How Did *Tarasoff* Affect Clinical Practice?

By WILLIAM J. BOWERS, DANIEL J. GIVELBER and CAROLYN L. BLITCH

ABSTRACT: The *Tarasoff* decisions of the California Supreme Court in 1974 and 1976 held that psychotherapists could be held liable for failing to protect the victims of their potentially violent patients. Our survey of psychiatrists, psychologists, and social workers in eight metropolitan areas showed that Californians were more likely to have heard of the case, to believe it required warning the likely victim, and actually to issue warnings in such cases than were psychotherapists from other jurisdictions. Therapists were more willing to take steps to protect victims in 1980 than in 1975, but willingness to warn increased more among Californians than among those in other states. We conclude that although *Tarasoff* has influenced therapists’ attitudes and behavior more in California than elsewhere, the case has also affected psychotherapeutic practice nationally.

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TARASOFF’S EFFECT

In 1974 the California Supreme Court held in Tarasoff v. Regents of the University of California that when a psychotherapist reasonably believes that one of his or her patients presents a credible threat of physical danger to another identifiable person, the therapist has a legal obligation to warn the potential victim. Should the therapist fail to discharge this obligation and the patient attacks the victim, then the therapist could be liable to the victim for money damages.

The 1974 Tarasoff decision was rendered in the face of a fervent argument by psychiatric associations that the proposed obligation contradicted the physicians’ ethical mandate to center attention on the welfare of their patients and imperiled the therapeutic process itself by compromising confidentiality, and, moreover, that it subjected therapists to potential liability for failing to predict what they claimed they could not—future violence. These arguments apparently moved the California Supreme Court to take the relatively unusual step of reconsidering the decision imposing a duty to warn on psychotherapists. Eighteen months later the court was evidently moved enough by the reargument to change the duty from warning the likely victim to one of exercising reasonable care for the protection of the victim.


The discharge of this duty may require the therapist to take one or more of various steps, depending on the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.

In the court’s view, the matter was clear: “The protective privilege ends where the public peril begins.” But if the psychiatric arguments are sound, the public peril may increase with the demise of the confidentiality said to be necessary for the effectiveness of psychotherapy, particularly psychotherapy with potentially violent persons.

DETERRENCE THEORY, TORT LAW, AND THE TARASOFF RULING

Classic deterrence theory holds that the perceived threat of legal sanctions, especially their certainty, severity, and celerity, will inhibit unlawful behavior, particularly when the perceived cost of the potential punishment outweighs the expected benefits of committing or continuing in the prohibited conduct. While most deterrence studies have concentrated on the impact of criminal law, the same deterrence logic applies to the operation of tort law. In the tort system, those who injure others through substandard behavior are, in effect, punished under the law when a court orders

4. Ibid., p. 347.
them to pay damages to the persons they have injured. Thus, persons who wish to avoid the possibility of being sued and held liable—or being sued even if not held liable—can be expected to regulate their behavior to conform with legally sanctioned standards of conduct.

Unlike the criminal law, the tort system is judicially administered and privately enforced. What actions or inactions are tortious is normally not the result of legislation but of standards of responsibility developed and applied by the courts. Whether violations of such standards will come to court does not depend on police or prosecutors but on the injured victims. Court-enforced standards of responsibility do not generally forbid or require specific actions but impose general duties and obligations that may be fulfilled in various ways. Moreover, the courts may change the law to include or exclude duties or parties to whom it applies, in accordance with evolving standards of responsibility as the courts define them. Thus, a person may be punished via the payment of damages for an action that is not specifically prohibited by statute or identified as tortious in a previous tort ruling.

It has been argued that the deterrent efficacy of criminal law is weak because it is generally applied to outsiders, for example, career criminals who have little stake in mainstream society. By contrast, tort law is usually applied to educated affluent persons in society's mainstream and often to the organizations in which they work, quite specifically because their financial resources are sufficient to make the private enforcement of a tort remedy worth pursuing. Because organizations as well as individuals can be sued and held liable, tort law may capitalize on the desires of both to avoid liability as an added impetus for compliance.

