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Tracing the Evolution of the *Tarasoff* Duty in California

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Since the first Tarasoff decision in 1974, the question of mental health professionals' "duty to protect" third-parties has been a topic of vigorous debate. The ensuing forty-three years witnessed considerable shifts in the statutory and legal landscape in the United States, including several significant changes in California state law over the past decade alone. In this historical review, I trace the evolution of the Tarasoff duty with a specific focus on the state in which that duty originated, California, with the intention of elucidating the major policy, ethical, and practical questions that have followed in the wake of the Tarasoff decision.

Key Words: Tarasoff, duty to protect, duty to warn

Since the era of deinstitutionalization in the 1960s, imminent danger to self (i.e., suicide) or others (i.e., homicide) has emerged as one of the standard criteria for mandatory psychiatric intervention in the United States (Ward, 2014). Whereas the duties of mental health professionals in California to suicidal clients have remained substantively unchanged since the 1967 passage of the Lanterman-Petris-Short Act, which mandated prompt risk assessment and, if necessary, involuntary commitment, the question of the duties of mental health professionals to potential victims of violence other than their clients has been the source of considerable back-and-forth in state courts and legislatures. In fact, prior to the mid-twentieth century, it was not at all clear that clinicians in California had *any* (legal) obligation to individuals other than their

clients. For reference, the first mandatory child abuse reporting law in California, which applied only to physicians, was enacted in 1963 (Rady Children's Hospital San Diego, 2012).

Due in part to an ever shifting statutory and legal landscape, as well as considerable inter-state variability, the duties of clinicians to potential victims continue to be a source of considerable confusion and an ethically contested subject. With these facts in mind, I seek to trace the historical evolution of the so-called "duty to protect" with a specific focus on the state in which that duty originated, California, and to elucidate the relevant policy, ethical, and practical questions that attend this duty.

In 1969, Prosenjit Poddar, a graduate student at the University of California, Berkeley, confided to his therapist that he intended to kill a woman he had previously dated, Tatiana Tarasoff. Poddar's psychologist, Dr. Lawrence Moore, warned campus police that Poddar was experiencing an acute psychotic episode and recommended that Poddar be involuntarily committed on the grounds of being a danger to others. Poddar was briefly detained by campus police, but was released shortly thereafter and subsequently desisted from treatment. Several months later, on October 27, 1969, Poddar carried out his plan, stabbing and killing Tatiana Tarasoff (for a more detailed discussion of the circumstances surrounding *Tarasoff v. Regents*, refer to Buckner & Firestone, 2000).

Following her death, Tarasoff's parents sued Poddar's therapists, campus police, and the Regents of the University of California for, among other claims made by the plaintiffs, failing to warn their daughter that she was in danger. In 1974, in a decision now commonly referred to as *Tarasoff I* (*Tarasoff v. Regents of the University of California*, 1974), the California Supreme Court held that psychotherapists had a duty of care not only to their clients, but also to individuals who might be harmed by their clients. Specifically, *Tarasoff I* held that therapists were obligated to warn potential victims of dangers posed to them by the therapists' psychotherapy clients. Failing to warn such victims would render therapists liable to civil judgment.

Judge Mathew Tobriner, writing for the majority in *Tarasoff I*, concluded that "public policy favoring protection of the confidential character of patient-psychotherapist relationships must yield in instances in which disclosure is essential to avert danger to others; the protective privilege ends where the public

peril begins" (Tarasoff v. Regents of University of California, 1974, section 2, paragraph 17). This statement encapsulates the central values tension at the heart of *Tarasoff*: at what point does a therapist's professional and ethical obligation to maintain a client's confidentiality come into conflict with a compelling interest to promote public safety, and, more to the point, how ought such conflicts be resolved?

Survey data collected by Givelber, Bowers, and Blitch (1984) highlight this conflict: out of the 2785 mental health professionals that they surveyed nearly ten years after *Tarasoff I*, 45% of clinicians who had breached confidentiality to communicate with a potential victim felt that they had violated their own clinical judgment by breaching confidentiality. This finding resonates with the widely held belief that confidentiality is essential to the practice of therapy (e.g., American Psychiatric Association, 2013). Nevertheless, respondents overwhelmingly endorsed a responsibility to potential victims as a matter of professional and personal ethics. This speaks to the deep bind in which clinicians sometimes find themselves when working with dangerous clients. In *Tarasoff I*, however, the court erred firmly on the side of public safety by clearly establishing a "duty to warn."

