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# The Psychotherapist's Calamity: Emerging Trends in the *Tarasoff* Doctrine

## I. *Tarasoff*: INFANCY TO ADOLESCENCE

In 1974 the door of legal liability opened wide to receive psychotherapists. In *Tarasoff v. Regents of University of California*,<sup>1</sup> the California Supreme Court announced its unequivocal, yet loosely defined decision that psychotherapists' legal obligations include a duty to warn intended victims of their patients' violent acts.<sup>2</sup> After 15 years of legal application, the parameters and implications of the *Tarasoff* doctrine and reasoning have changed significantly. In the most recent decision grounded in *Tarasoff* precepts, the Wisconsin Supreme Court has done more than any other jurisdiction to expand the reach and force of the *Tarasoff* doctrine.<sup>3</sup>

This note will use the Wisconsin Supreme Court decision of *Schuster v. Altemberg*<sup>4</sup> as a basis for examining the remarkable contrast between what the *Tarasoff* duty to warn obligation was and what it is becoming. *Altemberg* represents departures from the original *Tarasoff* ruling in four important areas: (1) the requirement of a particular victim; (2) the imminence of dangerousness required for liability; (3) the role of civil commitment, and (4) the standards for predicting dangerousness. Because *Altemberg* represents the current apex of a developing trend, other major decisions will be considered to allow full review and criticism of *Tarasoff*'s developmental path.<sup>5</sup>

### A. *Tarasoff* in Legal Infancy

The 1974 ruling in *Tarasoff I* stemmed from the murder of Tatiana Tarasoff by a voluntary outpatient of the University of

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1. 529 P.2d 553, 118 Cal. Rptr 129 (1974) (hereinafter "*Tarasoff I*"), *reargued*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (hereinafter "*Tarasoff II*").

2. *Tarasoff I*, 529 P.2d at 559, 118 Cal. Rptr. at 135.

3. *Schuster v. Altemberg*, 144 Wis. 2d 223, 424 N.W.2d 159 (1988).

4. *Id.*

5. *Tarasoff* is not binding as precedent in jurisdictions other than California. Nevertheless, *Tarasoff* type actions are becoming more commonly recognized and other states are using *Tarasoff* as a mold of legal reasoning to be applied in their own jurisdictions.

California Hospital at Berkeley.<sup>6</sup> Tatiana's killer had confided his intention to murder her to his psychotherapist, who subsequently failed to issue Tatiana any warning. As first announced, *Tarasoff I* stood for the proposition that a psychotherapist has "a duty to use reasonable care to give threatened persons such warnings as are essential to avert foreseeable danger arising from his patient's condition or treatment."<sup>7</sup> The *Tarasoff* decision represents the conceptual genesis for all psychotherapists' duties to third parties.

Immediately after the California Supreme Court's announcement of the psychotherapist's new duty, the defendants in *Tarasoff I* and the American Psychiatric Association vigorously petitioned the court for a rehearing.<sup>8</sup> This effort was largely fueled by the American Psychiatric Association's fear of the impact the decision would have on the mental health care profession. The court's unusual step of granting reargument indicated its sensitivity to the weighty policy and legal arguments involved in the decision.

Pleased by the opportunity for reargument, the psychotherapeutic community was greatly distressed by the product of its efforts. *Tarasoff II*<sup>9</sup> resulted in a broader and more robust announcement of the California Supreme Court's earlier decision. Specifically, the court held:

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6. *Tarasoff* involved the murder of Tatiana Tarasoff by Prosenjit Podder, a voluntary out-patient at the Cowell Memorial Hospital at the University of California at Berkeley. Two months prior to the homicide, Podder confided his intention to kill Tatiana to Dr. Lawrence Moore, the treating psychologist. Dr. Moore contacted the campus police and requested that Podder be detained. Podder was apprehended but released by campus police because he appeared rational and because police secured a promise from Podder to stay away from Tatiana. Dr. Moore's supervisor directed that no further action be taken to detain Podder. Neither Tatiana nor any of her family members were warned of the threat. Two months after these events Podder went to Tatiana's home and killed her. *Tarasoff II*, 17 Cal. 3d at 430-32, 551 P.2d at 339-40, 131 Cal. Rptr. at 19-20.

7. *Tarasoff I*, 529 P.2d at 559, 118 Cal. Rptr. at 135 (emphasis added). The court premised the finding of this duty on the relationship between the psychotherapist and the patient. This relationship was deemed to constitute the "special relationship" required by Restatement (Second) of Torts § 315 in order to create a right to protection from the actor to the third person. See RESTATEMENT (SECOND) OF TORTS § 315-20 (1965). Though initially controversial, the finding of this "special relationship" has now become widely accepted and is therefore not evaluated at length herein.

