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West Virginia Therapists' Knowledge of Tarasoff-related Court Cases

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WEST VIRGINIA THERAPISTS' KNOWLEDGE OF *TARASOFF*-RELATED COURT CASES

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Table of Contents

List of Tables

Abstract

The *Tarasoff* decisions regarding the duties to third parties were profoundly significant to the practice of psychology and counseling. Despite this, there have been few studies regarding the impact on these decisions on clinical practice. There are essentially three sources of data regarding the analysis of any *Tarasoff*-related clinical scenario. They include state statutes, court case law and the professional ethics codes. Most of the limited studies conducted have indicated serious knowledge gaps with respect to relevant state statues and the essence of the *Tarasoff* duties. This study evaluated West Virginia therapists' knowledge of *Tarasoff*-related court cases. It was hypothesized that the overall knowledge level of the original *Tarasoff* decisions and the subsequent *Tarasoff* court cases would be low. Furthermore, it was hypothesized that there would be no differences between measured accuracy rates of court cases and practitioner's discipline, years of experiences, or continuing educational experiences. With some moderate exceptions, all hypotheses were verified. The overall knowledge and understanding by respondents regarding *Tarasoff*- related court cases was low even though their overall levels of confidence about their knowledge were relatively high. Furthermore, respondents revealed a fundamental misunderstanding about judicial imperatives and their impact on other jurisdictions and professional codes of ethics. The implications of these findings were discussed in terms of risk management, supervision and consultation.

Chapter 1

Introduction

It has been nearly 40 years since the rendering of the landmark *Tarasoff* decisions from the state of California, which established the duties to warn and protect a third-party, who could be a potential target of threats expressed by a patient during an otherwise confidential psychotherapy session (*Tarasoff v. Regents of the University of California* 1974; *Tarasoff v. Regents of the University of California*, 1976). The decisions essentially codified an exception to the long-standing ethical and clinical tradition of therapist-patient confidentiality (Mills, 1984; Stone, 1976; Wise, 1978). The decisions initiated a great deal of concern among professionals about the impact of both legitimized and mandatory breaches of patient confidentiality on the therapeutic relationship. Since those decisions, other courts have used the *Tarasoff* decisions as the basis for their judicial renderings in cases involving potential violence or harm to third-parties perpetrated by clients of therapists who knew or should have known of the risks. The *Tarasoff* reasoning has been applied to such disparate issues as impaired drivers (Love, Welsh, Knabb, Scott & Brokaw, 2008; Pettis, 1992; Pettis & Gutheil,1993), genetic diseases (Petrila, 2001; Pullman & Hodgkinson, 2006) and cases involving repressed memories and abuse allegations (Slovenko, 1999). It has even been hypothesized as potentially relevant for researchers when participants reveal potentially threatening behaviors (Appelbaum, & Rosenbaum, 1989). It has also been argued that the *Tarasoff* reasoning could be relevant in HIV cases (Chenneville, 2000; DiMarco & Zoline, 2004; Fleetwood, 2006; Huprich, Fuller & Schneider, 2003; Simone & Fulero, 2001).

During the decades that followed the original *Tarasoff* court decisions, many states addressed the concerns expressed by professional organizations by codifying statutes that provided legal language relative to the issues of duty to warn and protect (Buckner & Firestone, 2000; Kachigian & Felthous, 2004). These statutory remedies range from permissive statutes (for example, West Virginia) to state codes establishing an affirmative duty to warn under specified circumstances. Many state statutes include the manner in which those established duties could be legally discharged and the degree of immunity from prosecution for professionals who breach patient confidentiality in order to comply with the law. A small number of state legislatures have remained silent on the issue (Herbert, 2002; Herbert & Young, 2002; Kachigian & Felthous, 2004).

Instead of promoting consistency and clarifying professional expectations and standards, these legislative initiatives and subsequent judicial decisions created varying degrees of ethical and clinical ambiguities for practitioners across the country (Felthous, 2006; Herbert & Young, 2002). Thus, where a clinician practices, in many instances, guides the management of these clinical scenarios rather than guidelines driven by professional consensus or the applicable code of ethics.

Prior judicial decisions constitute precedent upon which subsequent judicial analyses are conducted. Some state legislatures have utilized the *Tarasoff*-related court decisions to address concerns expressed by professionals about managing duty to warn imperatives and balancing the ethical standards related to confidentiality. Despite those initiatives at the state level, (Kachigian & Felthous, 2004) observed in some states where there were statutory duties to warn and protect, that their respective judicial courts often did not even reference their own state statute in their analyses of duty to warn cases. Thus, the judicial impetus and the extensive breadth of

subsequent *Tarasoff* cases have become important and dynamic factors in how clinicians evaluate and respond to duty to warn cases and the potential duties to third-parties (Fox, 2010; Quattrocchi, & Schopp, 1993).

This project evaluated West Virginia mental health practitioners' knowledge of court findings related to duty to protect or warn third-parties. Participants were asked to provide minimal demographic information including type of practice, years of practice, and experiences with duties to warn or protect. Participants were asked to evaluate implications of the original *Tarasoff* decisions. In addition, they were provided scenarios presented based upon the particulars of actual court decisions. Participants evaluated each scenario based upon what they would do as clinicians and what they believed the court decided. Finally, the participants will be asked to rate their degree of confidence about their respective responses to each analysis.

An understanding of judicial precedents as it relates to duties to warn or protect is significant for several reasons. First, rulings from one judicial circuit are often used as the basis for subsequent litigation in another jurisdiction as was true for the original *Tarasoff* cases. In order for therapists to practice ethically and manage risks, they need to have an understanding of significant findings from their own, as well as other, jurisdictions which could impact their ability to ethically manage risk in their practice (Hansen & Goldberg, 1999). Some of these findings may have direct impact on the way informed consent is articulated or the manner in which the warning is issued or documented. Monahan (1993) emphasized that because there are no legal standards for assessment of patient risk for violence, clinicians should be aware of the legal standards in their jurisdiction. He also opined that the state statues will likely undergo additional adjudication for clarity of statute language (Monahan, 1993).

Second, having a working knowledge of relevant judicial findings is advantageous in that the findings may include some nuance that is an improvement over current clinical practices. These changes could still consistent with ethics codes and current state statute. Fox (2010) opined that the *Tarasoff* duties have shaped some aspects of clinical assessment, particularly in the area of dangerousness, that have now become routine.

Third, in order to adequately attend to issues of risk management, it would be helpful for clinicians to have a working knowledge of judicial findings and incorporate that knowledge of those findings in the documentation of the decision-making process in actual cases involving duties to third-parties (VandeCreek & Knapp, 2000). Monahan (1993) has concluded that comprehensive documentation and demonstrating reasoning helps psychologists and other mental health professionals manage risk. Demonstrating that such findings are contemplated in the process shows due diligence.

Fourth, the significance of these research findings and this particular issue of judicial rulings cannot be overstated in terms of issues related to clinical supervision and case consultation. For example, most researchers in this area have generally recommended that part of the clinical protocol involve consultation with peers. Furthermore, research has concluded that both training programs and continuing education efforts are falling short of bridging a knowledge gap around issues of duty to protect (Pabian, Welfel, & Beebe 2009; VandeCreek & Knapp, 1989; Tolman, 2001).

There were five hypotheses for this project. First, the overall knowledge therapists have regarding *Tarasoff*- related court cases will be low. Second, there will be no differences observed between psychologists and counselors regarding their respective accuracy rates and knowledge of *Tarasoff*- related court cases. Third, the overall accuracy rates for counselors and

psychologists regarding their understanding of the original *Tarasoff* decision will be low and will have no significant differences between the disciplines. Fourth, there will be no relationship between accuracy ratings of the post *Tarasoff*- related court cases and continuing education experiences. Finally, the accuracy ratings of psychologists and counselors on the post *Tarasoff*-related cases will not be related significantly to years of experience

Chapter 2

Literature Review

The original *Tarasoff* case centered on the circumstances that preceded of the murder of a college student by a man who had made threats about her to his therapist**.** Tatiana Tarasoff was a young Russian-American woman who attended a community college in California and planned to eventually study at the University of California at Berkeley. She met a Bengalese graduate student, Prosenjit Poddar, who pursued Tatiana romantically. They saw one another regularly but she reportedly had no romantic interests in him. Poddar grew increasingly obsessed with Tarasoff. She made it known to him that she had no interest in a relationship with him.

A few months later, after she adamantly rejected his marriage proposal, Poddar became paranoid and his preoccupation with Tatiana became more intense. He was demanding of her time and scolded her when she fell short of his expectations. He taped phone conversations with her, listened to them repetitively and told his roommate he was in love with her and, later, that he had thoughts of killing her.

Tatiana went to Brazil during the summer of 1969. During this period, Poddar sought counseling. He was evaluated by Dr. Stuart Gold, psychiatrist at Cowell Memorial Hospital (University Hospital) on an outpatient basis. He also saw psychologist, Dr. Lawrence Moore. The client repeatedly shared his homicidal thoughts in the course of the first eight sessions. Dr. Moore told Poddar of his intention to detain him if he continued the threats. During the ninth session on August 18, 1969, Poddar verbalized that he was going to kill an unidentifiable female when she returned to California from Brazil.

Two days later, Dr. Moore informed two campus police officers that Poddar was capable of harming others and possibly himself. Moore also, on the same day, August 20th, wrote a letter to the Chief of Campus Police describing Mr. Poddar's clinical symptoms and that he was a danger to self and others. Dr. Moore stated that if Poddar were taken into custody and transported by police to Herrick Hospital, he (Moore) would sign an emergency detention order for Poddar to be held and evaluated. Dr. Moore further declared to the campus police that the client could present as rather rational at times. The psychologist's supervisors in the Psychiatry Department at Cowell Memorial agreed that Poddar met the requirements for the 72 hour detainment.

The campus police found Poddar at his apartment and interviewed him in the presence of his roommate. The interviewee admitted having a conflicted relationship with an unidentified woman but did not acknowledge any threats to harm her. The officers were satisfied that Poddar was rational and released him on his promise to stay away from the girl.

The university's health services chief of psychiatry asked the police to return the psychologist's letter and directed that any documentation concerning the case be destroyed. He ordered no action take place with regard to the request for the detainment in a treatment and evaluation facility.

Tatiana returned from Brazil in October. On October 27, Poddar went to her home. He found her alone and shot her with a pellet gun. She ran from the house to the yard where he fatally stabbed her 37 times. He called the police and awaited arrest.

Tatiana's parents sued the university's chief of psychiatry, the psychiatrist who initially interviewed Poddar, the treating psychologist and another consulting campus psychiatrist and the

campus police, alleging that defendant therapists did in fact predict the patient's violence and there was negligence for not warning her (Buckner & Firestone , 2000; Hubbard, 2007; Mossman, 2007).

Psychotherapy is based upon the effectiveness of the therapeutic relationship between the client and therapist (Baird & Rupert, 1987; Chaimowitz, Glancy, & Blackburn, 2000; Fisher, 2008; Stone, 1976). One of the most important aspects of the relationship is that it is confidential in nature. The issues raised in the original *Tarasoff* decisions involve warning and possibly taking steps to protect a potential victim. The warning of a third-party outside the therapeutic relationship involves violating the client's expectation of confidentiality. Therefore, confidentiality is best conceptualized as a conditional aspect of the relationship. Thus, when clients threaten third-parties, therapists are expected to breach confidentiality in order to protect the safety of others. Part of the ethical and legal conflicts involved in duty to warn scenarios are the tension between the confidentiality of the client and the duty to protect third-parties (Resnick, & Scott, 1997). Psychotherapists are now in the tenuous position of being held liable for breaching client confidentiality or for negligent failing to adequately protect the safety of a third party (Gutheil, 2001).

Ethical conflicts in the area of confidentiality have consistently been ranked among the most frequent and the most troubling dilemmas facing psychologists and other therapist (Helbok 2003; Helbok, Marinelli & Walls, 2006; Knapp, Gottlieb, Berman & Handelsman, 2007; Haas, Malouf, & Mayerson ,1988 ; Haas, Malouf, & Mayerson,1986 ; Pope & Vetter, 1992). To further complicate the matter, the literature reviews and judicial decisions in the area of duties to third-parties, which arise from client threats, often includes conflating confidentiality, privilege, and privacy (Klinka, 2009; Watts & Stankowski, 2009). Privacy is a complex concept which

generally refers to an individual's right to be free from the unwarranted intrusions by others and the right to limit the access others have to a person's personal affairs. Privacy is often considered a constitutional right in the United States (Weiner & Wettstein, 1993). Confidentiality, on the other hand, is often conceptualized as the professional duty to not disclose information obtained during the provision of diagnostic and treatment services, which could potentially harm the client or the therapeutic relationship (Klinka, 2009; Watts & Stankowski, 2009; Weiner & Wettstein, 1993).

Confidentiality is based upon professional ethics and generally applies to therapeutic and fiduciary relationships and professional interactions. By contrast, privilege is strictly a legal concept based upon the types of evidence which are made discoverable during litigation. Because of the legal ramifications of this concept, communication, which is considered privileged, is often conceptualized as "testimonial privilege" (Thomas, & Herbert, 2005; Weiner & Wettstein, 1993). However, some lawsuits involving negligence related to the failure to warn or protect a third-party have been complicated by the plaintiff raising the issue of privilege during the court proceedings or therapists being a witness against their own client (Aversa & Kapoor, 2011; Glancy & Chaimowitz, 2005; Weinstock, Leong, & Silva, 2001). This dilemma is especially relevant since the federal courts recognized the psychotherapist-patient privilege and a dangerous patient exception in *Jaffee v. Redmond* (1983).The duty to warn has essentially evolved into an exception to both psychotherapist-patient privilege and the ethical standard of confidentiality. Therefore, the legal exception has become the ethical exception (Weiner & Wettstein, 1993; Weinstock et al., 2001).

The ethical and legal conflicts brought forth from *Tarasoff* decisions were complex because they involved balancing multiple ethical principles and legal mandates. Because

therapists operate within parameters of conditional confidentiality, the cumbersome imposition of duties toward third-parties forced clinicians to, not only to evaluate the clinical presentation of their clients' risky behaviors, but to evaluate the impact of those risks upon society as a whole (Knapp, et al., 2007; Knapp, & Sturm, 2002). Furthermore, because these duties may be mandatory, the therapist may have no choice but to breach confidentiality and warn a threat to third-party or law enforcement about threats verbalized during a therapy session.

The traditional underpinnings of most professional codes of ethics included autonomy, beneficence, nonmaleficence, fidelity, and justice (Kitchner, 1984). Issues of autonomy have often been attenuated under *Tarasoff*-related scenarios because, once a threat is verbalized, the client may have no other option but to face the potential legal and personal consequences of a therapist relaying a warning to a third-party. Felthous & Kachigian (2001) argue, convincingly, that one legal interpretation is that the act of uttering a threat in the first place represents a criminal act. The therapist has been a witness to a crime which conflicts with issues of beneficence and nonmaleficence which were arguably at the heart of the *Tarasoff* duties because the duty to protect a potential victim outweighs the duty the clinician has to maintain confidentiality (Knapp et al. 2007). Although some have argued in favor of the right of unconditional confidentiality (Kipnis, 2006; Miller & Thelen, 1986), the prevailing professional standards for both counselors and psychologists reflect the concept of conditional confidentiality because legal mandates have weakened the client's expectation of confidentiality (Thelen, Rodriquez, & Sprengelmeyer, 1994; Weinstock et al., 2001). Fidelity has also been relevant to the extent that therapists must balance a set of duties that involve those to their clients and those to the potential victim of a threat of violence. Finally, concepts of justice and what is fair have

also been part of the decision-making process for therapists confronted with the duty to warn (Kitchner, 1984).

