progeny. *Tarasoff* is no exception. In an expanding list of court decisions, psychiatric patients are being convicted of crimes by virtue of actions by their psychiatrists or psychotherapists purportedly based on the duty to warn. One recent case has featured surreptitious evidence-gathering by a psychiatrist, the latest progeny of *Tarasoff*.

*J Am Acad Psychiatry Law* 32:91–5, 2004

## Tarasoff : A Tort Doctrine Aimed Against Future Harm

The rationale for *Tarasoff v. Regents of the University of California*<sup>1</sup> was quite clear: psychiatrists can prevent future violence by breaching the confidentiality of therapeutic communications, and therefore they must. The opinion grandly declared, in its most quoted turn of phrase:

We conclude that the public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins [Ref. 1, p 347].

Accordingly, in all but a handful of states, a psychotherapist is vulnerable to a tort suit if a patient harms a third party. The therapist can either settle or submit to a jury's decision about whether the therapist should have warned the victim and, if so, how much money he or she must pay.

I have argued elsewhere that the assumptions-masquerading-as-logic underlying *Tarasoff* are unproven and fatuous and that the duty to warn does plain harm but has yet to produce any demonstrated benefit, even 27 years later.<sup>2</sup>

*Tarasoff* is, in addition, an object lesson in ceding a portion of principle to the clutches of the law. The portion grows larger and larger in the hands of legislatures addicted to empty but progressive-sounding nostrums and of courts rapacious for evidence and therefore reflexively unsympathetic to privilege, confidentiality, and other evidentiary exclusionary rules.

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Soon our patients and our healing craft are compromised in ways the original duty-to-warn enthusiasts could not have imagined.

Perhaps the most disquieting metamorphosis of *Tarasoff* to date is the growing use of confidential communications (and the conscription of psychiatrists as witnesses) to convict psychiatric patients of criminal offenses.

## Tarasoff Criminalized: Psychotherapists as Witnesses Against Their Own Patients

The “dangerous patient exception”<sup>3</sup> to testimonial privilege exists to enable psychiatrists and other mental health professionals to testify at commitment hearings about a patient's otherwise privileged communications embodying plans for future violence. The court obtains the information it needs and the harm is averted (by committing the patient for evaluation and treatment). Though consistent with *Tarasoff* in its objective to prevent violence, the dangerous patient exception, an exception to an evidentiary (courtroom) privilege, has nothing to do with the duty to warn, an exception to the much older and much broader principle of physician-patient (including psychotherapist-patient) confidentiality.

Recently, however, prosecutors have begun to persuade courts to meld *Tarasoff* into the dangerous patient exception by ruling that, the moment a patient utters a *Tarasoff*-triggering statement, privilege is lost legally, even if the psychotherapist elects to maintain confidentiality factually. By this legerdemain, aptly derided as “the criminalization of *Tarasoff*,”<sup>4,5</sup> a psychotherapist or psychiatrist can be compelled to testify about a patient's otherwise confidential state-

ments in a subsequent prosecution of the patient for committing an alleged violent act.

Thus, the tort doctrine of *Tarasoff*, conceptualized as an exception to confidentiality and justified as the only way to protect third parties from a patient's future violence, has been expanded into a criminal law principle, reconceptualized as a rule of evidence under which psychiatrists become prosecution witnesses against their patients for purely past acts, where the prevention of violence rationale of both *Tarasoff* and the dangerous patient exception is moot.

Apart from its tortured logic, this conscription of mental health professionals into the war on crime misconceives the clinical application of *Tarasoff*. There is rarely a discrete moment when the duty to warn is irretrievably triggered, a "gotcha" moment. Rather, a conscientious psychotherapist or psychiatrist explores violent verbalizations with a patient and may eventually conclude (perhaps at a subsequent session) that there is no true intention or that the danger is too attenuated or contingent to justify a warning. Meantime, under the *Tarasoff*-infused dangerous patient exception, the privilege flicks on and off like a firefly, surely not sound in logic, tenable as law, or workable for therapy. Lawyers and lawmakers are generally unaware that mental health professionals deal with expressions of violence routinely (in many settings, daily), yet few will give *Tarasoff* warnings more than two or three times in a career.

Some courts, notably the Oregon Supreme Court<sup>6</sup> and recently the federal Sixth Circuit,<sup>7</sup> have rejected this contortion of the dangerous patient exception. Others, though, have eagerly embraced it.<sup>8,9</sup>

The United States Supreme Court beclouded the issue in a 1996 decision recognizing a psychotherapist-patient privilege in federal courts.<sup>10</sup> In a delphic and inapposite footnote, the Court seemingly groped to dilute the privilege: ". . . [W]e do not doubt that there are situations in which the privilege must give way, for example, if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist" (Ref. 10, p 18, n 19). The Court may have been musing about the duty to warn, though this would conflate privilege (the sole focus of the decision) with confidentiality (a separate legal realm). It would in any event be a heroic stretch to read this stray comment as endorsing a *Tarasoff*-infused dangerous patient exception, as how does courtroom testimony about a past alleged crime

"avert" the "harm"? However, some lower courts have pounced on just such an interpretation.<sup>11,12</sup>

## Psychotherapy as a Criminal Act

As if being compelled to testify against one's patient were not enough, psychotherapists and psychiatrists have now been held, by virtue of the duty to warn, to have produced crimes by proxy for which their patients have then been convicted and incarcerated.

