CONFIDENTIALITY, INFORMED CONSENT AND THE DUTY TO WARN: ATTITUDES AND PRACTICES OF PSYCHOTHERAPISTS

by

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CHAPTER I

INTRODUCTION

Confidentiality between the therapist and his or her client is generally held to be an essential feature of successful psychotherapy. The issues of confidentiality of therapy sessions and the privacy of clients are among the most compelling issues currently being confronted by psychotherapists. These issues have been brought to public attention by the landmark decision of the Supreme Court of California in Tarasoff v. Regents of the University of California, a case which has sparked a considerable amount of commentary from both the legal and mental health professions.[1] The court there held that a psychotherapist has a duty to protect third parties from a threat of serious danger posed by a patient under his care. A controversy has arisen as to the effects of the decision on the practice of psychotherapy, with critics of Tarasoff contending that it is an ill-considered judicial intrusion into the therapeutic process that may make the treatment and cure of some dangerous patients more difficult and actually increase the threat of violence to

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[1] Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (hereinafter cited as Tarasoff II).

society.

In this chapter, the Tarasoff decision is presented, along with the rationale the court used in making its ruling. Reactions to the decision by both legal and mental health professionals are presented next, followed by a discussion of the dilemmas and ethical issues raised by the case. Subsequent court decisions in California and other jurisdictions, proposed alternatives to the Tarasoff duty to protect third parties, and implications and impact of the Tarasoff ruling will then be discussed. Finally, a study to determine the attitudes and practices of psychotherapists with regard to the duty to warn, confidentiality and informed consent is outlined.

Tarasoff Facts and Holdings

In August, 1969, Prosenjit Poddar started voluntary outpatient therapy at Cowell Memorial Hospital, the student health facility at the University of California at Berkeley. He had become depressed over his rejection by Tatiana Tarasoff, a woman he had been dating who was not interested in continuing the relationship with him.[2] Upon the suggestion of a friend, Poddar sought psychological

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[2] People v. Poddar, 518 P.2d 342, 111 Cal. Rptr. 910 (1974).

assistance. He informed his therapist, Dr. Moore, a clinical psychologist, that he was going to kill an unnamed girl, readily identifiable as Miss Tarasoff, when she returned home from spending the summer in Brazil. Dr. Moore, along with two staff psychiatrists, decided that Poddar was dangerous and should be committed for observation in a mental hospital. Dr. Moore then notified the campus police both orally and in writing that Poddar was dangerous and should be taken by the campus police to a facility authorized under California's civil commitment statute.[3] The police took Poddar into custody but they concluded that he was rational and not dangerous, and they released him after he promised to stay away from Tatiana. The psychiatrist in charge of the clinic, who had been absent during these events, returned and apparently decided that the staff had overreacted. In the name of confidentiality, he requested that the police return all correspondence about Poddar and ordered that it and all other records of the therapy be destroyed. He also ordered that no further action be taken to detain or commit Poddar. Poddar never returned to the clinic for additional therapy.

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[3] CAL. WELF. & INST. CODE SECTIONS 5000-5404.1 (West 1972 & Supp. 1976).

While Tatiana was out of the country, Poddar broke his promise to the police and established a relationship with her brother, who not having been warned, was unaware of the danger Poddar posed. On October 27, 1969, shortly after Tatiana's return from Brazil, Poddar went to her home and killed her.[4]

Tatiana's parents brought suit against the Regents of the University of California, the therapists involved, and the police. The trial court dismissed the complaint, holding that there was no legal basis in the law of the state of California for a claim against them.[5] After the dismissal was affirmed by the court of appeal, the parents appealed to the Supreme Court of California, arguing that the defendants had a duty to warn Tatiana or her family of the impending danger and failed to use reasonable care to bring about Poddar's confinement pursuant to California's involuntary commitment statute, the Lanterman-Petrie-Short

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[4] Poddar was convicted of voluntary manslaughter and confined to prison. His conviction of second degree murder was reversed for failure to give adequate instructions concerning a defense of diminished capacity. He was released from prison and returned to India, his native country. Stone, A. A. The Tarasoff decisions: suing psychotherapists to safeguard society. Harvard Law Review, 1976, 90, 358, n. 1-2.

[5] Tarasoff v. Regents of Univ. of Cal., 108 Cal. Rptr. 878 (Ct. App. 1973), vacated and remanded, 529 P.2d 553, 118 Cal. Rptr. 129 (1974).

Act.[6]

In its first decision on December 23, 1974,[7] the supreme court noted that governmental immunity protected a psychotherapist working for the state from liability for failure to commit a patient. The only basis for liability seemed to result from a duty the defendants had to warn a threatened person of danger. This duty was found to exist as a result of the special relationship between the psychotherapist and his patient, and also because the defendants "bungled attempt" to confine Poddar may have deterred him from seeking further therapy and aggravated the danger to Tatiana. Having contributed to and partially created the danger, defendants incurred the ensuing obligation to give warning.[8] Even though at common law there was generally no duty to control the conduct of another or to warn a third person of another's dangerousness, exceptions were found if there was a special relationship between the defendant and either the person whose conduct needed to be controlled or the foreseeable victim, and if a defendant

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[6] CAL. WELF. & INST. CODE SECTIONS 5000-5404.1 (West 1972 & Supp. 1976).

[7] Tarasoff v. Regents of Univ. of Cal., 529 P.2d 553, 118 Cal. Rptr. 129 (1974) (hereinafter cited as Tarasoff I).

[8] 529 P.2d at 555, 557, 118 Cal. Rptr. at 131, 133.

had undertaken some affirmative action to protect the intended victim.[9] Prior California decisions had been limited to situations in which the defendant stood in a special relationship with both the victim and the person whose conduct created the danger, such as a hospital which must exercise reasonable care to control the behavior of a patient who may endanger other patients. The Tarasoff court found no reason to constrict a duty to warn to situations where there was a special relationship with the victim, and used the medical analogy of a physician's liability to third persons for negligently failing to diagnose contagious diseases.[10] A psychotherapist treating a mentally ill patient bears a duty to use reasonable care to give threatened persons such warnings as are essential to avert foreseeable danger arising from his or her patient's condition or treatment.[11] The court reversed the judgment of the lower court and found that the special relationship of the therapists to the patient had given them a duty to warn Tatiana, and also held that the police might be liable for a failure to warn because their conduct increased the risk of violence. Although the court

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[9] 529 P.2d at 557, 118 Cal. Rptr. at 133.

[10] 529 P.2d at 559, 118 Cal. Rptr. at 135.

[11] Id.

recognized the positive value of confidentiality in psychotherapy, it felt that its breach in the manner prescribed in Tarasoff would be rare and would not constitute a serious threat to confidentiality or psychotherapy.

The defendants petitioned for a rehearing and were granted one on May 5, 1975. In November, 1976, the court reaffirmed its initial opinion but with several modifications. It abandoned its position on the liability of the police and stated that the police did not have a special relationship with either Poddar or the victim sufficient to give rise to a duty to warn. With regard to the duty of the therapist, it formulated this duty more broadly and held that the standards of the profession are to be utilized to determine whether a psychotherapist using "reasonable care" would have foreseen that the patient presented a serious danger of violence to another. If so, the psychotherapist incurs a duty to protect the threatened victim. Since the defendants had made the determination that Poddar was dangerous, the question of foreseeability was not an issue. With regard to the discharge of this duty, the traditional negligence standard was to be utilized to determine whether the psychotherapist used reasonable care to protect the threatened victim. Psychotherapists have alternative means of discharging

this duty of reasonable care, including warning the victim or the police, securing voluntary or involuntary commitment, or taking "whatever other steps are reasonably necessary under the circumstances."[12] Realizing the difficulty of predicting violence, the court did not require a perfect performance but only the exercise of that "reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by {psychotherapists} under similar circumstances."[13] In the circumstances of the case, the court held that the plaintiffs might allege that the duty to protect took the form of a duty to warn. These duties were all predicated on the special relationship of therapist to patient, similiar to the doctor-patient relationship which under law may support affirmative duties for the benefit of third parties.[14]

The court acknowledged that the open and confidential nature of psychotherapy encourages patients to express threats of violence, few of which are ever executed. A therapist should not be encouraged to routinely reveal such threats, as this would have a deleterious effect on the therapist-client relationship. The therapist's

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[12] Tarasoff II, 551 P.2d 349, 131 Cal. Rptr. 29.

[13] Id. at 345, 131 Cal. Rptr. at 25.

[14] Id. at 343, 131 Cal. Rptr. at 23-24.

obligations to clients require that no confidences be disclosed unless such a disclosure is necessary to avert danger to self or others; in such an instance, the disclosure should be made discretely to preserve the privacy of the client to the fullest extent compatible with the prevention of the threatened danger. The public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. "The protective privilege ends where the public peril begins."[15]

Justice Mosk of the court concurred with the majority opinion but limited his agreement to the facts of the specific case. He concurred with the result only because the defendants did in fact predict that Poddar was dangerous, and believed that the issue should thus be decided narrowly. He dissented from the majority's broad duty of care to third parties because of a lack of standards for predicting a patient's tendency towards violence. He noted that the California Supreme Court in People v. Burnick found psychiatric predictions of violence to be inherently unreliable:

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[15] Id. at 347, 131 Cal. Rptr. at 27.

> It must be conceded that psychiatrists still experience considerable difficulty in confidently and accurately diagnosing mental illness. Yet these difficulties are multiplied manyfold when psychiatrists venture from diagnosis to prognosis and undertake to predict the consequences of such illness.[16]

The majority opinion distinguished Tarasoff from Burnick in that Burnick involved proceedings to commit an alleged mentally disordered sex offender and this case did not. Mosk disagreed with the validity of that distinction and believed that psychiatric testimony was inherently untrustworthy. He urged restructuring of the rule designed by the majority to eliminate all reference to conformity to standards of the profession in predicting violence and would impose liability only in cases in which a therapist does in fact predict violence.[17]

Reactions to and Criticisms of the Ruling

Shortly after the Tarasoff ruling was announced, articles analyzing the case began to appear in professional journals. Criticism of the case centered around three major areas: the duty to warn, the deleterious effect that such a duty would have on the confidentiality of the

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[16] People v. Burnick, 551 P.2d 352, 365, 121 Cal. Rptr. 488, 501 (1975)

[17] Id. at 353-54, 131 Cal. Rptr. at 33.34.

therapist-client relationship, and the inability of mental health professionals to predict dangerousness.

The Duty to Warn

One area of contention with the Tarasoff decision is that it created and imposed a duty on the psychotherapist to warn others of the threats made by a dangerous patient. The court concluded that the psychotherapist-patient relationship satisfied the requirements of a "special relationship" which overruled the common law rule that generally there is no duty to control the conduct of another or to warn those endangered. In reaching this conclusion, the court was strongly influenced by an article by Fleming and Maximov (1974) which was published while the case was on appeal to the supreme court. Their analysis of tort law[18] focused on cases in which the defendant had control over someone who was dangerous as a result of a social or mental maladjustment, and they relied in particular on cases in which hospitals have been held liable for suicides or violence against others resulting from negligent control of suicidal or homicidal patients. They admitted that the distinguishing factor in cases in which liability

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[18] Law dealing with wrongful acts or damage not involving a breach of contract for which a civil action can be brought.

has been found is that the defendant had a right to control in addition to de facto control over the conduct of another, but suggested that such a right should not be necessary for the imposition of a duty to protect third parties. They argued that the duty need not be restricted to situations where the defendant stands in a special relationship both to the victim and to the person whose conduct created the danger, since other jurisdictions have held that the relationship of a physician to his or her patient is sufficient to support the duty to exercise reasonable care to protect others against dangers emanating from the patient's illness. Fleming and Maximov concluded that there is sufficient authority from case law[19] to support the notion that by entering into a professional doctor-patient relationship, the therapist becomes sufficiently involved to assume some responsibility for the safety, not only of the patient, but also of any third person whom the doctor knows to be threatened by the patient.

Stone (1976) has criticized this conclusion on the grounds that it ignores the fact that the therapist seeing an outpatient in a clinic or office has no control over

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[19] Law derived from prior judicial decisions; as opposed to statutory law.

the client. Once the suggestion of control is eliminated, there is nothing in the nature of the relationship between a psychotherapist and his or her client to support an exception to the tort law presumption of no duty to control the conduct of a third person so as to prevent him or her from causing harm to another. Griffith and Griffith (1978) extended this analysis further and found it difficult to concede the imposition of this duty to control the conduct of another person if those upon whom the duty falls do not have it within their power to effect that control either legally or physically. The relationship between the psychotherapist and client cannot be equated with the relationship between a hospital and its patients. The admission to outpatient therapy should not impose upon the psychotherapist the same duty to control that arises whenever a patient is admitted to a hospital for treatment. The psychotherapist has no effective means of controlling clients except to the extent that the aid of other agencies may be solicited. The admission of a patient to a hospital assumes that the institution is able to exercise the restraint necessary to protect the patient and others around him or her from violence. People are not committed to the control of the psychotherapist in the same way that they commit themselves to the care of a

hospital. In an outpatient context, the client has not ceded any rights by virtue of either a voluntary or involuntary commitment process. The psychotherapist's function is clearly not to control; that right resides in other agencies. Without the right or ability to control, psychotherapists should have no duty to warn.

Effect on Confidentiality

The imposition of a duty on the psychotherapist to protect third parties raises the issue of breaching the confidential therapist-client relationship. Confidentiality is a professional ethic that protects the client from unauthorized disclosure of information about the client by the therapist without the client's permission or informed consent (Shaw, 1969). Positions on confidentiality range from a belief that confidentiality should be absolute (Siegel, 1979) to the thought that confidentiality may be breached under certain unusual circumstances (Jagim, Wittman, & Noll, 1978). In addition to being a professional ethic, confidentiality as a standard of conduct has been given legal status by case law, statutes and licensing regulations, and a practitioner can be civilly liable for breach of confidentiality (Swoboda, Elwork, Sales, & Levine, 1978).

Confidentiality is to be distinguished from privilege, which is a legal right imposed by statute to protect the client during legal proceedings from public disclosure of confidences without the client's permission. When the client claims the privilege, the therapist may not reveal information disclosed in therapy. If the client waives the privilege, the therapist may be required to testify in court and may be held in contempt of court for refusing to do so. The privilege to refuse to disclose communications or to waive the right is granted only to the client and is not held by the therapist (Shaw, 1969; Swoboda et al., 1978). In some jurisdictions, the right to privilege is waived in situations in which there is imminent danger to a person or to society (as in the case of child abuse), where the psychologist is appointed by the court to conduct a psychological examination, and where the client offers his or her mental condition as a claim or defense in a legal proceeding (Dekraii & Sales, 1982).

A hallmark of psychotherapy is the establishment of a relationship of trust between therapist and client (Everstine et al. 1980). Confidentiality in psychotherapy fosters several interests which promote effective treatment of clients (Poltz, 1976). Most importantly,

confidentiality protects the client's privacy interests. Clients may often reveal thoughts, fantasies and attitudes which are at variance with those of their daily life. Public disclosure of these communications could destroy the client's reputation or cause embarrassment and disgrace. If the possibility of public disclosure is likely, a client will not speak freely with a psychotherapist. Woods and McNamara (1980) found that college students receiving the promise of confidentiality were more open in their disclosures than individuals who were told that their disclosures would not be confidential. Meyers and Willage (1980) found that subjects who were instructed that their disclosures would not be confidential reported the most socially desirable responses and the fewest psychopathological symptoms. In addition to providing the assurance of protected disclosures, confidentiality also fosters the public interest of encouraging people who need treatment to seek therapy. People are much more likely to seek treatment with the assurance that there will be no publicity of the fact that they are being seen by a psychotherapist (Siegel, 1979). Research is needed in this area using actual therapy clients to determine their needs and expectations regarding confidentiality, and research is also needed to determine how therapists

actually perceive clients' needs for confidentiality. This latter research need was addressed by this study.

The duty to protect the public from dangerous clients may conflict with the maintenance of confidentiality. The action of a therapist in either seeking emergency hospitalization for an imminently dangerous patient or in warning third parties of that person's dangerousness discloses the fact that the person is in therapy as well as the content of the client's communications during therapy. Nevertheless, the consequent damage to confidentiality must be balanced against the potential societal benefit (Poltz, 1976).

Given their conclusion that tort law precedent supports an exception in the case of the therapist-client relationship to the general rule of no duty to control the conduct of another or warn those endangered, Fleming and Maximov (1974) argue that whether a duty to protect is to be imposed should depend on a policy analysis which balances the values of confidentiality and public safety. Since the California Evidence Code creates an exception to the psychotherapist-patient privilege

> (There is no privilege ...if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the

threatened danger),[20]

they suggest that the California legislature has struck the balance in favor of public safety.

A legislative decision that public safety requires that the therapist-client testimonial privilege allow for a dangerous patient exception, however, is quite different from a decision to impose a duty to reveal confidences to third parties outside the context of a hearing (Stone, 1976). The imposition of the duty to protect, which may take the form of a duty to warn threatened third parties, "will imperil the therapeutic alliance and destroy the patient's expectation of confidentiality, thereby thwarting effective treatment and ultimately reducing public safety" (Stone, 1976, p. 368). The type of dangerous person who voluntarily comes to therapy is typically not a hardened criminal but rather one whose violence is the product of passion or paranoia. The direction therapy must take is to acknowledge feelings while at the same time discouraging the impulses to act them out.

> Given the special significance of the potential victim to those whose violence is the product of passion and paranoia, nothing could be more destructive of the tenuous therapeutic alliance than the patient's perception that there exists a significant relationship between the therapist and the potential victim. Nothing is more

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[20] CAL. EVID. CODE SECTION 1024 (WEST, 1966).

> likely to give a patient the impression that such a significant relationship exists than being told by the therapist that he has a legal duty to protect, and perhaps warn directly, the potential victim. (Stone, 1976, p. 368)

If cautioned at the start of therapy that the therapist may be required to share certain revelations with others, the client may conceal any violent feelings and fantasies (regardless of whether or not they had any real intention to harm a third party). If the client does not disclose violent feelings or fantasies, the therapist can do little to reduce the client's potential for danger. At the time the court decided Tarasoff, it had no empirical evidence upon which to draw in evaluating these contentions (Wise, 1978). Research is still needed on clients in actual (non-analogue) therapy situations to determine if telling clients the limits of confidentiality at the start of therapy has a chilling effect on disclosure in therapy.

Predictions of Dangerousness

The determination that a person is "dangerous" can have drastic consequences on him or her, and can result in an indeterminate and lengthy involuntary confinement in a civil mental hospital (Brooks, 1978). Despite the significant individual deprivations that flow from a finding of dangerousness, the laws that authorize

involuntary commitments are circular and vague in their definitions of mental illness and dangerousness. Judicial definitions of dangerousness and violence have been similarly vague, and very loose and elastic interpretations have been quite typical (Shah, 1978; Dershowitz, 1968). The actual determinations of dangerousness are usually made by mental health "experts" as a function of judicial default, with each expert providing his or her own personal and subjective definition. Therapists who offer opinions on dangerousness are acting more as agents of social control than as mental health professionals, and many authorities suggest that therapists should refuse to give conclusive opinions on dangerousness (Mental Health and Human Rights: Report of the Task Panel on Legal and Ethical Issues, 1978 (hereinafter cited as Mental Health Task Report); Diamond, 1974; Hammond, 1980; Burns & Levien, 1980; Steadman, 1980).

Several authors have reviewed the literature on the reliability and validity of psychiatric judgments regarding the determination and prediction of dangerousness and have reached similar conclusions. Ennis and Litwack (1974) summarized their findings in concluding that:

> There is no evidence warranting the assumption that psychiatrists can accurately determine who is "dangerous"; there is little or no evidence that psychiatrists are more "expert" in making

> the predictions relevant to civil commitment than laymen; "expert" judgments made by psychiatrists are not sufficiently reliable and valid to justify nonjudicial hospitalization based on such judgments; and the constitutional rights of individuals are seriously prejudiced by the admissibility of psychiatric terminology, diagnoses, and predictions, especially those of "dangerous" behavior. (p. 696, footnote deleted)

Many reasons have been offered to explain the inability of mental health professionals to predict dangerousness. Rarely have courts or mental health statutes attempted to specify more adequately exactly what is being predicted other than the likelihood that an individual will display dangerous behavior in the future (Cocozza & Steadman, 1976). The prediction of dangerousness entails a complex decision-making process which includes the determination of the object, magnitude, probability, and imminence of the predicted danger. Judicial attempts at further defining these terms have been unsuccessful and may well be impossible (Brooks, 1978). Second, predictions of serious assaultive acts which have a low base rate of occurrence will include a large number of "false positives." The great majority of the persons predicted as likely to engage in future violent behavior will not display such behavior (Shah, 1978). Livermore, Malmquist, and Meehl (1968) give a hypothetical situation that illustrates this problem:

> Assume that one person out of a thousand will kill. Assume also that an exceptionally accurate test is created which differentiates with ninety-five per cent effectiveness those who will kill from those who will not. If 100,000 people were tested, out of the 1000 who would kill 95 would be isolated. Unfortunately, out of the 99,900 who would not kill, 4,995 people would also be isolated as potential killers. In these circumstances, it is clear that we could not justify incarcerating all 5,090 people. If, in the criminal law, it is better that ten guilty men go free than that one innocent man suffer, how can we say in the civil commitment area that it is better that fifty-four harmless people be incarcerated lest one dangerous man be free? (p. 84)

Third, clinicians are poorly trained for the predictive task. There is no consistent and structured framework for this evaluative process, and mental health professionals appear to be unlikely in their professional training to have any structured exposure to the sparse literature and framework that does exist (Dix, 1980). This study addressed this issue by inquiring as to the number of therapists who have had training in recognizing or predicting dangerousness.

Despite the commonly assumed predictive factors of future violence (such as childhood history of maternal deprivation, poor father identification, nocturnal enuresis, pyromania, cruelty to animals, brutalization by one or both parents; Goldstein, 1974), no report in the literature is supported by valid clinical experience and

statistical evidence that describe psychological or physical signs or symptoms which can be used reliably to discriminate between the potentially dangerous and the harmless individual (Diamond, 1974). In fact,

> Thus far no structured or projective test scale has been derived which, when used alone, will predict violence in the individual case in a satisfactory manner. Indeed, none has been developed which will adequately postdict, let alone predict, violent behavior. (emphasis in original, Megargee, 1970, p. 145)

Other reasons have been suggested to explain the inability to predict dangerousness. A mistake in finding a person nonassaultive is likely to have a greater adverse result than an error in finding a person assaultive. This fact creates a predisposition for mental health professionals to overpredict dangerousness by making false positive judgments. Also, clinicians probably rely upon factors that are not related to subsequent violent conduct such as the time and place of diagnosis, the clinician's personal bias, social pressures, and the class and cultures of the respective parties. Finally, clinicians receive little feedback on the accuracy of their predictions (Dix, 1980; Ennis & Litwack, 1974; Brooks, 1978).

If there is a question in the therapist's mind about the dangerousness of a client, then giving a warning to intended victims is seen as a far lesser inroad upon the

client's privacy than involuntary commitment.[21] The result of giving warnings to victims, however, would be to lower the threshold of dangerousness that would evoke actions from therapists, thereby compromising the client's confidentiality and possibly treatment. In addition, this would create two different standards of dangerousness, with a rigorous standard for commitment and a lower standard for issuing warnings to intended victims. This would further confuse psychotherapists as to their responsibility, given the growing opinion that they ought to be more modest about their predictive capacity (Roth & Meisel, 1977).

Assuming that clinicians could predict dangerousness perfectly, there are many legal and ethical issues associated with breaching confidentiality and/or confining individuals based upon a strong likelihood that they may engage in dangerous behavior in the future, especially when there is no evidence of prior violent acts. For this reason, it has been suggested that confidentiality should not be breached nor a person be subject to involuntary commitment unless there exists at least clear and convincing evidence that a future dangerous act is likely to occur if

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[21] Tarasoff II, 551 P.2d at 361, 131 Cal. Rptr. at 41 (Clark, J., dissenting).

no action is taken (Olsen, 1977, Lane & Spruill, 1980). Even this determining standard may be impossible to meet if, as Cocozza and Steadman (1976) suggest, clinicians cannot even predict accurately enough to be more often right than they are wrong.

The Tarasoff decision has placed mental health professionals in a dilemma in that they are now asked to respond to a request to predict dangerousness, an area in which they have not demonstrated expertise. If clinicians claim an inability to predict dangerousness in order to avoid liability for failing to warn potential victims of the dangerousness of their clients, then this inability to predict would seemingly disqualify them from the authority to incarcerate people, a right psychiatrists claimed in the past based on their ability to predict dangerousness (Hammond, 1980; Dershowitz, 1968; Ayres & Holbrook, 1974) and a right psychologists are now seeking in several states.[22]

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[22] For example, the Texas Psychological Association is presently lobbying for the passage of H.B. 212 relating to the inclusion of psychologists in civil commitment proceedings (Horwitz, 1983).

Dilemmas and Ethical Issues Raised by Tarasoff

Despite the court's opinion that its decision will have a minimum impact on the practice of psychotherapy, a number of practitioners feel that the Tarasoff ruling puts them in a no-win situation. Whatever action they take may subject them to civil liability, and the net result of having to confront these issues may lead them to abandon working with individuals with propensities towards violence. This section of this chapter examines several major concerns that people have raised about the Tarasoff decision and the implications the case has for the practice of psychotherapy.