Prior to *Tarasoff I*, no court anywhere in the nation had recognized such a legal duty to warn the potential victims of a patient (Cohn, 1983). In the wake of *Tarasoff I*, individual practitioners and professional organizations raised numerous objections to the court's ruling, arguing that the duty to warn would jeopardize the practice of psychotherapy by eroding the essential precept of confidentiality and contending that therapists could not reliably assess the likelihood of future violent acts by their patients (Quinn, 1984). Based on these and other objections, including concerns about civil liability, the American Psychiatric Association, the Northern California Psychiatric Society, and other professional organizations filed an *amicus curiae* brief to challenge the court's 1974 decision. In response, the California Supreme Court took the unusual step of agreeing to rehear the case, resulting in a second decision, known as *Tarasoff II* (Tarasoff v. University of California Regents, 1976), being handed down in 1976.

In keeping with the spirit of *Tarasoff I*, the 1976 decision imposed upon psychotherapists in California a legal duty to protect third parties from harmful acts perpetrated by their patients,

even if doing so required the therapist to breach the patient's confidentiality. Indeed, the court held that it was precisely because of the "special relationship" between therapists and clients that the therapists have "a duty to control the conduct" of their clients in cases in which third parties may be "foreseeably endangered" by their client's conduct (*Tarasoff v. Regents of the University of California, 1976, section 2, para. 5*).

However, contrary to *Tarasoff I*, the court ruled that discharging this duty to protect third parties did not *necessarily* require warning potential victims:

When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus *it may call for him to warn the intended victim* or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances. (emphasis added; *Tarasoff v. Regents of the University of California, 1976, para. 4*).

Having moved from a highly specific 'duty to warn' to a more general 'duty to protect,' the decision in *Tarasoff II* allowed for increased flexibility on the part of the clinician. At the same time, the 1976 decision also increased the ambiguity with which clinicians now had to contend by providing only vague guidelines as to how clinicians were expected to discharge the newly imposed 'duty to protect' (Mills, Sullivan, & Eth, 1987).

Moreover, a provision in the 1976 decision specifically found that therapists could be held personally liable if they "should have" known that a patient was dangerous prior to that patient committing a violent act. Yet the court left unspecified the extent or content of the knowledge that the therapist would have needed to possess to subsequently be held liable or the steps that therapists would need to have taken to protect themselves from liability (section 2, para. 14). This ambiguity resulted in civil actions in which therapists were held liable for situations in which it would have been nearly impossible for the therapist to anticipate the specific injury or to have protected the injured third parties, such

as substance-related car accidents that occurred months after the driver was seen by a therapist (Pettis & Gutheil, 1993).

At the same time, the initial concerns about breach of confidentiality and the ramifications of such breaches for the practice of psychotherapy persisted in the wake of the 1976 decision. In a dissenting opinion in *Tarasoff II*, Judge William Clark highlighted these concerns when he wrote that:

Given the importance of confidentiality to the practice of psychiatry, it becomes clear the duty to warn imposed by the majority will cripple the use and effectiveness of psychiatry. Many people, potentially violent—yet susceptible to treatment—will be deterred from seeking it; those seeking it will be inhibited from making revelations necessary to effective treatment; and forcing the psychiatrist to violate the patient's trust will destroy the interpersonal relationship by which treatment is effected. (*Tarasoff v. Regents of the University of California*, 1976, J. Clark dissent, paragraph 28)

Clark, channeling the concerns of many practitioners, was anxious that by codifying an exception to patient-client confidentiality, the court's decision would have the unintended consequence of dissuading potentially dangerous individuals from availing themselves of psychotherapy or from disclosing homicidal thoughts and plans.

Clark's sentiments were widely echoed by prominent mental health professionals, including by the presidents of the American Psychiatric Association (Stone, 1976) and the American Psychological Association (Siegel, 1979). Max Siegel, then the president of the American Psychological Association, wrote of *Tarasoff*, "This was a day in court for the law and not for the mental health professions. If the psychologist had accepted the view of absolute, inviolate confidentiality, he might have been able to have kept Poddar in treatment, saved the life of Tatiana Tarasoff, and avoided what was to become the Tarasoff decision" (Siegel, 1979, p. 253). Siegel's statement speaks not only to the abiding respect for the precept of confidentiality, but also to one of the tremendous difficulties in adjudicating Tarasoff cases: namely, that it is invariably possible to argue and nearly impossible to refute the counterfactual in which some set of actions taken or

not taken by a clinician (as opposed to the actions they actually took) might have saved a victim's life.

