

When the Patient Threatens Violence: An Empirical Study of Clinical Practice after Tarasoff

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The Tarasoff decisions have enunciated a new duty for psychotherapists — a duty to possible victims of potentially violent patients. This duty apparently complicates, and possibly undermines, the treatment of a class of patients already extraordinarily difficult to treat. Breach of the Tarasoff duty has been held to create a cause of action in only four states. Nevertheless, many psychiatrists elsewhere believe the Tarasoff decision will be used as a guideline for assessing whether, should violence occur, a therapist's behavior met the standard of good medical practice. Therefore, the question of whether Tarasoff makes clinical sense continues to concern psychiatrists.

The Tarasoff Decision

The first Tarasoff decision¹ stated that psychotherapists treating potentially dangerous patients have a duty to warn possible victims of such patients. This new duty to specific third persons touched off a storm of protest among psychotherapists who feared the resulting breach of confidentiality would undermine the trust on which the psychotherapeutic relationship was based. Through their several professional organizations, psychotherapists submitted an *amici curiae* brief arguing the court's holding would not achieve its stated purpose and asking the court to reconsider.²

The California Supreme Court reheard the case, and modified their original opinion. They held that the psychotherapist does indeed have a duty to the potential victim but they defined the discharge of that duty in far more flexible terms:

When a therapist determines or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the intended victim of danger, to notify the police, or take whatever steps are reasonably necessary under the circumstances (3, p. 346).

The Tarasoff opinions appear to draw heavily on the discussion of Flemming and Maximow⁴ who argued that the therapist of a potentially

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violent patient did have a duty to third parties as well as a duty to the patient. Flemming and Maximow recognized a potential conflict between the need to maintain the patient's privacy, liberty, and due process interests and the need to protect the interests of society. They argued that the best resolution of this conflict was based on the informed consent by the patient to the limits on confidentiality, so if the patient talked about violence it would be with the knowledge that confidentiality might be breached, and they suggested warning only in cases of feared *imminent* violence. Thus, obtaining the patient's informed consent to the limits of confidentiality was central to their argument on how best to deal with potentially violent patients.

However, in arguing against the Tarasoff decision *amici* seemed to suggest the therapist should warn the victim, while keeping the warning secret from the patient, "When a psychotherapist is compelled to, and does draw the conclusion that his patient may become violent, the therapist's own actions may well betray this judgement to the patient."

Commentary on Tarasoff

Stone continued the argument against Tarasoff stating that imposing this duty on psychotherapists would lead to more danger since potential patients would stay away from treatment. He also argued that a Miranda type warning on the limits of confidentiality would have a chilling effect on therapeutic communications. While noting there was no empirical study on the duty to warn, he commented, "Anyone who has worked in a therapeutic program serving drug addicts, prisoners, parolees, probationers, or juvenile delinquents can attest that the duty to breach the patient's privacy as required by Tarasoff II would eviscerate whatever possibility of treatment exists with these difficult patients."⁵

My own work in a court clinic in which all these types of patients are evaluated and treated does not confirm Stone's fears. Patients are routinely warned as to the limits of confidentiality in this setting, and for most patients this warning apparently interferes not at all with the therapeutic relationship. There is one subgroup of patients — those with character disorders but without any other mental disorder — who respond to the warning by becoming noncommunicative. However, the vast majority of patients accept the limits of confidentiality and attempt to make use of the opportunity to consult a psychiatrist.

Slovenko noted that "trust — not absolute confidentiality — is the cornerstone of psychotherapy. Talking about a patient or writing about him without his knowledge or consent would be a breach of trust. But imposing control where self-control breaks down is not a breach of trust when it is not deceptive."⁶ Slovenko quoted several eminent psychiatrists who stated that immediate threats override the need for confidentiality. But Goin, testifying for the American Psychiatric Association before the House Ways and Means Committee, stated that mental health treatment requires for its success an "absolute guarantee" that communication between patient and therapist be kept confidential.⁷

Wechsler noted, "To date, no systematic study has been completed of the sorts of voluntary psychiatric outpatients who make Tarasoff type threats of violence."⁸ Wechsler argued that the Tarasoff duty should be implemented by involving the victim and the patient jointly in a psychotherapeutic relationship. Wechsler here carries the informed-consent argument to perhaps its farthest point when he suggests the patient not only consent to having the victim informed but also to the victim being involved in the therapy.

