The Tarasoff Two-Step

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There is a “dance” that all therapists must know how to do, and do well, which means smoothly executing the “steps” involved, and not tripping over one’s feet in the process. This dance is called The Tarasoff Two-Step.¹ Some therapists resist learning it because they believe they will have only high-functioning, stable clients. Don’t fall for that canard! One never really knows when the discordant music of a dangerous patient situation may begin to play, and the time to “dance” has arrived. It is far better to be prepared ahead of time to handle these situations as opposed to being overwhelmed by them later. The Tarasoff Two-Step is not as energetic as “The Twist,” not as sexy as “The Tango,” and not as elegant as “The Waltz,” but it is absolutely necessary for therapists to know how to do, and do well.

The Tarasoff Cases

Since some reading this article may be encountering the “dangerous patient” issue for the first time, it seems prudent to review the factual background to the Tarasoff cases² for context. For purposes of this article, I am blending facts from the civil and criminal cases to help the reader better understand the issue.

The story begins in 1968 when Prosenjit Poddar, an Indian graduate student at UC Berkeley, met Tatiana Tarasoff while she was attending folk dancing classes at the International House, which is where Poddar lived. Poddar became infatuated with Tatiana. They saw each other weekly throughout the fall of 1968, and on New Year’s Eve Tatiana kissed Poddar, which caused him to believe they were involved romantically.

Tatiana, however, did not reciprocate Poddar’s feelings. After he confided to her about his feelings, Tatiana told him she was not interested in being his girlfriend, which devastated Poddar. He became depressed and neglected his appearance, his studies, and his health. He became a loner, stayed in bed interminably, spoke disjointedly, and often wept. He confided to a friend that he loved Tatiana, but thought about killing her by blowing up her room.

During the summer of 1969, Tatiana went to Brazil, and a friend suggested that Poddar seek counseling, which he did. On August 18, 1969, he was a voluntary outpatient at Cowell Memorial Hospital. Poddar confided to Lawrence Moore, a staff psychologist at Cowell, that he was going to kill an unnamed girl when she returned from Brazil. Given the history between Poddar and Tatiana, that “unnamed girl” was identifiable as Tatiana. Despite the fact that Poddar had expressly stated he would kill Tatiana when she returned from Brazil, no one communicated such intent to Tatiana or to a member of her family.

Moore was, however, genuinely concerned about Tatiana’s safety. He had diagnosed Poddar with “paranoid schizophrenic reaction, acute and severe,” and he attempted to have Poddar hospitalized on a 72-hour hold. He contacted campus police via the telephone and via letter, and even warned the police that Poddar could appear very rational. However, when members of the campus police interviewed Poddar, they were satisfied that he was not dangerous to Tatiana. They felt he had “changed his attitude altogether.” The campus police encouraged him to stay away from her, which he promised to do. Consequently, although Moore sought to have Poddar involuntarily committed, the campus police disregarded Moore’s recommendation and Poddar remained free.
Poddar then stopped attending therapy with Moore. About two months later, in October of 1969, Tatiana returned to California from Brazil, and Poddar began following her again. He heard her say that while she was in Brazil, she had an affair with another man.

On October 27, 1969, Poddar went to the Tarasoff’s home and found Tatiana alone. He was armed with a pellet gun and a kitchen knife. Tatiana refused to speak with him and she screamed. Poddar then shot her with the pellet gun, and Tatiana ran away from the house. Poddar followed her into the yard, where he caught her, and then stabbed her repeatedly, killing her in the process. He then returned to the Tarasoff’s home and called the police. When the police arrived, Poddar asked to be hand-cuffed.³

Thereafter, Tatiana’s parents, Vitaly and Lydia Tarasoff, sued the Regents of the University of California, the campus police, and Cowell Memorial Hospital, among others, seeking damages for the wrongful death of Tatiana. The Tarasoffs essentially sued on two theories: someone should have warned Tatiana, or notified her, that Poddar intended to kill her once she returned from Brazil, and the parties involved negligently failed to have Poddar involuntarily committed.