Risk management is a component of the analysis a therapist must complete in situations involving potential duties to third-parties (Monahan, 1993). The fear of litigation and the uneasiness of violating ethical principles have shaped the manner in which clinicians manage these high-risk situations (Knapp et al., 2007; Knoll & Gerbasi, 2006; VandeCreek, & Knapp, 2000). Therapists who fail to warn targeted third-parties who are subsequently injured or killed are subject to malpractice litigation based upon negligence claims. Negligence may occur when professional conduct falls below an established standard which impacts the safety and protection of others from unreasonable and foreseeable risk of harm or damage (Knoll & Gerbasi, 2006; Packman, Cabot, & Bongar, 1994; Weiner & Wettstein, 1993). Negligence claims are generally conceptualized as unintentional torts and, in the area of healthcare, malpractice is negligence related to failure in carrying out professional duties (Gutheil, Simon, & Hilliard, 2005; Marks, 1977).

In a malpractice claim, the plaintiff must prove that the defendant had a duty to the plaintiff and that there was a breach of duty which caused damages. Furthermore, those damages must be caused by the breach of duty (Knoll & Gerbasi, 2006; Slovenko, 1999; VandeCreek, et al., 1987; Weiner & Wettstein, 1993). Practitioners have been judged by standards established by their specialty. In cases of malpractice claims, the behavior of the practitioner has been evaluated on the skills, knowledge, and experience ordinarily possessed and used by similarly trained professionals, acting under similar circumstances and practicing in the same locale as in *Robbins v. Footer,* (1977).

Thus, therapists may be held liable for harm resulting for failure to issue a warning to potential victim (Felthous, 1987) or be held liable for defamation resulting from breaches in confidentiality as was the case in *Garner v. Stone* (1999).

Under principles of common law, no one has a duty to protect another individual from harm unless there is a special relationship between the parties (Monahan, 2007; Prosser, 1971; Slovenko, 2006; Slovenko, 1999). However, the basis of the duty to warn or protect third-parties, as reasoned by the original *Tarasoff* court cases, was based upon the existence of a special relationship between the psychotherapist and the patient. Essentially, the special relationship found in the confidential relationship between a therapist and patient constitutes the basis of an exception to the common law principle regarding the absence of a duty to control the conduct of another person so as to prevent harm (Slovenko, 1999). Thus, in *Tarasoff*, the presence of the special relationship between therapist and client gave rise to the duty to a third-party when there was a verbal threat toward an identifiable, or reasonably identifiable, third-party (Slovenko, 2006; Slovenko, 1999).

Aftermath of *Tarasoff* and State Responses

In its first *Tarasoff* decision, the Supreme Court of California articulated a psychotherapist's duty to warn a third-party of potential violence by a client. The court essentially said that when psychotherapists, exercising their professional judgment, determine or should determine, that a warning to a third-party might prevent harm, those professionals have a legal duty to issue that warning (Felthous & Kachigian, 2001). In its rehearing of the case in 1976, the California Supreme Court vacated the first decision and articulated a set of duties to protect third-parties. The court indicated that once a therapist determines or should have

determined the patient represents a serious threat to a third-party, the therapists have an obligation to utilize “reasonable care to protect" the intended victim (*Tarasoff,* 1976, p.340). There were no indications from the court about how to make the determination of dangerousness and there was also no requirement of a verbal threat or requirement to obviate the threat through additional clinical intervention or intensification of therapy. Felthous and Kachigian (2001) argued that following these decisions, courts and state legislatures began to distinguish between the duties to warn and the duties to protect or control. In subsequent *Tarasoff*-related cases, courts would either separate the two duties or sometimes only deal with one aspect of one of the articulated duties. Furthermore, both court systems and state legislatures began to deal with the *Tarasoff*-related duties in their various permutations, as well as the issue of foreseeability of risks and the ability to accurately identify potential targets. In tort litigation, foreseeability is a component of the analysis of negligence.

Following the promulgation of the 1976 *Tarasoff* decision, many professionals and commentators expressed grave concerns about the impact of these decisions upon the practice of psychology and psychiatry (Stone, 1976; Rosenhan, Teitelbaum, Teitelbaum, & Davidson, 1987; Roth & Meisel, 1977). Many were concerned that the threat of disclosures to a third-party would endanger the long tradition of psychotherapist-patient confidentiality and dramatically affect the efficacy of psychotherapy (Small, 1985; Quinn, 1984).Others have concluded that the duties are not as onerous as initially conceived (Walcott, Cerundolo, & Beck, 2001).

After *Tarasoff,* other jurisdictions began to reference the landmark California case in their reasoning of cases involving allegations of negligence on the part of therapists for failure to protect victims. These judicial findings, in other states, were often rendered in the absence of state statutes addressing these types of duties for mental health professionals. Most jurisdictions

subsequently began to establish statutes articulating the obligations mental-health professionals may have to third-parties, who are potential victims based on the seriousness of a threat from client (Kaufman, 1991).

At the current time, there are jurisdictions that permit, but do not mandate, psychotherapists to disclose warnings to third-parties based upon their assessment of risk and include West Virginia, Florida, New York, Oregon and the District of Columbia. There are other jurisdictions that impose an affirmative duty by statute to warn or protect potential victims and another nine states that have common-law duties to warn and protect based on court cases (Harmon, 2008; Melby, 2004). Other states that have either not ruled on the issue of duty to third-parties or have no statute (Pabian, et al., 2009).

There is tremendous variability with respect to state statutes regarding duty to third-parties and there is no precise consensus about the classification of the jurisdictions (Benjamin, Kent, & Sirikantraporn, 2009; Herbert & Young, 2002; Knapp, VandeCreek, & Shapiro, 1990; Pabian, et al., 2009). For example, the states of Maryland, Massachusetts, and New Jersey require a therapist not only to warn of explicit verbal threats made by the patient, but also mandate that the therapist consider the patient's history of violence in the process of assessment of duties. In Ohio, Minnesota, and California, therapists are also obligated to issue warnings based upon information reported by third-parties (Herbert & Young, 2002). These decisions were clearly the effect of the *Ewing* cases upon state legislatures. Other confusions and inconsistencies come from issues related to the types of disciplines covered within the statute. For example, Oklahoma statutes impose specific liability only on psychologists and leave the status of other professionals vague. The state of Michigan includes music therapists in their duty to warn statute (Herbert & Young, 2002) whereas the statutes of South Dakota appear to be

contradictory in terms of who receives a warning. For example, in one section of the code the warning should be issued to both law enforcement and the victim, and in another section of the code it is law enforcement or victim.

Among the permissive states, Oregon's statute, although providing immunity for not disclosing information is problematic in that the statute applies only to providers with public mental health agencies and their staff (Bloom & Rogers, 1988). This ambiguity leaves open the question of its relevance for private practitioners. In North Carolina, its statute appears to only apply to non-private practitioners. The Texas statute does permit disclosure to law enforcement agencies of threats but does not permit or require those warnings be issued to the victim (Barbee, Ekleberry & Villalobos, 2007). Herbert & Young (2002) caution that some of the permissive statutes, including Florida and West Virginia, may be susceptible to a subsequent duty being attached by judicial interpretation. They specifically caution practitioners in these jurisdictions to consider approaching the permissive language as more mandatory in clinical practice. Soulier, Maislen, & Beck (2010) concluded that states with permissive statutes actual experience more practitioner liability than states which have more mandatory language.

In one study, Kachigian & Felthous (2004) evaluated how various court systems across the country have utilized and referenced various appropriate state statutes regarding *Tarasoff*-related duties and corresponding immunities. They reviewed 76 court cases to evaluate the extent to which the rendered opinions included references to the relevant state statutes and whether or not the analysis did or did not create a duty for the therapists. Of the 76 cases evaluated, 21 of those cases did not include judicial references to the state statute, despite their likely relevance. In some instances, there was no indication by the court as to why the statute was not referenced. Further, the researchers found 12 cases in which the court referenced the appropriate state

statute, but did not use it in their analyses. In some instances, the lawsuits may have predated the ratification of the statute or, as they found in one case, the Michigan state statute applies to mental-health professionals and the defendant in the case reviewed was a mental-health facility. Thus, the efforts of state legislatures to enact reasonable statutory remedies to the *Tarasoff*-related court cases only punctuated the inconsistencies across jurisdictions and even within the same jurisdiction.

Selected Court Cases

Even prior to the *Tarasoff* cases, courts acknowledged duties to third-parties primarily based on negligent inpatient releases. In *Fair v. United States* (1959), an Air Force officer threatened to kill several people at his duty station including the commander, a student nurse, and several other medical personnel. The nursing school hired a guard to protect the student nurse and eventually the officer was hospitalized. During his hospitalization, the attending physicians assured the student nurse that she would be notified before the officer was discharged from the hospital. The officer was released and the physicians failed to notify the nurse or other personnel. Following his release from the hospital, he killed a student nurse, two other staff, and then himself. The hospital was found negligent regarding the officer's release. In a similar case in 1966, *Underwood v. United States*, a soldier, who had a history of stalking and threatening his ex-wife, was admitted to a psychiatric hospital in Alabama. The two treating physicians did not adequately document interventions and they did not thoroughly communicate with one another regarding the patient's violent history. The second treating physician released the soldier and placed him on restricted duty on the base. After his discharge, the soldier obtained a military weapon, shot and killed his wife and then himself. The Court of Appeals found negligence on the

part of the first treating physician, as well as the staff who maintained control of the weapons on the base.

One of the issues confronting therapists in dealing with *Tarasoff*-related cases when contemplating issuing a warning is the extent to which the threat is already known to the potential victim. Such was the case in *Bradley Center v. Wessmer* (1982), in which a man voluntarily admitted himself to a psychiatric treatment facility for symptoms of depression and anger toward his wife, in part, because she was having an affair and planned to divorce the patient. During Wessmer's treatment, he was given a pass in order to visit with his children. During his time away from the treatment center, he purchased a gun, confronted his wife and her lover and shot them both. The Georgia court held that the act was foreseeable and that the negligence of the Center was the cause of her death. Although the wife had prior knowledge of the threats, the treatment facility was aware that he had made threats during his stay at the psychiatric unit and they could have declined his request for leave. The victim's prior knowledge was part of the court's reasoning in the state of Iowa *In the Matter of the Estate of Votteler* (1982). A former outpatient of Dr.Votteler intentionally struck and killed the plaintiff while driving an automobile. The patient had, in the past, twice attempted to run her and the patient's husband down with her automobile and therefore the risk was known to the victim. The court found that there was no duty to protect third-parties when the foreseeable victim had prior knowledge of the threat from the patient. In *Boulanger v. Pol* (1995), a traumatic brain-injured male was released from a treatment facility back to the care of his uncle. The patient assaulted the plaintiff and he sued the defendant for negligent release. The court said that there was no special relationship existing in this case bringing about any duty and, finally, the duty to warn does not arise when the victim has prior knowledge of the danger.

Some courts have found liability for outpatient providers. In this case from Oregon, *Cain v. Rijken,* (1986), a psychiatric patient had been released from a hospital on the condition that he attends a day treatment program. During his treatment in this less intensive level of care, his symptoms began to worsen and he experienced hallucinations. He did not show up for his therapy appointment and two days later, while driving his car erratically, he collided with another car killing the driver. The Supreme Court held that the day treatment program had a duty to monitor the patient and remanded the case back to the lower court.

In *Delk v. Columbia/HCA Healthcare Corp., et al.* (2000), the plaintiff was admitted to a psychiatric hospital for suicidal thoughts and exacerbation bipolar disorder-related symptoms. The defendant claimed that the staff permitted a male patient, believed to be HIV-positive, to enter her room and remain there without supervision. She indicated that she was sexually assaulted by this male patient. The defendants pled that they owed no duty to protect the plaintiff from criminal attacks because there was no special relationship between the plaintiff and defendant. Furthermore, the defendant maintained that the sexual assault was not foreseeable. The trial judge rendered summary judgment for the defendants. The Virginia Supreme Court rejected the lower court ruling and found that there was a special relationship, creating a duty, between a psychiatric patient and a psychiatric facility. At that time, Virginia had no *Tarasoff* duty.

In one instance, the court extended liability to an eyewitness. In this California case, *Hedlund v. Superior Court of Orange County* (1983), a psychologist and a psychological assistant were providing therapy to a couple. The man threatened the woman and both therapists warned her of the threats. Eventually, he acted upon those threats and ran the woman and her son off the road in her car and then shot her. She sued the therapist claiming that they had not warned

her of the danger to her or her son and she further claimed that her son was traumatized by witnessing this violence. The Supreme Court of California held that the therapist did, in fact, have duties to both the woman and her son because the injuries were, in their opinion, foreseeable because children are generally in close proximity to their parents. Therefore, liability extends to bystanders.

The essence of most *Tarasoff* statutes includes a verbalized threat and a foreseeable victim. These were not the circumstances in the case of *Jablonski v. United States* (1983). In this case, Jablonski had a history of sexual assault and homicidal ideation directed at both his girlfriend and her mother. He had sought psychiatric treatment at a California Veterans Administration hospital for reoccurring thoughts of violence toward his girlfriend and her mother. His therapist at the Veterans Administration facility concluded that Jablonski may be potentially dangerous. One of his therapists even suggested that his girlfriend get out of the relationship for her own safety. She continued to maintain contact with him and the therapist gave her no further warnings. The treatment team did not feel that involuntary commitment was indicated. The team was unaware of Jablonski's long history of violence toward his ex-wife because they had failed to request previous medical records. Shortly after Jablonski's release from the hospital, he killed his girlfriend. This case essentially expanded the legal concept of foreseeability, as there was no specific verbal threat directed at the victim during his hospitalization and she had been warned about his behavior and advised to leave the relationship. The court reasoned that his lengthy history of violent behavior, absent a specific verbal threat directed at a particular victim, was sufficient evidence of reasonable foreseeability.

This expansion of foreseeability, directed toward a potential class of victims rather an identified target, was also seen in Arizona case, *Hamman v. County of Maricopa* (1989) where

the court outlined a zone of danger containing possible victims. Likewise, in *Lipari v. Sears, Roebuck and Co.* (1980), considered by many to be the broadest interpretation of *Tarasoff* duties, a patient of a local Veterans Administration Hospital purchased a shotgun at Sears, Roebuck & Co., while he was in a day treatment program. He never advised any of the treatment team members that he purchased firearms. He withdrew from treatment approximately three weeks after he purchased the shotgun. Approximately four weeks after that, he entered a nightclub and began shooting randomly, injuring a woman and killing her husband. The injured widow filed a wrongful death suit against Sears for selling firearms to someone they should have known had serious psychiatric problems. The Nebraska court rejected the *Tarasoff* limitation of an identified victim and extended the legal duty to foreseeable victims or a class of victims, even in cases in which there were no verbal threats. The courts concluded in the *Schuster v. Altenberg* (1989) case that a duty to protect exists and that the therapist was potentially liable for any harm that occurs to third-parties regardless of the issue of foreseeability.

The issues of foreseeability and frequency of patient contact were the focus in *Naidu v. Laird* (1988). The patient in *Naidu v. Laird* (1988) had a lengthy history of multiple psychiatric inpatient admissions based upon a history of medication noncompliance, deliberate automobile accidents, and multiple suicide attempts. During the hospital stay in question, he was there on a voluntary basis and ceased taking his medication upon discharge. Five months later, he intentionally drove his vehicle into a vehicle driven by the plaintiff, resulting in a homicide. The Delaware Supreme Court upheld the jury verdict and ruled that the psychiatrist had been negligent in his evaluation and release of the patient. In this case, there was also no specific threat or no readily identifiable victim. Plus, there was a five-month delay between the time of

discharge and the time of the vehicular homicide, which might have impacted the causality component necessary to establish negligence.

Driving cases have been part of the duty to warn literature. In *Peterson v. State* (1983), the patient was committed to a state hospital involuntarily and was known to have a history of erratic behavior and a lengthy history of substance abuse. During his stay in the hospital, he was noncompliant with his medication. Five days after his discharge from the hospital, the patient was driving recklessly and caused an automobile accident which resulted in injuries to the plaintiff. The court found the attending psychiatrist negligent in his release of the patient and for failure to seek further involuntary commitment proceedings. The court also held that the physician had a duty to protect anyone who may potentially be foreseeably in danger by the former patient's substance-abuse. In this case, there was obviously no verbal threat and no identifiable potential target of a threat.