It should also be noted that although the court's decisions in *Tarasoff I* and *II* applied only to California, the effects of those decisions reverberated nationally. As of 2012, a duty to warn or protect had been codified by legislative statute in twenty-three states and was present in the common law supported by judicial precedent in an additional ten states (Johnson, Persad, & Sisti, 2014). Although a review of statutes and common law precedents in states other than California is beyond the scope of this article, it is certainly interesting to reflect on the extent of state-by-state variability, particularly as it relates to the challenge of adequately training and educating clinicians (refer to Johnson et al., 2014 for a review of inter-state variability).

This challenge is undoubtedly magnified by the ever-changing and often conflicting legal landscape, even within a given state. A mere four years after *Tarasoff II*, in a case involving the decision to parole a juvenile offender who had threatened to kill a neighborhood child upon his release, the California Supreme Court held that Alameda County "had no affirmative duty to warn Plaintiffs, the police, the mother of the juvenile offender, or other local parents" (a decision which Judge Tobriner dissented) (*Thompson v. County of Alameda*, 1980). Meanwhile, in 1983, the 9th Circuit Court of Appeals, whose appellate jurisdiction includes California, went precisely the other direction and broadened the foreseeability criteria laid out in *Tarasoff* in *Jablonski by Pahls v. United States* (1983) (refer to Walcott, Cerundolo, & Beck, 2001 for a discussion of *Jablonski*).

In 1986, in response to concerns about ambiguity and liability that followed in the wake of the 1976 *Tarasoff II* decision, the California state legislature passed a statute that limited therapists' duty to protect and attendant liability to situations in which the patient communicated to the therapist an imminent threat to an identifiable victim, thereby clarifying that therapists could not be held liable for any and all future harmful actions committed by their current or former clients. Simultaneously, the 1986 statute shielded therapists from any potential civil action that might arise due to breach of confidentiality, as long as they did so within the narrow confines of discharging their duty to protect as defined by the statute.

Ironically, however, the 1986 statute introduced fresh ambiguity by referring to a “duty to warn and protect” (Cal. Civ. Code § 43.92, 1986), rendering unclear whether the legislature intended to reintroduce a specific duty to warn akin to that which had been outlined in *Tarasoff I*. Two years prior to the passage of the 1986 statute, Givelber and colleagues (1984) had found that over 90% of California clinicians believed that they were legally obligated to warn potential victims as a result of *Tarasoff*, so it is not difficult to imagine that the inclusion of the phrase “duty to warn” in the 1986 statute confirmed and reinforced this mistaken belief. That a misunderstanding of the court’s ruling in *Tarasoff II* was so pervasive in California at the time speaks to the need for clear communication of policy to stakeholders, especially in a case such as *Tarasoff*, in which the waters had been muddied by the court’s decision to rehear the case and amend their decision a mere two years after their initial, controversial (and therefore widely circulated) ruling.

Fast forward seventeen years, and the ambiguity inherent in the 1986 statute was explicitly interpreted and codified as a duty to warn in the 2003 issuance of the simplified civil jury instructions (Judicial Council of California Civil Jury Instructions, No. 503A and 503B, 2014), meaning that juries were being explicitly instructed to apply a ‘duty to warn’ criterion in determining whether a clinician could be held liable in a *Tarasoff* cause of action (Weinstock, Vari, Leong, & Silva, 2006). At around the same time in 2004, a pair of appellate court decisions, *Ewing v. Northridge Hospital Medical Center* and *Ewing v. Goldstein*, held that a specific duty to warn existed based on the ambiguous wording of the 1986 statute. In the *Ewing* decisions, the court held that therapists could be held liable if a serious threat to an identifiable victim was communicated to the therapist by the client or by one of the client’s immediate family members and the therapist failed to warn the victim *regardless of other protective actions taken by the therapist*, such as alerting the police. The combined effect of these appellate decisions and the revised jury instructions was that, for a period of several years in California more than twenty-five years after *Tarasoff II*, failure to meet the duty to warn was presumptive proof of negligence.