The lawsuit filed by the Tarasoffs was ultimately heard by the California Supreme Court twice, which is remarkable in itself, and on July 1, 1976, the court announced the following ground-breaking duty⁴ for psychotherapists:

“When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus, it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.”⁵

This duty to protect can be compartmentalized into two steps: the first is an “assessment” step. If the therapist’s assessment of the patient causes the therapist to reasonably determine the patient is dangerous to another person, the duty to protect the intended victim has been triggered, which leads to the “discharge” step. To avoid civil liability for the violent actions of patients, therapists must understand and be able to do both steps well.⁶

**Step One of the Tarasoff Two-Step: Assessing for Dangerousness**

As you work with a client, you may become privy to information that makes you concerned, or should make you concerned, that your client may kill or physically injure another human being. Perhaps the client has threatened to kill his former boss because the client was passed over for a promotion. Perhaps the client has a history of beating-up previous wives or girlfriends and that “history” is about to manifest itself now with the client’s current wife or girlfriend. Perhaps the client has suffered a psychotic break and believes God has commanded him to sacrifice his daughter to atone for the sins of Hollywood.

When privy to such information, you must conduct a thorough assessment of the individual and his or her situation to determine whether you reasonably believe there is a serious risk of loss of life or grave bodily injury to another person.⁷ The concept of “loss of life” is self-evident, and the concept of grave bodily injury includes such injuries as loss of consciousness, concussions, fractures, wounds requiring extensive suturing, loss or impairment of bodily members or organs, and serious disfigurement.⁸ In this article, I will use the generic word “violence” as shorthand for the concepts of loss of life and grave bodily injury.

It is possible, even likely, that although the patient said he would kill his former boss, an assessment...
of the patient reveals that there really is not a serious risk of violence against the boss because the patient was merely jesting or talking tough. The issue was addressed by the California Supreme Court in *Tarasoff* and the court explained that:

“We realize that the open and confidential character of psychotherapeutic dialogue encourages patients to express threats of violence, few of which are ever executed. Certainly a therapist should not be routinely encouraged to reveal such threats; such disclosures could seriously disrupt the patient’s relationship with his therapist and with the persons threatened. To the contrary, the therapist’s obligations to his patient require that he not disclose a confidence unless such disclosure is necessary to avert danger to others, and even then that he do so discreetly, and in a fashion that would preserve the privacy of his patient to the fullest extent compatible with the prevention of the threatened danger.”

The assessment should help you clarify what you believe about the patient’s capacity for committing violence. It is a myth to believe that every threat uttered by a patient must result in *Tarasoff* warnings; it is a truism to believe that every threat must be assessed.

Assessing for the likelihood of violence is different from predicting that violence will occur. The law does not expect you to predict future violence with one-hundred percent accuracy. Rather, it expects you to assess for the likelihood of violence by utilizing your education, training, and experience. In discussing this issue, the California Supreme Court in *Tarasoff* explained that:

“We recognize the difficulty that a therapist encounters in attempting to forecast whether a patient presents a serious danger of violence. Obviously, we do not require the therapist, in making that determination, to render a perfect performance; the therapist need only exercise reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of that specialty under similar circumstances. Within the broad range of reasonable practice and treatment in which professional opinion and judgment may differ, the therapist is free to exercise his or her own best judgment without liability; proof, aided by hindsight, that he or she judged wrongly is insufficient to establish negligence.”

In other words, you do not have to be perfect in predicting what will happen; you just have to be reasonably competent in assessing for what *could* happen. You demonstrate competence by applying your education, training, and experience to the facts of the patient’s situation.

The key is using an assessment tool that has been generally recognized by the psychotherapy community, which certainly includes assessment devices published in textbooks, practice handbooks, peer-reviewed articles, and information acquired from continuing education course instructors.

Whatever standardized assessment tool you utilize, the goal is to arrive at a reasoned and informed judgment about your patient’s capacity for committing violence. You must have good reasons for the judgments you make, and your records must reflect those reasons and judgments. Ultimately, those reasons and judgments will come from your understanding of your patient, from your understanding of human behavior, and from your understanding of the factors that can lead to violence.