Of course, professionals who might be sued typically purchase malpractice insurance to offset the financial risk—though not the stigma or increased premiums that may result from being sued, even if not found liable. Yet malpractice insurance among the members of a profession tends also to spread and equalize the cost of noncompliance within the professional community; hence the professional community will have a stake in compliance among its constituent members.

A further implication of private enforcement is that when a court in one jurisdiction applies a broader tort standard, it is not only new law for that jurisdiction, but it may also be grounds for a lawsuit in other jurisdictions. Injured parties in another state can seek to have the newly articulated standard established as law in their own jurisdiction by bringing a suit on these grounds. Thus, while both criminal and tort law are jurisdictionally specific, the private enforcement and after-the-fact determination of liability in the tort system mean that persons and organizations may be sued on grounds that have succeeded in other jurisdictions and thus suffer the stigma and psychic distress of a lawsuit even if not found liable because the new standard is not adopted where they reside.

While these features of the tort system suggest why therapists might be responsive to Tarasoff, there are features of this ruling that also cut the other way. In the typical case, a suing patient claims that the provided treatment fell below the standard that a competent

physician would normally observe. Through the testimony of experts, the profession itself supplies the standard of care; courts simply enforce it. In *Tarasoff*, however, the court did not pretend that it was simply enforcing the customary professional standard when it held that psychotherapists had an obligation to warn or otherwise protect potential victims. Rather, the court itself articulated a new standard of professional practice based on its own view of wise social policy and announced that psychotherapists ignored it at their peril. Thus, as the professional associations argued, *Tarasoff* may require psychotherapists to contravene normal, competent clinical practice in order to avoid liability—to follow a course of conduct that a court, rather than psychotherapists, believes feasible and necessary.

In this article we examine *Tarasoff*s impact on psychotherapeutic practice. We first explore what therapists know about the *Tarasoff* decision, what they understand it to mean, and whether they consider themselves bound by its prescriptions. We then turn to the effect of *Tarasoff* on their self-reported behavior and changes in their behavior over time. As we show, the decision has influenced therapists' beliefs and behavior. Finally, we consider why such influence occurred.

**METHODOLOGY**

Our analysis is based on a 1980 survey of psychiatrists, psychologists, and social workers in the eight largest metropolitan areas in the United States, as of the 1970 census. Psychotherapists were selected from the biographical directories of the American Psychiatric Association, the American Psychological Association, and the National Association of Social Workers. Questionnaires were mailed to 1000 members of each professional group stratified according to experience, type of practice, and location. The 1722 respondents—471 psychiatrists, 599 psychologists, and 652 social workers—were equally distributed among the eight urban areas—Boston, Chicago, Detroit, Washington, D.C., Los Angeles, New York, Philadelphia, and San Francisco. At the time of the survey, the *Tarasoff* ruling was the law in San Francisco and Los Angeles, but not elsewhere.8

In the survey instrument, we asked therapists two kinds of questions designed to reveal the possible impact of *Tarasoff*. One kind concerned their perceptions and beliefs about the *Tarasoff* decision itself: their knowledge of the case, their understanding of what it required, and their beliefs about whether and for what reasons it may apply to them. The other questions concerned their behavior when confronted with a *Tarasoff*-relevant situation: the steps they actually took in the “most recent case” in which they treated someone who might harm another person, and the steps they have become more willing to employ with potentially dangerous clients since the *Tarasoff* decision was handed down. Our purpose was to learn whether the behavior of therapists had come to incorporate the *Tarasoff* obligation, at least as they understood it.

**FINDINGS**

The analysis that follows examines, first, perceptions and beliefs therapists hold about *Tarasoff* and, second, the

actions they have taken in Tarasoff-relevant cases.