Many states and jurisdictions have refused to impose a duty on therapists. Among them is Florida, as evident by the Florida Court of Appeals in *Boynton v. Burglass* (1991). In this case, Lawrence Blalock was under the care of the defendant when he shot and killed Wayne Boynton. The plaintiff's family sued the psychiatrist, alleging that the doctor either knew or should have known that his patient had threatened serious harm to the decedent and failed to warn the decedent or notify the police of the alleged threats of harm. The court refused to apply the *Tarasoff* reasoning in this case. The court indicated that predicting and controlling the behavior of patients are unreasonable goals and that psychiatry was not an exact science. The Florida court further stated that the court in the original *Tarasoff* decision, misunderstood the special relationship exception to the rule that there are generally no duties to control the conduct of another person. Finally, the *Boynton v. Burglass* court concluded that because the therapeutic

relationship between Blalock and his therapist contained no element of control that it failed to meet the special relationship exception to the common law rule.

The special relationship concept was also rejected by the Virginia Superior Court in *Nasser v. Parker* (1995). In this case, a patient with a history of violence toward women threatened to kill his ex-girlfriend for apparently rejecting him. He voluntarily sought hospitalization and remained there for one day and signed himself out against medical advice. The attending psychiatrist did not warn the girlfriend even though he was aware of the recent threat. Approximately six days later, the patient shot and killed his girlfriend. The plaintiff alleged that there was a special relationship between the doctor and the patient and that the relationship would carry a duty to prevent physical harm to others. The court rejected the duty to warn concept and stated that a voluntary, patient-physician relationship is insufficient to create a duty, despite the fact that the patient had been hospitalized.

The Texas case *Thapar v. Zezulka* (1999) was appealed twice before it was finally heard by the Texas Supreme Court. For three years, a psychiatrist had been treating a patient with a diagnosis of posttraumatic stress disorder, paranoia, and delusional thinking. He had at least six hospitalizations under the doctor's care and during his last admission, he disclosed to his physician that he felt like killing his stepfather. The doctor did not issue any warning to the stepfather or notify the police about the threat. Approximately one month after his release from the hospital, the patient killed his stepfather. The patient's mother sued the psychiatrist for negligent care and failing to warn the patient's stepfather of the verbal threats. The Supreme Court affirmed summary judgment for the defendant psychiatrist, indicating that therapists do not have a duty to third-parties for negligent diagnosis or treatment. Furthermore, the court referenced the Texas state statute regarding patient confidentiality, which includes an exception

for therapists to disclose threats made by patients only to law enforcement but not to potential victims. The court indicated that such a proposed disclosure of the threat to the potential victim would have violated the state statute. Finally, the court reasoned that psychotherapists who issue warnings to third-parties may not be immune from liability resulting from those disclosures regardless of whether or not they are made in good faith.

The Ohio court expanded the duties to warn and protect regardless of prior knowledge or specified victim in *Estates of Morgan v. Fairfield Family Counseling Center* (1997). In 1991, Matt Morgan was having dinner with his family when he excused himself, returned and then shot and killed his parents. He seriously wounded his sister. In the year prior to that, Matt had been receiving treatment at Fairfield Family Counseling Center (FFCC). In January, 1990, after making threats toward his father, the authorities removed Matt from his parent's home in Ohio. He drifted for several months and subsequently was admitted to a psychiatric hospital in Pennsylvania. He was successfully treated with antipsychotic medications and diagnosed with schizophreniform disorder. Matt was discharged to the care of his family in Ohio and scheduled follow-up care locally. Dr. Brown, the psychiatrist consultant to FFCC, performed a half hour evaluation and continued the patient's medication, but then discontinued the medication a few months later. Apparently, he never familiarized himself with the treatment Matt received in the Pennsylvania hospital. Matt continued a therapeutic relationship with a vocational counselor at FFCC. Throughout his treatment, Matt's mother repeatedly shared with staff that she feared his mental state was worsening. She continued to express concerns that her son had become verbally abusive and threatening. Having heard her concerns, Matt's counselor indicated to Mrs. Morgan that Matt was not committable. In May 1991, Matt did not show up for a scheduled appointment. At the end of May, the counselor assessed Matt on an emergency basis and again concluded he

was not a candidate for involuntary hospitalization. Mr. and Mrs. Morgan wrote to the counselor's supervisor with yet another plea for help. They were informed on July 25, 1991, that the agency was not able to assist and could not recommend commitment. Later that day, Mr. and Mrs. Morgan were shot and killed by their son. The estate of the decedents sued the center for negligence. The Ohio court in a sweeping decision concluded that the defendants were negligent and that there was no immunity from civil prosecution except in civil commitment proceedings. They further stated that it was the duty of mental health professionals to curtail violence directed at the community at large. The Ohio legislature, following pressure from professional organizations, enacted a statute which was specifically aimed at curtailing the extensions of duties found in this particular ruling (Mossman, 2004).

The Vermont courts expanded the duty to include threats to property. In *Peck v. Counseling Service of Addison County* (1985), the courts of Vermont expanded the *Tarasoff* duties to include threats to property. John Peck set fire to the plaintiffs' barn. At the time, John was receiving outpatient services and was living at home with his parents. He had had an argument with his father and his immediately left home and went directly to the Counseling Service.

Upon arrival, John told his therapist that he had a fight with his father and that he did not feel that his father loved or respected him. His therapist arranged for John to stay with his grandparents and scheduled a session for the next day. John was still angry with his father during that meeting. During the next session, John asked if he could continue to talk about his thoughts and feelings about his father and admitted that he wanted to get back at his father. In response to the therapist's follow-up question on how he would get back at his father, he said that he could burn down the family barn. After discussion of the consequences of that decision, John promised

his therapist that he would not burn down his father's barn. The therapist did not inform his parents or anyone on the Counseling Service staff.

Peck subsequently did set fire to his family's barn and his family sued the counselor and the facility which had provided his care. The court was particularly critical of his therapist for failing to advise his family of the threat and also her failure to consult with her supervisors and obtain his previous records from other providers. The court ruled in favor of the plaintiff and found a duty to warn potential victims and protect property in cases of arson.

In a case in West Virginia, *Johnson v. West Virginia University Hospitals, Inc.*, (1991), a patient was brought to West Virginia University Hospital on June 2, 1988. Loftus Johnson was a security police officer on duty that night. When conscious, the patient became combative, unruly, and used obscene language. Seven doctors and nurses were present while they were treating the patient in the emergency room. The patient let it be known at this time that he was infected with HIV. The guard was called to the scene when the patient continued his uncontrollable, unruly behavior. The police officer initially only watched over the scene but he tried to help when the patient's bed fell over and the medical staff needed help restraining the patient. While lifting the patient back into his bed, the guard was bit by the patient in his forearm. He was notified by a paramedic, after the bite, that the patient was, in fact, HIV positive. Johnson sued West Virginia University Hospital for damages related to failing to warn him of the risks. The Supreme Court of Appeals affirmed a jury verdict for damage related to exposure to HIV.

In *Ewing v. Goldstein* (2004), the court expanded the threats to include those delivered by a concerned third party. Dr. David Goldstein, the defendant and a family and marriage therapist, provided counseling services to Geno Colello between 1997 and 2001. Colello, a former Los

Angeles Police Department employee, was being treated for work-related problems and personal issues with his ex-girlfriend, Diana Williams. He became noticeably more depressed after the ending of his relationship with Williams in early 2001. In mid-June, he became increasingly depressed after learning that Williams was seeing someone else. June 19, 2001 was the last meeting between Goldstein and Colello in the doctor's office. They communicated via telephone on both June 20th and June 21st. When Goldstein asked Colello if he was feeling suicidal, he responded that "he was not blatantly suicidal, but did admit to thinking about it." Goldstein asked Colello to think about checking himself into a psychiatric hospital. He also asked Colello for his permission to contact his father, Victor Colello. Geno had dinner with his parents on June 21st and was still apparently depressed. He told his father that he lost reasons to live and that he resented Williams' new boyfriend. He also told his father that he was thinking of harming Williams' new boyfriend. Colello's father, Victor, contacted Goldstein and told him what Geno had told him. Goldstein told Victor to take his son to Northridge Hospital Medical Center. He had arranged for Colello to receive psychiatric care there and he was voluntary admitted under the care of Dr. Gary Levinson, a staff psychiatrist. The next day, Levinson told Colello's father he was planning on discharging Geno. Believing his son was being released prematurely, Victor called Goldstein who, in turn, contacted Levinson and told him why Colello should remain hospitalized. Levinson told him that Colello was not suicidal and he would be discharged. Goldstein urged him to reconsider, reevaluate Colello, and keep him through the weekend. Geno was discharged on June 22nd and Goldstein had no additional contact with him. The next day, June 23rd, Geno Colello murdered Williams' boyfriend, Keith Ewing, and then killed himself.

Mr. Ewing's family sued Dr. Goldstein, for negligence resulting in wrongful death and subsequently, the inpatient facility and the attending psychiatrist treated the patient (*Ewing v.*

Northridge Hospital and Medical Center, 2004). The allegation of negligence was based on Goldstein's failure to warn Ewing of a threat toward a victim by means of a phone call from his patient's father. These allegations were part of the lawsuit despite the fact that Goldstein had arranged for inpatient treatment and did attempt to increase the duration of stay in the inpatient facility. Upon appeal, the California Court of Appeals overturned the decision to dismiss and held that Goldstein may be potentially negligent. As part of their decision, the court misinterpreted the meaning of the applicable statute (Weinstock, Vari, Leong, & Silva 2006). Specifically, the court's interpretation of the code implied that a warning was necessary to discharge the statutory duty to protect, despite the fact that the second *Tarasoff* decision vacated the first decision that had mandated warnings to third parties. Even though by some analyses, he discharged the duty as Goldstein had taken reasonable action to hospital his patient. Furthermore, the attorneys for the defense did not object to the court's analysis or raise the issue (Weinstock, et al., 2006).

The significance of the *Ewing* decision was based upon several findings. First, the court found that the communication of a threat by means of a family member is the clinical and legal equivalent of a threat made by a patient. In *Morgan*, there were similar concerns from family members expressed to the primary therapist but they were not construed by the court as equivalent to patient threats known to the family and the agency. Second, the *Ewing* court found that the duty was also contingent upon the therapist being convinced of the validity of the threat. If the therapist, in this instant case, did not feel that the information were credible, then there would be no duty. Furthermore, the duty may have actually existed beyond the subsequent recommendations of the second provider who determined the patient not to be dangerous implying that the duty to warn was generated by the first therapist's determination of

dangerousness and may have extended beyond the inpatient assessments (Weinstock, et al., 2006).

The family also litigated the mental health facility in which the patient was admitted and treated (Smith, 2006). The family alleged that the admitting psychotherapist was also aware of the threats to kill their son but did not warn law enforcement or the victim. The attending physician had settled out of court. Furthermore, they indicated that the threat of the patient, ultimately communicated to the therapist by the patient's father, should still be considered patient communication (Weinstock, et al., 2006). The court reversed the lower court decision. The implications of this case are discussed below.

In Georgia, the case of *Garner v. Stone* (1999) represents much of the competing interests that define duties to third-parties in a context of the ethical and legal implications of conditional confidentiality. Garner had been a police officer for 30 years and began experiencing job-related stress in the summer of 1995. He began seeing a psychologist and reported having feelings of anger, struggles at work, and suicidal thoughts. Garner was referred to Dr. Stein for evaluation regarding fitness for duty as a police officer.

Following an argument with a supervisor Garner told Stone that he had violent fantasies about killing a supervisor and other members of the Police Department. Stone found Garner unfit for duty and it was recommended that he be placed on a 30 day leave of absence. Stone did not warn Garner's supervisor about the fantasies and felt that there was no imminent danger. Two weeks passed and Stone did not re-evaluate him but he did consult with the previous psychiatrist and together they placed a telephone call to an attorney associated with the Georgia Psychological Association, who told Stone there was a duty to warn the targets of the verbal

threats. Stone notified Garner's supervisors about the fantasies. Garner was then placed on administrative leave and reassigned to work at a local animal shelter. He complained about the reassignment to his superiors and he was subsequently fired for insubordination. Garner sued Dr. Stone for malpractice including negligence and defamation based upon the unjustified issuance of the warnings. The jury trial found in Garner's favor and there was no appeal.

At that time in Georgia, there was case law establishing legal precedent for the duty to protect but there was no statutory duty to warn potential victims. Furthermore, there was also no statutory immunity for therapists issuing such warnings to third-parties. Therefore, therapists who would have issued valid warnings to third-parties had exposure to liability for damages related to breaching confidentiality.

Tarasoff Surveys

Despite the significance of the *Tarasoff* duties, there have been very few surveys which target either therapist's knowledge of *Tarasoff*-related duties or the impact of duty to warn court cases or state statutes. Wise (1978) surveyed nearly 1,200 California psychiatrists and psychologists regarding their experiences with high-risk patients and duties to third-parties. She found that 80% of her sample acknowledged treating at least one dangerous patient during the year preceding the survey. Of the participants, 49% of them had issued a warning to a potential victim prior to the *Tarsoff* decisions. Thirty-seven percent said they issued a warning in the year following the decision. Of those who had issued warnings, 31% of them warned a family member, while 16% notified potential victims, and 17% notified law enforcement. Most therapists in her survey indicated they had increased the frequency of consultation with peers, especially when dealing with risky patients. In addition, their record-keeping skills improved.

Most participants indicated their threshold for determining dangerousness was lower than previous years. They also reported an increase in the frequency of victim notifications they were issuing, as a result of the *Tarasoff* decisions. Finally, most respondents acknowledged that prior to the *Tarasoff* decisions they often issued verbal warnings to potential victims without a judicial mandate or internal ethical conflicts.

Givelber, Bowers, & Blitch (1984) sampled 2,875 psychiatrists, psychologists, and social workers in eight cities regarding how *Tarasoff*-related duties had impacted their practice. Most of the respondents believed there were means other than issuing a warning to the potential victim for complying with their ethical obligations to third-parties. The researchers also found that 75% of the participants incorrectly believed the *Tarasoff* duty required them to warn victims, rather than exercise due care in order to protect them from violence. Most of the clinicians in the survey also revealed they were more likely to communicate threats to public authorities rather than the potential targets. The researchers felt that this finding may be due to availability of law enforcement and difficulty locating potential victims. Those in private practice were more likely to issue a warning to potential victims and less likely to initiate involuntary commitment than their peers who work in institutional settings. Like the Wise (1978) study, these researchers also reported there were a significant number of clinicians who reported that prior to the *Tarasoff* decisions they, in fact, breached confidentiality in situations involving patient threats.

In one study, McNiel, Binder, & Fulton (1998) evaluated the manner in which therapists had given notifications and begun a voluntary commitment proceedings based on California's statute regarding *Tarasoff*-related duties. They evaluated involuntary civil commitment data from the greater San Francisco area by reviewing county health records. They also reviewed all duty to protect notifications, which were received by the San Francisco Police Department between

1986 and 1990. Of the total 337 clients, who made threats resulting in notifications, approximately half of them were subjected to civil commitment proceedings. This number of patients, whose threatening behaviors lead to duty to protect action, represented a small proportion of the total number of patients in that area, which were subject to emergency commitment proceedings. For example, researchers reported that in 1988, there were 3,777 patients who were the subject of involuntary commitment proceedings because they were considered to be dangerous. Another 890 individuals were referred for extended involuntary inpatient treatment. Yet, during that same year, there were only 81 *Tarasoff*-related notifications recorded by the local police department.

