The *Tarasoff* Duty to Warn in Child and Adolescent Psychiatry

Kim J. Masters, MD

Case: "John" is a 15-year-old male being evaluated for the first time by a child and adolescent psychiatrist for depression. During the clinical interview, John says that he has been thinking about killing himself with a rope or a rifle that he uses for target practice. His symptoms have become much more acute in the last week, when his 14-year-old girlfriend told him that she wanted to end their relationship. He says he cannot imagine living without her and is contemplating killing her as well as himself.

How should the clinician proceed? Two options are detailed below.

Background: *The Tarasoff* Decisions

The *Tarasoff I* and *II v. Regents of the University of California* decisions created a responsibility for clinicians to warn or protect potential victims of threats of violence by the clinicians' patients.[1] The case involved Prosenjit Poddar, who murdered Tatiana Tarasoff, a fellow student at University of California, Berkeley. He had met Ms. Tarasoff at folk dancing classes in the fall of 1968. She socialized with him there and kissed him. Mr. Poddar assumed these actions indicated that Ms. Tarasoff was interested in a relationship with him. When she rejected his advances and told him that she was involved with other men, he became depressed and angry. He went to the counseling center at the university for therapy. In a session with his counselor, Mr. Poddar expressed his intent to kill Ms. Tarasoff, who he felt had jilted him. However, Ms. Tarasoff was not informed of this threat because the director of the counseling center viewed disclosure to her as a violation of clinician–patient confidentiality.

Mr. Poddar again approached Ms. Tarasoff in October of 1969, and when she once again rejected his advances, he stabbed her to death. Subsequently, her parents sued the university. The case was reviewed twice by the California Supreme Court and was ultimately remanded for settlement.

Tarasoff I, the 1974 decision, established a clinician's duty to warn potential victims, if patients communicated threats of harm to their clinician during treatment. With Justice Matthew Tobriner writing in summary for the majority, the Court stated:

> We conclude that 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.[2]

This case was reviewed again in 1976. That decision, known as *Tarasoff II*, created a clinician's "duty" to protect potential victims when threats of harm against them were expressed by patients during treatment.[2] Since 1976 over 30 states have considered the limits of clinician–patient privilege, and over 20 have affirmed the *Tarasoff* decision either as a duty to warn or protect. Other states have either made the disclosure voluntary or found no clinician obligation to warn potential victims.[3,4] In most states, the warning process is restricted to identified potential victims, but some states have established a duty to protect the public from a potentially violent patient even if unnamed.[3] A website for individual states' duty to warn or protect laws is available online.[5] Mobley and Naughton[5] and Applebaum and Gutheil[6] have suggested that obligation to protect potential victims is an ethical obligation that overrides states' legal determinations.

Tarasoff I **(1974) determined that clinicians had a duty *to warn* potential victims of threats made by patients during therapy**

Tarasoff II **(1976) determined that clinicians had the responsibility *to protect* potential victims if threats against them were made by patients during therapy**

A *Tarasoff I* warning by a clinician to a potential victim and the police is an unusual activity for a mental health clinician, and in addition, it may disrupt the therapeutic relationship with the patient and the family. A complicating issue is determining what the warning would entail: for example, whether the clinician should disclose only that a threat had been made, or the specifics of the threat.[7]

One way to try to prevent the rupture of the clinician–patient relationship is with pre-treatment consents, reviewed with patients and families, that define the limits of patient–therapist confidentiality in the event of threats of harm to others. Another is to apply protection strategies as an alternative to warnings. Overall, as Applebaum and Gutheil have noted, "Clinicians should choose the intervention that occasions the least disruption of the therapeutic relationship while still being effective. On some occasions hospitalization is appropriate; on others, police notification serves the purpose."[6]

To Protect or to Warn?

Intent and Substantial Risk

Before embarking on a *Tarasoff* notification, it is important to consider when a duty to warn or protect obligation exists. In many states, *Tarasoff* statutes require that the patient has identified a victim by name, while in others, simply the threat of violence to others is sufficient grounds for a warn or protect action.[3,8]

Determining the dangerousness of a homicidal threat can be informed by the concept of "substantial risk." As Resnick has noted, the determination of substantial risk is based on the magnitude and probability of harm.[9] A threat to kill with a butcher knife could be fatal and thus represents substantial risk to the victim's life, even if it has a low likelihood of happening. On the other hand, a threat to slap a victim in the face would not have the potential to create a life-threatening situation, even if it had a high probability of occurring, and so would not be the type of situation for which the *Tarasoff* obligation was established.

Any youth who communicates threats to a clinician to harm another person needs to be assessed to determine the danger level of the threat. In substantial risk situations, the clinician needs to meet the *Tarasoff* warn or protect obligation requirements *according to rules in that jurisdiction*. It is important to understand facilities' policies and local laws to help clarify how these situations should be handled.