Perhaps a real life example will illustrate the process. Think back to the *Tarasoff* case. Moore, Poddar’s psychologist, believed (determined) that Poddar needed to be hospitalized to keep him from harming Tatiana, and possibly himself. But, what were the reasons for his belief? One reason was likely Poddar’s diagnosis of “paranoid schizophrenic reaction, acute and severe,” a severe psychiatric disorder. This is not to say, however, that everyone with this diagnosis will kill someone who does not return their love; rather, it is only to say that this is a serious disorder that can make people unstable. In terms of potential violence, it is a factor to be considered.
The second factor was likely Poddar’s obsession with Tatiana. Again, not everyone with an obsession is a potential murderer. Obsession can make people unstable, especially when the obsession is coupled with statements like “if I can’t have her, no one else will” or “since she has wronged me, she has to be punished.” In terms of potential violence, evidence of obsession is also a factor to consider.

The third factor, and likely the most compelling, was Poddar’s stated intent to kill Tatiana, especially when you combine such intent, with his serious condition, and his obsession. There may have been other reasons, but from the information chronicled in the published cases, these three seem to be the ones most acute at the time. When you combine Poddar’s serious diagnosis with his obsession for Tatiana and with his stated intent to kill her, confirmation bias notwithstanding, does he not sound dangerous to you? Remember, the goal is not to predict what Poddar will actually do; the goal is to make a reasoned assessment of his capacity for violence.

Another critical issue for consideration during the assessment phase is the patient’s history of committing acts of violence. Has this person killed or injured people before? Sometimes a person’s history of violence, coupled with present instability in that person’s life, may be enough to trigger the duty to protect under Tarasoff, even in the absence of a stated threat to kill or injure. The leading case for this proposition is Jablonski v. United States (1983) 712 F.2d 391, a case in which Mr. Jablonski murdered his girlfriend, Melinda Kimball.

In Jablonski, the United States District Court explained that “Unlike the killer in Tarasoff, Jablonski made no specific threats concerning any specific individuals. Nevertheless, Jablonski’s previous history indicated that he would likely direct his violence against Kimball. He had raped and committed other acts of violence against his previous wife. His psychological profile indicated that his violence was likely to be directed against women very close to him.”

Consequently, Mr. Jablonski is an example of an individual who was extremely dangerous to his current girlfriend although he never uttered a specific threat to harm her. It was his history of violence, coupled with his instability that made him so dangerous to Ms. Kimball. When doing Step One of the Tarasoff Two-Step, pay particular attention to the patient’s history of committing violence. Robert I. Simon, MD in his book Psychiatry and Law for Clinicians, Third Edition, relates that “Every study on the assessment of violence risk factors has found that the single factor most highly correlated with the potential for future violence is a history of violence.”

The bottom line is this: Assess, assess, assess (especially utilizing some form of standardized instrument), and then evaluate thoughtfully the information you learn from the assessment (drawing upon your education, training, and experience). Consulting with colleagues who are knowledgeable about these issues is always prudent and recommended. If possible, referring the patient for evaluation by a psychiatrist or psychologist is also prudent.

When assessing whether someone is reasonably likely to commit violence, you will come to a “fork in the road” regarding the situation. Either you believe your patient is reasonably likely to commit violence, or you don’t:

1. If, after assessing, you believe your patient is reasonably likely to commit violence, the duty to protect any intended victims has been triggered, and it is time to move to the second step of the Tarasoff Two-Step, which is discharging the duty to protect.

2. If, after assessing, you do not believe your patient is reasonably likely to commit violence, your job is not finished. You should continue assessing for violence during subsequent interactions with this patient, work with the patient to reduce any “friction” in the patient’s life.
Of course, your records need to reflect these decisions and document the rationale for them. If you believe your patient is reasonably likely to commit violence, state that and include why you believe so! Conversely, if you do not believe your patient is reasonably likely to commit violence, state that and why you believe so! Refer to the scholarly literature on these issues, and even include copies of relevant materials in the patient’s file.