Perceptions and beliefs about Tarasoff

At the very end of the questionnaire, after respondents had answered questions about themselves, their professional practice, and the kinds of patients or clients who might harm others, we turned specifically to the Tarasoff decision. We asked whether they had heard of the case, when they first learned of it, what their sources of information were, when the ruling applies, what it requires therapists to do, whether—including the reasons why—they feel bound by it, and what, if any, reservations they have about the Tarasoff decision or the principle embodied in it. In this section, we examine whether they had heard of the case, what they thought it required, and whether they believed it applied to them.

As indicated in Table 1, there is an astonishing degree of familiarity with Tarasoff by name among psychiatrists in both California and other jurisdictions and among Californians in all three professions. Although when the questionnaire was prepared there was no other “case like” Tarasoff, we presented therapists this option in order to see whether people were aware of the decision even if they could not remember the name. Those least apt to say they knew the case by name—social workers and psychologists outside of California—were the ones most apt to say they knew of a case like Tarasoff. In all professions and locations, a majority of our respondents had heard of Tarasoff or a case like it.

Requirements of Tarasoff. Awareness is only the beginning, however. One may know of a judicial decision without understanding what it requires. Indeed, there were two Tarasoff decisions: one, in 1974, that required warning, followed in 1976 by one that substituted exercise of reasonable care for warning and cited warning as an example of reasonable care. To see how psychotherapists interpreted this legally complicated development, we asked our respondents who had heard of Tarasoff or a case like it, “What does the case require therapists

<table>
<thead>
<tr>
<th>Percentage for Each Profession and Location</th>
<th>Psychiatrist</th>
<th>Psychologist</th>
<th>Social worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>California Other states</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heard of the Tarasoff case</td>
<td>96</td>
<td>86</td>
<td>76</td>
</tr>
<tr>
<td>Heard of a case like it</td>
<td>1</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Never heard of Tarasoff or a case like it</td>
<td>3</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>(N of respondents)</td>
<td>(113)</td>
<td>(146)</td>
<td>(163)</td>
</tr>
</tbody>
</table>


NOTE: Alternative response categories add to 100 percent.

NOTE: Multiple responses, adding to more than 100 percent; only respondents who are familiar with Tarasoff or a case like it are included.

to do?” and listed 11 possibilities including “nothing,” “unsure,” and “other.” Among those aware of Tarasoff or a case like it, Table 2 shows the percentage by profession and location saying that a given response was required.

**TARASOFF** was widely, if wrongly, understood to require a therapist to “warn the potential victim.” Of 10 Californians in each professional group, 9 believed that warning was required by **TARASOFF**, and 7 or 8 of 10 non-Californians in each group held this belief. California psychologists and social workers were also more likely than their counterparts elsewhere to say that the decision requires calling the police, though California psychiatrists were not. Regardless of location, social workers said that they were required to notify the appropriate supervisor or administrator in an institutional setting, and psychologists said that the decision required warning the family or guardian of a potential victim.

On the other hand, Californians were less likely in each professional group to say that **TARASOFF** required other steps such as seeking emergency involuntary commitment, dealing with the potential for violence in continued therapy, and seeking professional consultation. Indeed, Californians were less likely than their counterparts in other states to recognize that **TARASOFF** required them to use “reasonable care”—the language of the decision itself—to protect potential victims.
Combinations of Tarasoff requirements. Most therapists cited more than one Tarasoff requirement—usually warning the victim and one or more other steps. To show what combinations of requirements they thought Tarasoff imposed, we have tabulated the major patterns of responses to the question about what the ruling requires in Table 3. The response patterns fall into three successively more inclusive groupings—namely, warning the potential victim as the only requirement; warning the victim and notifying other persons; and warning the victim, notifying others, and taking other steps not limited to notification or warning. There was also a residual category of combinations that do not fall into one of these three groupings.

