Discussion

This case raises several concerns about the acquisition and use of mental health records by law enforcement and the judicial system. There is considerable social stigma attached to psychiatric treatment, and involuntary psychiatric hospitalization carries even more stigma. Therefore, privacy laws, hospital policies, and mental health providers strive to limit the release of mental health records. Preserving the confidentiality of mental health records is critical to bolstering the patient's relationship with the mental health provider.

This case hinged on the right to maintain confidentiality of mental health records and demonstrated the different, and sometimes opposing, goals of law enforcement and health care providers. Physicians and other providers must certainly obey the law, but they also have an obligation to their patients, including ensuring confidentiality if possible.

There are limits to this confidentiality, however. Public safety sometimes necessitates the violation of patient confidentiality. In the aftermath of the Virginia Tech campus shootings, increased attention was given to disclosing mental health information to prevent the purchase of firearms by the mentally ill. Since this tragic incident, there has been increasing demand that government ensure that people who have been involuntarily hospitalized for mental health reasons are placed on a registry that prevents them from obtaining firearms.

There are other limits to confidentiality of mental health commitment and other records, including applications for licensure and employment. State medical licensing boards may inquire about a history of mental health treatment when a physician applies for a medical license. In Virginia, for example, Question 15 on the medical license application asks, "Do you have a physical disease, mental disorder, or any condition which could affect your performance of professional duties? If so, provide a letter from your treating professional to include diagnosis, treatment, prognosis, and fitness to practice." A state's legal bar may ask about mental health history when an attorney applies to take the bar examination. For example, the application for the bar examination in Connecticut asks several questions about mental health history. Question 34 asks, "Since you graduated from college or for the past five years, whichever is shorter, have you been hospitalized for treatment of a mental, emotional, or nervous disorder or condition?" Question 35 asks the applicant about treatment in the past five years for any number of psychiatric disorders, including major depressive disorder. Government and private job applications may also include questions with similar content, all of which may discourage individuals from seeking mental health treatment.

A person who has received mental health treatment may be faced with a difficult decision when presented with an application or interview in which he is asked about past commitment or other forms of psychiatric treatment. By revealing this information, he is risking a disclosure that may have a financial or occupational impact. Because of the social stigma attached to mental health problems, the person may also feel embarrassed about providing this information. Whatever the motive for providing false information for a federal firearms purchase—wanting to obtain a firearm, financial or occupational considerations, social stigma, or embarrassment—we see in this case that a person is held accountable for knowingly making such a false statement.

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Repeated Threats in Therapy

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Psychotherapist-Patient Privilege Is Inapplicable When There Is No Reasonable Expectation of Confidentiality

In *U.S. v. Auster*, 517 F.3d 312 (5th Cir. 2008), the United States Court of Appeals for the Fifth Circuit reversed an interim order of the United States District Court for the Eastern District of Louisiana that suppressed communications involving a threat of harm relayed by John C. Auster to his psychologist, Dr. Fred Davis.

Facts of the Case

Mr. Auster was, at the time, a 58-year-old retired New Orleans police officer, who had been receiving worker's compensation since 1989. He was in treatment for paranoia, anger, and depression with Dr. Davis and psychiatrist Dr. Harold Ginzburg, paid for by the company that managed his compensation benefits, Cannon Cochran Management Services, Inc. (CCMSI). Over the 17 years that Mr. Auster was under Dr. Davis' care, he had a history of threatening various individuals whom he believed had harmed him, including CCMSI staff. Both Drs. Davis and Ginzburg had in the past, pursuant to their legal duty to warn, reported the threats to CCMSI and informed Mr. Auster that if he persisted in making them, they would be obliged to continue to report.

In September 2006, Mr. Auster was informed that his benefits would be reduced beginning October 1, 2006. During his September 13 therapy session with Dr. Davis, Mr. Auster expressed "anger and hostility" and threatened physical harm to "CCMSI personnel, city authorities, and police officials" (*Auster*, p 314). After the session, Dr. Davis sent Keith Smith, the CCMSI employee who handled Mr. Auster's claim, a letter stating that if CCMSI curtailed Mr. Auster's benefits, it would "serve as a provocation for Mr. Auster to carry out his plan of violent retribution." The letter stated that Mr. Auster planned to act on October 2 and indicated that he had "stockpiles of weapons and supplies to provide the basis of his actions" (*Auster*, p 314). Mr. Smith purchased a firearm for self defense and called the police, who notified the Federal Bureau of Investigation. Mr. Auster was arrested on September 29, 2006.

The Federal Grand Jury indicted Mr. Auster for committing extortion by "wrongful use of threatened force, violence and fear" (*Auster*, p 314), alleging that he had purposively used Dr. Davis as a conduit to convey his threats, thereby forcing CCMSI to submit to his demands. Mr. Auster's motion to dismiss the indictment failed. However, the court granted the motion to suppress communications between him and Dr. Davis, stating that, as "confidential communications," they were privileged. The United States Attorney appealed the order to suppress to the Fifth Circuit.

Ruling and Reasoning

The United States Court of Appeals for the Fifth Circuit reversed the district court's order of suppression, acknowledging a split in the federal courts. It cited the United States Supreme Court's *Jaffee v. Redmond*, 518 U.S. 1 (1996) decision, which held that confidential communications between psychotherapists and patients in the course of diagnosis or treatment are protected from compelled disclosure under Rule 501 of the Federal Rules of Evidence.