There has been one systematic study, a survey of California psychotherapists,⁹ that found, following the Tarasoff decisions, therapists increased their efforts to assess violence, warned more potential victims, and reported a generally heightened awareness of and concern with possible violence. Roth and Meisel¹⁰ have reported the only clinical data on Tarasoff type situations: four cases from an emergency room only one of which involved warning a potential victim. They attach such importance to informed consent that "in no instance have we directly warned the potential victim without first obtaining the patient's permission."

Dix¹¹ notes Tarasoff has been widely misunderstood by psychiatrists: the opinion does not say positively there is a duty to warn; rather it says therapists owe a duty to potential victims of dangerous patients, and this duty may be violated by failing to warn the victims. Dix then discusses 17 criteria a court might weigh in determining whether a defendant had adhered to a reasonable standard of professional conduct in identifying a dangerous patient and in deciding whether to warn. Dix rebuts the fears of Stone,⁵ but notes again that data are absent from which to assess the effect of Tarasoff on clinicians and on increasing or decreasing violence.

Slovenko⁶ thought the decision would "make little or no difference in the courts since the court would have to be convinced that the therapist believed that danger was imminent and then did nothing." Leonard¹² also commented that therapists had over-reacted to Tarasoff and thought there was a hierarchy of legal liability; the therapist being most liable if violence occurred after therapy terminated and the therapist still believed, at that time, danger existed. The therapist would be least liable if therapy were ongoing, and the therapist had not expected violence. Thus, greatest liability occurred under conditions that could not have interfered with therapy since it would have terminated.

Outcome of Recent Tarasoff Cases

Several recent courts have held that a Tarasoff duty exists,^{13,14,15} but there has been only one award for breach of Tarasoff.¹⁵ The Tarasoff case itself was settled for an undisclosed amount; Milano¹³ was found not to have violated the Tarasoff duty. *Lipari v. Sears*¹⁴ was settled before trial for over \$200,000. In *Davis v. Lhim*,¹⁵ a Michigan jury awarded \$500,000 to the estate of the decedent against the psychiatrist who had released her son from the hospital. Decedent, the mother of the patient, had been killed by him while attempting to prevent his suicide two weeks after he had been released from

a psychiatric hospital. The jury found that the psychiatrist should not have released the patient when he did and that he should have warned the victim.

In *Shaw v. Glickman*,¹⁶ the plaintiff was in bed with a married woman when he was shot by her husband. Both the husband and wife were patients of a psychiatric team. Plaintiff sued the team on the ground they should have warned him of the danger to him posed by the husband. The appellate court ruled Tarasoff did not apply in this case because there was no threat made by the husband prior to the shooting. The court said nothing about whether a Tarasoff duty held in Maryland; it held that the rationale of Tarasoff was inapposite to the instant case.

The Present

Clearly, the Tarasoff ruling has generated a continuing controversy in which two questions continue to be debated. First, does the Tarasoff decision have an adverse impact on the practice of psychotherapy? Specifically, is the therapeutic relationship interfered with by the therapist's duty to third parties? Second, is there any evidence that therapists' efforts on behalf of third parties effectively prevent violence? Many authors have noted the virtual absence of empirical data, although these are both empirical questions. The finding in other jurisdictions that the Tarasoff duty holds and the widespread belief among psychotherapists that there is a Tarasoff duty to which they will be held lends weight to the continuing controversy. In this context, there is a clear need for empirical studies of clinical experience with potentially dangerous patients in the years since Tarasoff.

This article specifically addresses the problem of determining whether the Tarasoff duty does impact on the practice of psychotherapy and if so how? Prior experience of Slovenko, Wexler,^{6,8} and myself suggests that whether the patient's informed consent is obtained and whether the warning given is warranted clinically (rather than whether a warning is or is not given) will determine how the therapist's action affects the therapy. An attempt is made to test this hypothesis.

Procedure

A sample of psychiatrists was recruited subject to the following constraints: (1) known personally to the author, (2) practicing in the greater Boston area, and (3) having a private practice and clinical administrative responsibility in an institution that serves violent patients or having a clinical position in such an institution.