California psychiatrists tended to take the narrow view that warning the potential victim was the only requirement of Tarasoff; more than a third of them adopted this position, a view also more common among psychologists and social workers in California than elsewhere. When California psychiatrists mentioned something in addition to warning the victim it tended to be a single additional step within a broader group of options, chiefly, calling the police. Almost half of the California psychiatrists said that Tarasoff required either warning only or warning plus calling the police; the figure exceeds half when we include notifying the family or guardian of the potential victim along with the victim.

By contrast, California psychologists took a somewhat broader view of the Tarasoff requirements. They were the group most likely to give responses that included warning the victim and notifying others, but not including steps beyond notification. Moreover, within this category of responses, they were likely to say that several or all forms of notification, in addition to warning the potential victim, were required by Tarasoff.

As a further contrast, California social workers appeared to take an even broader view of the Tarasoff requirement. They were the most likely to say that in addition to warning the victim and notifying others, the Tarasoff ruling also required steps that did not explicitly involve notification. From the specific combinations of responses within this broader category, moreover, it is clear that California social workers were more likely than others to include the requirement of “reasonable care” among these other steps—perhaps because they explicitly recognized this as the language of the Tarasoff decision or possibly because it was a broad common-sense statement of the Tarasoff principle of responsibility for protecting potential victims.

Among the combinations of requirements that do not fall within one of these successively more inclusive groupings, there were two notable patterns. First, non-Californians were overrepresented chiefly because they were less likely than Californians to cite warning the potential victim as a Tarasoff requirement. Second, California psychiatrists were more likely than others to cite reasonable care in these residual combinations as a Tarasoff requirement. Strictly speaking, reasonable care alone is the Tarasoff requirement, but this specific option was cited by only 26 respondents. Reasonable care and warning the potential victim, with 56 respondents, might be regarded as the best stand-in as it includes the legal requirement and a judicially articulated example of how it may be exercised.
### TABLE 3

**PATTERNS OF PERCEIVED TARASOFF REQUIREMENTS**

<table>
<thead>
<tr>
<th>Percentage for Each Profession and Location</th>
<th>Psychiatrist</th>
<th>Psychologist</th>
<th>Social worker</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>California</td>
<td>Other states</td>
<td>California</td>
</tr>
<tr>
<td>Warn potential victim only</td>
<td>36</td>
<td>27</td>
<td>21</td>
</tr>
<tr>
<td>Warn victim and notify others</td>
<td>23</td>
<td>20</td>
<td>33</td>
</tr>
<tr>
<td>Warn victim and notify police</td>
<td>12</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Warn victim and notify family</td>
<td>6</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Warn victim and notify all others</td>
<td>5</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>Warn victim, notify others, and take other actions</td>
<td>22</td>
<td>37</td>
<td>32</td>
</tr>
<tr>
<td>Warn victim, notify others, take other clinical actions</td>
<td>6</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Warn victim, notify others, and use reasonable care</td>
<td>5</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Warn victim, notify others, use reasonable care, and take other clinical actions</td>
<td>11</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Residual patterns</td>
<td>19</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>Warn victim and use reasonable care</td>
<td>8</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Use reasonable care only</td>
<td>5</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>All others</td>
<td>6</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>(N of respondents)</td>
<td>(109)</td>
<td>(318)</td>
<td>(138)</td>
</tr>
</tbody>
</table>

**NOTE:** Major headings sum to 100 percent; minor headings sum to major headings.

Among Californians, then, the common theme was warning; the differences are in what goes with it. California psychiatrists tended to take the single-minded view that nothing goes with it, that *Tarusoff* required warning alone; California psychologists tended to extend the scope of requirements one step to include other notifications as well as warning; and California social workers tended to extend the scope another step to include actions beyond warning or other notifications, chiefly including reasonable care. The most consistent differences between Californians and others in each profession came with respect to the place of warning the potential victim (as reflected in the top and bottom rows of Table 3). Californians in each profession more
often saw warning alone as the requirement; non-Californians more often mentioned requirements that did not include warning at all (bottom row).