The Fifth Circuit opined that Mr. Auster did not have expectation of confidentiality, citing a previous letter by Dr. Davis in which the doctor had written: "Mr. Auster is well aware of my position regarding violence and has agreed that he understands that I have such an obligation" (*Auster*, p 313). The court reasoned that *Jaffee*'s "explicit confidentiality" was "fatal to [Mr.] Auster's claim of privilege . . . because he had no reasonable basis to conclude the statement was confidential" (*Auster*, p 315). Therefore, because the confidentiality requirement had not been met, the psychotherapist-patient privilege did not apply. The Fifth Circuit disagreed with previous Sixth and Ninth Circuit rulings that statements made without a reasonable expectation of confidentiality are still privileged, stating that these rulings were not supported by *Jaffee*. It further argued that the latter circuits were erroneous in their conclusion that the harm of allowing information obtained from therapists into trial outweighed the benefits, stating that the "cost-benefit calculation is inapt where the patient already knows the confidence will not be kept" and "if the therapist's professional duty to thwart the patient's plans has not already chilled the patient's willingness to speak candidly, it is doubtful that the possibility that therapist might testify in federal court will do so" (*Auster*, p 318).

The Fifth Circuit reasoned that once a warning had been issued, its potential to spread exponentially beyond its intended target would be a greater deterrent than the possibility of disclosing psychotherapist-patient communications in trial.

Although the Tenth Circuit had held that a dangerous-patient exception to the psychotherapist-patient privilege existed, the Fifth Circuit declined to rule on the existence of such an exception but referenced *Jaffee* (p 18, n 19) regarding ". . . 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."

The Fifth Circuit opined that the United States Supreme Court had viewed the privilege as "limited in scope" and in similar situations involving dangerous patients where no confidentiality existed, the privilege would not apply.

Discussion

Confidentiality and testimonial privilege are distinct concepts, with confidentiality being a broad, ethical protection of the psychotherapeutic relationship's privacy, and privilege being patients' specific, legal right to prevent treaters from disclosing therapeutic communications in court.

The implications of confidentiality and privilege are complex as reflected in the divergence of opinions. If there are exceptions as to what constitutes confidential patient information, how does this affect clinical practice? How do we ascertain whether patients are well informed as to the limits of confidentiality? Should a threat expressed in therapy be used for prosecutorial purposes?

The Fifth Circuit rejected the notion that removing privilege would deter patients from disclosing their innermost feelings. However, a strict interpretation of the *Jaffee* footnote or a definitive dangerous-patient exception to the Rules of Evidence could discourage the very patients who struggle with such problems as anger, manipulation, paranoia, impulsivity or overall affective dysregulation, from seeking or remaining in treatment because their communications might not be privileged and could be used against them. The Sixth and Ninth Circuits in *U.S. v. Hayes*, 227 F.3d 578 (6th Cir. 2000), and *U.S. v. Chase*, 340 F.3d 978 (9th Cir. 2003), opined that the risk was great enough to justify arguing against a dangerous-patient exception and that statements made, even without the reasonable expectation of confidentiality, should be privileged.

We do not know for certain if Mr. Auster was dangerous and would have carried out his plan had he not been arrested. The district court acknowledged that both of Mr. Auster's doctors agreed that he was not violent but that "Dr. Davis felt it was his duty to inform CCMSI about the latest threats" (*U.S. v. Auster*, 2007 U.S. Dist. LEXIS 2693, 11 (E.D. La. 2007)). The question, put forth in *Chase* (p 990) to "balance the patient's need for candor, in service of therapy, against the potential victim's need for protection" remains difficult to answer.

When faced with patients who threaten, our primary duty is to protect them from harming themselves or others. Ascertaining whether actual dangerousness exists before acting is imperative in protecting when needed and in preventing misinterpretation and overuse of the duty to warn. If it is true that Mr. Auster was not thought to be dangerous, why was a warning issued? The level of assessment that determined the likelihood of Mr. Auster's carrying out his threat, as well as his history of violence, is unclear. His doctors may have attempted to increase his level of care, in addition to relaying a warning, as a way of mitigating the danger and avoiding legal consequences for their patient.

Disclosure used to protect patients from harming themselves or others is at times necessary. However, ethics-related dilemmas and questions arise when that disclosure might be used as a prosecutorial tool. What effect does the possibility of legal testimony have on a clinician's decision to conduct a therapeutic exploration of a patient's impulses? A warning may indeed compromise the psychotherapeutic "atmosphere of confidence and trust" referred to in *Jaffee*, especially since the details of a threat could leak past its target, causing lasting damage, even if the patient did not intend to carry out the threat.

The Fifth Circuit reasoned that allowing patient-therapist communications at trial would have only a minimal impact on an already compromised therapeutic relationship, but is this true? Does a duty-to-warn imply that the cat must be let out of the bag? Ultimately, does this use of therapists' testimony serve patients, society, or our field?

Addendum: On October 6, 2008, a writ of *certiorari* petition to address whether violent threats disclosed by a patient to a psychotherapist are privileged, even if the patient has reason to believe that the threat would be reported, was denied by the Supreme Court of the United States.

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