Impact on the Client

If people who have problems with violent tendencies are informed at the start of therapy that confidentiality can be easily compromised, they simply may not enter therapy, or if they do, they simply may not talk about these tendencies in the therapeutic relationship. This may considerably diminish the value of psychotherapy for these individuals, and if these tendencies are left untreated, the public is provided with little protection from their actions (Halleck, 1980, p. 78-79). Even if the clients do

make some disclosures to the therapist, it seems unlikely that they will be able to relate to the therapist with the full degree of trust necessary for effective psychotherapy (Stone, 1976). Clients may be discouraged from communicating information and feelings to therapists out of fear of disclosure, and may leave therapy when they discover the possibility or the fact of a breach of confidentiality (Slovenko, 1975). Had Poddar remained in therapy, it is possible that his therapist may have been able to work with him and prevent the murder of Tatiana Tarasoff. By being informed that confidentiality may be breached depending on the nature of disclosures made in therapy, the client may wonder to whom the therapist owes an allegiance. This potential disturbance in the relationship between the therapist and client may make it more difficult for the therapist to reduce the client's potential for danger (Halleck, 1980; Olsen, 1977; Stone, 1976).

Impact on the Potential Victim

Halleck (1980) received a warning from a colleague that one of his patients was planning to kill him. He debated what he could do about the threat such as leave town or carry a gun with him, and finally decided to call the police who talked to the patient and told him to stay

away from Halleck. Halleck admitted that during the ensuing few months, the warning caused him to be "overly anxious, hyperalert, and much more aggressive" than he usually was. He also stated that the emotional trauma he experienced by being warned "was in no way worth the very doubtful benefits" he accrued by having been warned (p. 81-82). To receive such a warning from a therapist or the police may persuade potential victims that the danger is imminent and that steps must be taken to secure themselves from the aggressor's onslaught. From the time the danger is communicated, the potential victim may shudder every moment in anticipation of a lurking attacker. The predicted event may never occur, but the person may always fear an attack (Griffith & Griffith, 1978). On the other hand, the warning Halleck received in this instance and the action he took in calling the police may have saved his life. Certainly some people would prefer to receive a warning and live with the potential trauma and anxiety of that warning than risk possible death from an unknown or unexpected source.

Legal Consequences of Warning

A therapist may be subject to liability for not warning if a threat of harm does materialize; giving a warn-

ing, however, may also subject the therapist to a risk of liability resulting from releasing information about his or her client in an unauthorized manner. The client may sue for breach of confidentiality, invasion of privacy or for defamation if, considering all of the circumstances, the therapist did not act reasonably in issuing the warning. What is reasonable in a given situation, though, has not been determined with scientific precision, and when it is determined by a jury it is after the fact. The psychotherapist's decision may appear questionable in retrospect no matter what action is taken, given the vagueness of the standards determining when the therapist must warn, the unpredictability of violence, and the vagueness of the meaning of the term "dangerousness" (Roth & Meisel, 1977). If the therapist, in order to be protected from civil liability, chooses to overpredict dangerousness and warn others, then the duty to warn may not only impair treatment of many who would never become violent but may result in a net increase in violence from those who engage in violent conduct as a result of unsuccessful treatment. In other words, the therapist's disclosures to other parties may prompt the client to carry out threats made.[23]

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[23] Tarasoff II, 551 P.2d at 361, 131 Cal. Rptr. at 41 (Clark, J., dissenting).

The therapist may face liability from improperly warning and may also face liability if warning invites violence by the intended victim against the potential aggressor (see Knapp & Vandecreek, 1982). There may also be grounds for attaching liability against the therapist for the consequences of an unnerving disclosure if instead of promoting caution by the third party, the warning engenders disquietude and anxiety. If the predicted event does not occur, the intended victim may suffer some emotional harm by the disclosure of information about an impending threat of danger (Halleck, 1980).

The dilemma of therapists charged with a duty to protect the victim is that they cannot be educated as to the standard of conduct to be observed because such a standard is nonexistent (Griffith & Griffith, 1978). Additionally, the "duty to exercise reasonable care to protect the foreseeable victim"[24] may cover a rather broad spectrum of alternatives. The court in Tarasoff did not delineate the contours of that duty, other than to imply that the method of discharging the duty to protect will vary according to the case.[25] Whatever "reasonable care" may entail, it may include more than a simple duty to warn (Griffith &

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[24] Tarasoff II, 551 P.2d 343, 131 Cal. Rptr. 23.

[25] Id. at 345, 131 Cal. Rptr. at 25.

Griffith, 1978). In addition to making a prediction of dangerousness, therapists must also decide what is reasonable conduct.

The doctrine of informed consent imposes another source of liability on the therapist. A trend in modern tort law has been the increasing imposition of liability upon professionals for the acts and omissions which occur in the performance of their professional services. Courts have often held that professionals are required to disclose fully to one who engages their services the probable consequences of the course of action they plan to pursue (Williams, 1977). Clients entering therapy may face some risk owing to lack of knowledge concerning some inherent consequences of that decision (Everstine et al., 1980). For example, violation of privacy, liberty and due process interests occur when clients enter therapy unaware that confidentiality is limited and assume that the psychotherapeutic relationship will afford them adequate protection. Informed consent becomes central to safeguarding clients' interests (Fleming & Maximov, 1974). A duty to warn, then, imposes on the therapist an obligation to advise clients of the duty and the limits of confidentiality before beginning treatment.

Informed consent and the duty to disclose risks are not absolute, but are tempered by the materiality rule, which states that physicians need not disclose risks that are likely to be known to the average patient or are in fact known to the particular patient as a result of past experience. "That therapists may be under a duty to make known to both the intended victim and police authorities threats to third persons made by their clients would clearly seem to be a material piece of information requiring disclosure to prospective clients" (Bersoff, 1976, p. 269). To fail to disclose the limits of confidentiality in the face of a concomitant duty to disclose threats may be to entrap the client. In addition to the legal obligation to disclose limits, therapists have an ethical obligation to do so, despite any harmful effects this may have on the course of therapy (Griffith & Griffith, 1978; Mental Health Task Report, 1978; Bersoff, 1976; Hare-Mustin, Marecek, Kaplan, & Liss-Levinson, 1979). Still, many therapists choose not to inform their clients on the limits of confidentiality at the start of therapy, and most therapists appear to discuss the limits of confidentiality with their clients only if the issue arises during the course of treatment, rather than raise the issue on their own (Wise, 1978).

The Double Agent Conflict

The largest ethical issue raised by the Tarasoff duty to protect is the question of who is the client: is the therapist's main responsibility to the client in a social service role, or is it to society and its protection by serving as an agent of social control (Lane & Spruill, 1980; Bersoff, 1976)? Fleming and Maximov (1974) note that the role of the psychotherapist at times blends with the role of police officer when therapists are expected to be watchful for indicators of developing danger. In cases of civil commitment, "the psychiatrist in many instances may serve not only as arresting officer, but also as prosecutor, judge, and jailer as well."[26] A trend has been developing towards more legislation that requires the reporting by therapists of an ever widening array of suspected crimes against the person, such as child abuse, child molestation and incest. The net effect of these laws is that "psychotherapists are being called upon to serve as gatekeepers of the criminal justice system,"

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26 E.g., CAL. WELF. & INST. CODE SECTIONS 5151-52 (West 1972) (person brought to facility for purpose of 72-hour emergency detention may be admitted, detained, or released in accordance with judgment of professional staff); SECTION 5250 (West 1972) (14-day involuntary intensive treatment following 72-hour emergency detention based on evaluation and decision of facility's professional staff) (p. 1046, footnote included).

raising the question of "when does the healer become the informer?" (Everstine et. al., 1980, p. 839). The more legislation of this type that is imposed, the more therapists' efforts to strengthen confidentiality are impaired. There are no easy answers to the ethical and legal issues raised by Tarasoff: therapists must weigh and balance what they feel are their respective duties to their clients and to the general public.

Subsequent Decisions after Tarasoff

Tarasoff has binding precedential value in California only, but slowly its rationale is being adopted in other jurisdictions. In McIntosh v. Milano, plaintiffs brought a wrongful death action against a psychiatrist because one of his patients murdered their daughter.[27] Dr. Milano had been treating Lee Morgenstein in therapy for over two years, during which time Morgenstein related fantasies of using a knife to threaten people who might intimidate him or frighten him, but allegedly never indicated or exhibited any feelings of violence towards the deceased, Kimberly McIntosh, who had been Morgenstein's next door neighbor. Morgenstein had related certain alleged sexual experiences

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[27] McIntosh v. Milano, 168 N. J. Super. 466, 403 A.2d 500 (Sup.Ct. New Jersey, June 12, 1979).

and emotional involvements with McIntosh, and Dr. Milano did advise Morgenstein to break off this relationship, even though Morgenstein had never threatened to kill or harm her. Following an incident in which Morgenstein stole a prescription form from Milano's desk, Morgenstein left the pharmacy where he had been unsuccessful in having the unauthorized prescription filled, obtained a pistol which he kept hidden at his home, and persuaded Kimberly to go with him to a local park area where he fatally shot her in the back. Plaintiffs brought suit asserting that the defendant had a duty to warn Kimberly McIntosh, themselves or appropriate authorities that Morgenstein posed a physical threat or danger to their daughter and that the defendant breached that duty. Milano's attorney argued that no duty to warn existed in New Jersey, and that the court should not create one or allow one to be asserted by plaintiff by adopting the Tarasoff rule or one comparable thereto. In denying the defendant's motion for summary judgment,[28] the court held that

> a psychiatrist or therapist may have a duty to take whatever steps are reasonably necessary to protect an intended or potential victim of his patient when he determines, or should determine,

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[28] A civil procedure permitting parties to a civil action to move for a judgment on a claim when they believe that there is no genuine issue of material fact and that they are entitled to prevail as a matter of law.

> in the appropriate factual setting and in accordance with the standards of his profession established at trial, that the patient is or may present a probability of danger to that person. The relationship giving rise to that duty may be found either in that existing between the therapist and the patient, as was alluded to in Tarasoff II, or in the more broadly based obligation a practitioner may have to protect the welfare of the community, which is analogous to the obligation a physician has to warn third persons of infectious or contagious disease.[29]

The court ruled that the jury was to decide whether or not Milano knew or should have known that Morgenstein presented a clear danger or threat to the decedent, along with the question of whether there was a duty which had been recognized by Milano, who had indicated that he would inquire when he felt a patient was endangering himself or others and might as a result contact appropriate persons. Tarasoff based the duty to warn on the special relationship between therapist and client; McIntosh accepted that basis for duty and extended it to include the obligation the therapist has to protect the welfare of the community. McIntosh also goes beyond Tarasoff in that the question of foreseeability is to be subject to a judicial ruling to determine the professional standards for predicting dangerousness. It is possible that this case may generate as much controversy as Tarasoff has, if not more, due to the

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[29] Id. at 403 A.2d 511-512 (footnote omitted).

new issues being addressed. Even though the initial decision in this case was handed down in 1979, no judicial update has been published as of this date.

In Lipari v. Sears, Roebuck & Co., a Nebraska federal court concluded that a Veterans Administration Hospital may have a duty to third persons which may go beyond warning them, and that this duty would not preclude attempts to detain a patient.[30] A patient participating in a psychiatric day-care program at a Veterans Administration Hospital (VA) purchased a shotgun from Sears and two months later entered an Omaha night club and fired a shotgun into a crowded dining room, killing one man and seriously injuring his wife. His wife brought suit against the VA, alleging that it failed to give proper care and treatment to the psychiatric patient who shot her and her husband. The Nebraska supreme court had never addressed the issue of what Nebraska law would be concerning a therapist's duty to warn third persons, but the federal court found the reasoning in Tarasoff and McIntosh to be persuasive and likely to be the opinion of the Nebraska state high court. The court refused to rule as a matter of law that a reasonable therapist would never be required to

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30 Lipari v. Sears, Roebuck & Co., 497 F.Supp. 185 (D. Neb. July 17, 1980).

take precautions other than warnings, or that there was never a duty to attempt to detain a patient. The therapist must initiate whatever precautions are reasonably necessary to protect potential victims of his or her patient. The VA argued that psychotherapists only owe a duty to those persons who can be readily identified as potential victims of their patients. The court did not limit this duty to identifiable victims but extended it to all individuals to whom the VA employees could have reasonably foreseen an unreasonable risk of harm. The supreme court of California in Thompson v. County of Alameda limited the scope of the Tarasoff duty to readily identifiable victims, and held that there would be little practical value in giving out general warnings of nonspecific threats (in regard to the parole of a juvenile who murdered a neighborhood child after his release).[31]

Other jurisdictions have also recognized the Tarasoff duty. In Mangeris v. Gordon, plaintiffs brought suit against the defendants, who knew that an individual (Danny Brimmage) on their premises had committed violent criminal acts and was a fugitive from the law.[32] Plaintiff's

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[31] Thompson v. County of Alameda, 614 P.2d 728 (Cal. Sup. Ct. 1980).

[32] Mangeris v. Gordon, 580 P.2d 481 (N.Sup.Ct. 1978).

deceased husband (John Mangeris) was a taxi driver and had driven Brimmage to the premises and later returned to take him to another location. On this second trip, Brimmage murdered Mangeris. Mangeris's wife sued defendants, alleging a duty to warn either her husband or the police of the dangerousness of Brimmage. Applying the Tarasoff principles, the Nevada supreme court found from the facts alleged no foreseeability of risk that Brimmage would murder Mangeris at a future time and place. Absent the foreseeability of such a risk, defendants had no duty to warn Mangeris of Brimmage's criminal conduct.

In Shaw v. Glickman, the Maryland court of special appeals found no duty to warn on the part of private practitioners, because the client had not made any violent threats.[33] The plaintiff in this case, Dr. Shaw, was a patient in the same psychotherapy group as a Mr. and Mrs. Billian. Dr. Shaw and Mrs. Billian became romantically involved, and early one morning Mr. Billian broke into Dr. Shaw's apartment and found his wife and Dr. Shaw asleep in the same bed. Mr. Billian shot 5 times at Dr. Shaw but did not kill him. Dr. Shaw brought suit against the psychiatric team for negligence in failing to warn him of

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[33] Shaw v. Glickman, 415 A.2d 625 (Md. Ct. Spec. App. 1980).

Billian's unstable and violent condition and the foreseeable and immediate danger that it posed to Shaw. The court distinguished this case from Tarasoff by the fact that Billian never disclosed any feeling of animosity towards Shaw to the doctor or to his staff. Had such an intention been disclosed, the psychiatrist would have faced the dilemma of either breaching Billian's confidence and warning Shaw, or keeping Billian's confidence and exposing Shaw to a potentially dangerous situation. The court concluded that under the state's statutory psychotherapist-patient privilege law, it would have been a violation of the statute for any therapist involved to disclose to the victim any propensity of danger on the part of the client.[34] While recognizing the Tarasoff duty, the Maryland court chose not to apply it in this case.

Mavroudis v. Superior Court for San Mateo raised the issue of how a plaintiff in a Tarasoff action can obtain discovery of psychiatric records of defendant's patient without that patient's consent.[35] Generally, California psychotherapist-patient privilege law[36] prevents such dis-

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[34] Id. at 631.

[35] Mavroudis v. Superior Court for San Mateo, 162 Cal. Rptr. 724 (Cal. Ct. App. 1980).

[36] CAL. EVID. CODE SECTION 1014 (West 1972 & Supp. 1976).

closure, but there is no privilege if the psychotherapist has reasonable cause to believe that the patient is dangerous to others.[37] In this case, the patient, who was being treated by a hospital, attacked his parents with a hammer causing them multiple physical injuries. The parents brought suit to compel the production of their son's psychiatric records, and alleged that the defendants knew or should have known that their son posed a serious threat of danger to them and that they failed to warn them of that threat.

The court held that the respondent superior court should determine if state law authorized discovery of the son's psychiatric records. The lower court was authorized to examine the records in an in camera review[38] to determine whether the therapist, prior to the time of injury complained of, determined, or reasonably should have determined, that the son presented serious danger of violence to his parents, and that disclosure was necessary to avert threatened danger. In addition, the parents need not have been named as intended victims by the patient,

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[37] CAL. EVID. CODE SECTION 1024 (West, 1966).

[38] A cause is said to be heard in camera either when the hearing is had before the judge in his or her private chambers or when all spectators are excluded from the courtroom.

but must have been readily identifiable as such by the therapist prior to the time of injuries complained of. The trial court was found to be competent to determine the standard of care in making these determinations on its own without needing outside expert testimony. If the patient has made an actual threat of violence or the therapist has actually determined that the patient posed such danger, there is an exception to the psychotherapist-patient privilege. If the records are devoid of such indications that the patient may be violent such that no person, under any reasonable standard of care, would have made such a determination, then the privilege holds and the records are not discoverable. To preserve the confidentiality of the records, where expert testimony is required, the court should appoint its own expert and receive the testimony in an in camera proceeding.[39] In contrast to McIntosh, in this case the court itself rather than a jury is to decide the question of foreseeability of dangerousness and whether a warning should have been given. This case may make therapists who fear Tarasoff liability cautious as to what information they record in their case records. This study determines if awareness of Tarasoff has had an effect on

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[39] Mavroudis v. Superior Court for San Mateo, 162 Cal. Rptr. 732-734.

record-keeping to see if there has been a change on the part of therapists to either maintain more detailed records or less detailed records.

In Bellah v. Greenson, a California court of appeal declined to extend the obligation to warn others in situations where the client threatens suicide, thereby posing a danger to himself rather than to others.[40] The court's refusal to require disclosure to the client's family was based in part on the absence of physical danger to others. The court appreciated the importance of confidentiality to the therapist-client relationship, and felt that there was no higher public interest to be served in requiring disclosure of suicide threats, even in view of the severe mental distress that might be experienced by the parents as a result of the client's actions. This case raised the issue of whether the threat of severe mental distress to others can be as ominous as the threat of physical assault, where disclosure of the threat is required. If mental distress is seen to pose a severe threat to others, then the confidentiality of the therapist-client relationship may be further eroded (Griffith & Griffith, 1978).

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[40] Bellah v. Greenson, 81 Cal. App. 3d 614, 146 Ca. Rptr. 535 (1978).

Proposed Alternatives to a Tarasoff Warning

Included in the commentaries on Tarasoff have been a number of alternatives to a Tarasoff warning, ranging from practical suggestions on how to deal with the issue of dangerousness when it arises in therapy to efforts to have changed existing laws regulating various aspects of psychotherapy and liability. Roth and Meisel (1977) related a number of cases in which the Law and Psychiatry Program at Western Psychiatric Institute and Clinic in Pittsburgh, Pennsylvania, has intervened in situations where the issue of a client's dangerousness had arisen. Because of Roth and Meisel's convictions about the importance of confidentiality in the therapist-client relationship, in no instance did they or the Institute warn the potential victim without first obtaining the client's permission. They believe that before entering into a treatment contract the therapist should inform the client of the confidential nature of the relationship and the various circumstances under which confidentiality may have to be breached. When a client does begin to speak convincingly of potential violence, the therapist should explain the varying actions that might have to be taken if the client persists in his or her threats. The therapist's need to act should be

assessed in light of the impact of the proposed intervention on future therapy with the client and in light of the likelihood of success in preventing violence. Since actual violence is relatively rarely carried out, Roth and Meisel recommend that the therapist "rely on the odds and hope for the best" rather than warn a potential victim or attempt to hospitalize the client involuntarily (p. 511). Their policy of obtaining consent before warning appears to be a more pragmatic alternative to the problem than does their suggestion that the therapist rely on chance and hope that no violence occurs.

Stone (1976) believes that a duty to warn potential victims will not be the course of action least harmful to the client's general welfare. The overriding goal when dealing with a dangerous client is to protect those threatened, and the duty to warn may in fact increase the likelihood of violence. Those who are both mentally ill and dangerous are difficult to treat. Private practitioners have been reluctant to treat dangerous clients, and given the increasing legal liability therapists are becoming subject to, they may be less willing to work with such clients (Wise, 1978; Halleck, 1980) and instead may refer them to community health facilities or other public mental health facilities (Stone, p. 371-372). Clients who are

referred from agency to agency in this way may lose whatever motivation for treatment they may have. More people may fall into this class of clients, as liability may have the consequence of aggravating the inevitable tendency to overpredict dangerousness. In order to prevent the gradual erosion of the assurance of confidentiality given by warning those threatened, Stone recommends that public safety may be served and the moral duty of the therapist be fulfilled in more traditional ways. The therapist who believes that a client poses a serious danger to third parties should attempt to have that person committed, and if that fails should call the police when he or she is convinced that such action will protect both the victim and the client. If the imminently dangerous client cannot be committed in time to protect those threatened, the police are equipped to warn potential victims and have the means to protect and enable potential victims to escape violence.

Stone feels that liability should be imposed only at the point at which the therapist has formed a judgment of dangerousness, rather than under some indeterminate malpractice standard dependent on the exercise of a nonexistent skill. If the legal duty was dependent on the therapist's determination of the client's dangerousness,

the number of instances in which suit could be successfully brought for failing to warn would be limited to those cases in which the therapist made a determination of dangerousness but failed to warn. In the usual case, once the therapist is convinced of a client's dangerousness, he or she would take some action. Liability would be imposed only at the point at which the therapist has formed his or her judgment of dangerousness, and this standard would help to diminish the tendency towards overprediction of dangerousness.

Advantages of compulsory hospitalization are that commitment may not involve a betrayal of the client's confidence to third parties with whom the client may have direct and personal relationships, and that commitment also prevents physical violence by physically incapacitating the actor. This approach may not afford any protection to the potential victim, though, because the client may still pose a threat to the victim after the client is released from the commitment. Ayres and Holbrook (1975) believe that both involuntary commitment and giving of a warning should be considered concurrent modalities of treatment.

The civil commitment approach is not without its problems. Fleming and Maximov (1974) view commitment as having a potentially detrimental impact upon patients and

find the process as constitutionally suspect on both substantive[41] and procedural[42] due process grounds. Statutes are vague as to the standards defining committable behavior, and in light of the lack of procedural safeguards and the mental health professions' inability to predict dangerousness, "the risk of treatment amounting to punishment without any legitimate need for restraint is great" (Fleming & Maximov, 1974, p. 1054). Civil commitment is clearly not a problem-free solution to the Tarasoff dilemma.

Wexler (1979) offers an approach which focuses on the client's relationship with the potential victim. His orientation is based on the paradigm of "interactional" or "couple" violence which focuses on troubled relationships. Victimology literature studies the offender-victim relationship and examines the nature of the client, the nature and identity of the potential victim, the role of the victim in promoting patient violence, and the types of thera-

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[41] Substantive due process refers to the constitutional guarantee that no person shall be arbitrarily deprived of life, liberty or property; the essence of substantive due process is protection from abitrary and unreasonable action.

[42] Procedural due process refers to an orderly process in which a person has an opportunity to be heard, and to defend, enforce and protect his or her rights with the assistance of counsel before a competent and impartial tribunal.

peutic interventions that would flow from knowledge about the client, the potential victim, and the relationship between the two. Although not the case in Tarasoff, the majority of threatened victims, in perhaps 88% of the cases studied, are either family members or those falling just beyond the technical definition of a member of the family such as guardians or lovers. Furthermore, the stereotype of the innocent and unsuspecting victim for the most part has proved to be false, and major studies support the assertion that victims often contribute to, precipitate, or even provoke the acts of violence directed against them.

Wexler argues that treatment of a dangerous person should transcend an intrapsychic individual pathology approach, and should in many cases involve not only the violence-prone client, but also the targeted victim, typically a family member, who may well contribute to a violence-prone ongoing pathological relationship with the potentially violent client. The client and the potential victim should both be considered prime candidates for a type of "couple" or "family" therapy. This approach assumes that the client would consent to notification of the potential victim (obtaining a client's consent avoids the risk of violating ethical or legal obligations to keep a client's confidences), that the potential victim would

consent to and would be motivated to be seen in therapy with the client, and that the client would consent to conjoint therapy with the potential victim. Given the fact that the client has expressed violent wishes towards the potential victim, it seems unlikely that these prerequisites will be satisfied in very many instances. Nevertheless, the potential victim may provide the therapist with important information about the client which may be used to enhance therapy. Despite the potential of Tarasoff for impeding treatment in certain instances, Wexler believes it may have the effect of generally enhancing the efficacy of therapy provided violence-prone clients by prompting practitioners to shift away from an intrapsychic model toward an interactionist model of treating violence-prone self-referred outpatients.

A number of alternative interventions are available which either do not involve breaching confidentiality or are less restrictive of the client's freedom than hospitalization. The goal of therapy when the issue of dangerousness arises is to dissuade the client from acting out threats made, and certain strategies may be adopted to facilitate this which would not erode the therapist-client relationship. The client may be persuaded to change environments by taking a leave of absence from work or

taking a vacation, may be persuaded to turn in weapons to the therapist or the police, may be placed on medication to diminish the danger of acting out aggressively, may be continuously monitored by friends and family of the client, or the help of family members or social support systems such as the church may be enlisted (Lane & Spruill, 1980).

If the therapist decides that to give a warning is the best course of action, then the standards of dangerousness should be clearly defined by law. Guidelines for determining dangerousness have included the following requirements: that a specific threat be made against an identifiable individual, that the client have the intent and capacity to carry out the threat, that the psychotherapist get a second opinion as to the dangerousness of the client, and that the psychotherapist have access to the intended victim (Eger, 1976). Once a determination of dangerousness is made, then no initiative should be taken until danger is truly imminent. In psychotherapy, this point would be reached when the client's interests may be justifiably subordinated to concern for the security of the would-be victim. The credibility of the threat and the severity of the harm threatened are as important ingredients in imminence of the danger as is its nearness

in time. When danger is imminent and action is justified, the therapist should select the form of intervention with the least harmful impact on the client's interests. Whatever action is taken, it should be weighed against overcaution (Fleming & Maximov, 1974, p. 1064-66).

Informing the client before therapy starts as to the limits of confidentiality is an essential condition for the client's right to accept therapy under conditions of informed consent (Hare-Mustin et al., 1979), and it may help make assessment of dangerousness more accurate by screening out some exaggerated threats of harm. It may discourage some disclosures by clients, but that is not too high a price for maintaining the integrity of the therapist-client relationship (Fleming & Maximov, 1974; Everstine et al., 1980; Schwitzgebel & Schwitzgebel, 1980; Van Hoose & Kottler, 1977).