Obligation to Tarasoff. One may know of a judicial decision and understand rightly or wrongly what it requires but not feel legally or ethically obligated to abide by the decision or to embrace the principle embodied in it. This is especially likely, as here, when a judicial decision is widely known by those living and working outside of the jurisdiction promulgating it. To learn whether and for what reasons therapists felt bound or obligated by the Tarasoff principle, we asked our respondents to indicate whether “the principle of responsibility on the part of a therapist for the physical well-being of another person threatened by his patient/client applies to you,” for any of the six reasons listed in Table 4.

The table shows that the vast majority of therapists across the country who were aware of Tarasoff or a case like it acknowledged that the principle of responsibility for others threatened by their clients or patients applied to them, though for different reasons in different locations. Roughly 9 out of 10 Californians recognized that the decision applied as law where they practiced—in California—and more than 8 out of 10 non-Californians correctly understood that the Tarasoff decision or one like it was not the law of their state.

But there is more to be said about perceived legal obligation. Approximately half of the non-Californians said they considered themselves legally obligated by Tarasoff or a case like it because it “applies to their profession” (line 3, Table 4). Strictly speaking, this is not true. The formal source of legal authority is the state as governmental unit. Tarasoff applied legally only in California. Nor were many of the non-Californians referring to some other law, administrative regulation, or license provision applicable to their profession in the state where they practiced (line 4, Table 4). Perhaps they were acknowledging the reality that once an influential state court attaches a particular responsibility to a professional group, the law elsewhere may be viewed as in flux until such time as the courts of other states make definitive rulings on the same point.

What about ethical obligation to the Tarasoff principle? Clearly, most therapists felt obligated to protect endangered persons as a matter of personal and professional ethics, quite apart from the law. With the exception of California psychiatrists, at least 6 out of 10 respondents believed that their professional ethics required them to protect threatened victims, and, even including California psychiatrists, at least 3 out of 4 felt that their personal ethics imposed such a responsibility. Thus, the following picture emerged. Californians were more apt to believe that they were legally, rather than ethically, obligated by the Tarasoff principle; for non-Californians the reverse was true. This is not due to differences in ethical beliefs—which were relatively constant by profession and location—but to the wide differences in legal beliefs by location, differences that accorded with legal reality except insofar as therapists outside of California held that Tarasoff or a case like it applied legally to their profession.

We now know that, as of 1980, most therapists across the country and virtually all of them in California had heard of Tarasoff or a case like it. Most who knew of it believed that it required warning a potential victim and many believed it also required notifying other parties including family, friends, police, and other authorities. Finally, most therapists felt ethically obligated to the
Might, confronted another. Examination of the Tarasoff principle; virtually all Californians also felt legally bound, as did about half of the non-Californians, who said the Tarasoff decision or a ruling like it was legally binding on their profession.

The next step in our analysis is to examine the actual behavior of psychotherapists in Tarasoff-relevant situations.

**Actions taken in Tarasoff-relevant situations**

What do therapists actually do when confronted with a patient or client who might, in their judgment, attack or harm another person? To answer this question we asked respondents about the most recent case in which they treated someone whom they believed "likely to physically attack or harm other people." Specifically, we asked, "What action or actions did you take in response to your judgment that the patient/client was potentially harmful to others?" and we listed some 15 alternative steps they might have taken. In Tables 5-8 we show their specific notification and hospitalization responses and the other actions they took, grouped under these headings: treatment, documentation, consultation, and decline/terminate/transfer treatment.