Each psychiatrist was contacted, the purpose of the study was explained, confidentiality was assured, and informed consent was obtained. A semi-structured interview was conducted including the following questions: Are you familiar with the Tarasoff decision? Have you been involved in any cases, either in your private practice or in your other work, in which the question of warning the possible victim of a potentially violent patient came up? Have you ever warned anyone? Please tell me about the case. Was the warning discussed with the patient prior to its being given? Afterward?

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What was the impact of the warning on the treatment? What was the outcome of the case?

One patient also was interviewed.

The Survey

Thirty-eight psychiatrists participated. Their average age was 40 years, S.D. = 6.4. Thirty-two were men; six were women. Thirty-three were in practice; five were residents. Thirty-six of the psychiatrists had an academic appointment. Thirty-seven were aware of the Tarasoff duty; one was not. Of those 37, 36 said that they accepted a duty to possible victims; one said it made no difference to him.

Sixteen psychiatrists reported being involved in a case in which a warning was given; 22 reported no such involvement. The 16 psychiatrists had been involved in 26 cases involving 27 patients: 18 men, 7 women, and one couple. Mean patient age was 31 years, S.D. = 11.2. Diagnoses included five paranoid schizophrenic, one manic, two psychotic, four neurotic, five borderline personality organization, three paranoid characters, two antisocial personality, three other character problems, one alcoholic, and one PCP ingestion. At the time of the threat, 13 patients were being evaluated, and 14 were in treatment. Seven patients were hospitalized; eight were seen at emergency services, eight in outpatient services, and four in other settings.

The intended victims included five girlfriends, five wives, two husbands, one boyfriend, and one wife's suspected lover. Also threatened were two sets of parents, one mother, one child, one grandchild, two therapists, one welfare worker, one inpatient unit, one Governor, one President, and one city (arson threats). All threats were of potentially deadly violence or serious bodily harm. In 19 cases the therapist warned the possible victim, in one case the victim's mother was warned, and in six cases the appropriate officials were warned, for example, FBI, state police, fire marshal.

Violence occurred in three cases: one patient provoked an assault on himself several weeks after the warning. One patient committed suicide 18 months later, and one patient seriously maimed his intended victims two years later.

The effect on the patient and on the therapist-patient relationship of the warning was rated by the clinician in one of three categories: (1) positive; (2) no apparent effect, not large enough to rate; (3) negative. The warnings were rated by the author as warranted by the clinical facts or unwarranted.

The effect of the warning on the therapist-patient relationship was rated by the clinician as positive in two cases, no apparent effect in 13 cases, and negative in four cases. In seven cases, the effect of the warning on the therapist-patient relationship was indeterminate since the relationship terminated before the warning was given. Twenty-five warnings were rated by the author as warranted; one was rated as unwarranted.

Fourteen warnings were discussed ahead of time with the patient and were rated as warranted. In these 14 cases, the impact of the warning on

therapy was positive in two cases, and not apparent in 12. In four cases, the warning was not discussed ahead of time, but was warranted. In three of these four cases, the impact was negative; in one it was not apparent. In one case, the warning was rated as unwarranted, but it was discussed ahead. In this case, the outcome was negative.

The relationship between type of warning and impact on the therapeutic relationship is shown in the Table. In every case in which a warning was warranted and was discussed ahead, there was either a positive impact on therapy or no impact was apparent. However, if either the warning was not discussed ahead, or was not warranted, then the impact was negative in four of five cases. If the positive and no impact categories are combined to create a 2×2 table, and Fisher's exact test is applied, then there is a significant relationship between impact and type of warning, $P < .001$.

Table. Relationship between Type of Warning and Impact of Warning on the Patient

Type of Warning	Impact of Warning on Therapeutic Relationship		
	Positive	None Apparent	Negative
Warranted and discussed first	2	12	0
Unwarranted and/or not discussed first	0	1	4

No clinician who warned a possible victim was threatened with legal action. Twelve of the 22 psychiatrists who had not warned anyone had seriously considered a warning in one or more cases. In none of these cases had later violence occurred, and in no case had a psychiatrist been threatened with suit for failing to warn.