The standard of the duty to warn should also be more clearly defined in statutes to specify such things as what professions the term "psychotherapist" refers to; whether the duty to warn also applies to information obtained in group psychotherapy; what kinds of procedures will be established to implement the duty to warn; guidelines as to what would be prudent time within which the responsibility could be discharged; whether the

psychotherapist has any continuing responsibility to the potential victim after the duty to warn has been implemented; and whether the law should provide protection to the psychotherapist from litigation on the part of the potential actor and client (Ayres & Holbrook, 1975, pp. 703-704).

If the result of the law is to place therapists in a no-win situation (i.e., they face legal liability from either their clients or from the potential victims or both, depending on the course of action they take in fulfilling their duty to protect), then legislation should be enacted to protect therapists from liability in these situations (Lane & Spruill, 1980). Such a bill was proposed in the California Legislature in 1978 which stated that a therapist who determines that his patient poses a potential or immiment threat of danger to a third person is considered to have fulfilled his duty of care to that person if he exercises reasonable care to have the patient taken into 72 hour custody for treatment and evaluation.[43] The bill died on the last day of the 1978 session and was criticized because of the difficulty of enforcement, the possible violation of due process rights of the patient, the detriment to the therapist-client relationship, and

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[43] AB 3514 (amended May 3, 1978) Cal. Leg. Sess. (1978).

the problems involved in issuing a warning to the potential victim (Shea, 1978).

The Tarasoff case may impose an unwieldy and unworkable duty to practicing psychotherapists. Therapists will have to deal with the duty as best they can if they are faced with Tarasoff situations in their practice of psychotherapy. A concerted effort should be made by both psychologists and psychiatrists to have existing laws changed so that legal rules are not put in medical terms, and so statutory requirements are spelled out so that their interpretation and implementation are not vague or ambiguous. In order to formulate a consistent legal standard of care, mutual appreciation and effort by both the legal and psychiatric professions are essential (Shea, 1979; Dershowitz, 1968; Brooks, 1978).

Implications and Impact of Tarasoff: The Present Study

Many of the dire warnings of Tarasoff's critics have remained highly speculative, as the critics offered no evidence to support the allegation that psychotherapy would be undermined. Only one study has been done which surveyed the effects of Tarasoff on psychotherapy, and this was made with therapists but not patients.

Nevertheless, the study done by Wise (1978) serves as a starting point for determining what effect Tarasoff has had on the practice of psychotherapy.

Wise reported on the experiences of 1,272 California psychiatrists and psychologists who received a questionnaire approximately one year after Tarasoff II. The intent of the study was to determine whether the new duty has been obeyed in the manner foreseen by the court, and whether Tarasoff has had any additional effects on the practice of psychotherapy. The survey revealed that therapists, acting under professional and ethical standards, have often given warnings to third parties in the past, and suggested that Tarasoff did not mandate a radical change in therapeutic practice. The study did reveal, however, that the imposition on therapists of a legal duty to warn, as opposed to the traditional discretionary professional duty, has had potentially detrimental effects on psychotherapy. Nearly 90% of those responding indicated at least one of the following changes resulting from Tarasoff: a change in the criteria they use to determine when to warn potential victims (apparently lowering the threshold of seriousness at which they would give a warning); a change in their discussions of confidentiality or dangerousness with clients; a change in the frequency

of consultation with their peer-professionals; a change in record-keeping to use their records as instruments to avoid liability. In addition, therapists indicated anxiety over Tarasoff issues such as fear of being sued for failure to exercise their duty to warn properly. They also noted skepticism about their own ability to make the predictions of dangerousness now implicitly required by law (Wise, 1978, p. 162). Therapists reported altering the character of their dialogue with their clients by focusing their own clinical attention as well as their clients' attention on the client's capacity for violent behavior and the possibility of breaches in confidentiality to respond to the risk of such behavior. In other cases, therapists indicated that they were more reluctant to probe into areas of their clients' lives that might uncover propensities to violence. To the extent that these changes indicate a new diversion of the therapist's energy, Tarasoff may interfere with successful treatment of certain mental health problems. The question left for the courts and for legislatures is to decide if the uncertain increase in public safety due to Tarasoff outweighs such potentially serious detriments to the practice of psychotherapy. At present, therapists are not able to determine precisely where "the protective privilege ends"

and "the public peril begins."[44]

An increasing amount of attention is being devoted in the psychology literature to professional ethics, with much attention given to the rights of clients and the ethical responsibilities of practitioners (e.g., Hare-Mustin et al., 1979; Everstine et al., 1980; Mental Health Task Report, 1978; Halleck, 1980; Bersoff, 1976; Van Hoose & Kottler, 1977; Lane & Spruill, 1980; Schwitzgebel & Schwitzgebel, 1980; Siegel, 1979; Shah, 1978; Pope, Levenson, & Schover, 1979). However, the results of two recent surveys in Nebraska and North Dakota indicate that psychotherapists either do not receive adequate training in professional issues, or else they have forgotten what they have been taught or choose to ignore some of their legal and ethical obligations.

Swoboda et al. (1978) surveyed mental health practitioners in Nebraska and found that a significant proportion of psychologists, psychiatrists and social workers were unaware of two basic laws that applied to their professions, one providing for the right of privileged communications (overall, 26% were unaware) and another requiring the reporting of child abuse (overall, 17% were unaware). Of those who were aware of the child-abuse

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[44] Tarasoff II, 551 P.2d at 347, 131 Cal. Rptr. 27.

reporting requirement, a majority refused to comply with it in a hypothetical case. Swoboda et al. suggested that this level of knowledge about these statutes gave an indication of the lack of general knowledge that professionals have about their legal obligations, and that more effort needed to be expended in teaching psychotherapists their legal obligations.

Jagim et al. (1978), in a limited survey of North Dakota mental health professionals (psychologists, psychiatrists, social workers, counselors; N = 64), found that 50% of the respondents were not familiar with the legal and ethical implications of privilege, and that some respondents were unaware of which professions were included under state statutes concerning privilege. The majority of those professionals surveyed believed that a therapist has both a legal and ethical obligation to keep information concerning a client confidential. The respondents also believed that clients expect communications with mental health professionals to remain confidential. Even though confidentiality was agreed to be important to the therapeutic relationship, a majority of the respondents indicated that they might break confidentiality under certain circumstances, such as in response to a situation involving danger to a third party. A small group of

professionals maintained an absolute position on confidentiality, and claimed they would choose a contempt-of-court citation rather than disclose confidential information.

The present study was a survey designed to provide data on the attitudes and practices of psychotherapists with respect to confidentiality, informed consent and the duty to warn. By the use of a more diverse sample, this study was more representative of current practices than the previous studies, which have been limited to statewide samples.

One of the main purposes of the study was to provide psychologists with feedback as to actual clinical practices in the areas of legal, ethical and professional issues relating to the practice of psychotherapy. Much has been written in the area as to what ideally should be done or known, but preliminary indications are that not enough practitioners are meeting these standards. The information provided by this study can be used to determine if more focus needs to be placed on these areas in both graduate training and continuing professional education. Practitioners need to be aware of their legal and professional responsibilities so that they can provide a high standard of care to their clients without having to

worry about civil liability resulting from careless or misinformed practice.

This study was also designed to be used by courts of law in jurisdictions that will be deciding whether or not to adopt the Tarasoff rule in their state. Up to the present, courts have had to rely mainly on scholarly law review articles on the subject which presented theoretical considerations, but were lacking in empirical data as to what effects a Tarasoff duty has had on the practice of psychotherapy. The data from this study may be used by courts to help determine this question.

This study will also be valuable to those psychologists who are interested in legal issues and who are actively involved in working to have existing laws relating to the practice of psychotherapy changed so as to be more reflective of conditions in the working relationship of the therapist and client.

CHAPTER II

METHOD

Sample

A pool of potential subjects from the 1981 APA Biographical Directory was established based on the following criteria: listed as a resident of New York, Texas, New Jersey, Florida, Illinois or Maryland, possession of a PhD degree in clinical or counseling psychology or listing clinical psychology as "major field," listing of "therapist in private practice" as primary or secondary occupation, and a 1980 or 1981 update. Six states were randomly selected for sampling from the 10 states having the largest APA membership, excluding California. California was not included as a state for this study, as Wise (1978) surveyed California in her Tarasoff study. A small number of states were chosen to assure a large enough sample size from each state to use the individual states as an independent variable for the analyses. The potential subject pool for each state was entered at random. Each nth name was chosen using a new n for each choice based on a random number table, until 109 subjects from each state were selected (654 total). The minimum acceptable response from each state was specified as 30 subjects.

No computer data were obtainable from APA other than state and division membership, so no information for prior stratification or quotas was available. Specific division membership was not chosen as a criterion for selection as a subject in order to maximize the population size and increase generalizability of the results. The sample selected was expected to be an unbiased sample based on the selection qualifications.

Materials and Procedure

The general methodology of this study approximates that of Dillman, Christenson, Carpenter and Brooks (1974). Subjects selected were mailed a one-page cover letter printed on Texas Tech Department of Psychology stationary (see Appendix A), the questionnaire (see Appendix A), a stamped return envelope, and a stamped postcard which could be returned separately from the questionnaire requesting information about the results of the study. The cover letter indicated the purpose of the study and explained the procedure to be followed in completing it. Since personalization has been found to increase response rates to surveys (Dillman & Frey, 1974), each cover letter was addressed with the name of the psychologist receiving it. One week after the questionnaires were mailed, a

thank you/reminder postcard was sent to all the subjects thanking them for completing the questionnaire and reminding them to complete and return the questionnaire if they have not already done so.

The questionnaire was designed to survey five areas relating to the practice of psychotherapy. These areas were: informed consent, confidentiality, issues directly relating to Tarasoff, awareness of general ethical and legal issues, and the issue of dangerousness. In addition, demographic data were obtained to provide information about the respondents.

A pilot study was conducted for the purpose of obtaining feedback about the clarity and content of the questionnaire. Advanced graduate students in clinical and counseling psychology, along with a number of practitioners at a Lubbock community mental health center and a small number of practitioners engaged in private practice in Lubbock served as subjects. Those who completed the pilot study first answered the questionnaire and then responded to a "Comments and Feedback" list of questions which followed. Appendix B presents the materials used in completing the pilot study. A number of revisions in the material used in the study were made based on the feedback from those participating in the pilot study. The average

time taken to complete the questionnaire in the pilot study was 20 minutes. The information that follows is a description of the final version of the questionnaire which was sent to the subjects.

The first two questions were concerned with the issue of informed consent, and were designed to measure the extent to which therapists incorporate ethical standards into their practices. Recommendations have been made that therapists respect and honor the rights of clients by providing them with enough information in order for them to make an informed decision about entering psychotherapy (Hare-Mustin et al., 1979; Everstine et al., 1980), but there have been no data published concerning the percentage of practitioners actually honoring these ethical obligations. To the extent that therapists provide clients with full information at the start of therapy, they should be able to avoid more difficult ethical and legal dilemmas later in therapy should Tarasoff-type fact situations arise. Clients would be aware of the limits of confidentiality, and therapists could warn knowing that their clients were informed that such action may have to be taken. (See Everstine et al., 1980 for a proposed "Client's Rights Statement" and "Informed Consent Form," two documents which could be given routinely at the start

of therapy advising clients of their rights. Such documents could fulfill therapists' ethical obligations to provide such information.) The next set of questions (3 to 6) are related to confidentiality and the informed consent issue of providing clients with information as to the limits of confidentiality. The APA Ethical Principles of Psychologists, Principle 5, Confidentiality, states:

> Psychologists have a primary obligation to respect the confidentiality of information obtained from persons in the course of their work as psychologists. They reveal such information to others only with the consent of the person or the person's legal representative, except in those unusual circumstances in which not to do so would result in clear danger to the person or to others. Where appropriate, psychologists inform their clients of the legal limits of confidentiality. (APA, 1981, p. 635-636)

Confidences may be broken without consent under certain circumstances, but there is no duty for the therapist to warn others. Therapists should inform their clients as to the limits of confidentiality "where appropriate." The clause "where appropriate" was added to the 1977 proposed revision of this principle, which stated in part, "Psychologists inform their clients of the limits of confidentiality" ("Council Pursues Ethics," 1981). The added clause implies that there are circumstances in which it is acceptable practice not to inform clients of limits of confidentiality, but Principle 5 does not specify any

exceptions. Questions 3-6 were designed to determine the frequency of disclosure of limits, the importance of absolute confidentiality in therapy, the effect on therapy of disclosing limits, and if any clients have left therapy because they feared a breach of confidentiality. Question 16 asked therapists what their choice would be between a hypothetical contempt-of-court citation or disclosure of confidential information.

Questions 7-15 were addressed to issues raised by the Tarasoff case. The questions were designed so that a knowledge of Tarasoff was not necessary. For the naive respondent, this section measured what their general experience and practice has been. For those who were aware of the case, Question 12 measured the effects of that awareness in order to determine if there had been a ripple effect from the decision, which has binding legal value only in California. Clinicians in other states may still be affected by the decision if they fear similiar liability.

The majority opinion in Tarasoff noted that the open and confidential character of psychotherapeutic dialogue encourages clients to express threats of violence, few of which are ever carried out.[45] If these threats of violence

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45 Tarasoff II, 551 P.2d 334, 347, 131 Cal. Rptr. 14, 27 (1976).

are made frequently by clients, then it places a burden on therapists to determine which threats are real, and which are just fantasies of the type routinely heard during psychotherapy. Questions 7-9 measure the frequency of clients disclosing fantasies, the diagnostic classification of those reporting violent fantasies, and the most likely target of the fantasies. If such threats occur frequently during therapy, then it might be expected that they would come from a variety of clients having a range of diagnoses. Question 8 is not designed as a predictor of dangerousness, but only as a question to provide information about the diagnostic range of clients who routinely make such threats.

Question 11 gave the holding of Tarasoff and asked for a reaction to the ruling. The trend in the literature seems to be that Tarasoff is an unpopular decision, but again, there have been no data on the point. Questions 12-15 were modified and expanded from Wise (1978) to include more specific and quantitative questions as to practices related to Tarasoff issues. If it is determined that as a matter of clinical practice, therapists have given warnings in the past, and they routinely obtain consent before warning, then the Tarasoff duty if adopted in their state would not depart much from established

practice. Should the state therapists are practicing in adopt such a duty, practitioners who already follow such procedures would not be affected by the imposition of a legal requirement. Of course, there are those who may refuse to follow such a legal duty, but they would face legal sanctions should they be sued for failure to warn when they had an obligation to do so. For clinicians who had never given warnings to third persons, questions in this section measured their stated willingness to do so.

Questions 17 and 18 were designed to measure a therapist's awareness of the laws and court decisions of the state he or she lives in. Only two of the states which were sampled have court decisions related to the Tarasoff case and the duty to warn. The Maryland decision of Shaw v. Glickman was handed down in 1980,[46] and the New Jersey decision in McIntosh v. Milano was given in 1979.[47] Question 17 was addressed to residents of these states to determine their awareness of the cases. Question 18 listed laws of the states surveyed regulating the practice of psychotherapy. Texas Tech University School of Law has a copy of all U.S. state statutes, and the laws presented in

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[46] Shaw v. Glickman, 415 A.2d 625 (Md. Ct. Spec. App. 1980).

[47] McIntosh v. Milano, 168 N.J. Super. 466, 403 A.2d 500 (Sup. Ct. New Jersey, June 12, 1979).

Question 18 were selected from the respective state statutes. Practitioners were presented with a list of laws of their state, and they were asked how many of those laws they recognized. Responses to this question from subjects living in Florida were not tabulated since at the time of this survey, state regulatory laws were suspended by "sunset" review legislation and the replacement legislation was not yet in effect. Swoboda et al. (1978) found between 3% and 32% of mental health providers (social workers, psychiatrists and psychologists) in Nebraska to be unfamiliar with the state's privileged communications law and child abuse reporting statute, and suggested that a substantial number of practitioners might be ignorant of their legal obligations. Question 18 directly tested this conclusion.

The next area surveyed was concerned with attitudes and practices relating to dangerousness. Questions 19-22 dealt with the amount of contact with potentially dangerous individuals, training received in recognizing or predicting dangerousness, the ability to foresee and predict dangerous behavior, and the threshold at which confidentiality is breached and third parties are warned. The duty to warn in Tarasoff is in effect "once a therapist does in fact determine, or under applicable

professional standards reasonably should have determined"[48] that the person he or she is working with poses a serious danger of violence to others. If psychologists disclaim an ability to predict dangerousness, then the impact of the court's holding becomes limited to situations in which the therapist does predict dangerousness. This is the standard that was argued for by Justice Mosk in the dissenting part of his opinion[49] in Tarasoff.

Question 23 asked respondents to indicate the nature and frequency of their contact with the legal profession. Question 24 asked respondents to rate their knowledge on legal and professional issues relating to the practice of psychotherapy. The more contact a therapist has with the legal process, the greater his or her awareness of legal and professional issues might be.

Finally, subjects were asked to give demographic information which was used in determining amount of experience, amount of time spent in private practice and seeing clients, type of clients seen, agency involvement, theoretical orientation, degree earned, and age and sex of respondents. A place on the questionnaire was also provided

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48 Tarasoff II, 551 P.2d at 345, 131 Cal. Rptr. at 25 (footnote omitted).

49 Id. at 353-54, 131 Cal. Rptr. at 33-34.

for subjects to make comments about the questionnaire or about any of the issues that it had raised.

CHAPTER III

RESULTS

Data Analysis

Since a major reason for this study was to provide information as to actual practices and attitudes among practitioners, descriptive statistics were calculated for all questions to determine frequency of responses, as well as means, standard deviations, and medians and ranges to the Likert-type items (7-point scales). There were no a priori hypotheses regarding the data. Instead, the data were to be examined for trends and relationships between items, with particular attention given to comparisons and correlations among items relating to Tarasoff, dangerousness, confidentiality, informed consent, legal issues, and sex differences. Nonparametric and parametric statistics (Siegel, 1956; Guilford, 1965; DuBois, 1965; Kirk, 1968; Nie, Hull, Jenkins, Steinbrenner, & Bent, 1975) were used for these analyses. In this study, a choice was made to treat an artificial dichotomous variable (e.g., familiarity with Tarasoff) as a genuinely dichotomous variable. This was done because for the purposes of this study, there was no interest in seeing what the correlation would

have been had the underlying variable been measured on a continuous scale. Rather, the interest was to treat the artificial dichotomy as if it measured simply the presence or absence of a particular quality or behavior. For this reason, *phi* coefficients were calculated in some cases rather than the tetrachoric *r*, and the point-biserial *r*, *r*pbi, was calculated in some cases rather than the biserial *r*, *r*bi . The result of this choice was a more conservative analysis, since both the tetrachoric and the biserial *r* give an inflated correlation coefficient as compared to the *phi* coefficient and the biserial *r* (Guilford, 1965). DuBois (1965) acknowledged the suitability of this substitution, given the purpose and reason for the analysis. Because of the large number of analyses performed, the level of significance for this study was set at .01 for all comparisons. Two-tailed *t* tests were used.

Response Rate and Demographic Variables

Within six weeks after the mailing of the questionnaires, 370 (56.6%) had been returned. Of these, 15 (2.3%) were returned as undeliverable, 2 were returned blank with a note that the subject was retired, and 4

respondents failed to complete at least 75% of the questions. A total of 349 completed questionnaires (no more than 5 unanswered questions) were used for the data analyses, for an adjusted response rate of 55%. The number of responses to 109 questionnaires sent to each state was: Florida, 68 (62.4% state response rate, 19% N), New Jersey, 57 (52.3%, 16.3% N), Illinois, 56 (51.4%, 16% N), New York, 55 (50.4%, 15.8% N), Texas, 53 (48.6%, 15.2% N), Maryland, 50 (45.9%, 14.3% N), and other states (some respondents had moved or practiced in a different state than that listed in the 1981 APA Biographical Directory), 10 (2.9% N). All completed questionnaires were used for the data analyses except in the analysis of the number of state laws correctly identified. For this analysis, only those subjects from Illinois, Maryland, New Jersey, New York and Texas who did not list more than one state of practice were used. At the time of this survey, state regulatory laws in Florida had been suspended by sunset review legislation, and the replacement legislation was not yet in effect. For this reason, answers to this question were not scored for Florida residents.

The questionnaires were sent to 437 males and 217 females, with response rates for both sexes of 53% (233 and 116 respectively). The mean respondent age was 43.5

years (SD = 9.9), with an average of 14.5 years of experience (SD = 8.5). The major PhD degree listed was in the field of clinical psychology (79%, n = 274), followed by counseling (12%, n = 41) and "psychology" or other (9%, n = 32). Nearly half the subjects (46%, n = 162) devoted full time to private practice, and nearly half the subjects (47.6%, n = 166) listed some agency affiliation (see Table 1). Mean time spent seeing clients weekly on an outpatient basis was 27.2 hours (SD = 12.6). Adult clients were seen by 96% (n = 336) of the subjects, adolescent clients by 82% (n = 285), and child clients by 57% (n = 198). Nearly all the subjects (97%, n = 340) did individual therapy, 43% (n = 150) did group therapy, 84% (n = 295) did marital therapy, and 64% (n = 223) did family therapy.

The major clinical orientations listed were psychodynamic (36%, n = 127), eclectic (32%, n = 112), cognitive-behavioral (16%, n = 55), humanistic (5%, n = 17), existential (4%, n = 13) and "other" categories (behavior-modification, systems, etc.) (6%, n = 21).

Membership in at least one APA division was indicated by 70% (n = 243) of the respondents, with Division 12, Clinical (32%, n = 110), Division 29, Psychotherapy (26%, n = 90), Division 42, Psychologists in Private Practice

TABLE 1

Agency or Institution Affiliation

Type	N	%
No affiliation	183	52.4
Hospital (public/private), medical school, psychiatric hospital, VA	41	11.7
Community MHMR	40	11.5
University/graduate school	19	5.4
Child guidance/child residential	18	5.2
Public agency (public defender, health, welfare, rehabilitation)	18	5.2
Public school	15	4.3
Private clinic	10	2.9
Other	5	1.4
Total	349	100.0

(15%, n = 52), Division 39, Psychoanalysis (11%, n = 38), Division 35, Psychology of Women (6%, n = 22), and General Psychology (6%, n = 21) the most popular divisions. Forty percent of the sample (n = 140) belonged to at least two divisions, 22% (n = 77) belonged to at least three, 11%

(n = 38) belonged to at least 4, and 4% (n = 14) belonged to over four divisions. The remainder of the results will be grouped in sections based on the design of the questionnaire. These sections include the following areas: effects of the Tarasoff decision, issues relating to dangerousness, confidentiality and informed consent issues, awareness of legal issues, and sex differences.

Effect of the Tarasoff Decision

The majority of the respondents (73%, n = 254) were familiar with the Tarasoff decision. Those with an agency affiliation were more likely to be familiar with the case than those with no affiliation, phi (n = 342) = .18, p <.001 (see Table 2). Individuals who had some contact with the legal profession were also more likely to be familiar with Tarasoff than those with no legal contact, phi (n = 348) = .20, p <.001 (see Table 2). A high rating on being well-informed on legal issues relating to the practice of psychotherapy was positively correlated with one's awareness of Tarasoff, rpbi (n = 343) = .382, p <.001, as was a higher number of state laws correctly identified, rpbi (n = 257) = .218, p <.001. The number of years of clinical experience a person had was not significantly related to knowledge of Tarasoff, nor was age.

TABLE 2

Agency Affiliation, Legal Contact and Familiarity with Tarasoff

		Familiar with Tarasoff	
		No	Yes
Agency affiliation	No	58	104
	Yes	35	145

		Familiar with Tarasoff	
		No	Yes
Legal contact	No	37	51
	Yes	57	203

Therapists were presented with the ruling of the case stating "when therapists determine, or pursuant to the standards of their profession should determine, that their client presents a serious danger of violence to another, they incur an obligation to use reasonable care to protect the intended victim of that danger" and were asked to

indicate their agreement or disagreement with that ruling (n = 346, M = 5.9, SD = 1.5, 7-point scale). Over 88% (n = 308) were in agreement, with most strongly and very strongly agreeing. A small percentage (3.4%, n = 12) were neutral, and the remainder were in disagreement with the decision (7.8%, n = 26). There was no difference in agreement on this statement between those familiar with Tarasoff and those who were not. Agreement with the ruling was negatively correlated with the rating of the importance of absolute confidentiality between therapist and client, r (n = 341) = -.188, p <.001; with the belief that informing clients of the limits of confidentiality at the start of therapy affected future client disclosure, r (n = 343) = -.220, p <.001; with being likely to refrain from warning a third party when there was a legal or ethical obligation to do so, rpbi (n = 321) = -.154, p <.01; and with a high threshold for warning others (the likelihood of a client's potentially dangerous act before confidentiality is breached and third parties are warned) r (n = 308) = -.171, p <.005. Agreement with the ruling was positively correlated with future likelihood of reporting a client for child abuse, r (n = 273) = .246, p <.001, and physical dangerousness, r (n = 281) = .349, p <.001. There was no significant difference between

respondents' agreement with the Tarasoff ruling and past reporting of child abuse, past reporting of physical dangerousness, past and future reporting of a crime confessed, and past and future reporting of a suicide threat made by a client.

To summarize these findings, agreement with the ruling was associated with a more moderate stance on confidentialty and a greater likelihood of breaching confidentiality, and disagreement with the ruling was associated with a stronger stance on the importance of absolute confidentiality and less likelihood of breaching confidentiality to report a client for any reason.

The overall effect of an individual's awareness of the Tarasoff decision on his or her practice (on a 5 point scale from (1) no effect to (5) very strong effect) was between (2) mild and (3) moderate (n = 256, M = 2.33). The effect of Tarasoff on 17 specific aspects of practice (M = 2.02, SD = .38) are listed in Table 3. Percentage of responses to this question (Questionnaire item 12b) ranged from 67% (n = 234) to 73.3% (n = 256).