For purposes of this analysis, we disregard cases handled before the Tarasoff ruling and we distinguish between cases with and without an

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**TABLE 4**

REASONS THE TARASOFF PRINCIPLE MAY APPLY TO THE RESPONDENT

<table>
<thead>
<tr>
<th>Percentage for Each Location and Profession</th>
<th>Psychiatrist California</th>
<th>Psychiatrist Other states</th>
<th>Psychologist California</th>
<th>Psychologist Other states</th>
<th>Social worker California</th>
<th>Social worker Other states</th>
</tr>
</thead>
<tbody>
<tr>
<td>Because the decision applies where respondent practices</td>
<td>94</td>
<td>18</td>
<td>90</td>
<td>17</td>
<td>84</td>
<td>19</td>
</tr>
<tr>
<td>Because a like ruling applies where respondent practices</td>
<td>49</td>
<td>17</td>
<td>56</td>
<td>18</td>
<td>55</td>
<td>27</td>
</tr>
<tr>
<td>Because the decision applies to the respondent's profession</td>
<td>77</td>
<td>48</td>
<td>93</td>
<td>53</td>
<td>83</td>
<td>50</td>
</tr>
<tr>
<td>Because other laws require it</td>
<td>13</td>
<td>7</td>
<td>43</td>
<td>14</td>
<td>31</td>
<td>18</td>
</tr>
<tr>
<td>Because professional ethics require it</td>
<td>48</td>
<td>60</td>
<td>77</td>
<td>69</td>
<td>72</td>
<td>71</td>
</tr>
<tr>
<td>Because personal ethics require it</td>
<td>75</td>
<td>78</td>
<td>85</td>
<td>82</td>
<td>81</td>
<td>83</td>
</tr>
<tr>
<td>No reason; principle does</td>
<td>-</td>
<td>4</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
</tbody>
</table>


**NOTE:** Multiple responses, adding to more than 100 percent; only respondents who are familiar with Tarasoff or a case like it and answered yes or no to each specific reason are included.

*Number of respondents on which percentages are based for a given response varies with the range shown.
explicitly identified potential victim who was threatened. Of the 1236 “last dangerous cases” reported by therapists between 1975 and 1980, 479 had an identified victim and 757 did not. Inasmuch as the number of respondents providing information on each of these situations falls well below the numbers represented in Tables 1-4, the percentages in Tables 5-8 may be somewhat less stable than those in Tables 1-4.

**Last dangerous case without a specific victim threatened.** There is virtually no evidence of a Tarasoff effect in cases where a potentially dangerous patient had not identified a specific victim (Table 5). The perceived Tarasoff requirement of warning the possible victim was, of course, problematic in such cases; the data showed that this was an uncommon step that varied little by profession or location. It was slightly more common among psychiatrists and psychologists—though not social workers—in California than elsewhere, but not enough to be a statistically reliable difference. Likewise, the other disclosures to third parties—notifying family or friends of the patient, calling the police, and contacting other public authorities—were steps that varied only slightly and not consistently by location for each profession. Differences by location in documentation, consultation, and treatment alternatives were also slight, scattered, and inconsistent among the professions. In fact, only 2 of the 30 comparisons between Californians and others in Table 5 resulted in differences of 10 percent or more, despite the reduced sample sizes relative to earlier tabulations.

**Last dangerous case with a specific victim threatened.** When there was a named victim the picture changed dramatically. Warning this likely victim...
was a consistently more common practice among all categories of psychotherapists regardless of location, although the magnitude of the difference between Californians and non-Californians varied from 10 percentage points for psychiatrists to a high of 22 points for social workers and a low of 3 points for psychologists.

Among psychiatrists, warning the victim was the only notification that distinguished Californians from others by more than a very few percentage points. Thus, the strictly victim-warning interpretation of Tarasoff, held chiefly by California psychiatrists (as shown in Table 3) was also manifested in their self-reported behavior.

Among psychologists, it was notifying family or friends, or other public authorities, more than directly warning the potential victim that distinguished Californians from non-Californians. Thus, the group most likely to cite other notifications in addition to warning the potential victim as required by Tarasoff, in practice preferred these other notifications as alternatives to the one mandated in the first Tarasoff decision and suggested in the second.