One such case, recently described by Jeffrey R. Weiner, MD,<sup>13</sup> involved "a woman with a history of psychotic symptoms" who became angry at a judge over the disposition of two jaywalking tickets:

Upon leaving the courthouse [she] began thinking about stabbing the judge in the throat. She did not have a weapon. [She] was concerned about the violent thoughts, so she took a bus to a local hospital and asked to be seen in psychiatric emergency services. At the hospital [she] continued to express thoughts of harming the judge. The staff placed her on an involuntary hold, and in accordance with *Tarasoff*, notified the police and warned the judge. Later that night she was arrested and transferred to the county jail, charged with making criminal threats. [She] eventually agreed to plead no contest to a misdemeanor and was released on probation after several months in jail [Ref. 13, p 240].

This woman did no act whatsoever that would constitute a crime. She merely sought psychiatric help for her anger and violent ideation. She did not threaten anyone. She headed straight for a hospital so that she would not commit a crime.

A purported crime sprang into existence only when the woman's treaters elected to divulge her confidential statements, thereby creating a "victim." But there is no reported evidence that the patient desired or anticipated this dubious application of the duty to warn. (Indeed, if she truly planned an assault, she probably did not want the victim tipped off.) The patient was thus convicted and criminally punished under *Tarasoff* for an independent act by her psychiatric treaters.

## Psychiatrists Under Cover

The latest deployment of psychiatrists against their own patients under the banner of *Tarasoff* occurred in a recent federal prosecution in Oregon.<sup>12</sup>

Psychiatrist "Mary Doe" testified against her patient Steven Chase about violent ideas he had repeatedly expressed to her in therapy concerning certain FBI agents. Chase was convicted of threatening to

murder federal law enforcement officers, and appealed.

The three-judge Ninth Circuit appellate panel jumped eagerly on the *Tarasoff*-infused dangerous patient exception bandwagon, brusquely sweeping aside well-reasoned and long-standing precedent<sup>6</sup> from the very state where the alleged crime occurred:

Just as the ethics of the profession . . . permit . . . disclosure of otherwise-confidential information when (1) a threat of harm is serious and imminent and (2) the harm can be averted only by means of disclosure by the therapist, we hold that the same exception extends to the psychotherapist's permitted testimony under the same circumstances. This holding is faithful to the Jaffee footnote and to the obvious policy considerations that underlie it [Ref. 12, at 1024].

The court did not divulge how “the obvious policy considerations that underlie” the *Jaffee* footnote, namely preventing imminent future violence, apply to a person who peacefully surrenders into federal custody, as Chase did, nor how, from his cell, he presents “a threat of harm [that] is serious and imminent and . . . the harm can be averted only by means of” trial testimony many months later.

In any event, the real significance of *Chase* is how Dr. Doe, actuated by the duty to warn and advised by her supervisors and her clinic's legal counsel, obtained the information she later presented in court.

Chase, diagnosed with Bipolar II Disorder, was under Dr. Doe's care, with appointments “every few months for counseling and medication management,” and was seeing a psychologist “more frequently for psychotherapy. . . . From the beginning of his treatment with Dr. Doe, Chase had expressed anger and threats toward a number of people. . . exhibit[ing] a great deal of volatility during his therapy sessions, sometimes contrasting anger with mildness during the same session and often reflecting a sharp change in that respect from one session to the next” (Ref. 12, at 1021).

This evidently continued over several sessions with Dr. Doe. Curiously, the court's opinion is opaque about what may have been transpiring in psychotherapy with the psychologist. After Chase “told Dr. [Doe] that he had begun drinking,” she became concerned about the possibility that Chase might act on his words, “although when she confronted him with her concerns Chase denied any intention to take immediate action” (Ref. 12, at 1021). Significantly, Dr. Doe “warned Chase that if he told her specifics about whom he planned to kill

she would have a duty to alert those people” (Ref. 12, at 1021). Dr. Doe thereupon consulted a supervisor, who quite reasonably suggested she explore the issue further with Chase before breaching confidentiality.

The next contact was two months later, when Chase phoned Dr. Doe, upset over an argument with his wife, and “mentioned that his life insurance policy would pay off if anything should happen to him, a statement that caused Dr. [Doe] to fear that he was losing his support system” (Ref. 12, at 1021). Dr. Doe again consulted a supervisor, and the clinic's legal counsel, who “instructed her to get in touch with the police department in the town where Chase lived” (Ref. 12, at 1021). She waited a day, did so, and a week later “heard from the FBI.” (Given the phlegmatic time line, one wonders how “imminent” the parties perceived the danger to be.)