8. Disturbed by the court's holding, the American Psychiatric Association joined in the effort for reargument. See Mills, *The So-Called Duty to Warn: The Psychotherapeutic Duty to Protect Third Parties From Patients' Violent Acts*, 2 BEHAVIORAL SCI. & THE LAW (1984).

9. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

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 his 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.<sup>10</sup>

The court's restructuring of its opinion is significant in three important respects. First, and most importantly, the court held that the psychotherapist's duty was to "protect" the intended victim rather than to warn. Second, the court invoked the traditional "standards of the profession" criterion for use in determining when the psychotherapist should determine serious threats of danger,<sup>11</sup> and third, the court was unacceptably vague in explaining how the newly prescribed duty could be discharged.<sup>12</sup>

Recognizing the inherent difficulty of the psychotherapist's new obligation, the court conceded to psychotherapists a broad buffer zone of reasonable professional standards as insulation from liability.

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 that the therapist,

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10. *Tarasoff II*, 17 Cal. 3d at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

11. Justice Mosk, concurred in the result of the opinion but dissented vigorously because of the court's adoption of the standards of the profession as a measuring stick of liability:

I would restructure the rule designed by the majority to eliminate all reference to conformity to standards of the profession in predicting violence. If a psychiatrist does in fact predict violence, then a duty to warn arises. The majority's expansion of that rule will take us from the world of reality into the wonderland of clairvoyance.

*Tarasoff II*, 17 Cal. 3d at 452, 551 P.2d at 354, 131 Cal. Rptr. at 34. (Mosk J., concurring and dissenting).

12. The court suggested the duty could be discharged by warning the victim or calling the police, but left open the possibility of clinical interventions conventionally employed by psychotherapists confronting potentially violent patients. *Tarasoff II*, 17 Cal. 3d at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20; See also Mills, *supra* note 8. In addition, the court failed to delineate to which mental health practitioners the duty applied. *Tarasoff* involved a staff psychologist at the University Hospital at Berkeley. Left open by the court was whether or not the duty to protect applied to other mental health practitioners such as counselors, marriage and family therapists and social workers.

in making that determination, render a perfect performance; the therapist need only exercise "that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [that professional specialty] under similar circumstances." (*Bardesono v. Michels* (1970) 3 Cal.3d 780,788, 91 Cal.Rptr. 760,764, 478 P.2d 480,484) [other citations omitted]. *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.<sup>13</sup>

Initially then, *Tarasoff* stood for the proposition that psychotherapists have a duty to use reasonable care to protect their patients' intended victims from serious threats of violence. This duty applied if the therapist either subjectively knew, or pursuant to the standards of his profession should have known, of the serious danger. Discharge of the duty required *whatever steps* were reasonably determined necessary<sup>14</sup> under the circumstances.

Two distinctive and well-defined features were then quickly added to the *Tarasoff* doctrine. First, it was determined that the doctrine did not require parents of suicidal patients to be warned of a patient's suicidal inclination.<sup>15</sup> Second, and most importantly, in *Thompson v. County of Alameda*<sup>16</sup> the duty to

13. *Tarasoff II*, 17 Cal. 3d at 438, 551 P.2d at 345, 131 Cal. Rptr. at 25 (emphasis added).

14. As to exercising "whatever other steps are reasonably necessary under the circumstances," 17 Cal. 3d at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20, the court failed to indicate whether the standards of the profession would be used to determine what other steps would be reasonably necessary. Yet, determining what steps are reasonably necessary under the circumstances will hinge on a professional determination of the most effective method of deterring violence for each patient. What appears reasonable to a practicing therapist as a method of deterring patient violence may not appear reasonable to the man of ordinary prudence.

15. *Bellah v. Greenson*, 81 Cal. App. 3d 614, 146 Cal. Rptr. 535 (1978).

16. 27 Cal. 3d 741, 614 P.2d 728, 167 Cal. Rptr. 70 (1980). *Thompson* involved the murder of a young boy by a juvenile delinquent released from the county's custody. The delinquent was known to have dangerous and violent propensities toward young children and the county knew that violent sexual assaults were a likely result of releasing the juvenile into the community. The county also knew that the juvenile had indicated he would, if released, take the life of a young child residing in the neighborhood. The juvenile was released to his mother's temporary custody. The county made no effort to warn his mother or anyone in the neighborhood of his release or dangerousness. Within 24 hours after his release the delinquent murdered a young boy in the garage of his mother's home.