Before leaving Step One of the Tarasoff Two-Step, it is important to clarify three issues that come up with regularity:

The first issue concerns threats made by patients that are reported to therapists from family members of patients. If a patient threatens to commit violence against another person, the psychotherapist does not need to hear that threat directly from the patient himself or herself to have to assess the threat. The threat to commit violence can be relayed to the therapist by a family member of the patient, and then the therapist must assess the patient’s capacity for violence in light of that relayed information. The therapist does not have to hear the threat directly from the patient.

The second issue concerns acts of violence threatened by individuals who are not patients of the therapist. For instance, your client tells you that her brother, whom you never met, threatened to kill his former girlfriend. Such a situation is not Tarasoff because the client’s brother is not your patient. Remember, one of the keys to these cases is the proper assessment of the individual, and you can only assess individuals who are actual clients. For Tarasoff obligations to arise, your actual patient must be the one you believe is reasonably likely to commit violence, not a third party. Such situations could, however, result in the reporting of suspected child, elder, or dependent adult abuse, depending on the facts.

The third issue is what to do if your patient is the potential victim of someone else’s violence. If your patient is the potential victim of violence, you should be working with your patient to formulate a safety plan for that person. Such cases, depending on the underlying facts, may also involve suspected child, elder, or dependent adult abuse reports to be made.

**Step Two of The Tarasoff Two-Step: Discharging the Duty to Protect**

Step two involves doing something affirmatively to help protect intended victims from threatened violence committed by patients. Although you have to take action to fulfill the duty, there is currently some ambiguity in the law with regards to the proper action to take to discharge the duty to protect. This ambiguity has been created by differences in the wording of two laws pertaining to Tarasoff situations. Those two laws are the Tarasoff case itself (Tarasoff the Case), as decided by the California Supreme Court in 1976, and California Civil Code § 43.92 (T arasoff the Statute), which was enacted by the California legislature in 1985. To discharge the duty to protect, you must understand the differences between these two laws.

Let’s take the rule of law from Tarasoff the Case first. In enacting the duty to protect in Tarasoff the Case, the California Supreme Court explained that the duty to protect “may require the therapist to take one or more various steps, depending upon the nature of the case. Thus, it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.”

The language of this law is very fluid. It reeks of options. It does not prescribe one way to address dangerous patient situations. It recognizes that Tarasoff situations can be very different factually and that thought is supposed to be given as to what is reasonable under the circumstances of the particular case.
In *Psychiatry and Law for Clinicians*, Dr. Simon envisions three types of Tarasoff situations and recommends a plan of action for each of them. In situations where there is a “low” risk of violence, as determined by the therapist in the exercise of the therapist’s professional judgment, Simon recommends continuing with the treatment plan to reduce “friction” in the patient’s life. In these kinds of cases, there is no need to call the police or warn identifiable victims. It is likely more important to preserve the patient’s confidentiality and trust, not destroy it by unnecessarily calling the authorities.

In situations where there is a “moderate” risk of violence, as determined by the therapist in the exercise of the therapist’s professional judgment, Simon recommends hospitalization, or some combination of frequent outpatient visits, warnings to identifiable victims, calls to the police, reevaluating the patient and the treatment plan frequently, and/or remaining available to the patient. For Simon, if the patient cannot be hospitalized, then the interventions listed under the “moderate” risk of violence scenario would have to be utilized to discharge the duty to protect.

The approaches suggested by Simon seem to harmonize with the rule of law from Tarasoff the Case. Under *Tarasoff* the Case, the duty to protect could be discharged in a variety of ways, with hospitalization, whether voluntary or involuntary, seemingly being an acceptable and lawful way of discharging the duty to protect.

You may be thinking, “But, my law and ethics professor taught me that in Tarasoff situations I have to make reasonable efforts to call the police and make reasonable efforts to warn identifiable victims. My professor never mentioned hospitalization as an option.”

The reason your professor did not mention hospitalization as an option is likely because the professor focused only on *Tarasoff* the Statute, but ignored *Tarasoff* the Case. As I mentioned before, to do *Tarasoff* Two-Step well, you have to account for both laws in your thinking.