Illustrative Cases

Case 1 A single male graduate student became delusional, unable to work, and seclusive. He was hospitalized and treated with phenothiazines and individual psychotherapy by Dr. A., a resident. The patient was discharged to be followed by Dr. A., but terminated six weeks later in a dispute over medication. After an intervening commitment to a state hospital, the patient reappeared at the outpatient department where he threatened to kill Dr. A. Outpatient staff consulted Dr. Z, a staff psychiatrist who interviewed the patient and offered him treatment, which he accepted.

The patient said Dr. A had killed some of his brain cells by prescribing a poisonous drug, Thorazine, and he accused Dr. A of being responsible for the suicide of another patient. He repeatedly said he would like to kill Dr. A. He recalled he had won a riflery medal as an adolescent, and said he was still an excellent shot. He did not own a gun, and there was no history of violence.

The patient's anger at Dr. A persisted. A chance meeting with Dr. A would stimulate the patient to murderous ideation. Dr. Z never believed that the patient was imminently murderous, but he thought the patient might impulsively assault Dr. A.

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Dr. Z decided a warning was necessary. He first discussed it with the patient, saying he was concerned for the safety of Dr. A and for the welfare of the patient and wished to protect both of them. The patient agreed that Dr. Z should speak with Dr. A, and Dr. Z subsequently did so. Dr. A, who lived near the patient and who had previously met the patient several times on the street, was grateful for the warning, and took action to avoid meeting the patient thereafter. Psychotherapy continued for several years. The patient took no medicine. At termination, he was living independently, had some friends, held a full-time professional job, was free of delusional beliefs concerning his current life, but was still angry at Dr. A.

One year later Dr. Z asked the patient to participate in this study and he agreed.

Dr. Z: "Do you remember whether my warning Dr. A made any difference one way or the other in therapy?"

Patient: "I have a vivid memory. I respected your response. I thought, 'that was a very wise response. I've just been really bizarre here. What would I have done sitting in his place?' It's amazing to me that you called now and that you are writing a paper about violence. If there is one psychological barrier I have not overcome, it's Dr. A. I fantasize about killing Dr. A and about Dr. A's death. The only thing that prevents me is prison"

Dr. Z expressed concern about the patient's continued wish to kill Dr. A. The patient responded that Dr. Z did not need to worry on his account.

Comment: This case illustrates that the therapist's efforts to comply with the Tarasoff duty can strengthen rather than impair the therapeutic relationship. The therapist was concerned to protect not only the victim but also the patient from the consequences of possibly violent action. The therapist treated the possible violence as a therapeutic issue; he discussed it thoroughly with the patient, and he obtained the patient's permission to warn. The patient himself was ambivalent about his violent wishes, although he did not acknowledge that at the time. Dr. Z demonstrated to the patient that the psychiatrist could remain committed to a therapeutic stance despite the severe threat to treatment posed by the patient's threat to kill Dr. A. The warning served a limit-setting function for the patient, and it was viewed by him as a corrective ego experience.¹⁷

The case illustrates when warning is indicated and commitment is not. Dr. Z never believed the patient was imminently murderous. The patient had no history of violence, owned no gun, and did have a therapeutic alliance. The warning may have helped prevent violence in that it permitted Dr. A to successfully avoid chance meetings with the patient, chance meetings that previously had provoked the patient's murderous fantasies.

Case 2 A depressed but not psychotic grandmother was in group therapy in an outpatient clinic. During a consultation between the patient, her therapist, and the therapist's supervisor, the patient revealed that she was having thoughts of strangling her grandchild whom she regularly cared for. The patient and therapist then met individually. The therapist stated her

concern that the patient might harm the baby and that it was her legal obligation to inform the baby's mother. After extensive discussion, the patient and therapist agreed the therapist would call the baby's mother in the patient's presence and the patient and her daughter would then talk as well. The frequency of baby-sitting subsequently was reduced, and the patient was able to discuss the whole episode in the group. The therapist believed the alliance between her and the patient was strengthened by sharing this experience.