Though *Thompson* arose in the context of a custody release, the specific victim re-

warn became strictly limited to situations involving a prior threat to a specific, identifiable victim.<sup>17</sup> The court found that only in situations where a specific threat of harm is posed "to a named or readily identifiable victim or group of victims"<sup>18</sup> was there sufficient policy justification to impose a duty to warn.<sup>19</sup>

The combination of *Tarasoff II* and *Thompson* represents the *Tarasoff* doctrine at its earliest, most distinguishable stage. Other decisions, though grounded in the *Tarasoff II* "duty to protect" reasoning, have produced a doctrine which stands in stark contrast to the image of their progenitor. The recent decision of *Schuster v. Altenberg*<sup>20</sup> will be used to illustrate this contrast. Other major decisions depicting key points of development will also be examined to allow full review and criticism of the course *Tarasoff* appears to be following.

#### B. *Tarasoff in Adolescence: Schuster v. Altenberg*

Edith Schuster was a psychiatric patient of Dr. Barry Altenberg from April 30, 1983 until her death on June 29, 1983.<sup>21</sup> Edith was killed in a car accident in which she was driving. Gwendolyn Schuster, Edith's daughter, was a passenger in the car and suffered severe injuries causing her paralysis. Edith's husband and the injured daughter brought suit against Dr. Altenberg to recover for the daughter's pain and suffering, her disability, medical expenses and loss of earning capacity. Edith's husband claimed damages resulting from his obligation to pay his daughter's significant medical expenses while she was a minor.<sup>22</sup> Plaintiffs' complaint contained no allegation that Edith was homicidal, suicidal, or had any inclination to harm anyone.<sup>23</sup>

The plaintiffs alleged that Dr. Altenberg was negligent in his management and care for Edith Schuster in failing to recog-

quirmen became applicable to situations involving psychotherapists. See, e.g., *Brady v. Hopper*, 570 F. Supp. 1333 (D. Colo. 1983).

17. *Id.* at 758, 614 P.2d at 738, 167 Cal. Rptr. at 80.

18. *Id.*

19. The *Thompson* court found that a warning to a large amorphous group of public targets would involve the expenditure of time and limited resources that parole and probation agencies could not spare and would be of questionable value. *Id.* at 755-56, 614 P.2d at 737, 167 Cal. Rptr. at 78.

20. 144 Wis. 2d 223, 424 N.W.2d 159 (1988).

21. *Id.* at 223, 424 N.W.2d at 160. Due to the fact that judgment was entered on the pleadings in this case the factual background is sparse.

22. *Id.*

23. Brief of Defendant-Respondents at 4, *Schuster v. Altenberg*, 144 Wis. 2d 223, 424 N.W.2d 159 (1988) (No. 87-0115).

nize or take appropriate actions in the face of her manic-depressive state. This included failure to seek her commitment, to modify her medication, and to alert and warn the patient or her family of her condition or its dangerous implications.<sup>24</sup> The court categorized the allegations as follows: (1) negligent diagnosis and treatment; (2) failure to warn the patient's family of her condition and its dangerous implications; and (3) failure to seek commitment of the patient.<sup>25</sup>

The trial court granted Dr. Altenberg judgment on the pleadings, finding that in order to have a cause of action the plaintiffs would have had to allege that Gwendolyn Schuster was a significant identifiable victim of the alleged negligence or misdiagnoses of Dr. Altenberg.<sup>26</sup> Plaintiffs appealed. Because Wisconsin had not yet adopted a position on psychotherapists' liability to third parties and because of the important legal and policy considerations involved, the case was certified directly to the Wisconsin Supreme Court for adjudication.

The court first found that judgment on the pleadings was improper because expert testimony could have revealed negligence in diagnosis and treatment. If established, this could have constituted cause-in-fact harm to the patient and third parties.<sup>27</sup> The court then went on to consider the claim of negligence for failing to confine Edith Shuster or to warn Edith and her family of her condition or its dangerous implications.<sup>28</sup> The court recognized a cause of action for failure to seek commitment of the patient. The court further held that "the duty to warn or to institute commitment proceedings is not limited by a requirement that threats made be directed to an identifiable target."<sup>29</sup>

The *Altenberg* decision represents much more than is superficially apparent from the court's announced holding. The facts of the case and the court's decision represent marked de-

24. *Schuster v. Altenberg*, 144 Wis. 2d at 223, 424 N.W.2d at 160.