California social workers appear in practice as well as principle to have adopted the broadest interpretation of Tarasoff. In practice they employed every notification option—contacting the patient’s family or friends, calling the police, and alerting other public authorities, as well as warning the potential victim—more commonly than social workers elsewhere. They were also the most likely of any group in Table 6 to document the danger, seek consultation from other professionals, and decline or terminate treatment. Apparently, the Tarasoff ruling had had a broad impact on their behavior.

Notification combinations. Strictly speaking, the data in Table 6 do not tell us in what combinations therapists employed the steps they took, as their responses were tabulated separately for each type of action. For a clearer picture of the choices they made between warning the victim and other notifications, in Table 7 we have tabulated notification combinations in the last dangerous case with an identified victim. There we show those whose only notification was warning the likely victim, those who chose any other notification response except warning, and those who chose both warning and other notifications.

The pattern in this section of the table is remarkably clear. Among psychiatrists the only difference by location was in warning the victim only. Among psychologists, the only difference occurred in notifications other than warning. And among social workers the only difference was in warnings joined by other notifications. Note that the consistency in Table 7 lies in the greater use of some notification response among Californians as compared to non-Californians of each professional group.

Changes in willingness to act. Any impact of the Tarasoff decision must be reflected in changes that have occurred in therapists’ behavior since the decision was handed down. We therefore asked therapists about their willingness to employ ten specific steps if faced with a potentially violent patient now—at the time of the survey in 1980—as compared to five years earlier. Respondents’ judgments about changes in their willingness to employ these ten specific responses to such patients are shown in Table 8.

Willingness to warn potential victims of impending harm was the response that increased most between 1975 and
1980. Among Californians, three-quarters of the psychiatrists and two-thirds of the psychologists and social workers said they were more willing to warn at the time of the survey than they had been five years earlier. In this response, Californians led non-Californians in each profession, and psychiatrists led the other professional groups in each location. Note that California psychiatrists, who led the parade of increased willingness to warn, fell behind the other groups in increased willingness to hospitalize when faced with a potentially dangerous patient.

In addition, Californians in each professional group have increased their willingness to notify public authorities and the police more than non-Californians have. The increased willingness to make various notifications designed to protect a potential victim appear to be what the California Supreme Court meant by "reasonable care"; such actions were mentioned by the court as examples of reasonable care in the second Tarasoff decision. Moreover, these retrospective self-evaluations indicate that it is not only the willingness to warn the potential victim but also the willingness to notify other parties that distinguished Californians from others.

Note further that the willingness to notify third parties, especially endangered victims, also increased markedly outside of California over this period. More than half of the non-California psychiatrists and psychologists said they were more willing to warn potential victims in 1980 than they had been five years earlier. The data suggest that notification in general and warning an endangered victim in particular became more accepted practice over this period not only in California but elsewhere as well, if not as fully. Thus, the impact of


**TABLE 7**

**PATTERNS OF NOTIFICATION IN LAST DANGEROUS CASE WITH SPECIFIC VICTIM THREATENED**

<table>
<thead>
<tr>
<th>Percentage for Each Profession and Location</th>
<th>Psychiatrist</th>
<th>Psychologist</th>
<th>Social worker</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>California</td>
<td>Other states</td>
<td>California</td>
</tr>
<tr>
<td>Warning potential victim only</td>
<td>14</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Notifying others only</td>
<td>30</td>
<td>30</td>
<td>42</td>
</tr>
<tr>
<td>Warning potential victim and informing other</td>
<td>24</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
<td>No notifying or warning action</td>
<td>32</td>
<td>42</td>
<td>27</td>
</tr>
<tr>
<td>(N of respondents)</td>
<td>(37)</td>
<td>(94)</td>
<td>(36)</td>
</tr>
</tbody>
</table>

**NOTE:** Mutually exclusive groupings of actions add to 100 percent.

*Tarasoff,* though concentrated where the decision applied as law, appears also to have been felt in jurisdictions where *Tarasoff* was not the law, but where it may increasingly have become a standard of professional practice.