Let’s take a closer look at *Tarasoff* the Statute, California Civil Code § 43.92. This statute says:

a) There shall be no monetary liability on the part of, ..., any person who is a psychotherapist in failing to warn of and protect from a patient’s threatened violent behavior or failing to predict and warn of and protect from a patient’s violent behavior except where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.

b) There shall be no monetary liability on the part of, and no cause of action shall arise against, a psychotherapist, who, under the limited circumstances specified above, discharges his or her duty to warn and protect by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.

This statute gives psychotherapists immunity from liability for the violence wrought by their patients when their patients make actual threats of violence against reasonably-identifiable victims, and such therapists then make reasonable efforts to communicate such threats to the identifiable victim or victims and to a law enforcement agency. Immunity from liability means that even if your patient actually goes out and harms intended victims, if you have accomplished the two parts required by *Tarasoff* the Statute, you cannot be held financially responsible for the violent acts of your patient.
Does it sound like Tarasoff the Case and Tarasoff the Statute are playing the same “tune” or different “tunes”? There seem to be three significant differences between Tarasoff the Case and Tarasoff the Statute. One difference between Tarasoff the Case and Tarasoff the Statute is how the duty to protect is triggered. Under Tarasoff the Case, the duty to protect is triggered when the therapist “determines” that a patient presents a serious danger of violence to another. But, under Tarasoff the Statute, the duty to protect is triggered when the patient communicates to the therapist a “serious threat of physical violence.”

The differences in language raises a key question: Do you need an actual threat of violence before you can determine whether someone is dangerous to another person? Think back to the Jablonski case. In that case, Mr. Jablonski was considered to be very dangerous to Ms. Kimball, although he never actually threatened her. His history of violence, coupled with his present instability, was enough to enable therapists to determine he was capable of violence.

A second difference between Tarasoff the Case and Tarasoff the Statute is the categories of people who could be victims of the patient’s violence. Tarasoff the Case stresses “intended victims,” but Tarasoff the Statute stresses “reasonably identifiable victims.” So, can you have victims of violence who may be intended, but not identifiable?

What if your patient said that “Tonight, people are going to die!”? You would, of course, try and get some additional details from your patient about this event by asking “Who is going to die?” “Where is this going to happen?” “Why do you feel the need to do this?” But, suppose the patient says “I’m not going to tell you because I know you will just call the cops; I just want you to know that people will die tonight and tomorrow I will be famous.”

If you reasonably believe your patient would go out and commit mass murder, you would have a duty to protect under Tarasoff the Case because intended victims can be foreseeable victims, although such victims cannot be identified specifically; however, you would not have the immunity provided by Tarasoff the Statute because you do not have identifiable victims, only intended/foreseeable ones. In a mass murder situation, there could be no identifiable victims to warn, but there could be intended/foreseeable victims to try and protect. In the case described above, the most prudent thing to do would be to call the police and inform them of the patient’s intent so that the patient could be taken into custody as soon as possible.

A third difference between Tarasoff the Case and Tarasoff the Statute is the difference in options available to discharge the duty to protect, once it has been triggered. Under Tarasoff the Case, to discharge the duty to protect, one could warn the intended victim or others likely to apprise the victim of the danger, one could notify the police, or one could take whatever other steps are reasonably necessary under the circumstances.

However, under Tarasoff the Statute, to discharge the duty to protect, one must make reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency. Thus, Tarasoff the Case provides three options and Tarasoff the Statute offers two options. Note, and this is crucial, that there is no automatic immunity for taking reasonable steps to discharge the duty to protect under Tarasoff the Case. There is a standard of care to meet, and if you meet it, then you should not be held liable for violence wrought by your patients. Having the immunity under § 43.92, on the other hand, would likely make it easier for your attorney to get you out of a lawsuit earlier than it would be if making a defense centering on complying with the standard of care.