TABLE 3

Effect of Tarasoff on Specific Aspects of Practice

N	M	SD	Category
256	3.37	1.26	Increased awareness of legal and/or ethical obligations and responsibilities
243	2.70	1.30	Increased therapist anxiety when an issue relating to dangerousness is brought up in therapy
242	2.65	1.45	Increased consultation with other mental health professionals when involved with a potentially dangerous client
241	2.46	1.38	Alerted clients that more circumstances could arise in which the therapist may have to breach confidentiality
245	2.36	1.29	Made the therapist fear a possible lawsuit for failing to warn
239	2.13	1.34	Made the therapist less likely to work with a potentially dangerous individual
243	2.10	1.30	Led the therapist to keep more detailed records to avoid legal liability
241	2.08	1.14	Led the therapist to focus more often on dangerousness with clients
239	1.89	1.24	Increased consultation with attorneys or law enforcement personnel when involved with a potentially dangerous client
241	1.88	1.21	Made the therapist fear a possible lawsuit for defamation of character or invasion of privacy as a result of breaching confidentiality

TABLE 3 (CONTINUED)

N	M	SD	Category
239	1.87	1.11	Led the therapist to focus more frequently on less serious threats made by clients
238	1.70	1.09	Made the therapist more likely to have a client civilly committed who poses a threat to a third party
237	1.64	1.15	Led the therapist to keep less detailed records to avoid legal liability
234	1.50	1.13	Led the therapist to obtain malpractice insurance
238	1.47	.93	Caused the therapist to increase the number of warnings given to third parties
234	1.30	.72	Led the therapist to focus less often on dangerousness with clients
235	1.20	.63	Led the therapist to keep 2 sets of records: one private set and one set for the file

Warning of Third Parties

Warning a third party about the dangerousness of a client was not a very frequent behavior among the psychologists surveyed except in the case of warning others about a serious threat of suicide a client had made. Approximately 65% (n = 228) of those surveyed had given warnings for suicide threats. Clients were reported for child abuse by 23% (n = 79) of the subjects, for a serious threat of homicide or physical injury to another by 24% (n = 83), and less than 4% (n = 13) have reported a crime confessed by a client. The victim's family was the third party most often warned (n = 122, 35%), followed by a warning to medical personnel (n = 71, 20.3%), the victim (n = 64, 18.3%), police (n = 46, 13.2%) and a court of law (n = 10, 2.9%). A total of 249 therapists (71.3% N) have given a warning in at least one category.

The percentages of respondents who indicated they would report child abuse, a threat of physical danger (a Tarasoff warning), and a suicide threat (and have not given such a warning in the past) were approximately equal (66.9%, 61.3%, and 67.9%, respectively, see Table 4). For those individuals who have not given a warning under these conditions, less than 3% stated that they would never report child abuse (n = 4), a serious threat of homicide

or physical injury (n = 7), or a suicide threat (n = 8). Over 32% (n = 113) would protect a client and never report a crime confessed, and only 8.0% indicated they would report a crime confessed in the future. Under certain circumstances, 60 therapists (17%) might refrain from warning a third party when there was a legal or ethical obligation to warn.

TABLE 4

Likelihood of Future Reporting for Therapists Who Have Not Reported Clients in the Past

	Would Report a Client:			
Category	Yes	Poss.	No	Total
Child Abuse	184	87	4	275
	66.9	31.6	1.5	100.0
Tarasoff Warning	174	103	7	284
	61.3	36.3	2.5	100.0
Crime Confessed	28	189	113	330
	8.0	54.2	32.4	100.0
Suicide Threat	133	55	8	196
	67.9	28.1	4.1	100.0

Note. The top figure is the number of therapists who who would report. The figure below it is the row %.

Those who have reported a client for a serious threat of homicide or physical danger to another were more likely to have reported a client for a crime confessed, *phi* (*n* = 331) = .215, *p* <.001, and for a suicide threat made, *phi* (*n* = 333) = .267, *p* <.001; were more likely to have had a client leave therapy because the client feared a breach of confidentiality, *phi* (*n* = 336) = .141, *p* <.01; and were more likely to have contact with the legal profession, *phi* (*n* = 338) = .172, *p* <.001, than those who had not reported a client in this circumstance (see Table 5).

Those who had reported a client for child abuse were more likely to have reported a client for a serious threat of homicide or of physical injury, *phi* (*n* = 338) = .182, *p* <.001; for a suicide threat made by a client, *phi* (*n* = 334) = .205, *p* <.001; for a crime a client confessed, *phi* (*n* = 331) = .230, *p* <.001; and were more likely to have some contact with the legal profession, *phi* (*n* = 343) = .176, *p* <.001, than those who have not reported child abuse (see Table 6).

Those who have reported a client for a threat of suicide were also more likely to have contact with the legal profession than those who have not reported a client in this instance, *phi* (*n* = 334) = .163, *p* <.005 (see Table 7).

TABLE 5

Reporting of Client's Threats

		Have reported client's threats: No	Have reported client's threats: Yes
Have reported crime confessed	No	248	70
	Yes	4	9

		Have reported client's threats: No	Have reported client's threats: Yes
Have reported suicide threat	No	98	8
	Yes	154	73

		Have reported client's threats: No	Have reported client's threats: Yes
Clients have left therapy fearing a confidentiality breach	No	220	61
	Yes	34	21

TABLE 5 (CONTINUED)

		Have reported client's threats	
		No	Yes
Contact with legal profession	No	75	10
	Yes	180	73

TABLE 6

Reporting of Child Abuse

		Have reported child abuse	
		No	Yes
Have reported client's threats	No	208	47
	Yes	53	30

		Have reported child abuse	
		No	Yes
Have reported crime confessed	No	254	64
	Yes	4	9

		Have reported child abuse	
		No	Yes
Have reported suicide threat	No	95	11
	Yes	162	66

TABLE 6 (CONTINUED)

		Have reported child abuse	
		No	Yes
Contact with legal profession	None	78	9
	Some	186	70

TABLE 7

Reporting of Suicide Threat and Contact with the Legal Profession

		Legal contact	
		None	Some
Have reported suicide threat	No	38	68
	Yes	47	181

In general, those individuals who have reported a client in any particular category were more likely to have reported a client for other categories than those who had not warned in that same category.

There was no correlation between knowledge of Tarasoff and reporting of child abuse, warning of client's threat of homicide or injury, reporting crime confessed, or reporting threat of suicide. Also, no difference was found between clinical orientation and number of warnings given in any category.

Table 8 lists the frequency with which therapists obtained a client's consent to warn before warning. Table 9 lists the frequency with which therapists informed clients that they were going to give a warning. The most frequent effect that giving a warning had on therapy was an improvement in therapy because of the issues confronted and addressed (N = 128, 51% of those who have warned). The next most frequent effect that giving a warning had on therapy was for the client to remain in therapy, but for the therapeutic relationship to be adversely affected (N = 45, 19% of those who have warned). Table 10 lists the various effects on therapy reported by therapists who have given warnings to third parties.

TABLE 8

Frequency of Therapists Obtaining Consent Before Warning

Frequency	n	N%	% of those who have warned
Always	62	18%	25%
Usually	59	17%	24%
Sometimes	48	14%	19%
Never	29	8%	12%
No response	51	14%	20%
Total	249*	71%	100%

*Note: 249 therapists have given at least one warning.

TABLE 9

Frequency of Therapists Informing Clients Before Warning

Frequency	n	N%	% of those who have warned
Always	121	35%	48%
Usually	40	11%	16%
Sometimes	31	9%	12%
Never	12	3%	4%
No response	45	13%	20%
Total	249*	71%	100%

*Note: 249 therapists have given at least one warning.

TABLE 10

Effect of Warning a Third Party on the Therapy Relationship

Effect	n	N%	% of those who have warned
Improvement in therapy because of issues confronted and addressed	128	37%	51%
Client stayed in therapy, but therapeutic relationship adversely affected	45	13%	19%
No observable effect on the therapeutic relationship	19	5%	7%
Client left therapy due to violation of confidentiality	18	5%	7%
Client hospitalized or referred for psychiatric care	6	2%	2%
No response	70	20%	28%
Total	286*	---	---

*Note: 249 therapists have given at least one warning. Totals are higher here than in the two previous tables because therapists endorsed more than one of the above items.

Issues Relating to Dangerousness

Violent Fantasies

Only 3% of those surveyed reported that none of their clients ever reported violent fantasies in therapy. The mean percentage of clients disclosing violent fantasies according to therapists was 21.7% (SD = 25.7%). At the upper range of the interval, 8% of the therapists reported fantasies by at least 80% of their clientele, with 2% of the therapists reporting violent fantasies by 100% of their clients (see Table 11). The clinical orientation of the therapist was directly related to the percentage of clients disclosing violent fantasies, F (5,338) = 5.22, $p < .001$ (see Table 12). Table 13 provides a further breakdown of the percentage of clients disclosing violent fantasies by clinical orientation of the therapist. The intervals listed (0-4%, 5-10%, 11-33%, 34-100%) were selected to approximate quartile divisions as closely as possible. One-third of psychodynamically oriented therapists reported that between 34% and 100% of their clients disclosed violent fantasies. The next highest percentage by orientation for this same range was for those classifying themselves as humanistic (29.4%), followed by "other" (19.0%), eclectic (12.6%), cognitive-behavioral (9.1%) and existential (7.7%).

TABLE 11

Reported Percentage of Clients Disclosing Violent Fantasies

%	n	N%	cum. %	%	n	N%	cum. %
0	11	3	3	35	2	1	80
1	26	7	11	40	8	2	82
2	27	8	18	50	17	5	87
3	7	2	20	55	1	0	87
4	4	1	22	60	10	3	90
5	57	16	38	65	1	0	91
6	1	0	38	70	2	1	91
8	2	1	39	75	4	1	92
10	64	1	57	80	11	3	95
15	11	3	60	85	1	0	96
20	35	10	70	90	6	2	97
25	21	6	76	95	2	1	98
33	1	0	79	100	6	2	100

TABLE 12

Percentage of Clients Disclosing Violent Fantasies by Clinical Orientation of Therapist

Clinical Orientation	N	Mean %	SD
Psychodynamic	127	30.0	31.2
Humanistic	17	24.5	30.6
"Other"	21	19.8	25.5
Existential	13	17.7	21.3
Eclectic	111	15.8	17.9
Cognitive-behavioral	55	14.2	17.5
Total	344	21.6	24.8

TABLE 13

Breakdown of Percentage of Clients Disclosing Violent Fantasies by Clinical Orientation of Therapist

Clinical Orientation	% of clients disclosing fantasies 0-4%	5-10%	11-33%	34-100%	row total
Psychodynamic	22*	37	26	42	127
	17.3	29.1	20.5	33.1	
	29.7	30.1	34.2	59.2	36.9
Humanistic	6	4	2	5	17
	35.3	23.5	11.8	29.4	
	8.1	3.3	2.6	7.0	4.9
"Other"	7	6	4	4	21
	33.3	28.6	19.0	19.0	
	9.5	4.9	5.3	5.6	6.1
Existential	2	6	4	1	13
	15.4	46.2	30.8	7.7	
	2.7	4.9	5.3	1.4	3.8
Eclectic	22	48	27	14	111
	19.8	43.2	24.3	12.6	
	29.7	39.0	35.5	19.7	32.3
Cognitive-Behavioral	15	22	13	5	55
	27.3	40.0	23.6	9.1	
	20.3	17.9	17.1	7.01	16.0
Column Total	74	123	76	71	344
	21.5	35.8	22.1	20.6	100.0

*Note. The top figure (22 in this case) is the number of therapists reporting clients in each interval, the figure below it (17.3) is the row %, and the bottom figure (29.7) is the column %.

Clients reporting violent fantasies fell in a wide range of DSM-III diagnostic categories. A listing of these categories is found in Table 14. The most commonly seen diagnostic category of clients reporting violent fantasies was that of paranoid disorders. Over 55% of the respondents noted experience with this type of client. The next most frequent diagnostic category was anti-social personality, reported by 51.3% of the therapists. The most common "other personality disorder" listed were borderline personality, obsessive-compulsive personality, and explosive personality. Other categories listed included depression, marital problems, conduct disorders, and "normals."

Therapists were asked to rank order the most likely object of a client's fantasies. The rankings for each classification were converted to a numerical score by summing each weighted ranking (8 for a rank of 1, 7 for a rank of 2, ..., 1 for a rank of 8) and dividing by the number of cases for each category. If an item was marked but not ranked, it was given a weighted ranking of 4.5. Table 15 presents a summary of this weighted ranking. Spouses were most often the object of violent fantasies from a client in therapy, and a public figure was the least likely object. A Kruskal-Wallis one-way analysis of

TABLE 14

Number of Respondents Who Have Seen Different DSM-III Diagnostic Clients Reporting Violent Fantasies

Diagnostic Category	n	N%
Paranoid disorders	194	55.6
Antisocial personality	179	51.3
Schizophrenic disorders	133	38.1
Substance use disorders	131	37.5
Passive-aggressive personality	127	36.4
Affective disorders	121	34.7
Anxiety disorders	118	33.8
Adjustment disorders	109	31.2
Other personality disorders	100	28.7
Psychosexual disorders	56	16.0
Other psychotic disorders	47	13.5
Organic mental disorders	46	13.2
Dissociative disorders	41	11.7
Somatoform disorders	27	7.7

variance by ranks showed the original rankings to be independent of each other, $\underline{H}$ (7) = 906.58, $\underline{p}$ <.001.

TABLE 15

Ranking of Object of Violent Fantasies by Clients

Object	n	ranking
Spouse	287	7.0
Parents	263	6.2
Boss or employer	260	5.2
Client's children	245	4.8
Friend	250	4.6
Other relative	224	4.1
Stranger	227	2.6
Public figure	221	2.1

Potentially Dangerous Therapy Clients

The average number of individuals seen in outpatient therapy per year whom the therapist considered to be potentially dangerous either to self or others was less than four ($\underline{M}$ = 3.96, $\underline{SD}$ = 8.4). Approximately 23%

(n = 78) of the respondents saw either no or less than one individual a year who they considered potentially dangerous. Sixty-one percent (n = 206) saw 1-5 potentially dangerous clients, and 11% (n = 36) saw 6-10 potentially dangerous clients. Less than 6% (n = 18) saw more than 10. The highest number reported was by a psychologist from New Jersey who saw approximately 100 such individuals a year in his outpatient practice.

The number of dangerous clients seen per year was positively correlated with having training in predicting dangerousness, rpbi (n = 331) = .159, p <.005. The number of dangerous clients worked with per year was not significantly related to the accuracy with which one believed one could predict a dangerous act, to the threshold of dangerousness for breaching confidentiality to warn others, to agreement with the Tarasoff ruling, to the past or future reporting of a client, or to agreement with the statement that psychologists are qualified to testify as expert witnesses with respect to the dangerousness of an individual.

Respondents were presented with the statement, "Psychologists are qualified to testify as expert witnesses with respect to the dangerousness of an individual" and were asked to indicate their agreement or disagreement (n = 347, M = 5.6, SD = 1.7). Of the respondents, 75.5%

marked agree to very strongly agree (n = 267), 13.2% marked disagree to very strongly disagree, (n = 46), and 9.7% were neutral (n = 34). Agreement with this statement was correlated with a self-rating on the ability to predict a dangerous act, r (n = 319) = .34, p <.001. Having training in predicting dangerousness was not related to one's opinion on this issue, nor was the amount of clinical experience one had. There was also no relation between agreement on this issue and the threshold of dangerousness for breaching confidentiality (the likelihood of a client's potentially dangerous act before a warning would be given).

Approximately 62% (n = 216) of the subjects had received some type of training in recognizing or predicting dangerousness. Having this type of training was not related to how well individuals thought they could predict a dangerous act, or to the threshold level of warning.

Subjects were presented with the question, "In general, how accurately do you believe you can predict a dangerous act?" and were asked for a response on a scale from 0 to 100% accuracy. On the whole, subjects rated their ability to predict dangerous acts at a 51.5% accuracy level (SD = 24%, n = 320). The range varied from 0% accuracy ("I don't sit in God's right hand") to 100%

accuracy (see Table 16). Others could not make an estimation of their predictive ability without specific knowledge of an individual. Those with more years of clinical experience did not rate their predictive ability any differently than those individuals having less experience. Self-rating on this ability was not significantly correlated with the past or future reporting of child abuse, the physical dangerousness of a client, a crime a client confessed, or a suicide threat made by a client.

Overall, therapists stated that a client's potentially dangerous act would have to be 64.7% probable (SD = 22%, n = 313) before they would breach confidentiality and warn others (see Table 17). The higher a therapist's threshold level for warning, the less likely he or she would be in the future to report child abuse, r (n = 246) = -.261, p <.001; the physical dangerousness of a client, r (n = 255) = -.211, p <.001; a crime a client had confessed, r (n = 296) = -.191, p <.005; or a suicide threat made by a client, r (n = 179) = -.259, p <.001. A high threshold was also associated with less reporting of a crime confessed, $r$pbi (n = 295) = -.219, p <.001. There was no significant relationship between theshold for warning and the past reporting of child abuse, physical dangerousness of a client, or a suicide threat.

TABLE 16

Accuracy with Which Therapists Believed They Could Predict a Dangerous Act

%	n	N%	cum. %	%	n	N%	cum. %
0	5	2	2	50	69	22	53
1	2	1	2	55	4	1	54
3	2	1	3	60	34	11	65
5	6	2	5	65	5	2	67
10	16	5	10	66	1	0	67
12	1	0	10	67	1	0	67
15	5	2	12	70	27	8	76
20	12	4	15	75	41	13	88
25	16	5	20	80	18	6	94
30	15	5	25	82	1	0	94
33	1	0	25	85	6	2	96
40	14	4	31	95	4	1	99
45	1	0	31	100	1	0	100
49	2	1	32				

TABLE 17

Likelihood of Client's Potentially Dangerous Act before Confidentiality would be Breached (Threshold for Warning)

%	n	N%	cum. %	%	n	N%	cum. %
1	1	0	0	55	4	1	40
10	8	3	3	60	22	7	47
15	1	0	3	70	15	5	52
20	4	1	5	75	49	16	68
25	8	3	7	76	1	0	68
30	6	2	9	80	28	9	77
33	2	1	10	85	4	1	78
35	5	2	11	90	46	15	93
40	8	3	14	91	2	1	94
45	1	0	14	95	8	3	96
49	1	0	14	98	3	1	94
50	58	19	33	99	1	0	98
51	4	1	40	100	7	2	100

Prediction of Dangerous Behavior

Respondents were asked to list factors which would make them more confident in predicting dangerousness. Over 50 different factors were listed, most of which fell into 8 major overlapping categories. These categories and the number and percentage of respondents listing each category are listed in Table 18. This section lists the various factors given by the respondents along with a brief description of those factors.

TABLE 18

Listed Factors Helpful in the Prediction of Dangerousness

Category	n	N%
Accurate case history	101	29%
History of violent acts	80	23%
Personality dynamics	77	22%
Psychological test data	70	20%
Present state of the client	38	11%
Knowing the client	38	11%
Clinical experience and training	38	11%
Current plan to commit violence	35	10%

Any type of previous dangerous behavior was seen as a good predictor of future dangerous behavior. This history included previous aggressive or dangerous acts, prior assaultive or suicidal behavior, a prior criminal record, a history of acting out, or very recent dangerous antisocial behavior.

An accurate case history would, of course, include a history of prior dangerous behavior. In addition, it would also include a complete knowledge of the client's life situation, demographic variables, and observations of significant others. The more history available, the better the prediction of future behavior.

Psychological test data were seen as another useful predictive tool. Both objective and projective tests (MMPI, Rorschach, TAT, etc.) were listed as helpful. A few psychologists, however, noted in comments that they believed that there were no reliable or valid test instruments useful in the prediction of dangerous behavior and called for more research on the efficacy of predictor variables as well as for more formalized diagnostic criteria.

Many personality variables were listed as being possible indicators of potentially violent behavior. These included the affective state of the client

(intensity of emotion, high anger, repressed anger towards others, lack of emotion, major depression, sense of nothing to lose, lack of anxiety in anti-social situations), the thought process (disturbed, schizophrenic, thought disorder, change in mental status, psychotic, confused, agitated, paranoid) and character structure and ego functioning (ego stability and strength, degree of insight, degree of self-control/poor impulse control, fear and insecurity, fantasy life, narcissism).

Respondents also viewed the prediction of dangerous behavior as taking into account factors such as the nature and intensity of psychosocial stressors in the environment, the support system available, current adaptation and energy level, the availability of outside controls, the severity of current symptoms with no immediately available alternative defenses, and the similiarity of the present situation to previous acts.

A clear plan to commit violence was also seen as a good predictor of future violence. Well laid plans, overt threats, a detailed method, repeated statement of intent, the availability or possession of a weapon, the relationship of the aggressor to the victim, and the people involved and the specific circumstances of the situation were all factors to be taken into account in predicting dangerousness.

Another set of predictive factors involved the nature of the therapist-client relationship. Seen as important were the length and quality of the relationship with the client, good rapport and therapeutic alliance, the nature of the transference, and the opportunity to observe the client in stressful situations.

Therapist factors included more training, greater clinical experience with violent and dangerous individuals colleague consultation, and clinical intuition. A few psychologists both facetiously and seriously recommended a therapist use a crystal ball or be omniscient and able to know and predict the future in order to be truly effective in predicting dangerousness.

Confidentiality and Informed Consent Issues

Respondents were presented with the question, "How important is absolute confidentiality between therapist and client in maintaining a positive therapeutic relationship?" and were asked to respond on a 7-point scale ranging from nonessential to essential (M = 6.03, SD = 1.12, n = 344). Only 4% viewed absolute confidentiality as nonessential (n = 15), 3% were neutral (n = 10), and 91% saw absolute confidentiality as being essential (n = 319).

There was a positive correlation between agreement with this statement and years of clinical experience, r (n = 334) = .169, p <.005, and with the age of a person, r (n = 340) = .189, p <.001. Agreement with this statement was negatively related to having reported a crime a client had confessed, rpbi (n = 326) = -.225, p <.001; to the future reporting of a crime confessed by a client, r (n = 325) = -.180, p <.001; and to future reporting of physical dangerousness, r (n = 279) = -.267, p <.001. There was no significant difference between agreement on this statement and the past reporting of child abuse, or the reporting of a suicide threat. The importance of confidentiality was negatively correlated with intent to report child abuse in the future (if one had not done so in the past), r (n = 270) = -.254, p <.001, but was not related to future intent to report a suicide threat.

Confidentiality was seen as a crucial issue for many clients of those surveyed, as 57 (16%) therapists reported that at least some of their clients left therapy because they feared a breach of confidentiality. Those therapists whose clients have left therapy under this circumstance were more likely to have contact with the legal profession, phi (n = 347) = .151, p <.001 (see Table 19); were more likely to have training in predicting

dangerousness, phi (n = 339) = .210, p <.001 (see Table 20); and were more likely to have reported a client for a threat of physical danger to others, (n = 336) = .141, p <.01 (see Table 5), than those whose clients have not left because they feared a breach.

TABLE 19

Therapists with Clients Leaving Therapy and Contact with the Legal Profession

		Legal contact	
		None	Some
Clients have left therapy fearing breach	No	82	208
	Yes	6	51

Therapists were about equally split on their agreement with the statement, "If clients are informed as to the limits of confidentiality at the start of therapy, they will not disclose as much during therapy as they would have otherwise," (M = 3.89, SD = 1.9, n = 346). In

TABLE 20

Therapists with Clients Leaving Therapy and Training in Predicting Dangerousness

		Training	
		No	Yes
Clients have left therapy fearing breach	No	116	166
	Yes	8	49

the sample, 46% marked disagree to very strongly disagree (n = 158), 11% were neutral (n = 37), and 45% marked agree to very strongly agree (n = 151). Agreement with this statement was associated with less frequent warning of a third party about the dangerousness of a client, rpbi (n = 335) = -.160, p <.005, and with less frequent reporting of a suicide threat made by a client, rpbi (n = 331) = -.015, p <.005. Among those individuals who had not given a warning to third parties in the past, agreement that client disclosure would be affected was negatively related to future likelihood of warning a third

party about the physical dangerousness of a client, r (n = 281) = -.227, p <.001, and to future reporting of child abuse, r (n = 273) = -.210, p <.001. There was not a significant difference between agreement and future likelihood of reporting a crime confessed, or future reporting of a suicide threat. In addition, agreement with this statement was positively correlated with the rating of the importance of absolute confidentiality between therapist and client, r (n = 342) = .23, p <.001; with less frequent discussion of limits to confidentiality with a client at the onset of therapy, r_{pbi} (n = 346) = .249, p <.001; with a higher threshold for warning third parties, r (n = 311) = .220, p <.001; and negatively correlated with agreement with the ruling of the Tarasoff case, r (n = 343) = -.220, p <.001.

Generally, the items "How important is absolute confidentiality between therapist and client in maintaining a positive therapeutic relationship?" and "If clients are informed as to the limits of confidentiality at the start of therapy, they will not disclose as much during therapy as they would have otherwise" distinguished between one group of therapists who tended to take an absolute stand on confidentiality and not report clients, and another group of therapists who did not hold absolute

confidentiality as important and who were much more likely to breach confidentiality under certain conditions. The groups these two items differentiated were consistent with the groups differentiated by agreement or disagreement with the Tarasoff holding. A factor analysis performed on the Likert items (see "Factor Analysis," below) identified a factor which appeared to identify one's stance towards the importance of confidentiality in therapy. Rating absolute confidentiality as essential to therapy had a positive loading on this factor, as did the belief that disclosure is affected by telling clients the limits of confidentiality. Agreement with the Tarasoff ruling (i.e., rating absolute confidentiality as less essential) had a negative loading on this identified factor.

When presented with a choice between a contempt-of-court citation or the disclosure of confidential information about one of their clients, 35% of the therapists (n = 122) stated they would be more likely to choose a contempt-of-court citation, 14% would be more likely to disclose information to the court (n = 47), and 50% did not know what they would do under the circumstances (n = 176). Several therapists stated they would make a decision after consulting with attorneys, colleagues, and their client. One respondent was faced with this choice

and decided to disclose after conferring with his client. The disclosure and the dialogue involved proved to be beneficial to the therapy.