Case 3 A married woman in her 40s had a long history of stormy personal relationships, especially with men. She threatened suicide and cut her wrists when her husband filed for divorce. She was then admitted voluntarily to a psychiatric ward. She told her physician, a psychiatric intern, she was going to kill her husband using either a knife, a gun, or poison, but she refused to say when this might occur. The intern was concerned. He warned the husband and then informed the patient of the warning. The patient was furious and refused to talk with her physician for two weeks. When therapeutic dialogue was re-established, the patient spent most of several hours telling the physician how betrayed and angry she felt. At discharge six weeks later, the patient acknowledged, "I knew you had to do it" (warn the husband); and she returned to her outpatient therapist. Eighteen months later, the patient committed suicide.

Comment: The effects of warning with and without discussion can be clearly distinguished. The warning was given without prior discussion and it had an immediate negative impact on the therapeutic relationship; the patient felt angry and betrayed. Subsequently, there was extended discussion of the warning. The patient's anger then subsided, and she was able to acknowledge the therapist had acted reasonably.

It is clear this patient did possess a potential for violent action. Perhaps the warning served a limit-setting function that helped the patient control her violent impulses over the impending divorce. Nothing is known about the circumstances of the later suicide.

Case 4 A single man in his 20s with a diagnosis of chronic schizophrenia was treated by a psychiatrist in a community mental health clinic. The patient believed a local university was trying to drive him crazy by planting in the minds of little girls the idea that he was the masturbator of Cambridge. He would often call the university to make bomb threats. In the psychiatrist's office, he talked about killing young women, one in particular, but he did not identify her or know where she lived. He broke all the windows in his psychiatrist's office and had thrown plants and a jar of honey against the wall. Neither oral antipsychotic medication nor psychotherapy had any effect on this patient. There was never a specific victim to warn, but the psychiatrist had seriously considered warning the university.

On several occasions, the patient has threatened to commit suicide by pouring gasoline into his sleeping bag and igniting it. The psychiatrist told the patient he had a duty to warn the landlady and to commit the patient, and

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on two occasions, the patient was involuntarily hospitalized. Neither the possibility of warning the landlady nor the actuality of commitment appeared to make a difference in this patient's treatment.

After one hospitalization, the patient was given I.M. Prolixin with dramatic improvement. On the nine-month follow-up, he was no longer actively psychotic, was working in a local YMCA and had reestablished social relations with his family and some old friends. He said it must have been awful for his psychiatrist to be with him while he was so ill and apologized for his past violent behavior in the psychiatrist's office.

Comment: There is no evidence the psychiatrist's attempts to meet his responsibilities to third parties interfered with his treatment of the patient. The psychiatrist discussed with the patient his concerns for the patient and the landlady before committing him. This grossly psychotic patient always returned to this psychiatrist after being released from the hospital, which suggests he valued the treatment relationship.

Commitment rather than warning was indicated because the patient was mentally ill with a history of violence. He had the means to carry out his threatened immolation, and there was a shaky therapeutic alliance. Once committed, the danger to the landlady disappeared, so there was no necessity to warn her. Although we cannot say with certainty that treatment prevented violence, treatment was eventually successful, and the patient never was violent outside the psychiatrist's office, so far as is known.

Case 5 A single 23-year-old factory worker planted a bomb at his work place, and then told the authorities what he had done. Clinical diagnosis was psychosis and schizoid character. My diagnosis is schizoid character with antisocial traits. The patient was sentenced to one-year probation with weekly outpatient psychotherapy. The patient kept all his appointments, but his therapist believed that no alliance was established. In therapy the patient expressed rage at his parents and expressed no regrets at planting the bomb. When his probation status ended, he abruptly terminated therapy. The therapist and his supervisor both believed the patient was still potentially dangerous to his parents. The court and the parents were so advised, and the patient was notified in writing of the therapist's action. No action was taken by the court or the parents. Two years later, while the parents were sleeping, he assaulted them with a heavy club. He broke their arms and legs and scarred the face of one.

Comment: This patient did not have a treatable mental disorder, and he had no apparent motivation to examine his own character or his violent impulses. No alliance was established. Whether psychiatric supervision is preferable to probation supervision in a case of this kind is questionable.

This warning was given without prior discussion with the patient, and ultimately the patient was violent. Perhaps prior discussion with the parents would have been effective in setting limits for this patient, even in the absence of an alliance.