Their research also found that approximately 65% of the notifications made within a two-year time period were made by counselors, social workers, and nursing staff. Nearly 25% of the notifications were placed by psychiatrists and only 1% by psychologists. Furthermore, their data indicated that most of the notifications were made by staff from psychiatric hospitals, while only approximately 10% came from outpatient-based services. Most of the intended victims of the verbal threats were female and were most likely to be a family member or a significant other of the patient. They concluded that, for the most part, psychotherapists were either ignoring their statutory duties or they were utilizing other ways of protecting potential victims. This study is important because it indicates that even in jurisdictions which have been on the forefront of issuing and codifying *Tarasoff*-related duties, the therapists and professionals in that jurisdiction exhibit a lack of understanding of existing statutory duties and may be utilizing the involuntary commitment process absent any type of notification.

In another study by Binder & McNiel (1996), the researchers were interested in the fact of *Tarasoff*-related warnings on the intended victim as well as the therapeutic relationship with

the patient. They surveyed 46 psychiatric residents at a university-based psychiatric training program in San Francisco. They were asked about their experiences regarding *Tarasoff* warnings and approximately half of them reported having issued a *Tarasoff* warning. This particular finding is consistent with the Wise (1978) study in which she found half of the clinicians had issued a warning in the previous year. The residents reported they were unable to reach the intended victim in half the cases and in most cases they reported the threat to local law enforcement. In cases in which the intended victim was reached, approximately 75% of the time, the intended victims were already aware of the threat. Most of the intended victims were grateful for the warning from the residents and indicated they planned to change their behaviors in such a way as to increase their personal safety. Other intended victims expressed denial and minimized the legitimacy of the threat directed at them. Finally, the physicians indicated that the issuance of the warning to the third-parties had either a minimal or overall positive effect on the therapeutic relationship. These findings are similar to the Beck (1985) study, in which he concluded that the issuance of the *Tarasoff*-related duties should be part of the overall clinical process and that involving the patient in the notification process can actually build the therapeutic alliance. Roth & Meisel (1977) reached a similar conclusion about client involvement in the notification.

Many statutory requirements mandate some form of notification to law enforcement in the execution of discharging the duties to third-parties. One survey described the experiences police stations in two states had regarding their experiences with *Tarasoff*-related warnings (Huber, Balon, Labbate, Brandt-Youtz, Hammer & Mufti, 2000). They surveyed, by telephone, 50 police stations in Michigan and 54 stations in South Carolina using a standardized questionnaire. Approximately 53% of the desk sergeants interviewed reported that the station

had never received any such warnings. Roughly 24% reported that the station had a specific policy regarding warnings from therapists while only 3% of the officers interviewed were familiar with the *Tarasoff* court cases. The majority of the desk staff indicated they would record and pass on warnings received from therapists regarding potential victims. Police stations in rural areas reported fewer experiences with *Tarasoff*-related warnings than stations located in urban areas. The limited experience by police stations with *Tarasoff* warnings is consistent with findings from McNiel and Binder (1998) in which they observed many clinicians prefer to hospitalize patients rather than make notifications. The significance of this study is that many statutes have notification requirements for local law enforcement. It appears from these data that the reporting of these warnings to police stations is relatively infrequent. Therefore, police officers in the stations have minimal experience with managing these kinds of threats. These findings imply that clinicians are using other means for dealing with high risk clients.

Pabian, et al., (2009) surveyed psychologists in Michigan, Ohio, New York, and Texas to evaluate their understanding of their particular state's statutory approach to *Tarasoff*-related duties, including the conditions that trigger the duties and, if applicable, the means by which the duties may be discharged. Furthermore, the researchers were also interested in the extent to which continuing education impacts the understanding of state codes. Texas and Ohio mandate continuing education hours in ethics while New York and Michigan have no such requirements (APA, 2006). Ohio and Michigan are considered duty to protect states, whereas Texas and New York have no legal duty to protect although they permit disclosure under some circumstances.

Some 98% of the 300 respondents held doctoral degrees in psychology and the majority of them practiced in outpatient settings. Approximately 17% of the respondents indicated they had completed continuing education credits in the last two years, which incorporated content

related to the legal duties in dealing with high-risk clients. The vast majority of the sample indicated they were very up-to-date or somewhat up-to-date regarding their knowledge of *Tarasoff*-related duties, whereas only 10.5% of the sample indicated they had substantial uncertainty about their own understanding of the legal obligations. The results indicated that on average, 76.4% of respondents were incorrect in selecting the one statement that most accurately represented the duty to protect law in their respective state. In the Ohio and Michigan sample, the vast majority of respondents were aware they had a statutory duty, but only 29.5% of them knew the specific means of discharging the duty. Nearly half of the psychologists from the Ohio and Michigan sample were unaware that the statutory duty in their states could be discharged through means other than issuing a warning. Moreover, 87% of the psychologists from the New York sample and 37.2% of the psychologists from Texas incorrectly believed they were legally mandated to protect third-parties. Additionally, 22% of the psychologists from Texas and 53% of the psychologists from New York believed they had a specific duty to warn despite the fact that both states have no such statutory requirement.

When asked under what circumstances they felt justified to warn the third-party, 41.5% of the respondents indicated they felt justified warning a potential victim when the likelihood of the client acting on the threat was low or in situations in which the therapist is unable to determine the specific likelihood of the individual acting on the threat. Pabian, et al. (2009) concluded these responses were inconsistent with the APA Ethics Code (2002) which requires client consent to release information absent a legal mandate. Moreover, the researchers found that the majority of the respondents failed to identify the various protective measures their particular state specifies relative to *Tarasoff* duties. For example, 52.1% of the Texas psychologists believed that they were authorized by statute to warn the potential victim, when, in

fact, the Texas statute has no such obligation. The researchers also considered the effect of mandated versus non-mandated continuing education hours in ethical and legal issues on the knowledge exhibited by respondents in the study. There were no significant accuracy differences between psychologists who saw more than five violent clients within the last two years and those who saw fewer. Thus, it appears that psychologists in this study are not only collectively misinformed about their respective state statute but also overestimated their confidence about their knowledge level. They also appear to be operating, likely unintentionally, outside the APA Ethics Code. Furthermore, therapists' experience with violent clients and continuing education appear unrelated to accuracy ratings.

The Present Study

Based on the literature reviewed, and as noted in the Introduction, this project evaluated West Virginia mental health therapists' knowledge of court cases related to duty to protect or warn third parties.

There were five hypotheses for this project. I predicted that:

- First, the overall knowledge therapists have regarding *Tarasoff*- related court cases will be low.
- Second, there will be no differences observed between psychologists and counselors regarding their respective accuracy rates and knowledge of *Tarasoff*-related court cases.
- Third, the overall accuracy rates for counselors and psychologists regarding their understanding of the original *Tarasoff* decision will be low and will have no significant differences between the disciplines.

- Fourth, there will be no relationship between accuracy ratings of the post *Tarasoff*- related court cases and continuing education experiences.
- Finally, the accuracy ratings of psychologists and counselors on the post *Tarasoff*- related cases will not be related significantly to years of experience

Chapter 3

Methods

Participants

The current research project was originally designed to survey psychologists, counselors and social workers in West Virginia on the issue of their knowledge of *Tarasoff*-related court cases. The survey instead focused on psychologists and counselors who were practicing in West Virginia because the email addresses of the social workers registered within the Board were not made available for this project. The developed survey was linked to a solicitation email sent to 597 licensed psychologists, 115 supervised psychologists, and 403 licensed professional counselors. A total of 163 participants began the survey and a total of 115 completed the survey.

Procedure

In order to assess participants' level of awareness of *Tarasoff*-related court cases as well as the particulars of the original *Tarasoff* decisions, a survey was developed which included basic demographic information, including age range, gender, years in practice, highest degree achieved, discipline, current site of practice and licensure status. One question dealt with whether or not their practice location was considered rural or urban. There were also questions regarding the participants' experiences with *Tarasoff*-related activities including whether or not they themselves have either issued a *Tarasoff* warning or whether they have been consulted by anyone regarding a duty to warn issue. Additional questions were included to evaluate respondents' experiences with warning intended victims including the relationship between the patient and the threatened third-party. Questions also were developed to measure the

participants' exposure to ethics training and the extent to which it was specific to dealing with dangerous clients.

Five clinical scenarios were developed and each was based on a particular *Tarasoff-related* case. The first scenario was based roughly upon the particulars of *Peck v. The Counseling Services of Addison County* (1985) in which there was a threat to do serious damage to property. The second scenario was based roughly on cases like *Boulanger v. Pol* (1995) in which the pivotal issue was the fact that the victim had prior knowledge of the existing threat. Scenario three was based upon the case of *Johnson v. West Virginia University Hospitals* (1991) that involved an unknowing hospital employee in West Virginia who was exposed to human immunodeficiency virus following an altercation with a patient. The fourth case was based roughly upon the *Ewing v. Goldstein* (2004) case in which the threat was not delivered verbally to the therapist by a client but conveyed to the therapist by a concerned family member of the patient. The final scenario was based roughly upon the particulars of *Garner v. Stone* (1999) and involved the issuance of a warning to a third-party in a jurisdiction with only a statutory duty to protect and no statutory immunity for professionals. A copy of this survey has been placed in the Appendix section of this document.

The process by which the court cases were selected was as follows. *Tarasoff*-related court cases were difficult to locate and retrieve. There was no clearinghouse for these cases and State Boards generally do not make applicable court cases within its jurisdiction available to members or researchers (Benjamin et al., 2009). Traditional search mechanisms were used including Nexus-Lexis and EBSCO. Arguably, the selection of court cases to be used as the basis for analysis in a survey was somewhat arbitrary. Despite this, the following variables were used in considering the cases to be selected for inclusion in the study. First, because the survey focused

on West Virginia mental health therapists, the selection of a case from West Virginia was both crucial and relevant. Second, consideration was given to court cases in which there was an expansion upon the original *Tarasoff* duties. Many times when courts render decisions either expanding or refining statutory duty or a common law duty, the decision often speaks to the question of when the duty was relevant. Generally, depending on the jurisdiction, *Tarasoff*-related court cases which were dismissed through summary judgment in favor of the defendant did not necessarily provide any additional definitions as to the form of the current *Tarasoff-related* duties within that jurisdiction. Those cases were generally dismissed due to insufficient cause of action, the lack of the definition of a special relationship, or the lack of duty to control the behavior of a client receiving outpatient services. Furthermore, these types of cases did not generally add additional risks to clinicians practicing within that jurisdiction.

Third, consideration was given to cases which were referenced in multiple publications or generated extensive commentary and analysis within the mental health literature. Some cases were the subject of multiple articles whereas others seemed to only receive cursory attention because they tended to not be expansive rulings or there was summary judgment for the defendant.

Finally, consideration was given to court cases which generated subsequent legislative action and statutory changes, which was the case in the original *Tarasoff* decisions and more recently true for *Morgan* in the state of Ohio. This criterion was true for both the *Peck v. The Counseling Services of Addison County* (1985) case as well as the *Ewing v. Goldstein* (2004) case. Some states now extend *Tarasoff* duties to extensive property damage threats and some states give due consideration to communications which were relayed to therapists by means of family members.

In addition to these five scenarios, the survey also included seven true/false questions regarding the original *Tarasoff* decisions. These questions included items designed to assess participants' knowledge of the scope and the ramifications of the original *Tarasoff* decisions.

The draft of the survey was distributed to a small group of doctoral students in clinical psychology to solicit feedback about clarity and readability of the survey. Feedback from this group was gathered and slight modifications were made in the wording of one of the scenarios.

The project was approved by Marshall University's Institutional Review Board. The informed consent form was situated as the first page of the survey. It outlined the scope of the project and highlighted the minimal risks to participants as well as the fact that the survey was confidential to the extent possible, including the lack of recording of IP addresses.

Requests for contact information were sent to the West Virginia Board of Examiners in Counseling; the West Virginia Counselors Association; West Virginia Licensed Professional Counselors Association; the West Virginia Board of Social Work Examiners; and the West Virginia Board of Examiners of Psychologists. Contact information was obtained for psychologists and counselors but the information for social workers was not made available for this project.

The survey was uploaded to Survey Monkey. The survey was linked to a solicitation email and sent to 597 licensed psychologists, 115 supervised psychologists, and 403 licensed professional counselors. Participants were encouraged to complete the survey and were advised that there was no penalty or negative consequence for exiting the survey at any point. A second solicitation email was sent approximately 15 days after the first solicitation.

Chapter 4

Results

The survey invitation was sent by email to 403 licensed professional counselors, 597 licensed psychologists, and 115 supervised psychologists. A total of 163 started the survey and 115 individuals completed the survey for a completion rate of 70.5% and a response rate of 14.6%. As indicated in Table 1, the largest percentage of respondents, 30.7%, was between the ages of 50 and 59, some 24.8 % of the sample was between the ages of 40 and 49, and 21.6% of the sample was between the ages of 30 and 39.

Table 1

Age Range of Sample

	Frequency	Percent
20-29	9	5.9
30-39	33	21.6
40-49	38	24.8
50-59	47	30.7
60-69	19	12.4
70+	7	4.6

As indicated in Table 2, the largest group within the sample reported being in practice more than 16 years (45.8) and those practicing between 11 and 15 years were 20.3% of the total. Regarding the gender of the therapist, the sample was 68% female and 32% male.

Table 2

Number of years in practice

	Frequency	Percent
0-2 years	7	4.6
2-5 years	16	10.5
5-10 years	29	19
11-15 years	31	20.3
16+ years	70	45.8

Individuals with a doctoral degree comprised 31.3% of the sample, while those with a master's degree constituted 68.7% of the sample. Psychologists accounted for 64.1% (n=98) of the total sample completing the survey, and 35.9% (n= 55) reported having counseling degrees. Table 3 indicated that the current sites of practice for participants which revealed that 37.9% of respondents were in private practice, and 30.3% were employed at a community mental health center.

Table 3

Current Site of Practice

	Frequency	Percent
Private practice	55	37.9
Hospital	26	17.9
Academic	15	10.3
Community Mental Health	44	30.3
School psychology	5	3.4

The vast majority of the sample was comprised of independently licensed practitioners (79.0%) whereas 21% were yet to be independently licensed. Participant responses indicated that 56.3% of respondents described their practice in an urban area, and 43.7% described their practice as being in a rural area.

Of those responding to the survey, 43.1 % (n=66) indicated that they have issued a duty to warn notice because of client threats, while 56.9% (n=87) reported that they had not. As shown in Table 4, the majority of the warnings were issued to intended victims and law enforcement.

Table 4

Percentages of Recipients of Warnings

	Frequency	Percent
Police only	9	15.5
Intended victim only	26	44.8
Police and intended victim	23	39.7

Regarding the nature of the relationship between the client and the intended victim, most of the intended victims were non-family members whereas family members and spouses constituted an almost equal percentage of the total, as displayed in Table 5.

Table 5

Percentages of the Relationship between the Client and the Target of the Threat

	Frequency	Percent
Spouse	11	18.6
Partner	2	3.4
Family member	12	20.3
Coworker	7	11.9
Another provider	5	8.5
Other non-family member	22	37.3

Regarding the respondents being consulted by a peer experiencing a duty to warn situation, 56.9% of the respondents indicated that they had been contacted and 43.1% indicated that they had not.

Regarding training in the area of duty to warn, 77.1% (n=118) of the participants indicated that they had received training specific to the area of duty to protect, and 22.9% (n=35) indicated that they had not received such training. Of those who reported that they had received training, most reported that the training was part of their graduate training (see Table 6).

Table 6

Percentage of Types of Training in Duty to Warn or Protect

	Frequency	Percent
Included in an ethics class which was part of your graduate training	44	37.6
Included in training or in service on general, legal issues	54	46.2
Specific to the topic of a therapist's duty to warn or protect	19	16.2

The reported degree of familiarity with the original *Tarasoff* cases was summarized in Table 7 which revealed that the vast majority of the sample indicated that they were somewhat to quite familiar with the cases.

Table 7

Degree of Familiarity with the Legal Decisions of the Cases Known as Tarasoff?