25. *Id.*

26. Brief of Defendant, *supra* note 23, at 4.

27. *Altenberg*, 144 Wis. 2d at 230, 424 N.W.2d at 162.

28. Once determining that a cause of action could be stated for negligent diagnosis, the court would normally not proceed to pass on the validity of other alleged theories. This principle was departed from because the trial court had ruled against the validity of the negligent failure to warn and negligent failure to commit claim. Therefore the plaintiffs would have no opportunity to prove their case as to these claims on remand if the negligent diagnosis claim did not permit recovery. *Id.* at 223, 424 N.W.2d at 163.

29. *Id.* at 234, 424 N.W.2d at 165.

partures from previous *Tarasoff* type analysis.<sup>30</sup> In every area of *Tarasoff* controversy, the *Altenberg* decision represents the current apex of *Tarasoff*'s legal maturation. These areas include: (1) the requirement of a particular victim; (2) the imminence of dangerousness required for liability; (3) the role of civil commitment, and (4) the standards for predicting dangerousness.

## II. EMERGING TRENDS IN THE *Tarasoff* DOCTRINE

### A. *The Specific Victim Requirement*

*Thompson v. County of Alameda*<sup>31</sup> set forth the requirement that victims be specifically identifiable in order to invoke a psychotherapist's duty to protect. This action represented a predictable clarification and not a departure from the original *Tarasoff* formulation. *Tarasoff* stated that the psychotherapist's duty was to protect his patients' *intended* victims from violence.<sup>32</sup> This directly implies that the patient must have a specific victim in mind in order to invoke the psychotherapist's duty. *Thompson* merely crystallized the requirement. This specific, identifiable victim requirement was initially well-accepted and even received added emphasis in some jurisdictions.<sup>33</sup>

#### 1. *Initial assaults on the specific victim requirement*

Subsequently, several cases began to call the specific victim requirement into question. *Bardoni v. Kim*<sup>34</sup> first qualified

30. *Tarasoff*, of course, had no binding impact on Wisconsin's decision. Wisconsin's decision is uniquely significant, however, because the breadth of its departure from *Tarasoff* represents an increased pace in the trend towards broadening liability for psychotherapists.

31. See *supra* note 16 and accompanying text.

32. *Tarasoff II*, 17 Cal. 3d at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

33. See *Brady v. Hopper*, 570 F. Supp. 1333 (D. Colo. 1983). *Brady* involved a suit to recover damages from the former psychiatrist of John W. Hinckley, Jr. at the time of the attempted assassination of President Ronald Reagan. Plaintiffs were all shot and seriously injured in the incident. The court ruled as a matter of law that even if the treating psychiatrist was negligent in diagnosis and treatment of Hinckley that liability could not be imposed because of the absence of a specific threat and identifiable target.

Unless a patient makes specific threats, the possibility that he may inflict injury on another is vague, speculative, and a matter of conjecture. However, once the patient verbalizes his intentions and directs his threats to identifiable victims, then the possibility of harm to third persons becomes foreseeable, and the therapist has a duty to protect those third persons from the threatened harm.

*Id.* at 1338.

34. 151 Mich. App 169, 390 N.W.2d 218 (1986).

*Thompson* by removing any doubt as to whether a psychotherapist's subjective knowledge of an identifiable victim was required in order to trigger the duty to protect. The court determined that the duty to protect did not arise when the therapist acquired actual knowledge, but rather when the therapist "should have known of the existence and identity of his patient's victim."<sup>35</sup>

Attenuation of the *Thompson* reasoning began in earnest in 1983 with the California Supreme Court's decision in *Hedlund v. Superior Court*.<sup>36</sup> *Hedlund* dealt with the shooting of a woman whose attacker had revealed to his therapist his violent intentions toward the woman. When the shooting occurred, the woman's son was seated next to her. Though the woman covered her son with her own body to protect him, the son suffered severe emotional distress from the incident. In *Hedlund* the court ruled that the minor son of the woman had a cause of action against the therapist for failure to warn of the possible attack.<sup>37</sup> The mother had been the object of the patient's verbal expressions making her an identifiable victim. The court then found that the foreseeability of the minor son's proximity to his mother at the time of attack also rendered him an identifiable victim.<sup>38</sup>

35. *Id.* 151 Mich. App. at 176, 390 N.W.2d at 224. The court stated:

Since our Court, as well as other jurisdictions, has extended a duty to protect or warn to situations where the psychiatrist knows or should have known of the danger posed by his patient, we must also extend the duty to specific persons whom the psychiatrist knows or should have known were endangered.