Informed Consent

Of the sample surveyed, only 41 psychologists (12%) provided their clients at the start of therapy with written material describing various aspects of therapy or informing them of their rights as a client. With regard to various issues discussed verbally with the client at the start of therapy, therapists most often discussed the client's goals for therapy (n = 335, 96%) and fees and payment (n = 334, 96%). Less frequently discussed were treatment methods used (n = 277, 80%), the right of confidentiality (n = 266, 76%), and terms of a treatment contract (n = 170, 49%).

Limitations to confidentiality were discussed with the client at the start of therapy by 27% of the respondents (n = 94). Over half (51%, n = 177) the subjects discussed such limitations if the client asked directly; 65% (n = 227) discussed limitations in the event that an outside party needed to be contacted; and 4% (n = 13) never discussed with clients limitations to confidentiality. A few therapists indicated that they

always informed their adolescent or child clients as to the limits of confidentiality but infrequently informed their adult clients.

Awareness of Legal Issues

Subjects were asked a number of questions to determine the nature of their contact with the legal system and about their familiarity with legal issues and the laws regulating psychology of the state they practiced in.

Familiarity with State Laws

A list of laws relevant to the practice of psychotherapy was presented to the respondents who were asked to identify which of the laws were in effect in the state in which they practiced. The laws were selected from the state statutes of Illinois, Maryland, New Jersey, New York and Texas. The residents of Florida responded to this question but answers were not scored for that state because regulatory laws had been suspended by sunset review legislation. Of the 68 respondents from Florida, only 8 (12%) noted the status of the licensing regulations and the new laws soon to take effect.

Nine laws were presented on the questionnaire, but the law relating to husband-wife privilege was not

included in any tabulation involving number of laws correctly identified since it was later considered not directly relevant to the practice of psychotherapy. (The percentage of respondents correctly identifying this law was: Illinois, 36.4%, Texas 30.8%, Maryland, 35.6%, New York, 22.6%, New Jersey, 28.3%; overall, 30.7%). Calculations involving the number of laws correctly identified will have an n varying around 258.

Table 21 presents the mean number of state laws correctly identified by respondents from the states listed above. There was a significant difference in the overall identification rate among the states, F (4, 253) = 7.01, p <.001, with Illinois having the highest mean percentage correct. The only significant differences between these state means (Tukey HSD) were between Illinois and New York (q = 1.32, p <.01), and between Illinois and New Jersey (q = 1.40, p <.01). Table 22 provides a breakdown of the percentage of respondents correctly identifying their state laws by each individual state law.

Respondents were much more accurate in identifying laws that their state had (M = 47.2% accurate) than they were in correctly stating that their state did not have a particular law (M = 12.7% accurate). The starred percentages in the columns of Table 22 are responses to

TABLE 21

Mean Number of State Laws Correctly Identified

State	n	Mean	SD
Illinois	55	3.64	1.82
Texas	52	3.21	1.74
Maryland	45	3.00	1.68
New York	53	2.32	1.60
New Jersey	53	2.24	1.47
Total	258	2.76	1.60

state laws which that particular state (identified at the top of the column) does not have. If these starred items are removed from the calculation of the overall hit-rate, then the mean percentage correct for the states becomes: Illinois, 58.8%, Texas, 44.6%, Maryland, 51.1%, New York, 40.4%, and New Jersey, 41.2% (47.2% overall). Looking at the laws which at least four of the five states have (privilege, confidential communications, liability for breach, child abuse, aged abuse), there is no longer a significant difference between states and number of laws

TABLE 22

Percentage of Respondents Correctly Identifying Their State Laws

Law	IL n=55	TX n=52	MD n=45	NY n=53	NJ n=53
1. Psychotherapist-patient privilege	72.7	57.7	73.3	60.4	64.2
2. Confidential communications	76.4	61.5	64.4	54.7	62.3
3. Liability for breach of confidentiality	36.4	32.7	20.0	7.5	15.1
4. Reporting of child abuse	83.6	71.2	77.8	64.2	60.4
5. Reporting abuse of disabled or aged	5.5*	11.5	20.0	15.1	3.8
6. Therapist notes are private property	49.1	42.3*	22.2*	18.9*	13.2*
7. Allows exception to privilege	5.5*	32.7	8.9*	5.7*	3.8*
8. Permits disclosure of confidential communications	34.5	11.5*	13.3*	5.7*	1.9*
Total % Correct	45.4	40.1	37.5	29.0	28.1

Note: A * by a number means that the state does not have that particular law. The number listed is the percentage of respondents who correctly noted this fact.

correctly identified, F (4,253) = 2.84 (n.s.). Texas residents had a hit rate of 26.9% in correctly stating that their state did not have particular laws when it in fact did not, followed by Maryland (14.8%), New York (10.1%), New Jersey (6.3%), and Illinois (5.5%).

All states had a law providing for psychotherapist-patient privilege and for the reporting of child abuse. The overall mean percentage correct for these two laws was 65.7% and 71.4% respectively. With regard to laws establishing confidential communications, states typically either modeled a statute on the attorney-client privilege establishing confidential and privileged communications, or they had a separate law establishing communications between psychotherapist and patient as confidential. Maryland's statute[50] establishes privileged communications between patient and psychiatrist or psychologist but does not refer directly to confidential communications. Court decisions[51] and commentary to the statute, however, interpret the statute as providing for confidential communications. The mean percentage correct for this law was 63.9% for all states. State statutes were less clear on

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50 ANN. CODE MD. COURTS AND JUDICIAL PROCEEDINGS SECTION 9-109 (1981).

51 Shaw v. Glickman, 415 A.2d 625 (Md. Ct. Spec. App. 1980).

providing for penalties for breach of confidentiality. Despite this stated absence in some cases, if a state has a law providing for a particular right, then a remedy is assumed both in statutory and case law, and a court would hold a psychologist liable for an unauthorized breach of confidentiality. A smaller percentage was aware of liability for breach of confidentiality (22.3%).

All states except Illinois had a law requiring the reporting of abuse of aged or disabled persons.[52] The overall percentage of all states correctly noting this was 11.2%. Illinois was the only state having a law stating that the personal working notes of the therapist (as opposed to the file notes) are private property and not discoverable in any type of proceeding. Nearly half of the Illinois residents correctly noted this.

Law 7 (see Table 22) is a Texas law allowing an exception to privileged communications which permits a psychologist to report only to medical or law enforcement personnel when he or she determines there is a probability of imminent physical injury by the patient to self or others. Less than a third of Texas residents correctly

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52 Illinois now has a law providing for this, 111.5 SECTIONS 4161-4172 PUBLIC HEALTH & SAFETY (1983). This law went into effect approximately two months after the questionnaire was mailed.

identifed this as a law their state has. Law 8 (see Table 22) is an Illinois law which permitted the disclosure of confidential communications under similar circumstances (except no restriction is applied as to whom the disclosure may be made), and 34.5% of Illinois residents correctly identified this law. Other states have exceptions to privileged communications; these two laws (Law 7 and Law 8) were broader than the laws other states had and were included for Illinois and Texas residents to see if they could recognize their own law. At the time of this survey, Illinois and Texas had the most comprehensive set of laws regulating the practice of psychology, followed by New York, New Jersey and Maryland.

Those individuals having some contact with the legal profession correctly identified a larger number of their state laws than those individuals who had no contact, r_{pbi} (n = 258) = .232, p <.001. The higher one rated oneself as being well-informed and up-to-date on legal issues relating to the practice of psychotherapy, the greater number he or she correctly identified, r (n = 254) = .426, p <.001. The number of years experience a person had was not significantly related to the number of laws correctly identified. Respondents who generally discussed the right of confidentiality verbally with clients at the start of

therapy correctly identified more laws than those who did not, rpbi (n = 258) = .151, p <.01. Those respondents who have reported clients in the past for child abuse, rpbi (n = 253) = .249, p <.001; for a crime confessed, rpbi (n = 243) = .171, p <.005; or for a suicide threat, rpbi (n = 247) = .185, p <.005, all identified more laws correctly than those who had not given such warnings.

Awareness of Tarasoff-type Litigation

Respondents were asked if the state they practiced in has had any litigation similiar to Tarasoff where one of the parties to the suit alleged that a psychotherapist had a duty to give a warning regarding the dangerousness of a client. Approximately 20% (n = 11) of the respondents from New Jersey were aware that their state had had such a lawsuit.[53] Of this group, 4 (7%) correctly identified the lawsuit as "Milano."

One respondent from Maryland (2%) was aware that his state had a lawsuit similar to Tarasoff and could identify some of the facts of the case[54] but could not name the

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[53] McIntosh v. Milano, 168, N.J. Super. 466, 403 A.2d 500 (Sup. Ct. New Jersey, June 12, 1979).

[54] Shaw v. Glickman, 415 A.2d 625 (Md. Ct. Spec. App. 1980).

lawsuit.

Contact with the Legal Process

Approximately 77% of the men (n = 180) and 70% of the women (n = 80) had some contact with the legal profession. The breakdown of percentage of all respondents by category of contact is listed in Table 23. The mean number of contacts per month was approximately two, with 60% (n = 209) of the subjects having no or less than one such contact per month. Those individuals who testified as to a person's dangerousness did not rate their ability to predict dangerousness any differently than those who did not offer this type of expert testimony, nor did they see a higher number of dangerous clients per year than those not testifying.

Familiarity with Legal Issues

Therapists were about evenly divided in how they rated themselves as being informed on legal issues relating to psychology, with 130 (37.2%) stating they were poorly informed, 137 (39.2%) stating they were well-informed, and 77 (22.1%) stating they were neither poorly nor well-informed (7-point scale, M = 3.9, SD = 1.6, n = 345). The amount of clinical experience a person had was not

TABLE 23

Respondents Reporting Contact with the Legal Profession

Nature of Contact	n	%
Consultation to an attorney about psychological questions	199	57.0
Court or agency referred psychological evaluations	185	53.0
Testifying as an expert witness	175	50.1
Testifying in child custody proceedings	154	44.1
Testifying as to a person's mental status	114	32.7
Testifying in divorce proceedings	91	26.1
Testifying as to a person's dangerousness	53	15.2
Testifying in involuntary commitments	41	11.7
Aiding in jury selection process	18	5.2

related to his or her ranking on this variable. There was a difference among the states in the rating on this variable, with Florida having the highest mean score and New York the lowest (see Table 24). This difference was significant at the .001 level, F (5,329) = 5.20. The only significant differences between state means (Tukey HSD) were between Florida and New York (q = 1.27, p <.01), and between Maryland and New York (q = 1.02, p <.01).

There was no relationship between the state rankings on this variable and the state rankings on mean number of state laws correctly identified (excluding Florida; see Tables 21 and 24), Spearman's rho = .50 (n.s.).

Self-rating on how well-informed a person was on legal issues was positively correlated with providing a client with written material at the start of therapy, $r$pbi (n = 341) = .178, p <.001; with discussing the right of confidentiality verbally with a client at the start of therapy, $r$pbi (n = 344) = .175, p <.001; with warning a third party that a client had made a serious threat of homicide or physical injury to another person, $r$pbi (n = 333) = .184, p <.001; and with having had training in predicting dangerousness, $r$pbi (n = 336) = .301, p <.001.

TABLE 24

State Ratings on How Well-Informed on Legal Issues

State	n	Mean	SD
Florida	68	4.47	1.45
Maryland	49	4.22	1.68
Texas	52	4.17	1.28
Illinois	56	3.82	1.54
New Jersey	56	3.64	1.60
New York	54	3.20	1.61
Total	335	3.94	1.53

Factor Analysis

A principal factor analysis was performed on the Likert items to determine if any underlying factors could be identified. These items included "How important is absolute confidentiality between therapist and client in maintaining a positive therapeutic relationship?" (nonessential to essential, Question 4); "If clients are informed of the limits of confidentiality at the start of therapy, they will not disclose as much during therapy as

they would have otherwise" (very strongly disagree to very strongly agree, Question 5); the Tarasoff ruling (very strongly disagree to very strongly agree, Question 11); "Psychologists are qualified to testify as expert witnesses with respect to the dangerousness of an individual" (very strongly disagree to very strongly agree, Question 20); and "How well-informed and up-to-date are you on legal and professional issues relating to the practice of psychotherapy?" (poorly informed to well-informed, Question 24).

The varimax rotated factor matrix is presented numerically in Table 25 and graphically in Figure 1. Two factors were identified. The first factor appeared to identify therapists' stance towards the importance of confidentiality in therapy. The belief that telling clients of the limits of confidentiality affects their disclosures had the strongest positive loading on this factor. How essential a therapist viewed absolute confidentiality also had a positive loading on this factor. Agreement with the Tarasoff ruling had a negative loading on this factor. This is understandable since agreement with the holding implies a willingness on the part of therapists to breach confidentiality in order to protect third parties from the potentially dangerous acts of their clients.

TABLE 25

Likert Items Varimax Rotated Factor Matrix

Question No.	Factor 1	Factor 2
4 (importance of absol. confid.)	.431	.040
5 (if told limits, less disclosure)	.502	.033
11 (Tarasoff ruling)	-.454	.166
20 (psy. as expert witness)	-.036	.632
24 (informed on legal issues)	-.000	.192

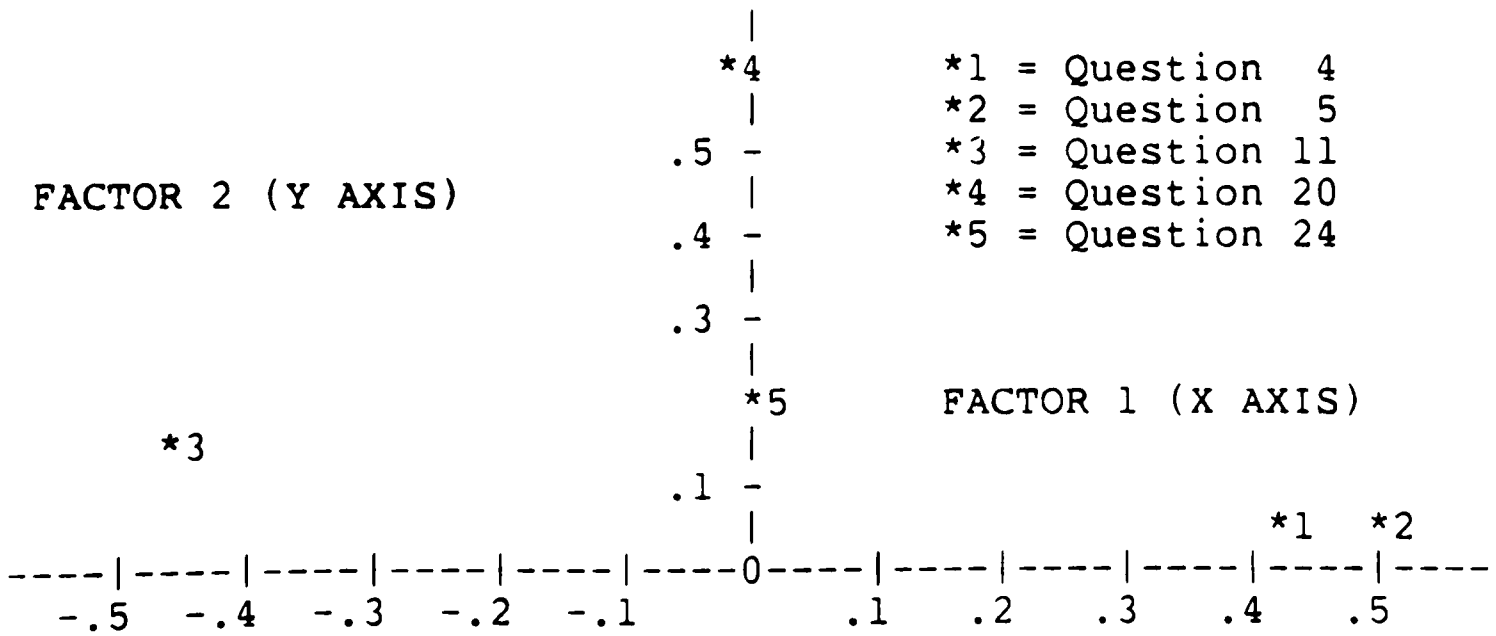

Figure 1: Plot of Varimax Rotated Factors

The second factor appeared to identify generally the self-rated competence level of psychologists, and specifically their competence to offer testimony as an expert witness regarding the dangerousness of an individual. Question 20 loaded highest on this factor. How-well informed on legal issues a person saw him or herself had only a very small loading on this factor. Agreement with the Tarasoff ruling also had a very small loading on this factor, implying that a psychologist's ability to make the determination of dangerousness of a client and to act on it appropriately involves a professional skill and level of competence.

Factor analyses were also performed on various combinations of these variables with other variables, but this effort was unsuccessful in identifying a small number of discrete factors that individual variables loaded strongly on.

The factors identified in this analysis (particularly Factor 1) are consistent with other analyses performed in this study.

Sex Differences

For the most part, there were only a few differences between the responses of the 233 men and 116 women who answered the questionnaire. Men had 2.7 more years experience than women, rpbi (n = 338) = .152, p <.001 (15.4 compared to 12.7), and they were also slightly older than women (44 years vs. 42.5 years, n.s.). Men and women had about the same overall percentage of contact with the legal profession (77.3% of the men, 69.6% of the women, n.s.), but women had fewer consultations with attorneys about psychological questions (46.1% vs. 62.2%), phi (n = 348) = .15, p <.01, (see Table 26); testified less often as expert witnesses (39.1% vs. 55.4%), phi (n = 348) = .15, p <.01 (see Table 27); and testified less often as to a person's mental status (20.9% vs. 38.6%), phi (n = 348) =.178, p <.001 (see Table 28).

Men more often reported anti-social personality disorder clients making violent fantasies than women, phi (n = 348) = .144, p <.01 (see Table 29), but did not report seeing a higher number of potentially dangerous clients per year than women.

With regard to Tarasoff-related issues, women obtained a client's consent before warning more frequently than men did, rpbi (n = 197) = .203, p <.001.

TABLE 26

Consultation with Attorneys by Sex

		Consultation	
		No	Yes
Sex	Males	88	145
	Females	62	53

TABLE 27

Testifying as an Expert Witness by Sex

		Testifying	
		No	Yes
Sex	Males	104	129
	Females	70	45

TABLE 28

Testifying as to Mental Status by Sex

		Testifying	
		No	Yes
Sex	Males	143	90
	Females	91	24

TABLE 29

Reporting Anti-social Personality Disorder Clients making Violent Fantasies by Sex

		Reporting	
		No	Yes
Sex	Males	102	131
	Females	68	47

CHAPTER IV

DISCUSSION

This chapter presents a discussion of the results, implications of the findings for psychologists in light of current developments in the area, directions for future research, and conclusions drawn from the study.

The Findings

Demographic Variables

The response rate obtained in this study (55%) was somewhat higher than that recently reported by researchers conducting large surveys of psychologists (Prochaska & Norcross, 1983, 1000 APA Division 29 members, 41.2% response rate; Norcross & Prochaska, 1983, 1000 APA Division 12 members, 47.9% response rate; Wogan & Norcross, 1983, 400 APA Division 29 members, 34% response rate; Wise, 1978, in her Tarasoff study, 3865 psychiatrists and psychologists, 34.5% response rate). The increase in response rate in this study may in part be attributed to the professional interest in the area being surveyed, but the use of a follow-up thank you/reminder postcard mailed one week after the questionnaire was sent also appeared to have stimulated a high rate of response. The surveys listed above did not mention use of a similar procedure.

Kahle and Sales (1978), in a survey of 440 APA Division 12 psychologists concerning attitudes towards involuntary civil commitment law, followed the methodology suggested by Dillman et al. (1974), and not only included a thank you/reminder postcard, but also sent those who had not responded after one month a replacement questionnaire by certified mail. Kahle and Sales were able to obtain a usable response rate of 72% by using this three-wave design. The question becomes one of utility and importance of response rate, as large surveys are expensive to conduct with just a single mailing; second and third mailings may become prohibitively expensive if funding is limited. For this reason, the use of a three-wave design appears very limited in the clinical literature despite its apparent effectiveness.

The percentage of men (66.8%) and women (33.2%) participating in this study approximates the total percentage of men (69.9%) and women (30.1%) APA members (APA, 1981). The mean respondent age of 43.5 yeaars was younger than the 45.6 years reported for Division 29 members (Prochaska & Norcross, 1983) and the 47.4 years reported for Division 12 members (Norcross & Prochaska, 1983). The average number of years of experience (14.5) was higher than that found in the Division 29 survey (12.6) and lower than that

found in the Division 12 survey (16.7). Many of the demographic variables among these three studies are comparable, and the interested reader is referred to the surveys cited above for additional comparisons.

Therapists' activities appeared diverse, with 48% involved at least part-time with some type of agency or institution. Hospitals and community mental health centers were the most common types of agency involvement. While nearly all subjects (96%) saw adult clients, a substantial portion saw adolescents (82%) and children (57%). Individual therapy was the most common clinical activity (engaged in by 97% of the therapists). The issues raised by Tarasoff are certainly not limited to individual therapy, and, in fact, issues such as confidentiality become heightened when more than one client is involved in the therapy (particularly in group therapy, where the therapist has no control over individual members' disclosures). In this survey, group therapy was practiced by 43% of the respondents.

Clinical orientations fell into three major categories, psychodynamic (36%), eclectic (32%) and cognitive-behavioral (16%). Prochaska and Norcross (1983) found that the percentage of eclectic clinical psychologists dropped from 55% reported by Garfield and

Kurtz (1975) to 30% in their study. The finding in this study appears to confirm that trend.

A large portion of the therapists (30%) did not indicate any APA division membership. While Divisions 12 (Clinical) and 29 (Psychotherapy) are the largest and third largest (respectively) divisions in the APA, membership in either one or membership in any APA division cannot be considered statistically representative of psychologists in private practice, especially considering the fact that 35.8% of all APA members have no divisional membership.

The Tarasoff Decision

Of those surveyed, 73% were familiar with Tarasoff. Wise (1978) found that 96.1% of her sample had "ever heard of the Tarasoff case before." Her study was done in California (where the decision applies) one year after the ruling was made. This study was done 5 years after the decision in states where the ruling did not have binding effect (except where Tarasoff was accepted as binding legal precedent). This study did not measure how subjects acquired knowledge of the case. The fact that those individuals having agency or institution involvement were more familiar with the case than those without such

involvement indicates that some aspect of this experience provided people with this knowledge. The acquisition of this information may have been from the opportunity to have contact with other professionals (as opposed to the notion of the "lone wolf" in private practice), from the opportunity of having continuing education opportunities or requirements, or the fact that agencies may tend to be lawsuit-wary and therefore take steps to keep abreast of current developments. Contact with the legal profession was also found to increase awareness of Tarasoff. Even though the nature of the contact may vary, the fact that a person is involved with attorneys and courts of law indicates an interest in legal matters relating to psychology and a desire to be aware of the law as it affects him or her. Subjects appeared to be accurate in their self-rating of how well-informed they were on legal issues, as a high self-rating was correlated with awareness of Tarasoff. The fact that age and clinical experience were not related to awareness of the case seems to show that graduate school training was not a significant source of knowledge. Of the sample, only 11% (n = 39) appeared to be recent graduates, with five or fewer years of clinical experience.

The great majority (88%) of the subjects were in agreement with the Tarasoff ruling, "When therapists determine, or pursuant to the standards of their profession should determine, that their client presents a serious danger of violence to another, they incur an obligation to use reasonable care to protect the intended victim of that danger." Subjects were not told that this was the Tarasoff ruling, but were simply presented with it (Question 11) and were asked to indicate their agreement with it on a Likert scale. The fact that so many psychologists were in agreement with the ruling is surprising, considering the reaction of those who were critical to the decision and who predicted that the case would be negatively received by the mental health professions (Stone, 1976; Olsen, 1977; Griffith & Griffith, 1978; Wise, 1978; Lane & Spruill, 1980). The percentage of therapists who have actually given Tarasoff warnings (24%), however, is quite small when compared with the number of therapists who were in agreement with the Tarasoff ruling. Several possibilities might account for this discrepancy. The actual need to give a Tarasoff warning to a third party may not be a common occurrence in therapy, and so the giving of warnings is not a frequent behavior. Another possibility is that therapists' acquisition of knowledge of the

Tarasoff case may be fairly recent, and not many instances may have arisen to date in which therapists became aware of their need to breach confidentiality. Or, therapists may be aware of the fact that the Tarasoff ruling is a California decision, and that they are not legally obligated to follow it. (This is not the case for New Jersey residents, as New Jersey did adopt the Tarasoff ruling, but only 20% of the New Jersey respondents even knew that their state had a court case similar to Tarasoff.) If this is true, however, then therapists may have given a socially desirable response when asked to indicate agreement with the ruling, and their actual behavior does not correspond with their stated beliefs.

There was a correlation between agreement with the ruling and past reporting of the physical dangerousness of a client (the actual duty the Tarasoff ruling refers to), but there was no difference between agreement with this ruling and past reporting of child abuse, a crime confessed, or a suicide threat. Those disagreeing more with the ruling took a stronger stance on confidentiality in that they rated absolute confidentiality between therapist and client more essential, believed that informing clients of the limits of confidentiality at the start of therapy affected future disclosure, would be more likely to

refrain from warning a third party when there was a legal or ethical obligation to do so, would have to be more sure of a client's potentially dangerous act before breaching confidentiality, and would be less likely to report a client in the future for any reason if they had not done so in the past, than those agreeing more with the ruling. For those individuals who are in disagreement with Tarasoff, the role of the psychologists is clear, and the primary and only duty is to the client. These therapists clearly reject the role of the psychologist as therapist and policeman. In doing so, however, they face possible legal sanctions should a Tarasoff-type situation arise and a court rule that they did have a legal duty to warn (Jagim et al., 1978).