Would commitment, rather than warning, have been preferable? The therapist considered commitment and rejected it on two grounds: first, there

was no good evidence of psychosis — the patient was neither delusional nor hallucinating; second, there was no evidence of imminent danger — the patient was not threatening anyone, and indeed he was not violent until two years later.

Case 6 A schizophrenic man was being treated in private outpatient psychotherapy. The patient threatened to kill his parents, with whom he lived. When interviewed for this study, the psychiatrist stated he had informed the patient it was necessary to warn the parents, and after discussing the warning with the patient, he had warned the parents. The patient was subsequently hospitalized. The hospital physician, who was also interviewed for this study, reported the patient was furious at his private psychiatrist and was actively psychotic. The patient stated the therapist had warned the parents in a family therapy session but had not first discussed this breach of confidentiality with him. The patient remained in the hospital for months, psychotic and unable to progress. In the opinion of the hospital physician, the angry impasse resulted from the patient's sense of betrayal by the therapist.

Comment: This case illustrates a warning associated with a negative outcome. What the therapist actually said is unclear; what is clear is that the patient experienced the warning as unexpected, felt betrayed by the therapist, and was subsequently psychotic for months.

Case 7 A depressed 23-year-old woman was treated in a psychiatric hospital. She told her psychiatrist she might throw her baby against the wall. He was convinced she might carry out this threat, and he told her in a team meeting that he had no option but to protect the child. He presented this to her as a fixed decision over which she had no control, and he then informed the welfare agency. The woman became increasingly depressed and anxious. Later, patient and psychiatrist discussed her feelings. She told him, "I could understand why you did it, but it would have helped if you had discussed it with me." The therapist commented, "I was so anxious about it I didn't discuss it enough with the patient. Afterward, when we had talked, she felt better about it. If I had another case like it, I would give the patient the opportunity to discuss it beforehand."

Case 8 A 50-year-old white male with depression, alcoholism, and probable borderline personality was seen in an emergency room. He had not been drinking for two weeks and was living in a halfway house. He was angry and said he might kill his roommate.

The resident discussed with the patient the need to warn the roommate. When the roommate was called, he said the patient had made threats to his face, and he had shrugged them off. The patient was offered, and accepted, hospitalization. He later told the resident he was angry at him for telling the roommate, because when he had come to the hospital, he thought everything was confidential.

The resident helped the patient relocate to a shelter in the community. The patient began drinking several weeks later, and provoked 30 people in a

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bar to beat him up by calling them names and throwing chairs at them. He was subsequently hospitalized for depression.

Comment: This case illustrates a warning that was probably unwarranted. The roommate was safe while the patient was in the hospital. Arrangement for a new living situation almost certainly reduced the danger to the point where a warning was no longer indicated.

Discussion

The Tarasoff decision has had an impact on clinical practice among psychiatrists who work in settings where violent patients are evaluated or treated. Virtually all accepted a responsibility to possible victims of potentially violent patients as a legitimate professional responsibility. The more legally sophisticated among them knew the Tarasoff decision was not binding in Massachusetts, but even these psychiatrists accepted a Tarasoff responsibility, because they had been advised by attorneys they would be held to a Tarasoff standard if a case of violence should occur. Other members of this sample have been given the same advice by colleagues or supervisors. Thus, despite an absence of precedent in this jurisdiction, this sample believes there is a Tarasoff duty and practices accordingly.

Forty-two percent of the sample had been involved in a case in which a warning was actually given, and another 32 percent had seriously considered giving a warning. However, contrary to the fears of *amici* and others, the warnings given seldom had an adverse effect on the therapeutic relationship. Only warnings that were not discussed with the patient or one which was given without good reason were judged to be harmful to the therapeutic relationship. There were only four such cases; in two of them, later discussion between patient and therapist repaired the damage to the therapeutic relationship. The results support the conclusion that warnings per se have little or no apparent effect; how they are integrated into the therapy is the important variable.