This evidence that the ruling’s major impact is not strictly contained within jurisdictional boundaries means that comparisons between Californians and non-Californians in their handling of potentially dangerous persons present a conservative picture of the overall impact of the *Tarasoff* decision. To the extent that therapists in both locations have been influenced by *Tarasoff,* comparisons of their behavior reflect only the differential effects of the ruling’s overall impact. We must examine how therapists’ awareness and interpretation of the *Tarasoff* decision and their commitment to the *Tarasoff* principle have affected the steps they are willing to take and have actually taken both inside and outside of California. The findings presented here are, therefore, a preliminary assessment of how the *Tarasoff* decision affected clinical practice in the first five years after it was handed down.

**DISCUSSION**

As professionals, health care providers are supposed to share and are expected to conform to a common set of standards and practices. The typical malpractice case amounts to an accusation that a particular professional has failed to perform with the same level of skill and knowledge possessed by other competent practitioners. In this way, tort law is thought to reinforce existing professional standards. But an atypical malpractice case like *Tarasoff* may actually serve to change professional norms and do so beyond the jurisdictional boundaries within which it is binding. Both inside and outside of California between 1975 and 1980 there was a substantial increase in the willingness to warn potential victims, and as of 1980 there was a widespread endorsement of the *Tarasoff* obligation to protect potential victims as a personal and professional norm. During this period, both the *Tarasoff* principle—protection of the potential victim—and the *Tarasoff*-specific intervention—warning—appear to have been adopted or
enhanced as values and practices of professional psychotherapists. Perhaps this is what our respondents were expressing when they told us that Tarasoff was legally binding upon them because it “applies to my profession.” Of course, we cannot attribute all post-Tarasoff beliefs and actions to the impact of the decision. No doubt a certain threshold of readiness or receptivity must be present before professional standards of conduct will change.

Yet, the California Supreme Court did not write upon a blank slate when it decided Tarasoff. Despite litigation-inspired claims to the contrary, the ethical guidelines of the mental health professionals represented in our study have explicitly stated for years prior to Tarasoff that confidentiality may be compromised in the event that failure to do so would endanger the client or others.9 Tarasoff put the force of tort sanction behind this ethical precept. At

the same time, it provided therapists with a legally required solution to the clinical and ethical dilemma of how to respond when the therapist is genuinely concerned about the patient’s danger to others. Thus, the dilemma of dealing with potentially violent patients and the ethical guidelines of the mental health professions may have provided the threshold of readiness and receptivity necessary for the acceptance of the Tarasoff principle and its implications for practice—a climate in which the tort sanction will promote normative change.

What is more, the social organization of mental health training and practice may make these professionals as a group especially responsive to the law and promote the incorporation of legal changes into professional standards. Legal decisions like Tarasoff may immediately be incorporated into the training programs of professional schools. The institutional settings in which many psychotherapists work are likely to be sensitive to the law and may issue directives and regulations designed to ensure compliance. Indeed, differences among the respective professions in the organization of training and practice may account for their contrasting interpretations and actions where Tarasoff applies as law, and the national reach of the professionally organized communities may help explain why non-Californians have been affected by the Tarasoff decision, issues that we will explore in continuing analyses.

But whether they are right or wrong about what Tarasoff requires and upon whom it is legally binding, most professional psychotherapists, according to the data presented here, have come to accept the Tarasoff principle as an article of personal and professional ethics, to regard the Tarasoff decision as legally binding upon themselves, and in turn to have their behavior influenced by these ethical and legal beliefs. We suggest that the Tarasoff principle was more readily accepted because it was consistent with preexisting ethical guidelines of the professions and because it provided a legal solution to a fundamental dilemma of practice. We further suggest that it affected professional behavior not primarily because individual psychotherapists are especially law compliant, but because the socially organized professional communities have adopted the Tarasoff principle as the right way to do things—as an emergent professional standard.