Immunity is a wonderful thing, but calling the police may not always be the best route to quell violence. In fact, such activity may actually increase the likelihood of violence occurring. In some cases, hospitalization may be most appropriate.
But, as of right now, Tarasoff the Case permits an activity, such as hospitalization, that Tarasoff the Statute does not grant immunity for, which is unfortunate. Hopefully, one day these laws will be harmonized and a therapist can get immunity from liability for hospitalizing a patient, but until then, when it comes to discharging the duty to protect, keep these principles in mind:

1. If your patient communicates to you a serious threat of physical violence against a reasonably identifiable victim or victims, and you reasonably believe your patient is likely to commit such violence after assessing for it, you can discharge the duty to protect by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency, which will get you immunity from liability under Tarasoff the Statute, if your patient actually harms such victims.

2. If your patient communicates to you a serious threat of physical violence against a reasonably identifiable victim or victims, and you reasonably believe your patient is likely to commit such violence after assessing for it, you can discharge the duty to protect by hospitalizing your patient, which will not get you immunity from liability under Tarasoff the Statute, but would be a reasonable measure to discharge the duty to protect under Tarasoff the Case. Instead of having immunity from liability, your defense would be that you met the standard of care by doing something reasonable under the circumstances to protect the intended victim.

3. If your client does not communicate a serious threat of violence but after assessment you determine your patient presents a serious danger of violence to another person, you can discharge the duty to protect by warning the intended victim or others likely to apprise the victim of the danger, by notifying the police, or by taking whatever other steps are reasonably necessary under the circumstances, including hospitalization of the patient, to discharge the duty to protect under Tarasoff the Case.

Ultimately Tarasoff comes down to two responsibilities: assessing for violence, and if the assessment reveals the likelihood of violence, discharging the duty to protect. As we have seen, however, depending on the facts of the case, the duty to protect can be discharged in different ways. Was a specific threat of violence made? Is immunity from liability available? Do you want immunity from liability? Is hospitalization a viable option for this patient? Do we have foreseeable victims, but not identifiable victims?

Tarasoff cases can be complex, but fortunately they are statistically rare events. This article should convey that they are not as simple as just calling the police and just warning identifiable victims. The relevant principles of law run much deeper than those ideas.

So, are you ready to do The Tarasoff Two-Step? The discordant music of a dangerous patient situation is now playing in the background. Are you ready to dance?

David Jensen, JD, is a staff attorney at CAMFT. He is available to answer members’ questions regarding legal, ethical, and licensure issues.

Endnotes
1. Some theorists believe there are actually three steps in the Tarasoff process, gathering information, evaluating information, and then acting on the evaluated information, but I have chosen to combine the activities of gathering and evaluating information into one process. This article, however, could just as easily been titled “The Tarasoff Three-Step.”

2. The murder of Tatiana Tarasoff by Prosenjit Poddar resulted in five published legal opinions by various California courts: Regarding the wrongful death action filed in civil court, see Tarasoff v. Regents of the University of California (1973) 33 Cal.App.3d 275; Tarasoff v. Regents of the University of California (1974) 13 Cal.3d 177; and, Tarasoff v.
3. Students and clinicians often ask what happened to Poddar? A jury found him guilty of second-degree murder, but due to some legal technicalities, a Court of Appeal reduced his conviction to manslaughter. Two years later, the California Supreme Court vacated his conviction entirely and ordered a new trial. Poddar, however, was never retried. The State of California agreed to release him on condition that he leave the United States immediately, which he did. Merton records that after returning to India, he fell in love with a lawyer, and was happily married for many years.


5. Tarasoff v. Regents of the University of California (1976) 17 Cal. 3d 425

6. Based on the Tarasoff case, the failure of a psychotherapist to properly discharge the duty to protect can result in civil liability for such psychotherapist, which means that such therapist would have to pay compensation to victims of any violence wrought by the therapist’s patient. Psychotherapists guard against this contingency by purchasing professional liability insurance.


8. Id.


12. Id.

13. Id.

14. Id.

15. There is current CAMFT legislation pending, SB 1134 (Yee), which would clarify the duty discharged under Section 43.92 (b) of the Civil Code to a “duty to protect” rather than a “duty to warn and protect.”