Treatment Planning

Individuals who threaten harm to others typically need intensive treatment such as hospitalization because it provides both supervision and therapy. If the adolescent or the parent does not agree with the treatment plan, then it would be necessary for the clinician to forge a compromise that meets his or her responsibility to protect potential victims. If that cannot be achieved, then immediate warnings to the victims and the police may be necessary (see Table 1).

Table 1. Steps for Dealing With a *Tarasoff* Duty to Warn/Protect Situation

- Clarify the specifics of the threat
- Formulate an intervention
- Immediately remove weapons, especially firearms
- Review if possible with a consultant
- Present the intervention to the adolescent patient
- With the adolescent, present the situation and intervention to the parent
- Carry out the intervention; hospitalization preferred but warn if refused
- Address the underlying psychiatric issues
- Review the specifics of the threat during hospitalization
- Attempt resolution with the patient and the family and, if appropriate, intended victim and his/her family
- Review threat at discharge and in follow-up visits, employing an intervention when indicated
- Document all steps taken, including correspondence, in the medical record

Elements to include in the treatment plan are: inquiry about weapons, especially firearms and documented evidence of their immediate removal; psychiatric diagnoses; cultural attitudes; statement of the threat; results of rating scales; interventions to address patient and victim safety; family and patient input in treatment goals; planned therapeutic individual and family interventions; and documentation of response to interventions. A copy of the treatment plan should be provided to the patient and the parents.

Rating scales such as the Brief Rating of Aggression by Children and Adolescents (BRACHA),[10] Structured Assessment for Violence in Youth (SAVRY),[11] and the Modified Overt Aggression Scale[12] provide state and trait information that may clarify patients' states of mind, for example, whether threats of harm are part of a stable coping response to stress or are specific to the individual abandonment situation. However, these scales do not provide information about the implementation of threats. The Columbia Suicide Severity Scale,[13,14] although not without clinical concerns,[15] could be used to ask questions about both suicide and homicide intent. Asking youths about the likelihood of acting on the plan (intent) is important, because patients' prediction of their own potential for violence has been shown to be a reliable indicator of future action.[16]

Cultural Considerations

During adolescence, disruptions in romantic relationships (as in the original *Tarasoff* case) are a well-recognized stressor that may precipitate homicidal and suicidal planning. Cultures may view this situation and its resolution differently, depending on societal expectations.[17] When an adolescent female makes threats entailing the use of violence, it can be occasioned by ongoing sexual abuse or a history of antisocial behavior.[18] There has also been growing concern in the US,[19] Japan,[20] and the UK[21] about the use of the internet, particularly among adolescents, to make murder–suicide pacts.

Firearms remain the most common method for both suicide and homicide events.[22,23] Table 2 lists biologic, social, and history events that increase the potential for violence.

Table 2. Historical Elements in the Psychiatric History that Help in Assessing the Likelihood of a Patient Carrying Out Threats to Harm Someone

- Self-harm, suicidal, assault, and homicidal ideation
- Self-harm, suicidal, assault, and homicidal plans
- Internet/social media communications about these issues including pacts for suicide
- History of both with emphasis on the most dangerous thoughts and actions
- Current and previous history of relationship initiation and ending
- Availability of weapons and specific plans to use them
- Current and previous history of substance use
- Adolescent patient's assessment of likelihood of acting on these thoughts and plans

Seeking consultation from a colleague about the clinical situation and the planned intervention can be helpful because it provides an independent opinion on how to proceed.

Possible Interventions

A. Hospitalize the adolescent; have the weapons removed; do not provide victim warnings at this time. If at discharge the threat of harm is no longer present, there is no duty to warn. Document these actions in the medical record. If the intervention is successful and leads to the elimination of harm risk, this option has the advantage of allowing a therapeutic intervention with patients, their families, and, if appropriate, the potential victims and their families. It may be the choice that causes the least disruption in the treatment alliance. If the threat remains active at discharge, then the warnings can be delivered to the potential victim and the police.

B. Discuss the warning plan, including its content, with the facility's legal counsel; as soon as possible, share this information with the patient and, if appropriate, the family. Warn the victim by phone and with regular and certified mail to increase the likelihood of delivery, and the police. Notification of both is necessary, because notification of the victim alone does not provide protection, and notification of the police alone does not ensure immediate action to protect

the intended victim.[6] Document these actions in the medical record. This option is likely to disrupt the treatment alliance, and it also might make the patient less likely to share these issues with other clinicians (as may have happened in the *Tarasoff* case).[1] However, warning may be the only workable choice.

Take Home Summary

The limits of clinician–patient confidentiality need to be discussed with patients and families at the initial visit. When youth threaten harm to others in treatment, weapons need to be immediately removed, and clinicians have a duty to protect potential victims, either by warnings or through intensive treatment, including hospitalization if necessary (*Tarasoff* obligation). All of these actions need to be documented in the medical record. The intervention should provide the least disruption to the therapeutic relationship that is effective.