	Frequency	Percent
Not familiar at all	9	5.9
Not very familiar	10	6.6
Somewhat familiar	103	67.8
Quite familiar	30	19.7

Results of Questions Related to the Original Tarasoff Decisions

There were seven questions developed that dealt with assessing participants' knowledge and understanding of the findings as well as the implications of the original *Tarasoff* decisions. The first question asked whether the court mandated that only intended victims need to be notified of threats directed at them. Of those responding, 56.6% of the total sample correctly identified this statement as false (see Table 8).

Table 8

Responses to Questions regarding Original Tarasoff Decisions by Discipline

Question #1: The court mandated that only intended victims be notified of threats directed at them.

True	Psychologists	n=44, (30.3%)
True	Counselors	n=19, (13.1%)
False	Psychologists	n=50, (34.5%)
False	Counselors	n=32, (22.1%)
	χ^2 (1) = 1.228, p = .268*	

Note. * indicates no significance and ** indicates significance, $p < .05$.

The second question asked whether the court in the original *Tarasoff* case mandated that only local law enforcement be notified of threats toward third-parties. Nearly all of the participants, with the exception of five psychologists, responded correctly (see Table 9).

Table 9

Responses to Questions regarding Original Tarasoff Decisions by Discipline

Question #2: The court mandated that only the local police be notified of a threat directed at an individual.

True	Psychologists	n=5, (3.4%)
True	Counselors	n=0, (0%)
False	Psychologists	n=90, (61.6%)
False	Counselors	n=51, (34.9%)
	χ^2 (1) = 2.779, p = .095*	

Note. * indicates no significance and ** indicates significance, $p < .05$.

The third question asked whether the original *Tarasoff* court stated that the duty to protect third-parties may be discharged by hospitalizing a threatening client. Only 15.8% of the sample correctly identified this as a component of the original *Tarasoff* decisions (see Table 10).

Table 10

Responses to Questions regarding Original Tarasoff Decisions by Discipline

Question #3: The court stated that the duty to protect third parties may be discharged by hospitalizing the client making the threat.

True	Psychologists	n=15, (10.3%)
True	Counselors	n=8, (5.5%)
False	Psychologists	n=79, (54.5%)
False	Counselors	n=43, (29.7%)
χ^2 (1) = .002, p = .966*		

Note. * indicates no significance and ** indicates significance, $p < .05$.

The next question asked whether the original *Tarasoff* decisions included that a therapist could discharge the duty to protect through verbally warning the intended victim. Approximately 66% of the total sample incorrectly believed that the original *Tarasoff* decisions resulted in a mandated duty to warn (see Table 11).

Table 11

Responses to Questions regarding Original Tarasoff Decisions by Discipline

Question #4: The court concluded that a therapist could discharge the duty to protect through the process of verbally warning the intended victim.

True	Psychologists	n=61, (42.4%)
True	Counselors	n=34, (23.6%)
False	Psychologists	n=33, (22.9%)
False	Counselors	n=16, (11.1%)
	χ^2 (1) = .140, p = .708*	

Note. * indicates no significance and ** indicates significance, $p < .05$.

Question five was based upon the perceived scope and power of court decisions from other jurisdictions. Specifically, the question asked if the original *Tarasoff* decisions mandated that therapists in all 50 states were required to warn and protect intended victims based upon verbal threats. Some 57.3% of the sample believed that the California court systems generated mandates for all 50 states regarding the issue of *Tarasoff* duties statement as false (see Table 12).

Table 12

Responses to Questions regarding Original Tarasoff Decisions by Discipline

Question #5: The decisions in the Tarasoff cases mandated that therapists in all 50 states are required to warn and protect intended victims based on clients' verbal threats.

True	Psychologists	n=51, (35.2%)
True	Counselors	n=32, (22.1%)
False	Psychologists	n=43, (29.7%)
False	Counselors	n=19, (13.1%)
	χ^2 (1) = .974, p = .324*	

Note. * indicates no significance and ** indicates significance, $p < .05$.

Similarly, question six dealt with the scope and power of the judiciary to mandate changes in professional codes of ethics. Some 56.7% of the respondents incorrectly believed that

the *Tarasoff* court mandated that all mental health professional codes of ethics be amended to include mandatory notification of client threats directed toward third-parties. There was a significant difference between the responses of the two disciplines on this question in that psychologists were significantly more likely to answer this question correctly (see Table 13).

Table 13

Responses to Questions regarding Original Tarasoff Decisions by Discipline

Question #6: The court in the Tarasoff cases required that all mental health professional codes of ethics be amended to include mandatory notification of client threats directed at third parties.

True	Psychologists	n=44, (30.8%)
True	Counselors	n=37, (25.9%)
False	Psychologists	n=49, (34.3%)
False	Counselors	n=13, (9.1%)
	χ^2 (1) = 9.431, p = .002**	

Note. * indicates no significance and ** indicates significance, $p < .05$.

The final question in this series asked about the applicability of the original *Tarasoff* decisions to suicidal threats. Some 58.1% of the respondents correctly identified the fact that *Tarasoff* duties were not applicable in cases of suicidal threats (see Table 14).

Table 14

Responses to Questions regarding Original Tarasoff Decisions by Discipline

Question #7: The decisions in the Tarasoff cases are not applicable to suicidal threats.

True	Psychologists	n=57, (39.9%)
True	Counselors	n=26, (18.2%)
False	Psychologists	n=36, (25.2%)
False	Counselors	n=24, (16.8%)
	χ^2 (1) = 1.152, p = .283*	

Note. * indicates no significance and ** indicates significance, $p < .05$

Next, total accuracy scores were generated for the *Tarasoff* cases with one point given for each correct answer by the respondents so as to facilitate further analyses. Individual scores were compiled into an accuracy score. Chi-square analyses were conducted comparing respondents' total accuracy scores with several variables which were relevant to the research questions. The mean accuracy score for the participants on the original *Tarasoff* cases was 3.4 out of a total of seven for a 49.5% accuracy rate. There was no significant relationship between participants' total accuracy scores of the *Tarasoff* cases and their affiliated discipline, χ^2 (5, N=141) = 4.454, p = .486. Furthermore, there was no significant relationship between participants' total accuracy scores of the *Tarasoff* cases and participants' continuing education ,χ^2 (5, N=143) = 4.372, p = .497.Also, there was no significant relationship between participants' total accuracy scores of the *Tarasoff* cases and participants' number of years in practice, χ^2 (20, N=141) = 15.284, p = .760. There was no significant relationship between participants' total accuracy scores of the *Tarasoff* cases and participants' level of degree, χ^2 (5, N=139) = 4.948, p = .422

The Post *Tarasoff* -Related Court Cases Survey

During this portion of the survey, participants were presented with scenarios based upon the particulars of five *Tarasoff*-related court cases. First, they were asked to evaluate each scenario and decide whether they felt they had a *Tarasoff*-related duty in this situation and second, what action they would take. Third, they were also asked to rate their degree of confidence about their personal decision on a four point Likert scale. They were also asked what they believed the court decided in this case and to rank their degree of confidence about their assessment of the court's actual decision.

Scenario #1: Therapist Decision

The first scenario involved the threat of potential lethal damage to property in which the court found there was a duty to warn and protect. Of those responding, 62% of the total sample endorsed the alternative that best represented actions consistent with the actual court decisions. There was a statistically significant relationship between counselors and psychologists. Counselors were more likely to endorse the correct (see Table 15).

Scenario #1: Therapist Ratings of Court Decisions

Approximately 62.5% of the total sample endorsed the alternative that best represented the actual court decision which was that there was a duty to warn in cases of potential risk to life. There was no significant relationship between psychologists and counselors on accuracy ratings regarding decisions by the court (see Table 15).

Table 15

Accuracy and Confidence Ratings for Post-Tarasoff Court Case Scenarios

Scenario #1. Issue: Threats to Property

Scenario #1 Therapist Clinical Decision

	% Correct	Degree of Confidence
Psychologists	56.5% (n=48)**	2.98*
Counselors	73.9% (n=34)**	3.00*
	χ^2 (1, N=131) = 3.878, p = .049	t (128) = -.19, p =.85

Scenario #1 Therapist Court Choice

	% Correct	Degree of Confidence
Psychologists	57.6% (n=49)*	2.47*
Counselors	71.7% (n=33)*	2.72*
	χ^2 (1, N=131) = 2.532, p = .112	t (129) = -1.56, p =.12

Note. * indicates no significance and ** indicates significance $p < .05$

Scenario #2: Therapist Decision

The next *Tarasoff*-related court case involved a scenario in which the victim was already aware of a threat which had been verbalized in the past, in which case there was generally no duty to warn. Approximately 60.6% of the total number of respondents endorsed the alternative that best represented actions consistent with the actual decisions of the court. There was not a significant difference between the professions on the issue of the degree of confidence (see Table 16).

Scenario #2: Therapist Ratings of Court Decisions

Some 66.7% of the psychologists (n=56), and 47.7% of the counselors (n=21), endorsed the alternative that best represented actions consistent with the actual decisions of the court. There was a significant difference between psychologists and counselors in terms of accuracy. Psychologists were more likely to endorse the correct answer in this scenario (see Table 16).

Table 16

Accuracy and Confidence Ratings for Post-Tarasoff Court Case Scenarios

Scenario #2. Issue: Threats are Known to Victim

Scenario #2 Therapist Clinical Decision

	% Correct	Degree of Confidence
Psychologists	63.9% (n=53)	3.04
Counselors	54.5% (n=24)	3.05
	χ^2 (1, N=127) = 1.044, p = .307*	t (125) = -.07, p =.95*

Scenario #2 Therapist Court Choice

	% Correct	Degree of Confidence
Psychologists	66.7% (n=56)	2.62
Counselors	47.7% (n=21)	2.73
	χ^2 (1, N=128) = 4.321, p = .038**	t (126) = -.73, p =.47*

Note. * indicates no significance and ** indicates significance $p < .05$.

Scenario #3: Therapist Decision

The next *Tarasoff*-related scenario was based upon *Johnson v. West Virginia University Hospitals* (1991) in which a hospital employee was intentionally bitten by a combative patient who was infected with human immunodeficiency virus. The hospital was held liable for damages for failure to warn. Approximately 11% of the total sample endorsed the alternative that best represented the actual court decisions. Only 8.4% of the psychologists (n=7), and 15.9% (n=7) of the counselors endorsed the alternative that best represented actions consistent with the actual decision of the court. Over 65% of the total respondents did not feel there was a duty to warn or protect in this situation because of the presence of universal precautions in medical facilities (see Table 17).

Scenario #3: Therapist Ratings of Court Decisions

Approximately 15.2% of the total sample endorsed the actual court decisions. Some 13.6% of the psychologists (n=11), and 18.2% (n=8) of the counselors, endorsed the alternative that best represented the decisions of the court. There was no significant relationship between the disciplines on accuracy regarding decisions by the court (see Table 17).

Table 17

Accuracy and Confidence Ratings for Post-Tarasoff Court Case Scenarios

Scenario #3. Issue: Exposure to Communicable Diseases

Scenario #3 Therapist Clinical Decision		
	% Correct	Degree of Confidence
Psychologists	8.4% (n=7)	2.78
Counselors	15.9% (n=7)	2.95
χ^2 (1, N=127) = 1.638, p = .201*		A:t (125) = -1.04, p =.30*

Scenario #3 Therapist Court Choices		
	% Correct	Degree of Confidence
Psychologists	13.6% (n=11)	2.54
Counselors	18.2% (n=8)	2.73
χ^2 (1, N=125) = .468, p = .494*		C:t (124) = -1.13, p =.26*

Note. * indicates no significance and ** indicates significance $p < .05$.

Scenario #4: Therapist Decision

The next *Tarasoff*-related scenario was based upon the *Ewing v. Goldstein,* (2004) case in which the information about the threat to a third-party did not come from the client but was conveyed to the therapist by the client's family. The court held that such communication is the equivalent of patient communication. Some 27.6% of the total sample endorsed the alternative that best represented the actual court decisions. Only 24.1% of the psychologists (n=20), and 34.1% of the counselors (n=15) endorsed the alternative that best represented actions consistent

with the actual decisions of the court. Nearly 30% of the sample indicated that they did not feel that there was a duty to warn or protect the intended victim in this case because the information did not come from the patient personally. Nearly 34% of the total respondents indicated that they did have a duty to warn or protect the intended victim but that the notification should have gone to the hospital staff. Finally, another 8.7% of the total respondents indicated that they did not have a duty to warn or protect because the patient was not presently under their care (see Table 18).

Scenario #4: Therapist Ratings of Court Decisions

Some 31.7% of the total sample endorsed the actual court decisions. With respect to how they evaluated the court's decisions, 24.4% of the psychologists (n=20), and 45.5% of counselors (n=20) endorsed the alternative that best represented the decisions of the court. There was a statistically significant difference revealing that psychologists on this particular scenario were more likely to endorse the incorrect answer (see Table 18).

Table 18

Accuracy and Confidence Ratings for Post-Tarasoff Court Case Scenarios

Scenario #4. Threat Communicated by Third Party

Scenario #4 Therapist Clinical Decision

	% Correct	Degree of Confidence
Psychologists	24.1% (n=20)	2.73
Counselors	34.1% (n=15)	2.77
	χ^2 (1, N=127) = 1.439, p = .230*	t (124) = -1.13, p =.26*

Scenario #4 Therapist Court Choice

	% Correct	Degree of Confidence
Psychologists	24.4% (n=20)	2.49
Counselors	45.5% (n=20)	2.66
	χ^2 (1, N=126) = 5.864, p = .015**	t (125) = -1.05, p =.29 *

Note. * indicates no significance and ** indicates significance $p < .05$.

Scenario #5: Therapist Decision

The next *Tarasoff*-related scenario was based upon the *Garner v. Stone* (1999) case. In this case, the scenario involved an independent psychological evaluation being conducted with an employee of a local utility company following a safety violation at work. The scenario clearly indicated that both the patient and the therapist resided in a state in which the state statute had only a duty to protect third-parties and provided no immunity for therapists who disclosed information to meet a duty to protect. During the evaluation, the patient became angry when discussing his supervisor and threatened to blow up the plant if he were terminated as a result of the evaluation. The therapist gave notice of the threat to the supervisory staff and the client was eventually terminated by the company.

A total of 56.9% of the sample endorsed the alternative that best represented the actual behavior of the therapist in the case. Approximately 53.1% of the psychologists (n= 43), and 64.3% of the counselors (n= 27) endorsed the alternative that best represented actions consistent with components of the actual decisions of the court (see Table 19).

Scenario #5: Therapist Ratings of Court Decisions

Some 8% of the total respondents endorsed the actual court decisions. With respect to how they judged the court's decisions, 11.0% of the psychologists (n=9), and 2.4% of counselors (n=1) endorsed the alternative that best represented the decisions of the court (see Table 19).

Table 19

Accuracy and Confidence Ratings for Post-Tarasoff Court Case Scenarios

Scenario #5. Independent Evaluation and Lack of Statutory Immunity

Scenario #5 Therapist Clinical Decision

	% Correct	Degree of Confidence
Psychologists	53.1% (n=43)	2.82
Counselors	64.3% (n=27)	2.85
	χ^2 (1, N=123) = 1.415, p = .234*	t (121) = -.24, p = .81*

Scenario #5 Therapist Court Choice

	% Correct	Degree of Confidence
Psychologists	11.0% (n=9)	2.36
Counselors	2.4% (n=1)	2.56
	χ^2 (1, N=124) = 2.767, p = .096*	t (120) = -1.19, p =.24*

Note. * indicates no significance and ** indicates significance $p < .05$.

Decision Accuracy Scores for Post-*Tarasoff* -Related Court Cases

In order to better quantify the collective performances of the respondents and to facilitate further statistical analyses, a total decision accuracy score was generated from answers to the post-*Tarasoff*-related Court Cases Survey. These scores were then used for comparison and hypotheses testing with participant demographics, participant experiences with *Tarasoff*-related cases, and their continuing education activities.