A warning that is discussed strengthens an alliance because the therapist demonstrates to the patient the ability to retain his therapeutic concern even in the face of imminent danger. Patients' proposed violent actions are seldom entirely ego syntonic. By making clear to the patient that the therapist proposes to prevent violence if he or she can, the therapist dramatically demonstrates to the patient an alliance with the healthier, more socially constructive aspects of the patient's personality. Even profoundly psychotic schizophrenic patients such as Case 4 appear to appreciate this.

The major implication of this finding is that psychiatrists should view the potential for violence primarily as a therapeutic issue. The patient should be engaged in a discussion that raises the question of what it would mean if he or she were to carry out the threat. Can a therapist permit a patient to carry out such an action any more than he or she would stand by and permit a suicide? A legal duty is present when a threat is made, but it is secondary to the clinical duty to the patient.

Psychiatrists in this sample did not find the Tarasoff duty to be an onerous burden. This is consistent with Gurevich's observation that academic psychiatrists were more comfortable with Tarasoff than were practitioners.¹⁸ The ready availability of colleagues with whom to discuss these cases and of a network of services and facilities may contribute to the sense of relative comfort this sample reported. Clearly, the present study is limited to academic psychiatrists and residents. The comfort these therapists felt may not be shared by clinicians working in greater isolation.

Dix has stressed that Tarasoff II gives therapists a choice of response,¹¹ and several respondents commented on that choice. Sixteen psychiatrists chose to warn and twelve chose not to warn, although, in some cases (for example, Case 4), the psychiatrist chose to commit the patient. This finding is consistent with that of Roth and Meisel who reported that psychiatrists are able to respond to the needs of the patient and the victim, once they have accepted the responsibility for so doing.¹⁰

Threatened violent behavior that was influenced by delusional beliefs or hallucinatory percepts and that the patient had means, motive, and opportunity to carry out influenced clinicians to take action. Typically, clinicians chose commitment when there was a threat of imminent violence to a specific victim (Case 4). Clinicians chose to warn when the threatened violence was not imminent (Case 1), when the threat was vague as to time (Case 3), or when the therapist judged the likelihood of violence to be remote (Case 2) because of the absence of a history of violence and the presence of a good therapeutic alliance. There are also cases of threatened violence, not reported here, in which therapists neither commit nor warn. Presence of a good therapeutic alliance and absence of any history of violence influence therapists to deal with threats within the therapy, rather than by involving third parties.

An unexpected finding of this study was that all but one warning occurred in institutional settings, not in private office practice. In these institutional settings, confidentiality is not absolute. Every commitment breaches confidentiality. All inpatients and many emergency patients are discussed by a team. Families and other agencies are contacted, often without the patient's consent. The idea, implicit in the *amici* brief,² that Tarasoff would intrude into the private, confidential world of a therapist and a patient is not supported by these data.

It is not possible to determine whether these interventions prevented violence because the base rate of violence in psychiatric patients is so low. However, violence occurred in the near future in only one of the 39 cases in which psychiatrists feared imminent violence. In that case (Case 8), no lasting damage was done. Review of the two cases of later and more serious violence failed to turn up any evidence that the warnings influenced the violence in any way. In two cases (Case 1 and Case 2), actions were taken as a result of the warning that immediately decreased the likelihood of violence. In Case 1, Dr. A took evasive action so he avoided the patient, and in

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Case 2, the mother and grandmother negotiated a more comfortable schedule of baby-sitting responsibilities and a subsequent decrease in family tension. It is my impression from subsequent clinical work with potentially violent individuals that warning a possible victim does serve a limit-setting function that decreases the possibility of violence. When a therapist warns a potential victim a threat has been made, he or she demonstrates a willingness to breach confidentiality. This action puts the patient on notice that if there is violence, the therapist will not be afraid to take appropriate further action. My impression is patients are reassured by this posture.

The number of cases in this study is too small to draw conclusions concerning the danger of a suit over breach of confidentiality or for failure to protect a victim, because the likelihood of a suit is so small that failure to observe one in 39 cases is not conclusive. However, we did not observe any threatened suit, and while this is not ground for rejoicing, it is not ground for alarm either. Finally, this study provides a basis on which to conclude the Tarasoff decision is not inimical to good clinical practice and may actually be beneficial to it. However, the sample is a limited one, and the question of how clinicians respond to Tarasoff is a subject that deserves investigation in a larger and more diverse sample.

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