Overall, awareness of Tarasoff had between a mild and moderate effect on an individual's practice. The strongest effect was to increase a person's awareness of legal and/or ethical obligations and responsibilities. Behaviorally, it is not clear how this effect translates into practice, given the fairly large percentage of respondents who could not correctly identify their state laws regulating the practice of psychotherapy. To be more fearful of possible sources of liability is one thing; to educate oneself to be more knowledgeable is another. In

fairness to practicing clinicians, self-education in this area is not a simple matter; responsibility for promoting awareness in this area should be a shared concern (see "Professional Standards," below).

Therapists who were aware of Tarasoff were more anxious when an issue relating to dangerousness was brought up in therapy, and were more likely to consult with other mental health professionals when involved with a potentially dangerous client. Therapist anxiety relating to dangerousness has taken the form of therapists fearing a possible lawsuit for failing to warn, becoming less likely to work with a potentially dangerous individual, improving record keeping by keeping more detailed records, and focusing more often on dangerousness with clients. Therapists also appeared to be aware of informed consent issues in that they have alerted more clients that circumstances could arise in which they may have to breach confidentiality. As far as increasing warnings given to third parties, however, Tarasoff awareness has had little or no effect. Apparently, once a therapist has established a pattern of warning third parties, future warning behavior is consistent with that pattern.

Tarasoff awareness had only a slight effect on the following areas: increased consultation with attorneys

when involved with a potentially dangerous client, fear of a lawsuit for breaching confidentiality, more focus on less serious threats by clients, more likely to have a client civilly committed, keeping of less detailed records, and obtaining malpractice insurance. Tarasoff awareness had little or no effect on increasing warnings given to third parties, focusing less often on dangerousness, and keeping a private set of records in addition to the file records. For those respondents who had worked with potentially dangerous individuals in the past, several stated that they were aware of the dangers involved and that the Tarasoff decision did not have much of an effect on their behavior. The same is probably true of malpractice insurance, with many respondents having this insurance before Tarasoff.

It is clear that Tarasoff has had a ripple-effect into other jurisdictions. Increased therapist anxiety and less willingness on the part of therapists to work with potentially dangerous individuals were both predictions by critics of undesirable effects of Tarasoff (Stone, 1976; Halleck, 1980; Wise, 1978), and both of these effects were found in this study. If potentially dangerous individuals find it difficult to receive adequate treatment, the harm they pose to society may increase. Even though anxiety

around dangerousness has been raised, generally therapists in this survey indicated that they did not engage in within-therapy avoidance behaviors (such as focusing less often on dangerousness or keeping less detailed records), but instead appeared concerned with clients' rights and the working through of the potential danger.

Comparisons cannot be made directly in this area with the Wise (1978) study, since she did not quantify responses to her questions, but instead only asked if Tarasoff has had any specific effect on various aspects of practice. She reported the following main effects (in sample percentages): increased fear of lawsuits (55.7%), increased anxiety when an issue relating to dangerousness is broached (54%), increased consultation when involved with patients where dangerousness may become an issue (32.9%), a change in the method or keeping records (28.1%), focusing more often on dangerousness (26.8%), and informing more patients that circumstances could arise in which confidentiality may have to be breached (26.7%). Interestingly, her three highest percentages corresponded with three out of the five strongest effects in the present study (increased therapist anxiety around the issue of dangerousness, increased consultation, and increased fear of lawsuits). Concerns of psychotherapists

appear to be fairly uniform to the ruling, regardless of the actual binding legal effect.

Warning of Third Parties

Wise reported that before Tarasoff, 49.7% of the sample (n = 573) reported warning a family, the potential victim, or the police that a patient posed a threat to someone. In the one year following Tarasoff, 37.6% (n = 426) reported giving such a warning. These figures are not directly comparable to this study, since Wise did not specify in her question for what reason was the warning given (such as for child abuse, physical danger, or suicide). Also her sample was composed of 85.9% psychiatrists, and only 14.1% psychologists. There is some evidence that there may be differences in the frequency of breaching confidentiality across professions, with internal medicine MDs more likely to breach confidentiality that psychiatrists, and psychiatrists more likely to breach confidentiality than psychologists (Lindenthal & Thomas, 1980; see "Other Professions," below, for a discussion of this study).

The present study shows that the giving of warnings to third parties by therapists is not an infrequent behavior, with 71.3% of the respondents having reported a

client at least once. The most common instance was in the reporting of a client for a suicide threat, with 65% of the sample having done so. Apparently, therapists are confident enough of their assessment of risk to a client in this situation to warn others of the potential danger. (As noted in Chap. 1, a California court held that the Tarasoff rule does not apply in instances of harm to self.) Warnings in other categories were much less frequent. Approximately 24% have given warnings in Tarasoff situations where a client threatens violence or serious physical injury to another.

The reporting of child abuse falls under a different category of warning, because all 50 states have passed laws which require individuals to report cases in which children have been or are being abused (Swoboda et al., 1978). About the same percentage of respondents have reported a client for child abuse (23%) as for Tarasoff warnings (24%). One might expect that since there is a law in all jurisdictions requiring the reporting of child abuse, the frequency of child abuse reporting would be higher than that for a Tarasoff warning, which is only a legal requirement (by case law) in a few states. There is no way to make a true comparison of the frequencies of warnings given, however, without data on the base rate

occurrences of these behaviors (child abuse, Tarasoff threats) among therapy clients.

The least frequent reporting was that of a crime a client had confessed or a crime the client was suspected of having committed. Only 4% of the subjects have reported clients for this reason. Crimes committed by clients may either be a low frequency behavior, a low reported behavior, a behavior which took place in the distant past (and the statute of limitations has passed), or a behavior that therapists do not believe they have an obligation to report. In support of this fourth hypothesis, only 8% of the therapists indicated that they would report such a crime in the future.

For those who had not reported a client for child abuse, a Tarasoff warning, or a suicide threat, approximately two-thirds indicated that they would make such a report in the future. This figure is consistent compared with those who have reported clients for a suicide threat in the past (65%), but it is inflated when compared with the percentage of therapists in the sample who have reported clients for child abuse (23%) and for Tarasoff situations (24%). It seems unlikely that there would be such a high percentage of reporting among this group of individuals in these two situations. Even assuming that

this self-report is accurate, a substantial proportion of this group still might refuse to report a client for any reason. A small minority (less than 3%) indicated that they would never report child abuse, a serious threat of physical injury, or a suicide threat, implying that they would ignore any possible legal or ethical obligation to do so. Nearly one-third of the respondents would not report a client for a crime confessed.

In determining what the professional standard of a Tarasoff warning is, the question becomes one of interpretation, given the relatively small percentage of those who have warned (24%), and given the fact that 17% of the sample indicated in response to another question that there were instances in which they would refrain from warning a third party when there was a legal or ethical obligation to do so. When determining the professional standard of warning, courts and juries should rely on data as to actual therapist behavior rather than data as to their attitudes on such practices.

The Tarasoff ruling was ambiguous in that it did not specify to whom a warning must be given. The holding only required that the therapist use reasonable care to protect the intended victim. Depending on the facts of the case, different individuals could be notified in order to

fulfill a therapist's legal obligations. If the primary consideration is to protect the intended victim, it seems that the victim should be the one most often notified. In answering the question, "If you have warned third parties about the potential dangerousness of one of your clients, whom have you warned?", respondents appeared to indicate to whom they had given a warning for all categories of reporting, not just for Tarasoff warnings. When a third party was warned, therapists most frequently reported warning the victim's family (35%), medical personnel (20.3%), the victim (18.3%), police (13.2%), and a court of law (2.9%). The fact that suicide threats were a frequently reported behavior may account for the higher incidence of warning the victim's family. The questionnaire did not differentiate between categories of reporting and who was warned (the Tarasoff ruling, for example, does not apply in the cases of suicide threat), but the data obtained are still informative in indicating the general pattern of warnings given to third parties. This questionnaire did not specify what type of medical personnel were warned, and it would have been helpful to know what types of medical personnel were typically warned (i.e., private physician, hospital psychiatrist, etc.) and what the intention of the warning was (medication, commitment,

etc.). For all cases of warning (pre- and post-Tarasoff), Wise found that 31.3% of her sample had warned a family, 16% warned the victim, and 17.7% the police. Again, this indicates a consistent pattern across studies.

A pattern emerged from the data which showed that those individuals who reported a client in any particular category (child abuse, threat of serious physical injury, a crime confessed, a suicide threat) were more likely to have reported a client for other categories than those who had not given such a warning. This may be interpreted as a type of threshold of warning, which once broken, leads to giving future warnings in the same or other categories. No difference was found in the frequency of warning across different clinical orientations.

Individuals reporting clients for child abuse, threat of physical injury, and threat of suicide were more likely to have some type of contact with the legal profession than those who had not reported under these circumstances. This may simply reflect the fact that the legal profession becomes involved in the process of warning (57% of the sample consulted with attorneys about psychological questions), or it could indicate that those involved with the legal profession are more sensitive to legal

obligations (or potential legal liabilities) and therefore are more willing to breach confidentiality and warn.

Familiarity with the Tarasoff decision was not correlated with whether or not an individual had reported a client for child abuse, for a threat of physical injury, for a crime confessed, or for a suicide threat. Whatever the other effects awareness of Tarasoff had, it did not have a significant effect on the behavioral measure of actual warnings given.

Effects of Warning Third Parties

The intent of the Tarasoff ruling was for therapists to reduce the risk of harm that some clients present to third parties. The California Supreme Court did not specify specific actions that should be taken in order to protect the intended victim, but only required that the therapist use reasonable care. The giving of a warning to the victim or to a third party was seen by the court as an acceptable method of carrying out this duty, but critics of the case saw the giving of a warning as problematic for both therapists and clients. Critics predicted that clients would leave therapy because they either feared a breach of confidentiality or because confidentiality was actually breached; that if a warning was given and the

client stayed in therapy, the therapeutic relationship would be adversely affected; and that clients' rights may be violated if clients are not provided with informed consent at the start of treatment (Stone, 1976; Griffith & Griffith, 1978; Everstine et al., 1980).

This study found that therapists who gave Tarasoff warnings of threat of injury to another were more likely than therapists who had not given such a warning to have had a client leave therapy because the client feared a breach of confidentiality. This leaving of therapy was not all in response to a third party being warned. Only 18 therapists (5.2%) reported a client leaving therapy due to an actual breach of confidentiality after a warning was given; 57 therapists (16.3%) reported being aware of a client leaving therapy because the client feared a breach of confidentiality. One of the criticisms of Tarasoff may be confirmed here if therapists who give notice about giving warnings tend to frighten away from therapy those individuals who may be the most likely to commit violence and who do not wish to be reported.

Whether or not to inform a client that a warning is going to be given can be a problematic issue for therapy. With regard to obtaining consent before warning, a therapist may or may not feel an ethical obligation to do

so, but there is no legal requirement that he or she obtain consent. However, not telling a client that a warning is to be given may subject a therapist to a lawsuit for failing to provide informed consent if the therapist never informed the client at any time during therapy that there were instances in which confidentiality may have to be breached (see Fleming & Maximov, 1974; Everstine et al., 1980). An argument could be made that to give a warning to a third party which results in some legal action taken against the client when the client was not informed of this possiblity is tantamount to entrapment. Dix (1981) argues that courts might accept the explanation that a therapist did not give advance notice of such a possibility to avoid discouraging the client from undergoing treatment or withholding information from therapy which would make therapy less effective. Though it is not clear how courts would adjudicate this issue, many feel that therapists have both a legal and ethical obligation to disclose limits at the start of therapy and should do so, despite whatever harmful effects it may have on the course of therapy (Mental Health Task Report, 1978; Bersoff, 1976; Hare-Mustin et al., 1979).

For those therapists who have given a warning, 31% always obtained a client's consent before warning, 30%

usually obtained consent, 24% sometimes obtained consent, and 15% never obtained a client's consent. The percentages of therapists informing clients that they were going to give a warning were: 59% always informing, 20% usually, 15% sometimes, and 6% never informing. If the client's consent is obtained before warning, as Roth and Meisel (1977) advocate, then the therapist and client can work through the unwieldy duty that Tarasoff may impose with minimal damage to the therapy relationship, and possibly an improvement. Dix (1981) interprets the consent involved in this instance as therapists informing clients that if the client continues in therapy, the therapist may have an obligation to breach confidentiality by warning a third party. For the therapist to continue therapy, he or she would need the client's consent to warn; without this consent, the therapist would no longer be able to treat the client. Should the client not be willing to give consent and drop out of treatment, the therapist may still have a duty to warn others. Consent in this scenario, however, would not seem to be truly voluntary as the therapist is the one dictating how the client is to respond if therapy is to continue.

As far as the actual effect on therapy of giving a warning to a third party, most often therapists reported

that therapy improved after a warning because of the issues confronted and addressed (n = 128; 51% of those who have warned). This is the ideal situation when a warning has to be given. In 45 cases (19% of those who have warned), the client stayed in therapy but the therapeutic relationship was reported to be adversely affected. This may not be too large a price to pay if the threatened danger is averted through warning. To prevent danger is the primary concern of warning, and therapy can then focus on the impact warning has had on the therapeutic relationship. In 18 cases (7% of those who have warned), however, the client left therapy due to the breach of confidentiality (as was the case with Poddar in Tarasoff). In some cases the therapist might be able to trace what happened to his or her client, but in many instances the therapist may not know what has happened or if the action of warning has actually increased the threat of harm (see "Confidentiality Issues," below). The other possibility in this situation is that giving of a warning has no appreciable effect on therapy or the therapeutic relationship, and 19 therapists (7% of those who have warned) reported this effect. As there is some overlap in the above categories, the same therapist may have different results with different clients and may not be able to predict how a

particular client may respond to a breach of confidentiality.

Data from this study indicate that many of the critics' fears surrounding the Tarasoff decision were not unfounded. Clients have left therapy fearing a breach of confidentiality or in response to an actual breach; 20% of the therapists who have given a warning to others reported that a therapeutic relationship was adversely affected by the warning; and 7% of the therapists who have given a warning to others reported that a client left therapy in response to a warning. Often times therapists do not inform their clients that there are instances in which confidentiality may be breached, or that they are going to give a warning when they decide to warn (see "Confidentiality Issues," below, for further discussion of these issues). Awareness of Tarasoff has increased therapists' anxiety when issues relating to dangerousness are brought up in therapy and has also made therapists less likely to work with potentially dangerous individuals. Not all of the effects of Tarasoff were negative, however. Fifty-one percent of the therapists who have given a warning reported that the warning caused an improvement in therapy due to the issues confronted and addressed. As a result of their awareness of Tarasoff, therapists have become

more aware of their legal and ethical obligations, and they are now more likely to consult with other mental health professionals when involved with a potentially dangerous client.

To the extent that therapists' actions as a result of Tarasoff have prevented harm to third parties, then the ruling has achieved what it intended to do. The ruling has failed to the extent that it creates more harm than it prevents (i.e., potentially dangerous clients do not receive the treatment they need, and their actual risk to society is increased). Most therapists did not know what happened to clients after they left therapy because of a breach or fear of a breach of confidentiality, and it may be impossible in many cases to accurately determine the actual negative consequences of Tarasoff. In viewing the results of this study, one should keep in mind that the majority of the respondents had no legal obligation to follow the dictates of the Tarasoff ruling. Had these respondents actually had a legal duty to protect third parties, the effects noted from the decision may have been even greater than those reported.

Dangerousness Issues

The Tarasoff ruling is based on the assumption that clinicians are able to determine that a client presents a serious danger of violence to another. There is a vast body of literature which presents evidence that no one has been able to predict dangerous acts with any degree of reliability (Birns, 1980; Brooks, 1978; Cocozza & Steadman, 1976; Diamond, 1974; Dix, 1980; Megargee, 1970; Shah, 1978; Stone, 1976). Nevertheless, psychotherapists' opinions as to a person's dangerousness are routinely sought and obtained as evidence in such proceedings as civil commitment hearings, criminal trials, and bail, sentencing and parole hearings. The U.S. Supreme Court, in a recent case stemming from an appeal of a capital murder sentence, rejected the American Psychiatric Association's contention that expert testimony regarding a person's future dangerousness is inherently unreliable and should not be admitted as testimony (see "Recent Court Decisions," below, for a discussion of this case). When presented with a Tarasoff case, a court will hold a therapist to the standard of warning (which involves making a prediction of future dangerousness) of the profession. As long as therapists continue to make predictions of dangerousness, other therapists of that profession will be held to that

standard. This study focused on several aspects of the dangerousness issue to collect data on current practices of psychologists.

Violent Fantasies. In order to make a prediction regarding a person's dangerousness, a therapist must either rely on some overt threatening or out-of-control behavior (such as bringing a gun or knife into therapy, or signs of psychotic behavior), or else verbal statements made by a client indicating an intention to harm oneself or others. With regard to verbal statements, the task for the therapist is to differentiate the serious threat from the threat which is simply a by-product of the cathartic process of therapy. Respondents reported that on the average, approximately one out of five clients (21.7%) disclose violent fantasies or threats towards another person. The range varied from 0% (11% N) to 100% (2% N). Clinical orientation was significantly related to the percentage of clients disclosing violent fantasies, with psychodynamic-oriented therapists reporting the highest mean percentage, followed by humanistic, "other," existential, eclectic, and cognitive-behavioral therapists. If the three smallest groups are excluded, the psychodynamic mean percentage is approximately twice as large as the mean percentage for either eclectics or cognitive-behaviorists. The trends for the three smallest groups remain ambiguous.

Different styles of therapy obviously emphasize different aspects of a person's personality and use different treatment approaches, and it should not be surprising that a psychodynamic approach (30% mean percentage) which works with free association and making the unconscious conscious would faciliate more "primal" material. At the other end of the spectrum, cognitive-behaviorists reported a mean percentage of 14.2. This approach would seem to reflect less of an emphasis on unconscious processes and more of a concern with modifying thoughts in the here-and-now to achieve the desired result. The importance of the clinical orientation with respect to violent fantasies is that the more violent fantasies that are encouraged by the process of therapy, the more threats the therapist will have to evaluate for actual potential danger. Even though psychodynamic therapists reported seeing a higher percentage of clients who made violent fantasies, clinical orientation did not make a difference as far as frequencies of actual warnings given to third parties. Obviously, other factors besides a client's disclosing of a violent fantasy are considered in making a determination of dangerousness.

Another variable relevant to the issue of dangerousness is that of the psychopathology present in

the client. The less control a person has, the more likely he or she would be to perform some type of socially inappropriate behavior ranging anywhere from a statement or comment to a homicidal act. Over 50% of the respondents reported seeing clients with a diagnosis of paranoid disorder or anti-social personality. Other commonly seen DSM-III diagnostic categories included schizophrenic disorders, substance use disorders, passive-aggressive personality, affective disorders, anxiety disorders, and adjustment disorders. When a therapist works with a client who falls into a diagnostic category which is associated with violent behavior (such as explosive personality or borderline personality), the therapist will have a need to take seriously threats made by such a client. A therapist will not need to take as seriously threats made by a client who falls into a diagnostic category not typically associated with violent behavior. However, as respondents noted, "normals" make violent threats and have been known to engage in violent acts with no previous history of violent behavior. Diagnostic category may be a helpful indicator of seriousness of potential danger, but it is not foolproof.

Spouses were listed as the most frequent object of violent fantasies in therapy. This can be problematic for

Tarasoff warnings and confidentiality if the spouse does not know the other spouse is in therapy. (This same problem arises whenever the third party is not aware of the client being in therapy.) The next likely objects were parents, employer, client's children, friend, relative, stranger, and public figure. The higher the object of the fantasy on this ranking, the more intense or close or frequent (in terms of amount of time spent with that person) the relationship would seem to be. This finding is consistent with Wexler's (1979) contention that the majority (88%) of the victims of violence are either family members or individuals with close emotional ties to the offender. His suggestion for treatment of a dangerous person is to not only treat the violence-prone client, but also the targeted victim, who may be contributing to a violence-prone pathological relationship with the potentially violent client.

Causality is not implied in terms of seriousness of threat by ranking (i.e., threats made about a spouse should not be interpreted as being more or less serious than threats made regarding a public figure). Therapists were not included in this list even though clients direct violent fantasies towards them, since there is no third party involvement in terms of warning someone outside the

therapy context. Therapist-directed violent fantasies still raise Tarasoff concerns since the therapist may wish to warn third parties such as the police about the threat made.

Dangerous Individuals in Therapy. On the average, therapists reported seeing approximately 4 outpatients a year who were considered to be potentially dangerous. Less than 6% of the sample saw more than 10 such individuals. Therapists reported spending an average of 27 hours a week seeing clients on an outpatient basis. Assume that this translates to 27 clients per week (a conservative amount, ignoring group, family and couples therapy). Assuming a turn-over of clients every three months, this would yield an average of 108 different individuals seen per year. Approximately 23 of these individuals (21.7%) disclose violent fantasies. Given that on the average, only 4 outpatient clients per therapist are considered to be potentially dangerous, this would translate to about 1 potentially dangerous individual for every 6 clients who reported a violent threat. Since these are the figures reported by therapists, they either must view only a small percentage (approximately 17%) of threats made in therapy as potentially dangerous, or else they are able to differentiate violent fantasy threats from genuine violent threats.

No relationship was found between the number of dangerous clients worked with per year and the accuracy with which one believed one could predict a dangerous act, to the threshold level of warning, or to agreement with the statement that psychologists are qualified to testify as expert witnesses with respect to the dangerousness of an individual. This implies that no sense of expertise is gained from working with individuals which would help therapists in making decisions relating to dangerousness. This could either be a function of the unreliability of generalization in this area, or it could be that therapists simply do not see enough dangerous individuals in their practices to acquire much of a working skill (on the average, less than four a year in this study).

Over half (62%) the respondents stated that they had received some type of training in recognizing or predicting dangerousness, but having this training was also not related to how well they thought they could predict a dangerous act or to the threshold level of warning. The questionnaire did not ask for the amount or nature of training obtained, but it would appear that the training was not helpful in improving one's self-assessment of predictive skills over one who had no such training.

The majority of therapists (76.5%) believed that psychologists are qualified to testify as expert witnesses with respect to the dangerousness of an individual. The higher one rated one's dangerousness predictive ability, the more likely he or she was to be in agreement with this statement. It is interesting that while such a large percentage were in agreement with this statement, overall, therapists rated their ability to predict dangerous acts at only a 51.5% accuracy level. This figure corresponds with the conclusion of the American Psychiatric Association that psychiatrists have no expertise in predicting long-term dangerousness, that psychiatric predictions of dangerousness are accurate in no more than one out of three cases, that psychiatric training is not relevant to the factors that validly can be employed to make such predictions, that psychiatrists consistently err on the side of overpredicting violence, and that a layman with access to relevant statistics can do at least as well and possibly better.[55]

Dix (1981), however, distinguishes the long-term prediction of behavior of a person with a criminal history from the prediction faced by a psychotherapist of the

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[55] Barefoot v. Estelle, 103 S.Ct. 3383 (1983), 3408-3409, Justice Blackmun, dissenting, citing American Psychiatric Association brief.

short-term behavior of a person without an extensive criminal history. He views the task Tarasoff requires of mental health professionals as more akin to that presented when a prospective patient is evaluated for purposes of determining whether short-term emergency hospitalization is warranted. The current dangerousness prediction research is based on long-term predictions of behavior of criminals, and there are no data on the accuracy of short-term risks. Since no one knows how accurate psychotherapists are in predicting assaultiveness in Tarasoff situations, Dix believes that it is a mistake to completely accept the available evidence as indicating no ability to predict. Nevertheless, there are going to be instances in which warning a third party would be appropriate, but the client may not appear dangerous enough to meet the requirements for civil commitment (i.e., the harm may not appear imminent enough). The therapist is still left with the decision of whether or not to warn in such a situation. Also, given that dangerous acts are a low base-rate behavior, the frequency of such acts are more likely in a population with a past history of violent acts than they are in a population with no such history. Even though there are no data on short-term predictions of violent acts, there is no reason to conclude that

short-term predictions of dangerousness would be significantly different than long-term predictions.

Therapists distinguished their ability to predict a dangerous act (51.5%) from the threshold level of warning, and would require a higher likelihood of dangerousness (64.7%) before they would breach confidentiality and warn others. In essence, therapists are saying, "I do not believe I can predict dangerousness very well, but I have to be able to predict it even better before I will breach confidentiality." Indeed, the higher the threshold level of warning, the less likely they were in the past to have reported a client for any reason, and the less likely they would be in the future to report a client. Considering that acts of violence are a low base-rate behavior, a 51.5% level of accuracy is not that poor of a prediction rate. Still, one's stated prediction level may have little or no correlation with how accurately one can actually predict a violent act.

Since there was no correlation between how well one believed he or she could predict a dangerous act and past reporting of clients for making serious physical threats to others, therapists must base their decisions to report on other factors besides their ability to predict dangerousness. If this is true, then therapists do not

depend on a high degree of certainty before deciding to warn, but instead base their decision on the weighing of other factors such as risks of warning versus risks of remaining silent. There was no correlation between one's dangerousness predictive ability and past or future reporting (if one had not done so before) of child abuse, dangerousness, a crime, or suicide threat.

Clinical Predictions. Therapists listed a variety of factors which they felt were useful in making them more confident in predicting dangerousness. These factors included an accurate case history, client's history of violent acts, client's personality dynamics, psychological test data, present state of the client, familiarity with the client, client's current plans to commit violence, and the therapist's clinical experience and training. These factors are discussed in more detail in Chapter 3, supra. Dix (1981), in an analysis of this issue from a legal perspective, believes that in determining whether or not a Tarasoff warning should have been given, courts would look to such factors as the extent to which the client has engaged in similar action in the past, any threats made by the client and the specificity of those threats, and any indication to the therapist that the client has made specific plans for the assault. The decision of whether

or not dangerousness should have been predicted (and whether or not to give a warning) may always appear clearer in retrospect; as some psychologists stated, the only truly accurate and useful method of predicting dangerousness in advance is to be omniscient.