The overall knowledge of *Tarasoff*-related court cases as measured by the responses of participants to the scenarios indicated an overall accuracy rating of approximately 44%. There were no significant differences between psychologists and counselors on the overall accuracy scores, t (120) = -1.820, p = .071, but a significant difference was observed between doctoral level and masters level professionals in that the masters level professionals were more accurate. Furthermore, a post hoc analysis using univariate analysis of the variance, showed an interaction between highest degree and discipline, F (1, 116) = 4.980, p = .028, indicating that counselors and those with masters degrees were more accurate, F (1, 116) = 5.162, p = .025.

Chapter 5

Discussion

Nearly 43% of the sample in the present study reported that they have issued a warning notice because of client threats, which underscores the importance of duty-to-warn issues. Nearly 57% reported that they had not. Similarly, half of the sample in the Binder & McNiel (1996) study had experience with issuance of warnings. Wise (1978) reported that 49.7% of the sample had issued a warning the year prior to the *Tarasoff* decisions and 37% of the sample indicated that they had issued warnings post *Tarasoff*. In the present study, of those who indicated they had issued such a warning, nearly 45 % indicated that they had notified only the intended victim, while nearly 40% responded that they had notified both the intended victim and police. Another 15% of respondents indicated that they had only notified the police. In contrast, 31.3% of the respondents who had issued warnings in the Wise (1978) study indicated that they had notified a family member of the victim, while only 16% notified the victim. In the current study, almost 60% of the respondents indicated that they had been contacted for peer consultation in a potential *Tarasoff*-related situation, while nearly 40% indicated that they had never been contacted for consultation.

In sum, the sample in this study had a comparable amount of experience with *Tarasoff*-related situations as previous studies mentioned above. Over half of the respondents in this study indicated that they had been consulted by a peer for consultation in a *Tarasoff*-related situation. The continuing education experiences of this sample were extensive, indicating that they should have been a well-informed group of participants. In contrast, the accuracy ratings from questions related to the original *Tarasoff* decisions as well as the post-*Tarasoff*-related court cases were

relatively low. By contrast, participants' confidence ratings were relatively high regarding their decision-making and knowledge of *Tarasoff*-related cases. Thus, over half the sample in this study could be described as having dealt with a *Tarasoff*-related case, and were under informed and overconfident about their understanding and knowledge of the outcomes of various *Tarasoff*-related cases.

Overall, the knowledge participants demonstrated on this survey regarding the original *Tarasoff* decisions was quite low despite the fact that nearly 90% of the sample reported that they were somewhat or quite familiar with the cases known as *Tarasoff.* The vast majority, over 80%, of the sample indicated they were very up-to-date or somewhat up-to-date regarding their knowledge of *Tarasoff*-related duties, whereas only 10% of the sample indicated they had substantial uncertainty about their own understanding of the legal obligations. While the overwhelming majority correctly stated that the *Tarasoff* duties were not applicable to suicidal threats, only 16% of the sample knew that a therapist could discharge the *Tarasoff* duties by hospitalizing a dangerous patient. This particular question represented the essence of the original *Tarasoff* duties. Furthermore, 66% of the participants in this survey incorrectly believed that therapists could discharge the duty to protect third-parties by verbally warning the intended victim.

Equally revealing were the findings regarding the scope and power of the judiciary related to issuances of mandates of the *Tarasoff* duties. Approximately 60% of the respondents in the survey erroneously believed that court systems from other jurisdictions can promulgate rulings directly applicable to other states and jurisdictions. Similarly, nearly 60% of respondents in the survey also erroneously believed that the scope and power of the judiciary included mandating changes in professional codes of ethics. The participants exhibited profound levels of

misunderstanding of the case law and they also erroneously attributed tremendous authority to the judiciary to mandate changes in other jurisdictions and to compel changes in ethics codes. If those were in fact true, then participant accuracy scores for court decisions from other jurisdictions should have been higher. Furthermore, the reported level of familiarity with these cases was clearly overstated. The combination of overconfidence and lack of understanding observed here may explain why the *Tarasoff* duties are often oversimplified and mistakenly reduced to a duty to warn. Slightly less than 10% of the total respondents endorsed the decision by the court that the therapist was held liable for breaching confidentiality because of the nature of the state statute. If this apparent disregard for statutory immunity were actually part of the manner in which a therapist was to proceed with breaching confidentiality, that therapist could have liability exposure in the event that the client could prove damages resulted from the warning.

Overall, the knowledge and understanding demonstrated by therapists regarding post-*Tarasoff*-related court cases was low in most instances as evidenced by the accuracy scores. In contrast, participants' confidence levels range was 2.75-3.04 out of a possible score of four. Furthermore, therapists in this survey overall did not generally anticipate court decisions accurately. Their accuracy scores for cases involving threats to property and scenarios in which the victim was aware of the threat were more accurate than responses to situations involving communicable diseases and threats conveyed by concerned family members. Taken together with the accuracy results from the original *Tarasoff* cases, the overall knowledge and understanding of the *Tarasoff* duties remain problematic for therapists. Their relatively high confidence ratings of their perceived knowledge were in contrast to the relatively low accuracy scores. Furthermore, the lack of regard for immunity, as in the fifth scenario, and the

overreliance on hospital policy, as in the third scenario, are potential negligence risks for therapists. The latter case represented an area of *Tarasoff*-related expansion and potential risks for therapists in West Virginia particularly as the hospital case was based on a court case adjudicated in West Virginia. Finally, as hypothesized, total accuracy scores for respondents on the *Tarasoff*-related court cases were essentially unrelated to discipline, licensure status, years of experience, and continuing education training.

The results from this study indicated that, across all demographic variables, the overall accuracy scores for both counselors and psychologists were low. However, there were findings within these data that warranted exploration. Although overall accuracy scores were low for psychologists and counselors, post hoc analyses revealed some noteworthy results. First, those with less experience tended to be slightly more accurate than their more experienced peers and counselors were slightly more accurate than psychologists on accuracy ratings of court cases. These post hoc analyses must be viewed cautiously as overall participant accuracy scores were low across all categories including discipline, years in practice and continuing education experiences.

Research has revealed conflicting results regarding novice therapists compared with experienced ones. Some research has found differences between novice and experienced therapists on some outcome measurements including treatment planning and case conceptualization analyses (Boisvert and Faust, 2006; Martin, Slemon, Hiebert, Hallberg, & Cummings, 1989; Mayfield, Kardash, & Kivlighan, 1999). For example, O'Byrne & Goodyear (1992), in their research comparing the assessment strategies of novice and experienced therapists, found that novice therapists tended to focus more on the crisis-related aspects of the client's situation than their more experienced counterparts. Therefore, it is possible that in

scenarios involving potential homicidal threats, therapists with less experience focused more on the legal and ethical risks associated with the situation than a focus on underlying, thematic issues. Furthermore, experienced therapists have learning histories in which they successfully intervened with clients uttering various types of threatening behaviors upon which they rarely act. Experienced therapists may spend more time contextualizing the threatening behaviors and generating interventions than simply focusing on whether or not a *Tarasoff* duty exists. This is not to imply that experienced therapists are somehow indifferent to duties to third-parties. It is merely suggested that experienced therapists focus on different aspects of client behaviors than do novice therapists which could account for any subtle difference noted between the two groups. Also, experienced therapists may have slightly higher thresholds for what constitutes a duty to a third-party because of their varied experiences with threatening clients.

Another possible explanation for the findings in this study regarding experience and accuracy scores was that the less- experienced participants were more likely to have had more recent exposure to didactics in the area of ethics. Therefore, their accuracy scores may be slightly impacted by the recency of relevant training experiences.

Another potential reason for this slight but significant difference observed on the issue of experience and accuracy may reside in the characteristics of the sample itself. In particular, over half of the respondents were between the ages of 40 and 60. Some of those individuals would have been in training prior to, or just after, the original *Tarasoff* decisions were handed down in 1974 and 1976. More importantly, the clinical instructors and supervisors of this group would have likely had values representing an ethical and legal body of knowledge more reflective of a pre-*Tarasoff* professional environment. As previously mentioned, before the original *Tarasoff* decisions were issued, it was not unusual for practitioners to warn or protect third-parties for

purely ethical reasons absent a legal mandate (Wise, 1978). Also, the first Tarasoff ruling primarily articulated the duty to warn. Much of the consternation following *Tarasoff* was based on the arduous acceptance of a mandated duty to warn. Therefore, those professionals, who trained most of the therapists in the sample in this study, would likely have held the views that prevailed just after *Tarasoff,* which were generally negative. Many viewed the duty to warn as intrusive with regard to the judgment of therapists and generally detrimental to the psychotherapeutic relationship (Stone, 1976). Also, many of the teaching professionals would have had little to no formal ethics training with regard to the duty to third-parties given that their own training predated the decisions and the mandated continuing education in ethics. Now required in many states for licensure renewal, those requirements had yet to be instituted (Neimeyer, Taylor & Wear, 2011).

The issue regarding the slight though significant differences between the professions is more difficult to explain. Part of the explanation may be related to supervision. Borders & Usher (1992) found that the majority of the counselors in their sample worked in settings other than private practice. Therefore, it is likely that the counselors in this particular study are situated in large organizations which typically have policies and procedures governing risk management which would likely sensitize professionals to the issues related to duties to third-parties. Secondly, counselors in these types of organizations are more likely to have access to multidisciplinary opinions. Borders & Usher (1992) found that most of the counselors in their study were, in fact, supervised by non-counseling professionals including psychologists, psychiatrists, social workers and administrators. It is, therefore, plausible that on average, counselors may have a more diverse exposure to different clinical opinions, including those involving duties to third-parties. Exposure to these divergent clinical opinions may contribute to

improved judgment and accuracy in *Tarasoff*-related scenarios. Also, there could be differences in undergraduate and graduate curricula that may account for the differences noted in this study between counselors and psychologists.

Research has shown (Felthous, & Kachigian, 2001; Fulero,1988; Givelber et al.,1984; Herbert, 2002; Herbert & Young, 2002; Pabian et al., 2009) that therapists tend to construe the *Tarasoff* duties as primarily issuing warnings to others rather than a duty to exercise due care to protect the third-party. This presupposition is likely to be observed across all levels of experience in part due to the reasons discussed above. Even internet search mechanisms like Psych INFO used the "duty to warn" phrase as the appropriate search term when seeking data on psychotherapists' responsibility with respect to dangerous clients (Pabian et al., 2009). Thus, the duty to warn concept, which was part of the first *Tarasoff* decision and subsequently vacated by the second *Tarasoff* decision, has become the stereotypical descriptor for this particular set of duties. This is likely still the case among all mental health professionals and is likely to bias their analysis of their options in *Tarasoff*-related scenarios. That bias was likely a factor in the responses of the sample in this study. The gravity of this bias is addressed below.

Implications of the Research

The significance of understanding post-*Tarasoff*-related court decisions and their subsequent impact upon risk management for therapists is the essence of the current project. Following the initial *Tarasoff* decisions, both state legislatures and courts systems in other jurisdictions utilized the *Tarasoff* principles to address duties to third-parties within their local jurisdictions. *Tarasoff* shaped both subsequent judicial decisions as well as the statutory language used in relevant state codes. Practicing clinicians need to be aware of subsequent

Tarasoff-related court cases in order to adequately manage risk (Glancy & Chaimowitz, 2005). The essence of managing the risks of potential *Tarasoff*-related duties in one jurisdiction includes recognizing the potential areas of expansion within their own jurisdiction, based upon the expansion of *Tarasoff* duties that have occurred in other jurisdictions. These expansions are part of the history of the *Tarasoff*-related cases. Therefore, when therapists are confronted with threatening clients, it is essential that those therapists have a working knowledge of their respective codes of ethics, their local state's statute regarding unauthorized disclosure, and an awareness of court cases that may have articulated expansions of *Tarasoff*-related duties, particularly those that have not been addressed sufficiently within a particular therapists jurisdiction - either statutorily or through case law. The relevance of post-*Tarasoff*-related court cases for individual therapists reside in essentially two clinical areas; the point at which a *Tarasoff*-related duty is triggered and the circumstances under which the application of the *Tarasoff* principle is relevant.

There are essentially three sources of data regarding the analysis of any *Tarasoff*-related clinical scenario. The first source of these data is the relevant professional ethics code. In general, the ethics code for both psychologists and counselors are essentially permissive of disclosures that are consistent with legal mandates or conform to statutory language (American Counseling Association, 2005; American Psychological Association, 2002). Because there is not a national standard for issues related to duties to third-parties, the respective ethics codes offer little guidance on how to manage a *Tarasoff*-related scenario except to encourage therapists to comply with the law.

The second source of data regarding the management of *Tarasoff*-related duties is the relevant state statute. Participants in this study were asked to apply their knowledge of state

statutes to their case analyses. In the case of West Virginia, the statute is brief and somewhat vague. It only speaks to allowing unauthorized disclosure in order "to protect from substantial and imminent threat to self or others" but is silent with respect to what actions are considered appropriate in order to properly exercise the discretion to protect others from harm (W. Va. Code §27-3-1). Furthermore, the relevant West Virginia state statute makes no reference to the issuance of a warning and there is no mention of immunity from civil prosecution for disclosures or any other protective measure. Essentially, it states that unauthorized disclosure may occur in an attempt to offer protection. Also, the West Virginia state statute tends to conflate homicidal and suicidal threats in the language of the statute.

The third source of information for therapists who are confronted with a potential *Tarasoff*-related duty is the progeny of *Tarasoff*-related court cases. To be certain, cases that have been litigated within the jurisdiction in which the therapist practices would likely have the most relevance in the decision-making process, as those cases would have likely clarified the duties either by expanding it or defining a new threshold for triggering the duties. Also, they would be case law for subsequent litigation. Arguably, given the manner in which the *Tarasoff* principles have been applied nationwide, court cases from other jurisdictions may have potential relevance for therapists who deal with threatening clients, as they approach final disposition for a particular client and attempt to manage their own exposure to risk and liability. Monahan (1993) argues that documentation of the plans contemplated can minimize liability in the event of alleged malpractice. Based on the findings of this project, it is recommended that contemplation of the relevant court cases should be part of those analyses in a manner advocated by others including Hansen & Goldberg (1999).

The results of the present study indicated that the West Virginia psychologists and counselors responding to this survey exhibited an overall lack of knowledge of the original *Tarasoff* decisions and displayed difficulty with their ability to accurately anticipate the outcomes of post-*Tarasoff*-related court decisions. Furthermore, there was also a significant misunderstanding of the manner in which court decisions from one jurisdiction became relevant in other jurisdictions. Also, the respondents in the survey seemed to lack an understanding of the interactions among specific court cases in one jurisdiction and the implications of those decisions for applicable codes of ethics. Therefore, therapists may be inadequately prepared to apply ethical standards and legal principles derived from court cases to their own clinical reasoning process during the management of a particular *Tarasoff*-related scenario. These errors could seriously impact their exposure to liability for negligence either for improper disclosures or failure to apply *Tarasoff*- related protective measures.

Furthermore, it is likely, although not tested directly in this study, there may have been a lack of understanding of the relevant West Virginia state statutes regarding exceptions to patient-therapist confidentiality, which may have impacted some responses to the survey. Most respondents in this study apparently believe that the duties to third-parties in all states are based on fiat from California courts and not necessarily based on a state statute. One could infer that their knowledge of the statute was limited as well. Further, the language of the applicable, and discretionary, state statute in West Virginia (W. Va. Code §27-3-1) is grossly different from the language of affirmative duties promulgated by the *Tarasoff* court. Finally, the participants in the survey, overall, rated their levels of confidence regarding their awareness and judgment of these cases relatively high. The implications of these general findings will be considered in context of risk management.