*Id.* at n.7.

36. 34 Cal. 3d 695, 669 P.2d 41, 194 Cal. Rptr. 805 (1983). *Hedlund* involved an assault on LaNita Wilson who received psychotherapy counselling from Bonnie Hedlund. LaNita's attacker, a client of the same psychotherapist, communicated his specific intentions to commit serious bodily harm upon her. LaNita received no warnings from the therapist.

37. *Id.* at 704-708, 669 P.2d at 46-48, 194 Cal. Rptr. at 810-11.; See also Kelleher, *Psychotherapists and the Duty to Warn: An Attempt at Clarification*, 19 NEW ENG. L. REV. 597 (1983).

38. *Hedlund*, 34 Cal. 3d at 706, 669 P.2d at 46, 194 Cal. Rptr. at 810. The court based its decision on *Dillon v. Legg*, 68 Cal. 2d 728, 441 P.2d 912, 69 Cal. Rptr. 72 (1968). *Dillon* allowed a cause of action for emotional distress to a mother who witnessed the killing of her child by a negligent driver.

No threats were made toward the minor son in *Hedlund*, nor did the son claim a duty of warning was owed to him. The son claimed rather that the duty owed to his mother extended to him as her son. *Hedlund*, 34 Cal. 3d at 705, 669 P.2d at 46, 194 Cal. Rptr. at 810.

## 2. *Rejection of the specific victim requirement*

In *Altenberg*, the Wisconsin Supreme Court flatly rejected the *Thompson* identifiable victim requirement because it was deemed inconsistent with fundamental principles of Wisconsin tort law.<sup>39</sup> The court reaffirmed its commitment to the minority position articulated in *Palsgraff v. Long Island R.R.*:<sup>40</sup>

A defendant's duty is established when it can be said that it was foreseeable that his act or omission to act may cause harm to someone. A party is negligent when he commits an act when some harm to someone is foreseeable. Once negligence is established, the defendant is liable for *unforeseeable consequences* as well as foreseeable ones. In addition, he is liable to *unforeseeable plaintiffs*.<sup>41</sup>

Under a strict reading of this approach the potential scope of psychotherapist's liability to third parties is unusually broad. Generally, the scope of liability is determined by the foreseeability of the harm caused; it is the failure to take into account the foreseeability of the harm that constitutes the breach of duty and thus results in a finding of negligence. However, the Wisconsin approach suggests that once there is a finding of any negligence, by failing to act reasonably in view of *some specific* foreseeable harm, the psychotherapist is liable for *any harm* consequentially ensuing—whether or not it was the type of harm foreseeable or to a person who was foreseeable.

While other jurisdictions have loosened or removed the *Thompson* identifiable victim requirement,<sup>42</sup> no other court has

39. *Schuster v. Altenberg*, 144 Wis. 2d at 234, 424 N.W.2d at 164. The Court reviewed its previous decisions involving duty and foreseeability in which the court refused to narrow the scope of liability to exclude third parties. See *A.E. Inv. v. Link Builders Inc.*, 62 Wis. 2d 479, 214 N.W.2d 764 (1974) (narrow concept of duty rejected as applied to architects); *Schilling v. Stockel*, 26 Wis. 2d 525, 133 N.W.2d 335 (1965) (once it is determined that a negligent act has been committed a finding of non-liability can be made only in terms of public policy); *Auric v. Continental Gas. Co.*, 111 Wis. 2d 507, 331 N.W.2d 325 (1983) (attorney may be held liable in negligence to a beneficiary of a will who was not in privity with the attorney).

40. 248 N.Y. 339, 162 N.E. 99 (1928).

41. *Schuster v. Altenberg*, 144 Wis. 2d at 235, 424 N.W.2d at 164 (emphasis added) (citing *A.E. Inv. v. Link Builders Inc.*, 62 Wis. 2d 483, 484-85, 214 N.W.2d 764 (1974)). In a concurring opinion Justice Steinmetz disagreed with the majority's characterization of Wisconsin's adherence to the *Palsgraff* minority. Instead, Justice Steinmetz determined that Wisconsin has followed its own distinct approach and limited liability through policy considerations after elements of duty and causation have been established. *Altenberg*, 144 Wis. 2d at 266, 424 N.W.2d at 176 (Stienmetz J., concurring).