References

1. Gostin LO. Surveillance and Public Health Research: Privacy and the "Right to Know." Tarasoff v. Regents of the University of California. In Public Health Law and Ethics: A Reader. 2002. http://www.publichealthlaw.net/Reader/docs/Tarasoff.pdf. Accessed June 14, 2016.
2. Wise TP. Where the public peril begins: a survey of psychotherapists to determine the effects of Tarasoff. *Stanford Law Review*. 1978;31:165-190.
3. Herbert PB, Young KA. Tarasoff at 25. *J Am Acad Psychiatry Law.* 2002;30:275-281.
4. National Conference of State Legislatures (NCSL) staff, Simms G. Database of State Tarasoff Laws. http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx. February 2010. Accessed June 16, 2016.
5. Mobley KA, Naughton E. Tarasoff and the duty to protect in North Carolina. *NC Perspectives.* 2011;4:5-14.
6. Applebaum PS, Gutheil TG. Clinical Handbook of Psychiatry and the Law. Philadelphia, PA: Wolters Kluwer; 2007.
7. Felthaus AR. Warning a potential victim of a person's dangerousness: clinician's duty or victim's right? *J Am Acad Psychiatry Law.* 2006;34:338-348.
8. Buckner F, Firestone M. "Where the public peril begins". 25 years after Tarasoff. *J Leg Med.* 2000;21:187-222.
9. Resnick PJ. Risk assessment for violence. *Audio Digest Psychiatry.* 2015;44:01.
10. Barzman DH, Brackenbury L, Sonnier L, et al. Brief rating of aggression by children and adolescents (BRACHA) development of a tool for assessing risks of inpatients' behavior. *J Am Acad Psychiatry Law.* 2011;39:170-179.
11. Borum R, Bartel P, Forth A. Manual for Structured Assessment for Violence in Youth (SAVRY). Tampa: University of South Florida; 2002.
12. Yudofsky SC, Silver JM, Jackson W, Williams D. The Overt Aggression Scale for the Objective Rating of Verbal and Physical Aggression. *Am J Psychiatry.* 1986;143:35-39.
13. Posner K, Brown GK, Stanley B, et al. The Columbia-Suicide Severity Scale. Initial Validity and Internal Consistency Findings from Three Multisite Studies with Adolescents and Adults. *Am J Psychiatry.* 2011;168:1266-1277.
14. Research Foundation for Mental Hygiene. Suicide Risk Identification and Triage Using the Columbia-Suicide Severity Rating Scale. http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/cssrs_web/course.htm. 2013. Accessed June 16, 2016.
15. Giddens JM, Sheehan KH, Sheehan DV. The Columbia-Suicide Severity Scale (CSSR-S): Has the Gold Standard become a Liability? *Innov Clin Neurosci.* 2014;11:66-80.
16. Skeen JL, Manchak SM, Lidz CW, Mulvey EP. The utility of patients' self perceptions of violence risk: consider asking the person who may know best. *Psychiatr Serv.* 2013;64:410-415.
17. Cultural and societal influences on adolescent development. Boundless Psychology. https://www.boundless.com/psychology/textbooks/boundless-psychology-textbook/human-development-14/adolescence-73/cultural-and-societal-influences-on-adolescent-development-285-12820/. 26 May 2016. Retrieved 4 November 2016.
18. Roe-Sepowitz D. Adolescent female murderers: characteristics and treatment implications. *Am J Orthopsychiatry.* 2007;77:489-496.
19. Covington C. How a Florida teenage romance ended in a violent suicide pact. The Week. http://www.theweek.co.uk/crime/57878/how-florida-teenage-romance-ended-violent-suicide-pact. March 27, 2014. Accessed June 16, 2016.
20. Ozawa-de Silva C. Too lonely to die alone: internet suicide pacts and existential suffering in Japan. *Cult Med Psychiatry.* 2008;32:516-551.
21. Rajagopal S. Suicide pacts and the internet. *BMJ.* 2004;329:1298-1299.
22. Fingerhut LA, Christoffel KK. Firearm-related death and injury among children and adolescents. *Future Child.* 2002;12:24-37.
23. Harvard Injury Control Research Center. Homicide. https://www.hsph.harvard.edu/hicrc/firearms-research/guns-and-death/ Accessed June 16, 2016.

About the Author

Kim J. Masters, MD, is a fellow in the American College of Physicians and a Distinguished Fellow of AACAP and the American Psychiatric Association. He currently teaches physician assistant students principles of psychiatric care. He is an assistant adjunct professor of Psychiatry in the Department of Psychiatry and in Physician Assistant Studies at Wake Forest University, and an assistant adjunct professor in Physician Assistant Studies at the Medical University of South Carolina. He is a faculty member of AT Still Health University, Mesa, Arizona.

Disclosure: Dr. Masters reports no biomedical financial interests or potential conflicts of interest.