Dr. Doe detailed for the FBI “the threatening statements Chase had made during the therapy sessions and described whom he had threatened” (Ref. 12, at 1021). What happened next, though reported blandly by the court, stretches credulity: “Her supervisors instructed [Dr. Doe] to cooperate further by attempting to elicit more information about Chase's plans during their next appointment” (Ref. 12, at 1021–2).

She did so, at that moment ceasing to be Chase's psychiatrist and becoming instead an undercover cop. “At [the next] appointment, Dr. [Doe] said nothing to Chase about her conversations with the authorities” (Ref. 12, at 1022). Chase voiced further violent ideation and his psychiatrist, as an agent of the police, deceived him: “Dr. [Doe] again warned Chase about her obligation to alert Chase's intended targets, and Chase assured her that he would not act on any of his impulses” (Ref. 12, at 1022).

The FBI again debriefed Dr. Doe and shortly thereafter arrested Chase. Not, however, before several further attempts by a distressed Chase, still believing Dr. Doe to be his treating psychiatrist, to reach her. “Dr. [Doe] did not return Chase's calls, but she did call [FBI agent] McMullen to warn him that Chase was aware that law enforcement people were coming” (Ref. 12, at 1022).

Agent McMullen arrived at Chase's home to make the arrest. After telephone negotiations, “Chase. . . walked into his yard, assisted McMullen over a retaining wall, and permitted McMullen to handcuff him without incident. . . . Chase. . . referred to the statements he made to Dr. [Doe]

about killing people as ‘hypothetical’ ” (Ref. 12, at 1022).

In this case, a psychiatric patient was convicted and imprisoned on the testimony of his psychiatrist concerning evidence she had obtained by repeatedly misleading the patient, lulling him into believing he was still in therapy and that she had not yet talked with the authorities, while, cooperating with the FBI, she assiduously worked him for self-incriminating statements.

Tellingly, this did not elicit so much as a passing comment from the court, not even from the dissenting judge. Such, it seems, is the status of psychotherapeutic confidentiality and professionalism in the eyes of the law.

On appeal, the *en banc* Ninth Circuit affirmed.<sup>14</sup>

Superficially, the *en banc* decision seems to repudiate the panel’s assault on psychotherapeutic confidentiality. The court held that admission of Dr. Doe’s testimony against her own patient was in error. It affirmed the conviction, however, since adequate additional evidence supported the verdict, in the court’s view. A close examination of the court’s reasoning, however, reveals the familiar judicial dismissiveness of psychiatry that typifies *Tarasoff*-inspired case law.

In the first place, the evidence that saved the conviction was testimony by two telephone operators at Dr. Doe’s clinic. Chase left desperate messages for Dr. Doe with the operators as he knew he was about to be arrested—after Dr. Doe had not returned his repeated voice-mail messages. This evidence clearly is just as inadmissible as Dr. Doe’s own testimony, since the clinic’s operators were speaking with Chase as agents for Dr. Doe within the scope of their duties (analogous to a lawyer’s secretary speaking with the lawyer’s client about his case). Indeed, the impropriety of this evidence is all the clearer for having been induced by Dr. Doe’s avoidance of Chase’s calls in cooperation with the FBI’s arrest maneuvers.

Second, the court totally accepts Dr. Doe’s “cooperation” in deceiving Chase while she pumped him for self-incriminating statements. This, of course, effectively allowed the FBI into the consulting room without a warrant, to interrogate Chase vicariously, in derogation of his privacy, self-incrimination and due process expectations. Though Dr. Doe’s subsequent testimony was ruled improper, nothing in the decision precludes a psychiatrist in a future case from wearing a wire, so that a recording (or the testimony

of eavesdropping agents) can be adduced to convict the hapless patient.

Third, a comment to a psychiatrist—with absolutely no evidence of an intent or expectation that he or she pass it on—simply does not constitute a threat against a third party. Uttering words to one person is no more a threat to an absent separate person than would brandishing a weapon against Smith be an assault against Jones. The court knew this but shielded the conviction behind the pretext that the issue was unreviewable because it had not been raised by counsel (Ref. 14, at 993–4). In fact, where the prosecution’s factual allegations do not make out a crime, the defect is jurisdictional and not procedural, so the court plainly had the power (and the duty) to act.

Three judges concurred separately, evidently concerned that the court’s opinion was insufficiently clear in its disdain for psychiatrist-patient confidentiality:

... [t]he psychotherapist observed the patient committing a crime in her office, just as she would have if she had seen the patient steal her receptionist’s purse on the way out. As a participant witness to a felony, she ought to be required to testify to what she perceived [Ref. 14, at 994].

More important than the legal nuances of *Chase* is the lesson its underlying facts teach of how a quarter century of *Tarasoff* has altered the view psychiatrists take of themselves, their patients, and their oath to do no harm.

## Conclusion

The *Tarasoff* era has seen ever more spurious options of psychiatrists against their own patients, built ostensibly on the original invasion of the psychotherapeutic relationship in that famous though misunderstood<sup>15</sup> case.

Oddly, many psychiatrists continue to defend *Tarasoff* and to teach deference to it, rather than defending psychotherapy and psychiatric patients against *Tarasoff* and its ongoing metastases.

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