Confidentiality Issues

Imposing a duty on therapists to protect third parties directly affects the confidential therapist-client relationship. The issue of confidentiality is critical in examining the impact of Tarasoff on the practice of psychotherapy, since the Tarasoff duty potentially decreases the level of communications made by a therapy client which are confidential and protected. Therapists' attitudes and practices regarding confidentiality are important since it is their practices which determine how much disclosure is made to third parties. Potential therapy clients have no way of knowing how protected their communications are until they enter therapy. If therapists do not provide clients with relevant information regarding treatment, then clients may be unaware of any limits to confidentiality until a situation arises in which confidentiality may need to be breached.

A high percentage of the respondents in this study believed that absolute confidentiality between therapist and client was essential in maintaining a positive therapeutic relationship (M = 6.03 on a 7-point scale). Only 4% viewed this as nonessential, and 3% were neutral. Those therapists who were older and had more clinical experience were more strongly in agreement with this statement than younger and less experienced therapists. Those rating absolute confidentiality as more important were less likely to have reported a client in the past for dangerousness or for a crime confessed than those rating confidentiality as less important. This stance towards absolute confidentiality was one of the factors identified in a factor analysis of the Likert items. Also loading positively on this factor was the belief that disclosure is affected by telling clients the limits of confidentiality at the start of therapy. Agreement with the Tarasoff ruling (agreeing that therapists have a duty to protect third parties) loaded negatively on this factor.

There was no correlation between how essential a respondent rated absolute confidentiality and past reporting of child abuse or a suicide threat. This indicates that whereas a therapist may hold absolute confidentiality essential, there are certain circumstances under which he

or she would breach it. This same discrepancy shows up when comparing agreement with this statement with the relatively large number of therapists who have given warnings in the past for suicide threat (65%), physical dangerousness of a client (24%), and child abuse (23%). The most reliable indicator of what people actually do is their past behavior as opposed to what they say they would be likely to do.

A sizable minority (16%) of the respondents indicated that at least some of their clients left therapy because they feared a breach of confidentiality. Wise (1978) reported that 25.7% of her sample reported losing a patient because the patient feared a breach of confidentiality. She may have found a higher percentage in her study for a number of reasons. First, her study was conducted in California where Tarasoff applies. Her study was conducted shortly after the ruling was given, when publicity regarding the case was highest. A higher percentage of both therapists and clients may have been aware of the case and its implications for them. In addition, her sample size (N = 1328) was nearly four times as large as the sample in this study, which might account for differences between studies. Her study also consisted largely of psychiatrists, who may be more likely to breach

confidentiality than psychologists (see "Other Professions," below). The most significant of these reasons would be the fact that there is a differential warning rate across professions. There is some evidence for this across these two studies, as 49.7% of Wise's sample reported warning a third party that a client posed a threat to someone prior to Tarasoff, and 37.6% did so in the year following Tarasoff. Only 24% of respondents in this study reported making such a warning.

In Wise's study, the median loss of patients leaving therapy because they feared a breach of confidentiality was 3 patients per therapist (range = 1 to 100). When asked what became of those patients, 62.6% said they did not know, 23.2% said the patient refused further treatment, and only 11.1% reported that the patient had returned to therapy or had been successfully referred to other therapists. If this is already a trend present in psychotherapy, it would appear that by increasing the number of situations in which there is a legal requirement to breach confidentiality (i.e., more states adopt the Tarasoff rationale), the number of clients leaving therapy for this reason may increase.

A profile of therapists with clients leaving therapy fearing a breach showed that they were more likely to have

training in predicting dangerousness, and were more likely to have reported a client for a threat of physical danger to others, than those who did not report clients leaving under this circumstance. The most troubling statistic here is that therapists who have given Tarasoff warnings in the past were more likely to have clients leave therapy than those who have not given such warnings. As noted above, clients who left therapy did not all do so in response to a third party actually being warned, but may have left therapy fearing that a warning was going to be given. The fact that contact with the legal profession and having training in predicting dangerousness were associated with clients leaving therapy may indicate that this particular group of therapists may have become sensitized (possibly overly sensitized) to their legal and ethical obligations and duties, and, in the process of attempting to carry them out, inadvertently have driven some clients away from therapy.

Agreement with the statement, "If clients are informed as to the limits of confidentiality at the start of therapy, they will not disclose as much during therapy as they would have otherwise," identified a group of therapists with a similar profile as those who rated absolute confidentiality between therapist and client as

essential. Respondents were about equally divided on this statement, with 46% disagreeing with it and 45% in agreement with it. Those who more strongly agreed with this statement were more likely to have not reported a client to a third party for any reason, and were generally less likely to report a client in the future, than those disagreeing with the statement. Those agreeing also rated absolute confidentiality more important, less frequently discussed limits to confidentiality with clients at the start of therpy, would have to be more certain about a client's dangerous act before warning, disagreed more with the Tarasoff ruling, and tended to have more clinical experience than those disagreeing. That therapists who believe that informing clients as to the limits of confidentiality has a chilling effect on disclosure tend not to discuss these limits with clients shows a consistency between how they feel and what they actually do.

If a therapist was genuinely protective of his or her client's confidentiality interests, then the ultimate manifestation of this protection would be to face a contempt-of-court citation or jail sentence for refusing to disclose court-requested information. Over one-third (35%) of the respondents stated that they would be more likely to choose a contempt-of-court citation, 14% would

be more likely to disclose, and 50% did not know what they would do under the circumstances. Thirty-five percent seems like a high figure, and it is questionable whether this many therapists would actually accept a contempt-of-court citation. Certainly the facts of the situation (the reason for disclosure, effect on the client of disclosure, penalties involved) would influence a therapist's behavior in the situation. The fact that so many therapists at least say they would choose a contempt citation indicates a very strong feeling towards the right of confidentiality and the protection of clients.

Informed Consent. The decision to enter psychotherapy can involve a client waiving some of his or her privacy rights if there are situations in which the therapist can reveal certain information about the client without the client's permission. If clients are not told of this at the start of therapy, their decision to enter therapy cannot be considered to be made with informed consent. Many recently have advocated that therapists inform clients at the start of therapy, preferably in written form, of their rights as a client so that they can make an informed decision about entering therapy. Suggestions have been made as to what types of things clients should be told regarding their rights as clients (Everstine et

al., 1980; Hare-Mustin et al., 1979; Levine, Stolz, & Lacks, 1983). Written material has the advantage of being able to be read at the client's leisure and also ensures that no information is inadvertently omitted by the therapist (Levine et al., 1983). The primary consideration, however, should be the conveying of essential information, rather than the form it is presented in.

Only 12% of the respondents provided clients at the start of therapy with written material which described various aspects of therapy or informed clients of their rights. Only one psychologist included a copy of this written material with the completed questionnaire. This particular form explained the group's approach to couple and family therapy, goals focused on, evaluation of therapy, confidentiality policy ("NO information will be released to anyone without the written consent of all persons seen in treatment."), video recording policy, cancellation policy, and insurance policy.

About 76% of the respondents said they discussed the right of confidentiality at the start of therapy, but only 27% indicated that they discussed limitations to that right at the same time. A sizable portion of clients, then, may enter therapy believing that confidentiality will be absolute and only further into therapy may find

out that their idea of complete confidentiality was inaccurate. About half the subjects discuss limitations when the client asks directly, and 65% discuss limitations if an outside party needs to be contacted. Again, it seems too late to bring up the issue of limits to confidentiality only when confidentiality may have to be breached. A very small percentage (4%) indicated that they never discuss limits to confidentiality with clients. Working with children and adolescents presents a different perspective on confidentiality in that therapists may vary in what they disclose about therapy to the parents. A few therapists indicated that they always inform young clients as to the limits of confidentiality but infrequently inform their adult clients.

Therapists who are faced with having to give a warning to a third party are faced with a dilemma when their clients do not know that breaching confidentiality is a possibility. This may be the situation when therapists decide not to routinely inform clients of this possibility. This puts therapists in the position of having to tell a client that they have to breach confidentiality and (should the client ask) that they knew about this possibility when the client entered therapy but chose not to tell him or her. Therapists who do not routinely

provide clients with relevant information regarding treatment face placing themselves and their clients in this awkward situation.

Legal Issues

Familiarity with State Laws. Swoboda et al. (1978) noted that mental health practitioners have been criticized for having less than adequate knowledge of their legal obligations. In a limited survey of mental health professionals in Nebraska (31 psychologists, 22 psychiatrists, 35 social workers, and 10 bachelor-level case workers), Swoboda et al. found that a significant proportion of all professionals were unaware of two of the most basic laws that applied to their professions, one providing for privileged communications and another requiring the reporting of child abuse. The percentage of psychologists who were unfamiliar with each of these laws was 32%. Furthermore, when presented with a hypothetical child abuse case, 66% of the subjects (87% of the psychologists) indicated that they would not have reported child abuse, despite the law requiring its reporting. Taken as a preliminary survey, it indicated to Swoboda et al. that more efforts needed to be expended in teaching mental health professionals their legal obligations.

Even though their sample of psychologists was very small (n = 31), the percentage of psychologists unfamiliar with privilege and child abuse reporting laws that Swoboda et al. found was comparable to that found in the present study. Here, 34.7% were unfamiliar with their state law providing for psychotherapist-patient privilege, and 28.6% were unfamiliar with the law requiring the reporting of child abuse. Swoboda et al. did not survey respondents' knowledge regarding confidential communication since, "it is difficult to imagine any mental health professional being ignorant of the law of confidentiality" (p. 449). This turned out to be a rather optimistic assumption, as this study found that 36.1% of the respondents were unaware that their state had a law providing for confidential communications. It is hard to imagine that this many psychologists do not at least treat communications as confidential, despite their ignorance of their state law. With regard to incurring liability for breach of confidentiality, only 22.3% were aware that they may be civilly liable for an unauthorized breach of confidentiality. All states now have a law requiring the reporting of abuse of disabled or aged persons (Illinois did not have such a law at the time of this survey). Only 11.2% were aware of this fact.

For all states, residents correctly identified only 47.2% of the laws which their states actually had (excluding laws which their state did not have). This finding substantiates the criticism that mental health professionals (at least psychologists) have less than an adequate knowledge of their legal obligations.

There was a consistency between self-report and actual knowledge, as those who rated themselves as better informed and up-to-date on legal issues relating to psychotherapy correctly identified a larger number of their state laws than those who rated themselves as less informed. Contact with the legal profession appeared to increase one's awareness, as did the reporting of a client to a third party. Those who correctly identified more state laws also discussed more often the right of confidentiality verbally with clients at the start of therapy than those who correctly identified fewer laws. Therapists who do discuss this right with clients provide clients with more information regarding treatment than those therapists who do not discuss this right.

Tarasoff-type Litigation. The New Jersey decision of McIntosh v. Milano in 1979[56] adopted the Tarasoff

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56 168 N.J. Super. 466, 403 A.2d 500 (Sup. Ct. New Jersey, June 12, 1979).

rationale for residents of that state. Over two years after the decision, only 11 (20%) New Jersey respondents were aware of this fact, and only 4 (7%) could give the name of the lawsuit. Only one respondent from Maryland (2%) knew that Maryland had a Tarasoff-type lawsuit (which rejected the Tarasoff rationale), but that individual could not name the lawsuit.[57] These cases are no less relevant to the residents of these states than the Tarasoff case is to the residents of California (and of states adopting the Tarasoff rationale), yet very few individuals knew of them. (See "Implications" below, for a further discussion of psychologists' awareness of relevant legal issues.)

Legal Contact. Over the past two decades, there has been "a veritable profusion of professional and scientific literature dealing with various issues at the interface of the legal and mental health systems," along with greatly increased attention and interest shown in the areas of forensic psychiatry, forensic psychology, and related mental health disciplines (Shah, 1981, p. 219). This growing trend appears to have been embraced by psychologists, as the majority of those surveyed reported some type of

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[57] Shaw v. Glickman, 415 A.2d 625 (Md. Ct. Spec. App. 1980).

contact with the legal profession, and over 40% had two or more contacts per month. Attorneys were frequently consulted regarding psychological questions, and court or agency referred psychological evaluations were the most common law-related activity reported. Over half the respondents indicated that they had testified as an expert witness. About 15% testified as to a person's dangerousness, indicating that psychologists are beginning to follow the trend set by psychiatrists, who have long claimed an expertise in this area (and who now, ironically, are claiming as a profession that they have no special expertise in this area, at least as far as long-term predictions of violence). Psychologists also reported involvement in divorce and child custody proceedings, testifying as to a person's mental status, testifying in involuntary commitments, and aiding in jury selection process.

Familiarity with Legal Issues. Respondents were split in their self-reporting of how well-informed they were on legal and professional issues relating to the practice of psychology, with about 40% stating they were poorly informed and a similar number stating they were well-informed. Florida residents rated themselves the highest on this question, yet only 12% of the Florida

respondents noted the current status of their suspended licensing. There was no significant correlation between state ranking on this question and mean number of laws correctly identified (by state), but there was a significant correlation on an individual basis between self-rating on this question and the number of laws correctly identified. Those with more clinical experience did not rate themselves differently than those with less experience. Behaviorally, a higher self-rating on this variable was associated with providing clients with written information at the start of therapy, the giving of more Tarasoff-type warnings, and having training in predicting dangerousness.

As therapists' awareness of legal and professional issues increases, the level of competent service they provide to clients may also increase. This may take the form of providing more clients with information relevant to informed consent, such as informing clients of the limits of confidentiality. At the same time, therapists may increase the number of instances in which they breach confidentiality, possibly resulting in some of the negative consequences of Tarasoff, such as clients leaving therapy prematurely, or having the therapy relationship adversely affected. In this instance, increased knowledge is desirable, but it may turn out to be a mixed blessing.

Sex Differences. Generally, there were very few sex differences among the respondents. Compared to men, women had fewer contacts with the legal profession in certain areas (consultations with attorneys, testifying as an expert witness, and testifying as to a person's mental status), less often reported seeing anti-social personality disorder clients who made violent threats, and more often obtained a client's consent before warning.

Implications

Recent Court Decisions

There have been several court decisions handed down after this survey was conducted which are directly relevant to the issues involved here and have significant implications as far as the impact Tarasoff may have on the profession of psychology.

In Hasenei v. United States, a U.S. District Court took exception to the "special relationship" between psychotherapist and patient which imposes an affirmative duty on the psychotherapist for the benefit of third persons.[58] The defendant in this case was Dr. Gerber, a Veterans Administration psychiatrist. On August 9, 1976, he

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[58] Hasenei v. United States, 541 F. Supp. 999 (D. Md. 1982).

examined John Hock at a VA Outpatient Clinic in Harrisburg, Pennsylvania, on a follow-up visit scheduled after Hock's discharge from the Lebanon, Pennsylvania, VA in March, 1976. Hock had been treated as an inpatient since January of that year and was diagnosed as suffering from alcoholism and schizophrenia, paranoid type. Dr. Gerber diagnosed Hock as a paranoid schizophrenic in partial remission, concluded that he was not actively psychotic but was competent, changed Hock's medication, and scheduled another appointment to see him on September 13, 1976. On August 21, 1976, Hock collided head-on with plaintiffs' car and was killed. Plaintiffs brought suit, alleging the psychiatrist was negligent in permitting Hock to leave the VA outpatient clinic. Defendant alleged that under Pennsylvania law, the United States owed no duty in tort law to protect plaintiffs or the general public from any danger allegedly posed by Hock. They relied on Leedy v. Hartnett, a previous Pennsylvania case[59] which assumed that Pennsylvania courts would entertain a Tarasoff theory of liability, but held that the doctrine could not be extended to cover the facts of a case where the particular victim had not been identified in advance. In Leedy, plaintiffs, husband and wife, alleged that the Lebanon VA

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[59] Leedy v. Hartnett, 510 F. Supp. 1125 (M.D. Pa. 1981).

Hospital was negligent in failing to warn them of the alleged violent tendencies of a veteran, Hartnett, who had been released from that hospital and who had come to live in the plaintiffs' home. About six months later, Hartnett attacked his hosts and beat them while they slept. The victims sued the hospital for having failed to apprise them of Hartnett's assaultive tendencies. The court held that Hartnett did not pose any danger to the Leedys any different from the danger he posed to anyone with whom he might be in contact when he became violent. The Leedys were not the type of readily identifiable victim or group of victims the Tarasoff case has been interpreted to apply to.

In reviewing the cases which recognized that the psychotherapist-patient relationship may impose a special duty to control the behavior of another (i.e., Tarasoff and subsequent cases which adopted the Tarasoff rationale), the Hasenei court noted that none of the cases indicated what it was about the relationship that caused it to be an exception to the general rule of tort law that generally there is no duty to control the conduct of a third person so as to prevent him from causing physical harm to another. The court went on to hold that the typical relationship existing between a psychiatrist and a

voluntary outpatient would seem to lack sufficient elements of control necessary to bring such a relationship within the exception which requires a special relationship between the actor (in this case, Dr. Gerber) and the third person (in this case, Hock). The court also noted the near-impossibility of accurately or reliably predicting dangerousness, and held that there was no way the defendant could have predicted with any reasonable degree of medical or psychiatric certainty that within 12 days or one month Hock would do harm to himself or others. Judgment was entered for the defendant.

The Hasenei case is important because it offers to juridictions a federal case which explicitly rejects the Tarasoff duty by holding there is no special relationship between psychotherapist and patient. What a particular court decides, however, depends on its interpretation of the law, and at this time there is more support for Tarasoff in case law.

A U.S. Appeals Court[60] in Jablonski v. United States rejected the identical contention argued successfully by the defendants in Hasenei. In this decision, defendants, also Veterans Administration psychiatrists, argued that

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[60] Jablonski v. United States, 712 F.2d 391 (9th Cir. 1983).

there was no special relationship between them and outpatients in their care, and therefore there was no duty to any third parties. The court, applying California law (the relevant law for the jurisdiction the case involved), interpreted Tarasoff to hold that a special relationship exists between any psychotherapist and his or her patient (emphasis added). Philip Jablonski was a veteran with a prior criminal history of raping his wife (Melinda Kimball) and also had previous psychiatric treatment for homicidal ideation towards his wife. After attempting to rape his wife's mother (Isobel Pahls), Jablonski volunteered to undergo a psychiatric examination at the Loma Linda VA Hospital (no formal charges were filed with the police). The police did inform the head of psychiatric services of Jablonski's prior criminal record and recent activities and told him that he needed to be treated on an inpatient basis. The psychiatric head did not convey this information to the psychiatrist who examined Jablonski on July 10, 1978; no attempt was made to locate Jablonski's prior medical records; and no effort was made to hospitalize Jablonski. Jablonski was seen again as an outpatient on July 14 and was scheduled for some tests and given a prescription for valium. On July 16, Jablonski attacked and murdered Kimball. The district court found that the

plaintiff had proven several claims of malpractice against the hospital psychiatrists, including failure to record and transmit information from the police, failure to obtain past medical records, and failure to adequately warn Kimball of the danger Jablonski posed to her. The appeals court held that there was a special relationship between defendant and Jablonski, and affirmed the district court's findings of malpractice. With regard to the issue of foreseeability, even though Jablonski made no specific threats concerning any specific individuals, his previous history indicated that he would likely direct his violence against Kimball. The finding that Kimball was a foreseeable victim was dependent on the district court's finding that the doctors had been negligent in failing to obtain Jablonski's prior medical history. Furthermore, warning Kimball would have posed no difficulty for the doctors, especially since she had previously expressed her fear of Jablonski directly to them.

So, the Tarasoff saga continues, with new twists added by each court which has had an opportunity to hear a Tarasoff case. Probably the most widely published of these cases is the case that three men shot and seriously injured by John W. Hinckley, Jr. brought against a psychiatrist who had been treating Hinckley prior to his

assassination attempt on President Reagan on March 30, 1981.[61] Plaintiffs in this case alleged that Dr. Hopper was negligent in examining, diagnosing and treating Hinckley in conformity with reasonable standards of psychiatric care, and that he knew or should have known that Hinckley was a danger to himself or others and should have warned Hinckley's parents of their son's dangerous condition and should have warned law enforcement officials of Hinckley's potential for political assassination. Judge Moore acknowledged that Dr. Hopper's treatment of Hinckley fell below the applicable standard of care and that the doctor-patient relationship between Hopper and Hinckley gave rise to certain duties on the part of Hopper. Moore concluded, however, that plaintiffs' injuries were not foreseeable, and that there was no relationship between Hopper and plaintiffs which created any legal obligation to the plaintiffs. The requirement of foreseeability led Moore to conclude that a therapist cannot be held liable for injuries inflicted upon third persons absent specific threats to a readily identifiable victim. Hinckley had no history of violence directed to persons other than himself; he had no history of arrests, no previous

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61 Brady, McCarthy, and Delahanty vs. Hopper, No. 83-JM-451 (D. Co., Sept. 14, 1983).

hospitalizations, and did not appear to be a danger to others. Further, plaintiffs made no allegations that Hinckley made any threats regarding President Reagan, or that he ever threatened anyone. Moore granted defendant's motion to dismiss. Plaintiffs have subsequently filed an appeal with the 10th U.S. Circuit Court of Appeals.

The U.S. Supreme Court recently addressed the issue of whether psychiatrists are competent to testify as to prediction of the future dangerousness of an individual.[62] Barefoot v. Estelle involved application for a stay of execution pending appeal of a death sentence. On November 14, 1978, Thomas Barefoot was convicted of the capital murder of a police officer in Texas. A separate sentencing hearing was held before the same jury to determine whether the death penalty should be imposed. One of the questions submitted to the jury was whether there was a probability that the defendant would commit criminal acts of violence that would constitute a continuing threat to society. The state introduced petitioner's (Barefoot's) prior convictions and called two psychiatrists who, in response to hypothetical questions, testified that petitioner would probably commit further acts of violence

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62 Barefoot v. Estelle, 103 S.Ct. 3383, L. Ed. 2d 1090 (1983).

and pose a continuing threat to society. On appeal, petitioner contended that the use of psychiatrists at the punishment hearing to make predictions about his future conduct was unconstitutional because psychiatrists, individually and as a class, are not competent to predict future dangerousness. The state appeals court rejected these contentions and affirmed the conviction. A federal district court rejected these contentions, and after a series of additional appeals, the Supreme Court heard the case.

Justice White of the Supreme Court concurred with the opinion of the lower courts and viewed "the suggestion that no psychiatrist's testimony may be presented with respect to a defendant's future dangerousness is somewhat like asking us to disinvent the wheel."[63] To accept petitioner's petition that this type of expert testimony is far too unreliable to be admissable would immediately call into question other contexts in which predictions of future behavior are constantly made. Whether or not an individual is mentally ill and dangerous to himself or others and needs confined therapy depends on the meaning of facts which must be interpreted by expert psychiatrists and psychologists. White acknowledged that future

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[63] Id. at 103 S.Ct. 3396.

predictions of dangerousness by psychiatrists and psychologists have shown to be accurate in no more than one out of three predictions, but held that the jury may make up its own mind about the reliability of psychiatric testimony predicting dangerousness. White rejected the contention of the American Psychiatric Association amicus curiae (friend of the court) brief that the unreliability of psychiatric predictions of long-term future dangerousness was an established fact within the profession. He noted that there are members of the Association who expressly disagree with the Association's point of view, and that disputes between expert witnesses are within the province of the jury to resolve. White further held that testimony regarding future dangerousness need not be based on personal examination of the defendant, but may be given in response to hypothetical questions (as was done in this case). The Court affirmed the judgment of the District Court.

From this case, it would appear that the only way there will be a change in the use of dangerousness testimony will be from within the psychiatric professions. As long as there are individuals who present themselves as competent to testify as expert witnesses with regard to the future dangerousness of a person, courts will admit

their testimony and juries will decide as to their reliability. If this type of testimony can meet the requirement of evidence in cases where the greatest individual liberty is at stake (life), then it would certainly qualify in cases where a less rigid evidentiary standard applies.

The implication of this case for psychologists with regard to Tarasoff cases is that they will be held to the standard of other psychologists who claim an expertise in predicting dangerousness. Merton (1982) views the developments of Tarasoff as reflecting a problematic regulation and imposition of professional standards on the practice of psychotherapy by outsiders who are less sensitive to the profession's special problems and less knowledgeable about them than those within the profession. She believes this regulation has come about from failure of those within the profession to resolve their role conflicts and to grapple with the limits of their expertise. One solution to this problem would be for psychotherapists en masse to refuse to render opinions of "dangerousness" during their testimony in commitment proceedings and at death-penalty trials, and for lawyers and judges to learn to challenge those who continue to make such claims. Given the present state of practice, this solution appears unlikely.

Professional Standards

It is clear from this study and others (Swoboda et al., 1978; Jagim et al., 1978) that psychologists possess an unsatisfactory level of knowledge about the law as it relates to the practice of psychology (see also Shah, 1981). Ethically, psychologists should be aware of the law as it relates to them so that they can provide clients with a competent level of service and offer clients the opportunity for informed consent to treatment.[64] The logical place for this type of training to begin would be in graduate school courses. Grisso, Sales, and Bayless (1982) found that 23% of the graduate programs (both APA and non-APA approved programs) in psychology responding to a survey (N = 365, 88.4% response rate) offered a course in which at least half of the content examined issues in the relationships between psychology and the law. An additional 11% indicated that they intended to add such a program to their curriculum. The percentage of APA-approved programs in clinical and counseling psychology offering such courses was 32%, with an additional 16% of the programs planning to add such a course. They also

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64 Ethical Principles of Psychologists, Principle 2, Competence: Psychologists "maintain knowledge of current scientific and professional information related to the services they render" (APA, 1981, p. 634).

surveyed the content of these courses, and concluded that students are not being broadly trained even in departments that offer courses in law and psychology. They concluded that the majority of psychology graduate training programs do not provide training in the laws that apply to psychologists, in how to find the laws and subsequent revisions, or in how to interpret them.