Given the overall low accuracy scores of the participants in the survey and their relatively high levels of confidence regarding their knowledge and judgment of these cases, therapists with that particular constellation of attributes, are at risk of misapplying the *Tarasoff* principles. For example, the West Virginia state statute regarding exceptions to authorize disclosures has no explicit immunity language within that statute. Furthermore, there is no language specific to a duty to warn. The statutory language approximates a position that disclosures may be made in order to protect. There is neither specificity about the conditions under which such a trigger should occur, nor is their specificity about steps therapists may or should take that would be consistent with providing some form of protection.

If therapists maintain that the essence of the *Tarasoff* duties is a duty to warn and other courts can mandate compliance, they may be too eager to issue a warning that may, in fact, be insufficient to reach a legal threshold of protection implied in the state code. Conversely, they may not contemplate a duty when other variables such as institutional policies, like universal precautions, become paramount. For example, participants in this particular study did not accurately anticipate the liability extended to the defendants in one documented West Virginia case in which *Tarasoff* principles were applied to an HIV exposure context. In *Johnson v. West Virginia University Hospitals, Inc*. (1991) the case had elements of both duties to warn and to protect in its analysis. Now it is case law in West Virginia and carries the power of judicial precedence. Furthermore, if there is not clarity about the point at which a *Tarasoff* duty becomes relevant, therapists could erroneously over-predict the threat of violence in the context of high levels of misplaced confidence and low levels of actual legal knowledge. By contrast, therapists did not perceive the relevance of a *Tarasoff*-related duty and therefore not apply it in their case analysis. This reasoning may have been the rationale for the responses to that scenario in this

study in which the majority of participants did not recognize a duty because of universal precautions. This could result in unnecessary interventions, problematic warnings and potential liability risks clearly unseen by the majority of this sample.

A second related risk for therapists in West Virginia is that they may issue a warning to a third-party in good faith and may, in fact, be unjustifiably breaching confidentiality. This type of exposure could happen in the event that the threat was determined to not be substantial or imminent, or if the court were to decide that a warning was insufficient to meet the letter or intent of the law around the protection language of the statute. Therefore, part of the therapists' liability could be an ethical and legal issue related to an unwarranted violation of confidentiality as was decided in *Garner v. Stone* (1999) and in *Hopewell v. Adebimpe* (1981). In the latter instance, a psychiatrist was found guilty of breaching confidentiality because he did not adequately assess the likelihood of a patient acting upon threatened violence before notifying the patient's supervisor of the threat.

Furthermore, unwarranted warnings could also create interpersonal and, therefore, emotional difficulties for the client. There have been several cases involving *Tarasoff*-related duties and the issue of privilege including *Vivano v. Moan* (1994), in which *Tarasoff*-related warnings were issued and therapists were subsequently compelled to testify against their own client regarding the essence of the threatening behavior (Goldstein, & Calderone, 1992; Herbert, 2004). Similarly, in *U.S. v. Auster* (2008), the U.S. Fifth Circuit Court of Appeals decided that the issuance of a *Tarasoff* warning, with patient's prior knowledge that such a warning would be issued following a threat, placed the communication of the threat outside the privilege and therefore makes that fact admissible in a subsequent criminal proceeding against the patient.

This dynamic has been referred to as the "criminalization of *Tarasoff*" by some commentators (Weiner, 2003; Weinstock et al., 2006).

The lack of knowledge of court cases and the confusion about the nature of the *Tarasoff* duties have other risks which require discussion. Therapists who lack understanding of the legal context of their clinical decisions also may inadvertently be operating outside their respective professional codes of ethics when failing to properly apply *Tarasoff* principles or failing to maintain competence about legal and ethical matters (Pabian et al., 2009). For example, the APA *Ethics Code* Section 2.03, on competence, states "Psychologists undertake ongoing efforts to develop and maintain their competence" (p.5). The issue of competence can become relevant in the event of alleged malpractice based upon negligence. Negligence is based, in part, upon a professional causing damage by deviating from recognized standards of care. Therapists who lack sufficient knowledge of relevant case law and statutory boundaries may also deviate from both the legal standards and, therefore, the ethical standards when engaging in unauthorized disclosures of confidential information. For example, the APA *Ethics Code* Section 4.05b (2002) states that "Psychologists disclose confidential information without the consent of the individual only as mandated by law or where permitted by law for a valid purpose…." (p.8). When legal compliance is imprecise, ethical violations may be applicable. It must be assumed that both legal and ethical risks would be greater for therapists with significant knowledge gaps in the areas of legal and ethical dynamics, as was seen in the sample in this study.

Another risk for therapists lacking sufficient knowledge of court cases and the original *Tarasoff*-related duties is in the area of informed consent. As Pabian, et al., (2009) observed, it is difficult for therapists operating with a significant knowledge gap of legal and ethical issues to provide informed consent to their clients. Traditionally, informed consent includes, in part,

articulating the nature of the limits of confidentiality within the therapeutic relationship (Fisher & Oransky, 2008). Just as therapists need to know the point at which a *Tarasoff* duty is legally triggered by a particular clinical presentation, likewise they need to understand both the statutory limitations and the relevant case law in order to derive a legitimate informed consent process. Statutory changes typically lag behind judicial decisions. If the informed consent documents are based upon erroneous information regarding the scope of confidentiality, therapists could have liability exposure for failing to provide substantial informed consent. This particular issue has significant implications for therapists that have a high level of unwarranted confidence and a commensurate lack of understanding about their legal and ethical knowledge of duties to third-parties.

Therapists who practice in jurisdictions in which *Tarasoff* duties have been expanded beyond their original statutory descriptors would be advised to consider inclusion of those extensions within their informed consent process. For example, therapists who practice in Vermont would be advised to consider including, in their informed consent process, possible duties to third-parties when serious threats to property are made by clients. Therapists who practice in other jurisdictions would be advised to be aware that potentially lethal property damage has been litigated in Vermont and should be a consideration in their reasoning regarding *Tarasoff*-related cases involving, for example, threats of arson. Likewise, therapists who live outside of California should be aware that the issue of threats of violence reported by family members have been construed by the courts as being the equivalent of patient communication and, therefore, may trigger a *Tarasoff*-related duty. Therapists in West Virginia should not necessarily consider this type of information the equivalent of receiving a threat from a patient directly. It is an important variable which should be considered when articulating a plan of action

with a patient who may be at risk of acting upon a threat of violence that has been uttered to someone other than the therapist.

A few of the studies, conducted just after the original *Tarasoff* decisions were handed down, found that many therapists were uncomfortable about explicitly articulating the possibility of mandatory disclosures to third-parties, fearing that such acknowledgment would either damage the therapeutic relationship or cause the client to withdraw from therapy (Givelber et al., 1984; Stone, 1976; Wise,1978). A therapist who intentionally withholds information from clients, and maintains that such behaviors are somehow in the client's best interest is potentially violating a principal of the ethics code (Fisher, 2008). Specifically, without full disclosure of the nature and scope of the conditions under which unauthorized disclosures can be made, therapists are undermining their professional conduct and possibly attenuating the ethical underpinning of fidelity and justice.

Finally, it is advised that therapists generate a set of clinical alternatives based upon relevant state statutes and applicable case law to help manage the risks involved in treating the next potentially homicidal client. This preparation would also include the clinician's best approximation of the understanding of the scope of the *Tarasoff* duties as well as the point in the clinical evaluation at which the *Tarasoff* duties may be triggered. Even in situations in which the clinician feels that a strict duty to warn is clinically indicated and is legally and ethically sound, the prudent therapist must have an action plan beyond the actual execution of a *Tarasoff*-related duty to warn. That therapist still has a dangerous client to treat.

Approximately 40% of the sample in this study indicated that they had professional experiences in dealing with *Tarasoff*-related duties. Another 57% of the respondents indicated

that they had been contacted for peer consultation in a potential *Tarasoff*-related situation, while 40% indicated that they had never been contacted for consultation. The levels of misplaced confidence about knowledge of *Tarasoff*-related duties and the commensurate low accuracy scores on post-*Tarasoff*-related court cases demonstrated by participants in the study highlighted the potential risks related to seeking and providing case consultation in *Tarasoff*-related situations. Just as the substantial lack of knowledge and understanding of the *Tarasoff* duties impacts a clinician's ability to shape appropriate informed consent, so these deficits affect the validity of consultations sought and provided. Low levels of understanding of *Tarasoff*-related duties and high levels of misplaced confidence can have their most harmful impact in the area of informed consent.

Consultations are generally sought and provided in good faith. However, considering the data from this study, it is probable that there are instances in which individuals seeking consultations are likely receiving varying degrees of inaccurate and potentially misleading information from a professional with a high degree of misplaced confidence about duties to third-parties. Furthermore, considering that there is a widely-held misconception that the *Tarasoff* duties are essentially distilled to a duty to warn, it is quite feasible that this misperception is fortified and promulgated through repetition of the phrase during individual case consultations. It is conceivable that the individuals seeking consultation may be as equally informed, or equally misinformed, as the person providing the consultation. Another issue, related to the provision of consultation, is how professionals are identified as a potential, credible resource within a given specialty area of psychotherapy. It is likely that these types of resources are identified either by years of experience or by reputation within the professional community. Given the results of this particular study and the low level of accuracy *Tarasoff*-related cases,

clinicians would be advised to be extraordinarily judicious regarding the selection of potential sources for consultation.

Clearly, the significant knowledge gaps in *Tarasoff*-related cases may actually be traced back to the type of supervision provided to developing therapists. It is very probable that some of the deficits in knowledge regarding the development of ethics codes, the importance of state statutory requirements and the relevance of significant court cases could be the byproduct of inadequate supervision. Furthermore, it is likely that perpetuation of misinformation about the duty to warn bias and other results pertinent to this study are related to problematic supervision. It is unlikely that clinical supervisors question their own presuppositions about the nature of the *Tarasoff* duties. It is certainly beyond the scope of this particular research project to be speculative or unduly critical of the current system of supervision of psychologists and counselors. However, as mentioned before, the ethics code for psychologists includes standards related to the maintenance of competence (Harrar, VandeCreek, & Knapp, 1990; Recupero & Rainey, 2007).

It is the responsibility of the supervisor to maintain his or her competence in areas in which they practice, which would include a measure of competence regarding the adequate supervision of other clinicians. It is simply too easy to say that the solution to this potential problem would simply be more training for supervisors. Supervisors should be in a position to role model a certain degree of flexibility when approaching clinical scenarios involving homicidal patients and potential duties to third-parties including a reasonable degree of knowledge of the *Tarasoff* duties and more importantly, local statutory requirements.

It was hypothesized that there would be no relationship between continuing education activities in the area of ethics and the accuracy scores of respondents on the *Tarasoff*-related cases. There was, in fact, no relationship between reported continuing education activities and the accuracy scores of respondents on the *Tarasoff*-related cases. Similar results with respect to continuing education activities were observed by Pabian, et al., (2009) in their research on psychologists' knowledge of state statutes. The APA (2006) has reported that 26 states mandate continuing education hours in the area of legal and ethical issues. Currently, seven states have no continuing education activity requirements for licensure renewal. Research indicated that psychologists from states with both mandated and non-mandated ethics training tended to describe their continuing education activities as favorable and, in some instances; those activities increased therapist confidence about risk management (Neimeyer et al., 2011). The exact relationship between ethics training, continuing education activities and the knowledge of *Tarasoff*-related duties is not clear. It would appear, based upon this research and the work of others, that continuing education activities and/or mandated ethics training has little impact on knowledge of *Tarasoff*-related duties. Tolman (2001) as part of an attempt to develop recommendations for clinical training related to the duty to protect, surveyed several pre-doctoral internship programs in Michigan to assess the degree of training provided to interns on issues related to the original *Tarasoff* decisions, as well as information specific to the state of Michigan. He reported that 92% of the training programs surveyed indicated that they provided some kind of didactic instructions to their students on issues related to duty to warn. However, only 50% of the programs indicated that they provided specific training and information to students regarding the nature of Michigan's duty to protect statute. Only 25% of the programs indicated that they provided any information or training to their clinical students regarding state specific case law.

Tolman (2001) reported that at least one of the training directors did not seem to be familiar with the Michigan statute and requested a copy of the law from the researchers (2001, p.398). Tolman (2001) overall expressed concern about a lack of training regarding statutory requirements and about the lack of a risk educator within the internship sites.

Concluding Summary

This study utilized a series of questions regarding the initial *Tarasoff* decisions and a collection of scenarios based upon the particulars of actual court cases involving *Tarasoff*-related duties to evaluate therapists' knowledge and understanding of these cases. It was hypothesized that the overall knowledge therapists have regarding the original *Tarasoff* decisions, and subsequent *Tarasoff*-related court cases, would be low and that there would not be significant differences found between accuracy between counselors and psychologists. The data in this study seem to support these hypotheses.

Furthermore, it was hypothesized that there would be no relationship between accuracy ratings of post-*Tarasoff*-related court decisions and therapists' years of experience or with continuing education experiences. The data from this study appeared to support this hypothesis as well. The data from this study indicated that approximately 88% of the sample reported that they were somewhat or quite familiar with the cases known as *Tarasoff* and yet their overall understanding of the basis and the scope of the cases was quite low. Furthermore, participants rated their degree of confidence within the range of 2.75-3.04 out of the possible score of four. Therapists in general, despite inflated confidence levels, did not anticipate actual court decisions accurately. Also, it can be concluded that the majority of the sample in this study overestimated their understanding of the initial *Tarasoff* cases. For example, less than 20% of the sample

correctly identified the fact that the original *Tarasoff* duties could be discharged by hospitalizing a threatening patient. Similarly, approximately 66% of the sample in this study endorsed a statement that the *Tarasoff* duties could be discharged by verbally warning a victim. Another 60% of the sample believed that the California court systems can generate mandates relative for all 50 states. The language between the original *Tarasoff* decision and the relevant West Virginia statute articulating an exception to confidentiality is quite different. Furthermore, 60% of the total sample in this survey believed that the original *Tarasoff* court mandated that all mental health professional codes of ethics be amended to include mandatory notification of client threats directed at third-parties. Thus, it is likely that the sample in this study not only had a lack of understanding about the implications of the original *Tarasoff* decisions, they were likely to also be unaware of relevant state statutes regarding this issue. Thus, in effect, they may be subordinating state statutes to one court decision from another jurisdiction. It would appear that these data indicate that the majority of the participants in this sample believed that there is a duty to warn, it is a national standard of care and that the court in the original *Tarasoff* case mandated both changes in professional codes of ethics and behavior generally governed by state legislatures.

The specific manifestation of the *Tarasoff* duties within local jurisdictions has, by and large, become more of a legal question than an ethical question. The significance of subsequent court cases, including the ones used for the basis of this study is found in the manner in which they impact the scope and permutations of the current form of the duties and the impact upon state legislatures.

The apparent misunderstanding of the nature of the relationship between relevant judicial findings and a particular ethics code, as it relates to managing clients that are potentially harmful

to others, has the potential to impact risk management and clinical decision-making. Specifically, nearly 40% of the sample in this study indicated that they had experience with *Tarasoff*-related duties and yet seemed to exhibit a fundamental misunderstanding of the nature of the original *Tarasoff* cases, as well as the implications of those decisions relative to ethical behavior. It behooves prudent therapists to have a working knowledge and understanding about, not only their particular state statute, but also court cases within their jurisdiction and outside their jurisdiction.

The findings in this study have potential serious implications for practitioners in the state of West Virginia. Furthermore, continuing education experiences and years of practice are not related to accuracy scores derived from case analyses underscores the complexity of understanding the evolving concept of *Tarasoff.*

Critique of the Project

One of the criticisms of this study is to be found in the selection of cases for analysis. Although the rationale for the selection of these particular cases was articulated elsewhere in this document, a case could be made that the selection of those cases was somewhat arbitrary or biased so as to increase the difficulty level. A second concern involves the brevity of the case scenarios and the limited alternatives associated with each scenario. Each scenario could have been considerably lengthier. Each scenario was developed to encapsulate a particular theme upon which the particular *Tarasoff*-related case was decided.

A related limitation involves the multiple-choice format associated with each scenario. Most of the scenarios had one pair of answers reflecting the presence of a duty to warn or protect for two different reasons and the lack of a duty to warn or protect for two different reasons.