In 2007, in response to the decisions in *Ewing* and *Ewing*, the state legislature was prompted to revisit the 1986 immunity statute. Although the legislature did insert language clarifying that

warning a potential victim was merely one of a set of actions by which the duty to protect could be satisfied, they elected to retain the phrase “duty to warn and protect” (Cal. Civ. Code § 43.92, 2007). In light of past confusions, it is perhaps unsurprising that this attempt at clarification proved insufficient: in 2013, the state legislature updated the statute yet again, this time removing the phrase “duty to warn” altogether (Cal. Civ. Code § 43.92, 2013). As part of the 2013 revision, and in order to forestall additional misinterpretation, the legislature felt moved to explicitly lay out their intent: “It is the intent of the Legislature that the amendments made by the act adding this subdivision only change the name of the duty referenced in this section from a duty to warn and protect to a duty to protect” (Cal. Civ. Code § 43.92(d), 2013).

Alongside these legislative actions, the California Judicial Council revised the civil jury instructions in 2007 and again in 2014 to clarify that therapists were not necessarily obligated to warn potential victims to discharge their duty to protect. The cumulative effect of these changes to the immunity statute and the jury instructions is that if a therapist chooses not to warn, but instead pursues an alternative course of action, their actions must be affirmatively proven to have been negligent for the therapist to be held personally liable. Still, there remains considerable room for interpretation by judges, juries, and clinicians in the current statute. As one example, what precisely constitutes a “serious threat” of physical violence as opposed to an unserious threat?

It is within this shifting and ambiguous landscape that the legacy of *Tarasoff v. Regents of the University of California* continues to be contested to this day. Alan Stone, the former president of the American Psychiatric Association who had lambasted *Tarasoff II* in 1976, conceded in 1984 that the duty to warn was “not as unmitigated a disaster for the enterprise of psychotherapy as it once seemed to critics like myself” (Stone, 1984, p. 181). Yet as recently as 2014, Donald Bersoff, himself a former president of the American Psychological Association, described *Tarasoff* as “perhaps the most notorious case in mental health law” (Bersoff, 2014, p. 461). In insisting that *Tarasoff* was “bad law, bad social science, and bad social policy,” Bersoff emphasized, as previous critics had, that the legal obligations imposed by *Tarasoff*, particularly obligations to warn third parties, might have the consequence of reducing the likelihood that patients would disclose violent urges and increasing the likelihood of desistance from therapy,

thereby “making it impossible to work through the threat of violence” (Bersoff, 2014, p. 461).

Douglas Mossman (2009) has offered a parallel critique of the *Tarasoff* doctrine as “a legal mechanism whereby society assigns mental health professionals the duty of reducing the risk of violence, with the threat of tort liability representing the professionals’ incentive to accede to the duty” and has argued that violence prevention through effective psychotherapy, as opposed to violence prediction, should be the focus of mental health professionals (p. 112). Whereas Givelber and colleagues (1984) found that clinicians were startlingly confident in their own ability to predict violence, there is ample empirical evidence that clinicians’ judgment in this domain is suspect (Large & Nielssen, 2017; Mossman, 2009). One aspect of Mossman’s (2009) critique of *Tarasoff* that is particularly striking, yet directly in line with the court’s reasoning in *Tarasoff* that therapists have a ‘duty to control,’ is that the duty to protect positions mental health professionals squarely as agents for social control, which may come into conflict with social justice values (see also Gurevitz, 1977).

What about the functional consequences of *Tarasoff*? To date, no empirical analyses have specifically addressed whether acutely homicidal clients who receive and remain engaged in therapy are, in fact, less likely to act on their homicidal intentions than similar clients who desist from therapy. It does appear to be the case, however, that psychosocial interventions for violence and aggression can be effective, which supports the broader notion that reducing barriers to adequate treatment receipt and keeping violent clients engaged in therapy are important therapeutic goals (McGuire, 2008; O’Brien & Daffern, 2015; Sher & Rice, 2015). This would seem, in turn, to substantiate Bersoff’s concerns about violent clients avoiding or desisting from therapy because of *Tarasoff*-related concerns. Unfortunately, there is minimal empirical evidence to assess whether *Tarasoff* has actually affected clients’ engagement in therapy in this way.

In a recent analysis, Edwards (2010) suggested that duty to warn laws may actually increase the rate of homicides, which Edwards attributes to mental health professionals being more reluctant to provide services to potentially violent clients as a result of duty to warn obligations and to clients being less willing to disclose after becoming aware of the limits to confidentiality.