A survey of APA-approved clincial psychology programs published in 1979 found that only 67% of such programs offered courses in ethics (Tymchuk, Drapkin, Ackerman, Major, Coffman, & Baum, 1979). The same year, the APA published criteria for accreditation of doctoral training programs and internships which mandated instruction in "scientific and professional ethics and standards for all students in every doctoral program in professional psychology" (APA, 1979, p. 6). To what extent these required courses provide students with adequate training in this area is unknown. This study found that more recent graduates were not better informed regarding state laws than older graduates, but then only 11% of the sample appeared to be recent graduates with five or fewer years of clinical experience. To be truly effective, a course which provides training in laws that apply to psychologists should teach students about the types of

laws which different states have so that they would know how to go about obtaining that information should they take up practice in a different state. It is questionable how much initiative people would have to seek out this type of information on their own, given the lack of ease with which this information is usually obtained (one needs access to the current laws of the state he or she is in, one needs to know how to find all relevant laws, and one needs to know how to interpret those laws).

Another possibility for educating psychologists in this area is to have state psychological associations provide their members with this information. This is not completely practical, aside from the cost, since not all psychologists in a state belong to their state psychological association. One option that seems to be the most workable would be for the state licensing board (assuming all states have an active licensing regulation) to distribute information of recent developments in the law when psychologists apply to renew their licenses. The cost could be covered as part of the licensing fee, and this policy would insure that at least all licensed psychologists have access to the information. Another option is continuing education courses, but again, not all psychologists would take such a course, and such courses

are probably not universally available. Several Texas respondents requested such a course on the topics covered in the questionnaire. The APA itself is a rich source of information on the interface between law and psychology, but not all psychologists belong to the APA, and not all APA psychologists subscribe to all the journals which present such information. Not all responsibility for continuing education, however, should be structured. Psychologists should take the initiative for self-education as an ethical obligation.

This survey itself was instructive to the respondents, as many wrote how it made them aware of just how poorly informed they were. Other surveys have provided a similar function, but this is a rather haphazard method of educating the population of psychologists.

Other Professions

The Tarasoff ruling, in referring to psychotherapists, would likely be interpreted as applying not only to psychologists and psychiatrists, but to physicians, social workers, registered nurses, counselors, and other mental health workers as well. Articles on Tarasoff have appeared in a variety of professional journals discussing how the case applies to that profession (see, for example,

Roth & Meisel, 1977, psychiatrists; Roth & Levin, 1983, physicians; Kjervik, 1981, psychiatric nurses; Gehring, 1982, counselors; Merton, 1982, lawyers). Professions differ in their ethical standards on confidentiality, ranging from a vague, broad standard such as the American Medical Association Principles of Medical Ethics, "A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law" (AMA, 1981, p. ix), to the recently adopted American Bar Association Model Rules of Professional Conduct, which states that a lawyer may reveal confidential communication "to prevent the client from committing a criminal or fraudulent act that the lawyer believes is likely to result in death or substantial bodily harm, or substantial injury to the financial interest or property of another" (ABA, 1981, pp. 37-38; Quade, 1983). Given these different ethical standards and the different type of training received by individuals of various professions, it seems that respective "appropriate professional standards" will vary.

A comparative study of psychiatrists, psychologists, and internists (internal medicine MDs) done by Lindenthal and Thomas (1980) found significant differences among the

three groups of clinicians regarding the handling of confidentiality (N = 439, 41.1% response rate). Clinicians were presented with 10 vignettes representing a conflict involving confidentiality which clinicians might confront in their practices (shoplifting, family abandonment, reckless driving, embezzlement, altering of scientific data, incest, alcoholism, pyromania, rape, and premeditated murder). Clinicians were asked to check one or more categories representing potential means of handling these conflict situations, and responses were scored as to whether the response represented a patient orientation, a society orientation, or both. When confronted by a patient with a potentially dangerous situation, interns were most likely to say they would break confidentiality, psychiatrists were next most likely, and psychologists were least likely to say they would do so. Clinicians (psychiatrists and psychologists) with a psychoanalytic orientation were found to be the least likely professional orientation to break confidentiality. (In the present study, no difference was found between clinical orientation and the number of warnings given in any category.) Work setting was found to be related to the stated disposition to break confidentiality, as the more time spent in a private office, the less likely the

clinician was to state that he or she might break confidentiality. The greater percentage of time spent by psychologists in a public general hospital, the greater the likelihood to breach confidentiality. Clinicians who experienced similar situations in their practices were less likely to state a willingness to break confidentiality than those who had not. The authors offered this study as suggestive of new hypotheses and empirical research, and acknowledged that what clinicians say they would do does not necessarily reflect what clinicians would do in practice.

As different professions struggle with the problem of the increasing infringement of the law into the arena of confidentiality and privacy, it seems the real issue is not simply one of interpretation of a court case on a particular profession, but one of interpreting the meaning of the case on a broader social level. Society is struggling with the issue of increasing violence among members of society and is trying to find new ways to curb that violence. In the process of doing so, by legislation, common law, and professional self-regulation, the at best blurred distinction between law, ethics and morality is becoming even more blurred. The worst-case scenario would be "Big Brother is not only watching you, but is watching you

watching other people." Increasing the responsibility of those in helping professions to be alert and possibly overly alert to the possibility of violence to members of society may actually reduce some potential violence, but it only addresses the symptom and not the cause. Through judicious self-regulation, a profession can curb this trend by refusing to do things it once said it could do (such as predict dangerousness), or, on a more practical (and probably realistic) level, a profession can actively lobby for legislation which will be in its best interest (see Dorken, 1981). If therapists have a duty to protect third parties imposed by statutory law or case law, they could lobby to have laws passed which would protect them from civil liability for making such a warning (i.e., they would be protected from liability for breach of confidentiality) when the warning was issued in good faith and in accordance with the standards of the profession. Also, laws could be passed which clarify the standards of dangerousness to be used in deciding whether or not a warning should be given. Such laws would greatly reduce the ambiguity now present in this area and in all areas which require a judicial determination of dangerousness. Such a lobbying effort would require strong and dedicated state professional associations which are well-informed as to

the interface of law with that profession. Lobbying is neither a quick nor easy answer to the problems raised by Tarasoff, but given the complexity of the issues involved, solutions are unlikely to be simple.

Future Research

This study confirmed trends noted in Wise's Tarasoff study, and also improved upon her methodology. Further replication in other states would certainly be useful, and another study is reportedly in progress, though no mention is made of the nature of the population used (Appelbaum, 1981). Another population that would be useful as a comparison group would be to survey non-APA psychologists in order to see if belonging to the APA helps one's awareness of relevant professional issues. Areas of the present study which could be expanded as separate areas of research include collecting more data regarding psychologists' attitudes and practices regarding informed consent, determining to whom therapists actually convey information about clients (for example, what kind of information is provided to insurance companies, how frequently colleagues are consulted about a case, etc.), how therapists actually make assessments of potential harm to another, how often therapists have reported clients in the past and the

process involved in making such a decision (i.e., is it an ethical, legal, or self-protective decision), what sources have provided therapists with certain types of legal and professional ethics-type related information, and how psychologists keep abreast of current developments in the field. More important than finding out just how well (or poorly) informed psychologists are is finding out ways to maximize the dissemination and assimilation of current developments in the law as it relates to psychotherapy. Efforts also need to be made to increase psychologists' awareness of the power and effectiveness of lobbying to have legislation passed favorable to psychologists.

Almost lost in the Tarasoff shuffle are the clients themselves. After all, they are the ones whose confidentiality we are concerned about. Schmid, Appelbaum, Roth, and Lidz (1983) reviewed the literature and found a paucity of research on either the effect on genuine therapy clients of altering the level of confidentiality offered to them or data on clients' views of the importance of confidentiality. Two recent studies, which must be taken as preliminary, were done on psychiatric populations and have begun to fill this research gap. The Schmid et al. study involved a semi-structured interview on 30 psychiatric inpatients prior to their discharge from a

university teaching hospital. Confidentiality was found to be highly valued by the majority (77%) of patients in the study. Patients were willing to permit disclosure of confidential material when disclosure could be construed as being in their best interest, but many objected to release without their consent of information to certain parties, such as employers (83% objected), family members (40%), a court (33%), and a third-party provider (21%). Patients were found to be "strikingly ignorant" of their legal rights or remedies as far as confidentiality was concerned.

Lindenthal and Thomas (1982) did a comparative study on the attitudes of psychiatrists, people under the regular care of psychiatrists, and individuals with no experience with psychotherapy towards confidentiality (N = 344, 59% response rate). Subjects answered a questionnaire concerning attitudes towards and effects of confidentiality in the doctor-patient relationship and also completed 10 vignettes (the same vignettes used in their 1980 confidentiality study cited above). They concluded from their findings that high proportions of people under psychiatric care as well as others in the general public are aware of the problem that confidentiality represents for the psychiatrist and are seriously concerned about this issue.

The fear that a psychiatrist might divulge confidences may sometimes be an important impediment to obtaining psychiatric care. Both lay groups were significantly more likely than psychiatrists to have a tendency to reveal confidential information.

Studies such as these using improved methodologies need to be conducted both on inpatient and outpatient clients of psychologists. Studies should focus on what clients' expectations of their rights are when they enter therapy, and what responsibilities and duties they see the therapist owing to them. Long-term therapy studies could be done varying the amount of disclosure made to clients at the start of therapy of various aspects of therapy, and outcome measures could look at the effect of these disclosures on client disclosure during therapy. Also, these studies could determine whether increased disclosure at the start of therapy has an effect on initial drop-out rate. This would identify individuals who are reluctant to enter therapy because they fear a breach of confidentiality. Studies such as these would resolve clinicians' untested fears about the supposed chilling effect of providing clients with more complete information about the limits to confidentiality. Studies done to date focusing on therapists' attitudes and behaviors, while important,

are not as germaine to the issues of client rights as are studies involving the clients themselves.

Conclusion

The Tarasoff case has presented mental health professionals with a host of issues and problems which accentuate already unresolved questions and problems regarding professional roles and responsibilities. Other jurisdictions are gradually beginning to adopt the Tarasoff ruling, and concern over the case has spread to all the jurisdictions surveyed. This study found that many of the predictions of detrimental consequences stemming from the case have come true. Therapists indicated that clients have left therapy in response to a breach of confidentiality or a fear that confidentiality would be breached, that in many cases the therapeutic relationship has been adversely affected as a result of giving a warning to a third party, that therapists do not always provide clients with informed consent to treatment, that therapist anxiety has increased when an issue relating to dangerousness is brought up in therapy, and that therapists are less likely to work with potentially dangerous individuals. Some positive results of Tarasoff were also found, such as therapists having an increased awareness of legal and

professional issues relating to psychotherapy, and an improvement in therapy in many instances after a warning was given. Whether or not Tarasoff prevents more harm to society than it creates cannot be determined from this study.

This study clearly identified a group of psychologists whose past and present practices are consistent with the duties imposed by Tarasoff and for whom the legal imposition of such a duty would create no problems. Another group of psychologists was also identified which took a relatively absolute view on confidentiality and preserving clients' privacy rights. These psychologists did not view themselves as agents of social control; for them, their sole responsibility was to their client. The remainder of psychologists fell between these two extremes. Given the relatively small percentage of psychologists who have given Tarasoff warnings (24%), it is difficult to conclude from the data exactly what the professional standard of warning should be.

Different positions on confidentiality cannot be said to solely reflect a role crisis among psychologists. Our society has laws and court cases which seek to preserve privacy and confidentiality, and it also has laws and court cases which require that confidentiality be breached

and privacy invaded. It is likely that both trends will continue (Everstine et al., 1980). Current practices of psychologists indicate advocates of both positions. Given the double-bind aspect of the conflicting stance towards confidentiality in the law, it seems unwise and indeed impossible to expect psychology as a profession to reconcile these contrary positions. Law will be as it is, ethics will be as it is professionally and individually, and morality will be as it is individually and collectively.

As a profession, psychologists may adopt certain practices which do not conflict with the law and which are designed for the best interest of the client. Weighed against the client's interest is a moral duty psycholgists have as individuals to prevent probable harm from happening to non-clients. The issue of prediction of dangerousness may never be adequately resolved scientifically, but this should not be an excuse when a therapist passes that threshold of prediction and determines that his or her client presents a real danger to another. Individual therapists are free to act at variance with whatever legal and professional standards are imposed, but in doing so they face sanctions for their behavior when it causes or fails to prevent harm to another.

Just as clients cannot make an informed decision about entering psychotherapy if they are not appraised of their rights, psychologists cannot make informed decisions about appropriate professional behavior if they lack information as to what their legal and ethical obligations are. As a profession, psychologists must take more responsibility for education and continuing self-education if they are to provide a competent level of service to the public.

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APPENDIX A

COVER LETTER AND QUESTIONNAIRE*

*Reduced to 74% of original size.

Texas Tech University

Department of Psychology

October 15, 1981

Dear Dr.

Psychologists who work with a client population now face an increased risk of lawsuits as a result of recent developments in case law. In 1976, the California Supreme Court handed down its decision in Tarasoff v. Regents of the University of California. This case held that a psychotherapist has a duty to protect third parties from a threat of serious danger posed by a client under his or her care. Tarasoff raised a number of controversial ethical and legal issues such as how absolute is the right to confidentiality and what effect giving such a warning to outside parties would have on the therapist-client relationship. The ruling has sparked a considerable amount of commentary from both the mental health and legal professions.

Although the Tarasoff ruling only has binding legal status in the state of California, recently several other states have either acknowledged or adopted the Tarasoff rationale that there should be a legal duty to protect endangered third parties. In deciding whether or not to adopt the Tarasoff rationale, courts have had almost no empirical data on which to rely, and instead have made their judgments based on theoretical arguments as to the effects of such a duty on the practice of psychotherapy.

The enclosed questionnaire is part of a nationwide survey of APA psychologists to determine attitudes and practices of clinicians with regard to professional issues concerning various aspects of psychotherapy. Your input is very much needed to provide information to courts in jurisdictions which have not yet addressed this issue, and it is also needed by psychologists who are working with their state legislators to modify existing laws regulating the practice of psychotherapy so that the laws are more representative of the actual working relationship of the therapist and client. The results of this study will be published in law and psychology journals.

Completion of the questionnaire should require only about 20 minutes of your time, and your cooperation in completing it will be greatly appreciated.

Your responses will remain completely anonymous. A stamped envelope is provided for you to return the questionnaire. If you would like to be sent results of the study when it is completed, fill out and return separately the enclosed postcard.

When you have completed the survey, please mail it in the enclosed envelope by October 30, 1981. Thank you for your time and interest.

Sincerely,

Robert H. Weiner

Box 4100 / Lubbock, Texas 79409 / (806) 742-3736

PLEASE ANSWER THE FOLLOWING QUESTIONS:

(make an "x" or check in the spaces provided)

1. At the start of therapy, do you generally provide your clients with any type of written material either describing various aspects of therapy or informing them of their rights as a client?

O yes O no

2. Which of the following areas do you generally discuss verbally with your clients at the start of therapy? (check all that apply)

O the client's goals for therapy
O treatment methods you use
O the right of confidentiality
O terms of a treatment contract
O fees and payment
O other: _____

3. Under what circumstances do you discuss with your clients limitations to confidentiality (the possibility of having to contact outside parties concerning them)?

O as a general practice at the onset of therapy
O if the client asks directly
O in the event that I will need to contact outside parties
O never

4. How important is absolute confidentiality between therapist and client in maintaining a positive therapeutic relationship? (mark one)

nonessential	----	----	----	----	----	----	----	essential
	1	2	3	4	5	6	7	

5. If clients are informed of the limits of confidentiality at the start of therapy, they will not disclose as much during therapy as they would have otherwise.

very strongly disagree	----	----	----	----	----	----	----	very strongly agree
	1	2	3	4	5	6	7	

6. Are you aware of any of your clients having left therapy because they feared a breach of confidentiality?

O yes O no

7. Approximately what percentage of your clients ever disclose violent fantasies or threats towards another person? Give your answer considering all clients who report such fantasies, regardless of whether or not you felt they had any intention to carry out the fantasy.

_____ (give a % from 0 to 100%)

8. Under what DSM-III diagnostic categories have those who have reported violent fantasies fallen? (check all that apply)

O schizophrenic disorders
O paranoid disorders
O affective disorders
O other psychotic disorders
O anxiety disorders
O organic mental disorders
O substance use disorders
O somatoform disorders
O dissociative disorders
O adjustment disorders
O psychosexual disorders
O anti-social personality
O passive-aggressive personality
O other personality disorder
O others: _____
_____

9. Who is most likely to be the object of these violent fantasies? Please rank order from 1 to 8, with 1 most likely, 2 next likely,...8 least likely.

___ spouse ___ the client's child or children ___ parent(s) ___ other relative

___ boss or employer ___ friend or acquaintance ___ stranger ___ public figure

10. Are you familiar with the Tarasoff case?

O yes O no

11. When therapists determine, or pursuant to the standards of their profession should determine, that their client presents a serious danger of violence to another, they incur an obligation to use reasonable care to protect the intended victim of that danger.

very strongly disagree ---- 1 ---- 2 ---- 3 ---- 4 ---- 5 ---- 6 ---- 7 very strongly agree

12. (If you answered "no" to question 10, go on to question 13.)

a. What overall effect has your awareness of the Tarasoff decision had on your practice?

O 1 has had no effect
O 2 has had a mild effect
O 3 has had a moderate effect
O 4 has had a strong effect
O 5 has had a very strong effect

b. Using this same 5 point scale, what effect has your awareness of Tarasoff had on the following specific aspects of your practice?

1	2	3	4	5	
O	O	O	O	O	has increased my consultation with other mental health professionals when involved with a potentially dangerous client
O	O	O	O	O	has increased my consultation with attorneys or law enforcement personnel when involved with a potentially dangerous client
O	O	O	O	O	has increased my anxiety when an issue relating to dangerousness is brought up in therapy
O	O	O	O	O	has led me to focus more often on dangerousness with my clients
O	O	O	O	O	has led me to focus less often on dangerousness with my clients
O	O	O	O	O	has led me to focus more frequently on less serious threats by my clients
O	O	O	O	O	has led me to alert more clients that circumstances could arise in which I might have to breach confidentiality
O	O	O	O	O	led me to keep more detailed records to avoid legal liability
O	O	O	O	O	led me to keep less detailed records to avoid legal liability
O	O	O	O	O	led me to keep 2 sets of records - one private and one for the file
O	O	O	O	O	led me to obtain malpractice insurance
O	O	O	O	O	made me less likely to work with a potentially dangerous individual
O	O	O	O	O	made me more aware of my legal and/or ethical obligations and responsibilities
O	O	O	O	O	caused me to increase the number of warnings I have given to third parties
O	O	O	O	O	made me more likely to have a client civilly committed who poses a threat to a third party
O	O	O	O	O	made me fear a possible lawsuit for failing to warn
O	O	O	O	O	made me fear a possible lawsuit from my client for defamation of character or invasion of privacy as a result of breaching confidentiality
1	2	3	4	5	

13. Have you ever reported your client to any outside party under any of the following circumstances? If you mark "no," please indicate if you would ever make such a report under that circumstance.

a. to report child abuse:

O yes O no - would you ever: O yes O no O possibly

b. to warn any third person that your client has made a serious threat of homicide or physical injury to another:

O yes O no - would you ever: O yes O no O possibly

c. to report a crime your client has confessed to or you suspect has been committed:

O yes O no - would you ever: O yes O no O possibly

d. to report to any third party that your client has made a serious threat of suicide:

O yes O no - would you ever: O yes O no O possibly

14. If you have warned third parties about the potential dangerousness of one of your clients,

a. who have you warned:

O the potential victim O the police O a court of law
O the victim's family O medical personnel O other: _____

b. did you obtain your client's consent before warning?

O always O usually O sometimes O never

c. did you inform your client that you were going to give a warning?

O always O usually O sometimes O never

d. did warning a third party have any of the following effects on your therapy relationship with your client? (check all that apply)

O client left therapy due to violation of confidentiality
O client stayed in therapy, but the therapeutic relationship was adversely affected
O therapy improved because of the issues confronted and addressed
O other: _____

15. Would you ever refrain from warning a third party when you thought you had a legal or ethical obligation to do so?

O yes O no

16. If you had to choose between a contempt-of-court citation or disclose confidential information about one of your clients, which do you think you would be more likely to choose?

O contempt-of-court citation
O disclose confidential information
O don't know

17. a. In what state do you practice? _____

b. Has this state had any litigation similar to Tarasoff where one of the parties to the suit alleged that a psychotherapist had a duty to warn them of the dangerousness of a client?

O yes O no O don't know

If yes, list the name of the lawsuit if you know it: _____

18. Does this state have a law providing for:

a. psychotherapist-patient privilege	a. 0 yes	0 no	0 not sure
b. establishment of confidentiality of therapist-client communications	b. 0 yes	0 no	0 not sure
c. civil liability for unauthorized breach of confidentiality	c. 0 yes	0 no	0 not sure
d. privileged communications between husband and wife	d. 0 yes	0 no	0 not sure
e. requiring the reporting of child abuse	e. 0 yes	0 no	0 not sure
f. requiring the reporting of suspected abuse of disabled or aged persons in a public or private facility	f. 0 yes	0 no	0 not sure
g. declaring working notes of the therapist to be private property and not subject to discovery in any judicial, administrative or legislative proceedings	g. 0 yes	0 no	0 not sure
h. allowing an exception to privileged communications to report to medical or law enforcement personnel when a psychologist determines there is a probability of imminent physical injury by the patient to himself or others, or where there is a probability of immediate mental or emotional injury to the patient	h. 0 yes	0 no	0 not sure
i. permitting disclosure of confidential communications when the therapist determines that disclosure is necessary to protect the recipient or other person against a clear, imminent risk of serious physical or mental injury or disease or death being inflicted upon the recipient, or by the recipient on himself or another	i. 0 yes	0 no	0 not sure

19. How many clients do you see per year in an outpatient setting that you consider to be potentially dangerous?

_____

20. Psychologists are qualified to testify as expert witnesses with respect to the dangerousness of an individual.

very strongly disagree ---- 1 ---- 2 ---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- very strongly agree

21. a. Have you ever received any training in recognizing or predicting dangerousness in an individual?

0 yes 0 no

b. In general, how accurately do you believe you can predict a dangerous act?

with _____% accuracy (give a % from 0 to 100%)

c. What factors would make you feel more confident in predicting dangerousness?

_____

22. How likely would your client's potentially dangerous act have to be before you would breach confidentiality and warn others?

_____% probability (give a % from 0 to 100%)

23. a. What is the nature of your contact with the legal process? (check all that apply)

O aiding in jury selection process
O court or agency referred psychological evaluations
O consultation to an attorney about psychological questions
O testifying as an expert witness
O testifying in divorce proceedings
O testifying in child custody proceedings
O testifying in involuntary commitments
O testifying as to a person's dangerousness
O testifying as to a person's mental status
O other: _____

b. Approximately how many such contacts do you have per month? ____

24. How well-informed and up-to-date are you on legal and professional issues relating to the practice of psychotherapy?

poorly informed ---- 1 ---- 2 ---- 3 ---- 4 ---- 5 ---- 6 ---- 7 well informed

25. a. Highest degree earned: ____ in _____ (major field)

b. Current major field: _____

26. How many years of clinical experience do you have? ____

27. Please describe your practice as:

a. _____ % inpatient and _____ % outpatient

b. _____ % private practice and _____ % agency or institution affiliation

type of agency or institution: _____

28. Approximately how many hours a week do you see clients on an outpatient basis? ____

29. What is your primary clinical orientation? If more than one, rank order.

___ cognitive-behavioral ___ behavior modification ___ other: _____
___ psychodynamic ___ humanistic
___ existential ___ eclectic

30. What types of clients do you see? (check all that apply)

a. O individual O group O marriage O family

b. O child O adolescent O adult

31. What divisions of the APA do you belong to? (list either by number or name)

_____

32. Your sex: O male O female

33. Your age: _____

If you would like to make any comments about this questionnaire or about any issues that it has raised, please do so on the back side of this page.

APPENDIX B

PILOT STUDY: COVER LETTER AND FEEDBACK FORM

Dear Fellow Students,

The following questionnaire is designed as a part of my dissertation and is to be mailed to 650 psychologists nationwide to determine their attitudes and practices with regard to a variety of issues affecting the practice of psychotherapy. Your input is requested so that I can get your feedback on the readability, clarity and relevance of the questions that I am asking.

Please fill out this questionnaire and then answer the list of questions which follow asking for feedback. Feel free to write comments anywhere on the questionnaire. Please time how long it takes you to answer the questions, as I would like to get a general estimate to put on the cover letter.

When you have finished, return the entire study to me or place in the "W" mailbox as soon as possible, preferably by the end of this week. Detach this top sheet if you wish to remain anonymous. Thanks for your helpful input.

Bob Weiner

Dear Clinician,

The following questionnaire is designed as a part of my dissertation and is to be mailed to 650 psychologists nationwide to determine their attitudes and practices with regard to a variety of issues affecting the practice of psychotherapy. Your input is requested so that I can get your feedback on the readability, clarity and relevance of the questions that I am asking.

Please fill out this questionnaire and then answer the "Comments and Feedback" questions which follow. Feel free to write comments anywhere on the questionnaire. Please time how long it takes you to answer the questions, as I would like to get a general estimate to put on the cover letter. Your comments will remain anonymous.

Thank you for you helpful input.

Robert Weiner

COMMENTS AND FEEDBACK

1. Approximately how long did it take you to complete the questionnaire?

2. Please comment on the number of questions asked and the time it took you to complete them.

3. Did you find any questions irrelevant or redundant? If so, please specify and explain.

4. Did you find any questions ambiguous or hard to understand? If so, please specify and explain.

5. Were any questions insulting or annoying?

6. Please comment on the cover letter. Are there any additions or deletions that should be made?

7. Are there any questions which were asked which should be omitted? If so, please specify.

8. Are there any questions you can think of related to the area which should be asked, but weren't?

9. Is the purpose of the study clear from the cover letter and from the questionnaire itself?

10. Any other general or specific comments:

Thank you!