There was only one "correct" answer per scenario. It is conceivable a respondent could have endorsed the "correct" action (…there was a duty to warn or protect …") for the "wrong" (different from the court's reasoning) reason. Therefore, there may be alternative ways of scoring these types of scenarios in future research.

Another limitation of this study was the failure to include specific questions about West Virginia state statutes regarding unauthorized release of confidential information. Given the serious misunderstanding of the relationship among court decisions, codes of ethics and state statutes, the addition of that particular variable would have added greatly to this particular project.

This research design has the possibility of having used a non-representative sample of mental health therapists. It is certainly possible that responders and nonresponders differ in some significant way which is presently unknown.

Suggestions for Future Research

Suggestions for future research include evaluating the confidentiality beliefs of therapists relative to their willingness to potentially breach confidentiality. This particular research project could shed light on the personal belief system of the therapists and how that relates to their willingness to carry out a *Tarasoff* duty. It would be an extension of the work done by Haas et al., (1988). Furthermore, it would also provide clarity on the issue of what percentage of mental health therapists still believe in absolute confidentiality compared with those that believe in conditional confidentiality.

Second, research needs to be conducted with practitioners in West Virginia in such a way as to include therapists' understanding of state statutes and privilege issues and how those variables impact their reasoning of *Tarasoff*-related duties.

Third, another research project could evaluate the impact of involuntary commitment relative to therapists' experiences with duty to warn scenarios. The availability of involuntary commitment proceedings may greatly impact the decision-making process for therapists confronted with a potential duty to warn or protect scenario.

Fourth, another interesting research project could be a closer examination of the consultative process in a *Tarasoff*-related duties scenario. Specifically, researchers could evaluate how therapists choose their consultant and assess how the consultant manages the perceived risks for consulting in situations involving duties to third-parties. Furthermore, it would also be constructive to understand under what conditions a consultant would refuse to proffer advice to a peer.

Fifth, another potential research project might involve a closer look at what therapists do after they have issued a *Tarasoff* warning. It would be enlightening to understand the interventions and strategies therapists would use after they have issued a *Tarasoff* warning. The *Tarasoff* warning is the duty to the third-party. Therapists still have other duties to their clients after such warnings are given.

Another potentially viable research project could involve a qualitative design to understand the process by which therapists' reason through *Tarasoff*-related scenarios. A related qualitative study could also be done to understand the experiences of those individuals who are

the targets of the verbal threats and the impact those threats have on them as well as their relationship with the perpetrator.

Finally, psychologists who obtain prescription privileges may have additional duties to warn or protect as many *Tarasoff*-related cases have been litigated on the issue of dangerous drivers due to sedation from prescription medication (Pettis, 1992).

Proposal for Remedy

This project, as well as the conclusions of other researchers, highlights the lack of knowledge and understanding of state statutes and judicial decisions regarding *Tarasoff*-related duties. Because there is no national standard of care regarding *Tarasoff*, the major thrust of any set of solutions which might address the documented lack of knowledge in this area, must occur at the state level. Each jurisdiction has dealt with the *Tarasoff* duties differently. Some jurisdictions have mandated the duties by statutory requirements while others have extended discretionary judgment to its clinicians. Herbert & Young (2002) have cautioned that clinicians who practice in states which have discretionary statutes, like West Virginia, might consider approaching an interpretation of that statute as if it were an affirmative duty.

Currently those seeking licensure renewal in the state of West Virginia are required to provide documentation regarding continuing education hours in the area of ethics. However, there are no guidelines regarding the specific content of those continuing education experiences. It is proposed that the West Virginia Board of Examiners require that all psychologists, who are qualified and certified to provide clinical supervision, be required to demonstrate competence in relevant state statutes regarding exceptions to authorized disclosures of protected health information. Also, the Board should maintain information regarding known *Tarasoff*-related

court cases that may impact practitioners in the state. This information should be promulgated to interested parties semiannually. This information should be collected and distributed for informational purposes only and should not be construed as legal advice or legal opinion. Furthermore, those individuals who seek licensure in the state of West Virginia, or licensure renewal, should be expected to demonstrate their competencies in these areas prior to issuance of their license. Also, the West Virginia Psychological Association should offer an annual continuing education session specifically related to the review of relevant West Virginia statutory language regarding *Tarasoff*-related court cases and other potential mandatory reporting requirements including child abuse and neglect as well as elder abuse and neglect.

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Appendix

West Virginia Therapists' Knowledge of *Tarasoff*- related Court Cases Survey

Intro and Demographic Information

- Age range: __20-29 __30-39 __40-49 __50-59 __60-69 __70+
- Gender __F __M
- Number of years in practice___
- Highest degree:__ Masters __ Doctoral
- Degree: __Psychology __Counseling__Social Work
- Current site of practice : __Private practice __Hospital __Academic __Community Mental Health __School psychology __Employee Assistance Program
- Independently Licensed __ Yes __No
- Do you describe your community as rural or urban? __Rural __Urban
- Have you ever been contacted by a peer for consultation in a duty to warn or protect situation? __Yes __No
- Have you ever received training specific to the area of a therapist's duty to warn or protect a third party? __Yes __No
- If your answer was yes to the previous question, was the training: __ included in an ethics class which was part of your graduate training __included in a training or inservice on general, legal issues in clinical practice __ specific to the topic of a therapist's duty to warn or protect.
- When was your most recent training experience in the area of a therapist's duty to warn or

protect a third party? __within the last year __within the last 2 years__ within the last 5 years__ more than 5 years ago.

- In your clinical practice, have you ever had to warn a third party because of a client's threats ?__Yes __No

If yes, whom did you notify during the most recent intervention? __ Police only__ Intended victim only __Police and intended victim

What was the relationship between the client and the target of the threat? __Spouse __Partner___Family member __Coworker__Another provider __Other non-family member

- How familiar are you with the legal decisions of the cases known as *Tarasoff* ?

1 2 3 4 5 6 7

- Please answer the following questions (true or false) regarding your understanding of the cases known as *Tarasoff* .
- The court mandated that only intended victims be notified of threats directed at them.
- The court mandated that only the local police be notified of a threat directed at an individual.
- The court stated that the duty to protect third parties may be discharged by hospitalizing the client making the threat.
- The court concluded that a therapist could discharge the duty to protect through the process of verbally warning the intended victim.
- The decisions in the *Tarasoff* cases mandated that therapists in all 50 states are required to

warn and protect intended victims based on clients' verbal threats.

- The court in the *Tarasoff* cases required that all mental health professional codes of ethics be amended to include mandatory notification of client threats directed at third parties.
- The decisions in the *Tarasoff* cases are not applicable to suicidal threats.

Instructions for Scenarios and Scenario #1.

What follows are five scenarios based on actual court cases. Please evaluate these scenarios and respond to the questions which follow each.

Scenario #1

Dr. Wells was treating Mr. Black for anger problems, adjustment problems related to marital separation and job stress. During one session, Mr. Black was discussing his anger toward his wife and threatened to "tear up" his estranged wife's house and set it on fire since he was "the one making the house payments." Despite interventions during that session, Mr. Black remained angry and refused to withdraw his threat. He subsequently broke into the house and set it on fire. He was arrested for destruction of property and arson and his estranged wife sued Dr. Wells for not alerting her about the threat.

Applying your knowledge of your state code, your understanding of your professional ethics and your clinical judgment, what you do in this case?

a. I do have a duty to warn / protect because his wife could have been injured during the crime.

b. I do have a duty to warn / protect because therapists have a duty to prevent violent crimes.

c. I do not have a duty to warn / protect because there is no duty to protect property.

d. I do not have a duty to warn / protect because the threat had no intended victim.

Please rate your degree of certainty about your answer.

1 2 3 4 5 6 7

What was the decision in this case rendered by the court?

a. There was a duty to warn / protect because his wife could have been injured during the crime.

b. There was a duty to warn / protect because therapists have a duty to prevent violent crimes.

c. There was no duty to warn / protect because there is no duty for therapists to protect property.

d. There was no duty to warn / protect because the threat had no intended victim.

Please rate your degree of certainty about your answer based on your awareness of legal cases.

1 2 3 4 5 6 7

Scenario # 2

Emily and Jake have been married for seven years and are currently in marital counseling with Dr. May. Jake has been verbally abusive in the past and Emily filed a domestic violence petition against him two years ago which is currently not in effect. During a joint session, Jake threatens to kill Emily and himself if marital therapy fails to save their marriage. Emily said that she has just learned to live with his anger outbursts. Later that week, Jake physically assaulted Emily. Emily sued Dr. May for failure to warn and protect.

Applying your knowledge of your state code, your understanding of your professional ethics and your clinical judgment, what you do in this case?

a. I do have a duty to warn / protect because the threat was made face-to-face.

b. I do have a duty to warn / protect despite previous threats.

c. I do not have a duty to warn / protect because she was already aware of the threat.

d. I do not have a duty to warn / protect because I could not have protected her from the assault.

Please rate your degree of certainty about your answer.

1 2 3 4 5 6 7

What was the decision in this case rendered by the court?

a. There was a duty to warn / protect because the threat was made face-to-face.

b. There was a duty to warn / protect despite her knowledge of previous threats.

c. There was no duty to warn / protect because she was already aware of the threat.

d. There was no duty to warn / protect because there was no other action the therapist could have taken to protect the victim.

Please rate your degree of certainty about your answer based on your awareness of legal cases.

1 2 3 4 5 6 7

Scenario #3

Kevin is a 25-year-old male who was brought to the emergency room of a hospital by the Sheriff's Department for aggressive behavior and acute cocaine intoxication. During his evaluation by the nursing staff and the attending physician, it was determined that he was HIV-

positive. While staff was attempting to render medical care, he became agitated and began to destroy furniture in his treatment room. After Kevin began to threaten the staff, the physician summoned the hospital security guard to Kevin's treatment room. The security guard attempted to restrain Kevin and during an altercation with the guard, Kevin bit the guard in such a way that body fluids were exchanged. Months later, the guard developed HIV and he sued the hospital for failure to protect him.

Applying your knowledge of your state code, your understanding of your professional ethics and your clinical judgment, what you do in this case if you were on the hospital staff ?

a. I do have a duty to warn / protect because the medical staff have a duty to others treating the patient.

b. I do have a duty to warn / protect because of the combination of violence and an infectious disease like HIV.

c. I do not have a duty to warn / protect because universal precautions are standard procedures for all hospitals.

d. I do not have a duty to warn / protect because facilities do not have duties to protect individual staff.

Please rate your degree of certainty about your answer.

1 2 3 4 5 6 7

What was the decision in this case rendered by the court?

a. There was a duty to warn / protect because the medical staff have a duty to others treating the patient.

b. There was a duty to warn / protect because of the combination of violence and an infectious disease like HIV.

c. There was no duty to warn / protect because universal precautions are standard procedures for all hospitals.

d. There was no duty to warn / protect because facilities do not have duties to protect individual staff.

Please rate your degree of certainty about your answer based on your awareness of legal cases.

1 2 3 4 5 6 7

Scenario #4

Mr. P. was seen for the first session with Dr. D. who found the patient to be suicidal and referred Mr. P. to an inpatient treatment unit due to suicidal thoughts. Two days later, Dr. D. received a telephone call from Mr. P.'s father who told him that Mr. P. was divorced and making threats of violence toward his ex-wife's new boyfriend, Mr. B. Dr. D. had not heard these threats during his interview with the patient so he notified the hospital currently providing care to Mr. P.

The next day, the inpatient psychiatrist told the patient's father that he was planning to discharge the patient that same day. Alarmed, the father called Dr. D., who contacted the psychiatrist and urged him to re-consider. The psychiatrist stated that because the patient was not suicidal, he was going to follow through on the plan to discharge him that day. Mr. P subsequently was

discharged and he murdered his ex-wife's boyfriend. The estate of the deceased sued Dr. D. for failure to warn / protect.

Applying your knowledge of your state code, your understanding of your professional ethics and your clinical judgment, what would you do if you were Dr. D.?

a. I do not have a duty to warn / protect the boyfriend of his ex-wife because the information did not come from the patient.

b. I do have a duty to warn / protect the boyfriend of his ex-wife by alerting hospital staff about the threat.

c. I do have a duty to warn / protect the boyfriend of his ex-wife despite the source of the threat.

d. I do not have a duty to warn / protect the boyfriend of his ex-wife because the patient is not under my care.

Please rate your degree of certainty about your answer.

1 2 3 4 5 6 7

What was the decision in this case rendered by the court?

a. Dr. D. had no duty to warn / protect hospital staff because the information did not come from the patient.

b. Dr. D. had no duty to inform the hospital staff of the threat because the information was hearsay.

c. Dr. D. had a duty to warn / protect the new boyfriend regardless of the source of information.

d. Dr. D only had a duty to inform the hospital staff of the threat.

Please rate your degree of certainty about your answer based on your awareness of legal cases.

1 2 3 4 5 6 7

Scenario# 5

Dr. D. is conducting an independent psychological evaluation with Mr. P. an employee of a local utility company following an incident in which Mr. P. was accused of a serious safety violation and appearing to be "impaired." They reside in a state which has a state statute that has only a duty to protect third parties but provides no immunity for therapists who disclose information to meet the duty to protect. Dr. D provided informed consent about the scope of the evaluation and the unique relationship among the examiner, the company, and Mr. P. During the evaluation, Mr. P became angry discussing his supervisor and threatened to "blow up the plant" if he were terminated because of the results of the evaluation. Dr. D. passed the threat on to the supervisory staff who ultimately terminated Mr. P.

Mr P. sued Dr. D. for breaching privacy and going beyond the intent and scope of the evaluation.

Applying your knowledge of your state code, your understanding of your professional ethics and your clinical judgment, what you do in this case?

a. I do have a duty to warn / protect regardless of the type of evaluation being conducted when the threat is made.

b. I do have a duty to warn / protect because the threat is serious regardless of the lack of immunity.

c. I do not have a duty to warn / protect because there is no specified victim identified in the threat.

d. I do not have a duty to warn / protect because, during independent evaluations, the company paying for the evaluation is the primary "client," not the individual being evaluated.

Please rate your degree of certainty about your answer.

1 2 3 4 5 6 7

What was the decision in this case rendered by the court?

a. The therapist was not liable for damages because he complied with the current standard of care.

b. There was a duty to warn because the threat is serious regardless of the lack of immunity.

c. The therapist was held liable for breaching confidentiality because statute does not include a duty to warn only to protect third parties.

d. The therapist was found to have done no harm because violence may have been prevented.

Please rate your degree of certainty about your answer based on your awareness of legal cases.

1 2 3 4 5 6 7

IRB Letter

Office of Research Integrity
Institutional Review Board
401 11th St., Suite 1300
Huntington, WV 25701

FWA 00002704

IRB1 #00002205
IRB2 #00003206

March 2, 2012

Martin Amerikaner,
Ph.D. Psychology

RE: IRBNet ID# 313646-1
At: Marshall University Institutional Review Board #2

(Social/Behavioral) Dear Dr. Amerikaner:

Protocol Title:	[313646-1] "West Virginia Therapists' Knowledge of Tarasoff-related Court Cases."	
Expiration Date:	March 2, 2013	
Site Location:	MU	
Submission Type:	New Project	APPROVE
Review Type:	Exempt Review	

In accordance with 45CFR46.101(b)(2), the above study and informed consent were granted Exempted approval today by the Marshall University Institutional Review Board #2 (Social/Behavioral) Designee
for the period of 12 months. The approval will expire March 2, 2013. A continuing review request for this study must be submitted no later than 30 days prior to the expiration date.

This study is for student Bruce Clay.

If you have any questions, please contact the Marshall University Institutional Review Board #2 (Social/Behavioral/Educational) Coordinator Michelle Woomer, B.A., M.S at (304) 696-4308 or woomer3@marshall.edu. Please include your study title and

reference number in all correspondence with this office.