This contention is not in line with Givelber and colleagues' (1984) finding that clinicians who viewed themselves as bound by the court's holding in *Tarasoff* did not report being less willing to treat dangerous patients or being more willing to terminate treatment. Moreover, clinicians who viewed themselves as legally bound by *Tarasoff* were considerably more likely to report having taken concrete steps, such as warning potential victims and notifying the police, when they deemed their clients to be at serious risk of harming another person than clinicians who viewed themselves as ethically, but not legally, obligated to protect potential victims, suggesting that *Tarasoff* was having its intended effect of binding clinicians to a duty to protect (Givelber et al., 1984).

Although the moral-ethical question of whether an increased willingness to warn is desirable is ultimately beyond the scope of this review, it is interesting to note that, in at least some cases, *Tarasoff* warnings may unintentionally be leading directly to the criminal prosecution of individuals with mental illness in California. Issuing violent threats is a criminal offense in California, and police may opt to pursue criminal charges if such threats are brought to their attention (Weiner, 2003). Violence risk assessments conducted by mental health professionals have also come to play an increasingly prominent role in multiple aspects of the workings of the criminal justice system since the *Tarasoff* decisions were handed down (Buchanan et al., 2012) (for more on the ethics of violence risk assessment as it relates to *Tarasoff*, refer to Mossman, 2006). Such cases highlight the delicate and occasionally perilous balance that clinicians are forced to strike between confidentiality and their obligations to their clients on the one hand and their duty to protect on the other, as well as the intersection between mental health professionals and law enforcement officers in applying *Tarasoff*.

In a similar vein, a survey of police desk sergeants conducted by Huber and colleagues (2000) in Michigan and South Carolina, both of which have duty to warn statutes, found that fewer than a quarter of the police stations in question had specific policies related to *Tarasoff* warnings and hardly any of the desk sergeants personally had knowledge about the *Tarasoff* case, although nearly half reported that their station had received at least one such warning from a mental health professional. Huber and colleagues also observed considerable variability in desk

sergeants' responses to hypothetical questions (e.g., if a warning was received, would the potential victim be notified?), suggesting that not only clinicians, but also law enforcement agencies ought to be formulating responses to and raising awareness about *Tarasoff* (Huber et al., 2000).

Forty-plus years after *Tarasoff I*, if there is one thing on which *Tarasoff's* proponents and critics agree, it is on the far-ranging impact that *Tarasoff* has had on mental health policy. To wit, Douglas Mossman (2006) declared that "no court ruling has had a broader or more enduring impact on day-to-day mental health practice.... Thirty years after its promulgation, *Tarasoff* remains, to mental health professionals, the most influential ruling in mental disability law" (pp. 524-526). As evidence of its far-reaching effects on mental health policy, one need only consider the fact that *Tarasoff* not only motivated corresponding legal action and legislation in states across the country, but also shaped thinking about other contexts in which health professionals may have a duty to protect third parties, such as the controversy surrounding whether physicians ought to warn the partners of HIV positive patients (for a detailed discussion, refer to Burke, 2015). Simultaneously, *Tarasoff* prompted numerous and vigorous discussions of the ethical obligations of mental health professionals and reflections on the importance of confidentiality as a central tenet of clinical work.

With respect to the actual practice and provision of mental healthcare in the state of California, *Tarasoff*, as most recently codified by California Civil Code § 43.92 (2013), has established that mental health professionals do have an affirmative obligation to take reasonable steps to protect third parties from a patient's violence behavior, at least in cases in which the patient "has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims" (Cal Civ Code § 43.92(a), 2013). Although this obligation need not necessarily entail warning the intended victim, therapists who fail to discharge their duty to protect may be held personally liable. On the other hand, if, in discharging their duty to protect, the therapist does elect to communicate the threat to the victim or to a law enforcement agency, they are shielded from liability that might otherwise result from the breach of confidentiality.

This is the status of the *Tarasoff* duty in California today; yet, given the number of alterations, both small and large, that have been made to the duty to protect in California over the last

forty-three years by the courts and the state legislature, it seems almost certain that mental health policy in this arena will continue to evolve over time, necessitating ongoing engagement by and education for mental health professionals practicing in the state of California, as well as consumers and law enforcement agencies.

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