42. See e.g., *Lipari v. Sears, Roebuck & Co.*, 479 F. Supp 1985 (D. Neb. 1980);

grounded the decision on such a fundamental basis as Wisconsin, nor has any other decision had such a far reaching and absolute impact. Moreover, and most importantly, other cases rejecting the *Thompson* requirement are not as expansive as the *Altenberg* decision because they can be distinguished on two important grounds: (1) control of the patient through inpatient status; and (2) the imminence of the danger.

a. *Specific victims: inpatients vs. outpatients.* *Tarasoff* and all of its progeny have premised psychotherapist liability to third parties on the existence of a special relationship between the therapist and patient. This special relationship is important because it supposedly grants the therapist the right as well as the ability to control the conduct of the person inflicting the harm.<sup>43</sup> This right or ability to control represents the cornerstone for the imposition of liability.

The broadest expansion of psychotherapist liability, based on a removal of the identifiable victim requirement, has arisen in a context distinguishable from the forum of this note: the negligent release of in-patients.<sup>44</sup> The distinction between outpatients and in-patients is important because of the degree of control the psychotherapist has over an in-patient vis-a-vis an out-patient. The ability of psychotherapists to control the actions of an in-patient far exceeds the psychotherapist's ability to control a casual out-patient. Indeed, in the in-patient setting, it is frequently the psychotherapist's permissive release that gives the patient the requisite liberty to inflict the harm caused. Outpatients, on the other hand, are at liberty in the first instance and frequently remain at liberty because they are not subject to involuntary confinement.<sup>45</sup>

Based on this important distinction, these negligent release cases, which broaden liability by removing the *Thompson* identifiable victim requirement, are better viewed as a sub-set of *Tarasoff* cases. The increased liability in negligent release cases is distinguishable from out-patient situations and justified be-

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Chrite v. United States, 564 F. Supp. 341 (E.D. Mich. 1983); Naidu v. Laird, 539 A.2d 1064 (Del. 1988); Durlinger v. Artiles, 234 Kan. 484, 673 P.2d 86 (1983); Peterson v. State, 100 Wash. 2d 421, 671 P.2d 230 (1983).

43. See RESTATEMENT (SECOND) OF TORTS §§ 315-320 (1965).

44. See Naidu v. Baird, 539 A.2d 1064 (Del. 1988); Peterson v. State, 100 Wash. 2d 421, 671 P.2d 230 (1983).

45. See e.g., WIS. STAT. § 51.20(1)(a)1 (1987). Standard for involuntary commitment requires a showing of both mental illness, and a substantial probability of danger to others or himself.

cause of the increased control the psychotherapist has over the patient.<sup>46</sup> *Altenberg*, however, expands psychotherapists' liability to third parties by removing the *Thompson* requirement in the out-patient setting. This result suggests that the important distinguishing feature in virtually all other liability expanding cases was either unnoticed or deemed irrelevant in *Altenberg*.

b. *Specific victims: imminence of danger*. The case most frequently cited for the proposition that an identifiable victim is not required is *Lipari v. Sears Roebuck*.<sup>47</sup> However, *Altenberg* has little in common with the *Lipari* decision because of important differences in the type and likelihood of harm. *Lipari* involved a mental patient, Ulysses Cribbs, who purchased a shotgun at Sears and later fired the gun into a crowded night club killing one person and seriously injuring another.<sup>48</sup> The district court, applying Nebraska law, refused to grant a motion for summary judgment in favor of the Veterans Administration Hospital which had been treating Cribbs. The court ruled that the victims were not, as a matter of law, unforeseeable, and that plaintiffs could prevail upon a showing that the Veterans Administration Hospital could have foreseen an unreasonable risk of harm to the Liparis or a class of persons of which the Liparis were members.<sup>49</sup>

The Fourth Circuit has recognized *Lipari* as a lonesome and wayward decision.<sup>50</sup> Moreover, *Lipari* is distinguishable from *Altenberg* because of the imminence and type of harm foreseeable. Cribbs, the attacker in *Lipari*, had been committed to a mental institution prior to purchasing his shotgun and had received psychiatric treatment at the Veterans Administration Hospital after purchasing his gun. Cribbs then removed himself from treatment against the advice of his doctors shortly before the shooting incident. Compare this to Mrs. Schuster, whose treatment was strictly as an out-patient; there were no expressions nor symptoms of violence, and the injuries suffered by her

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46. It is noteworthy that in *Thompson*, the first clear statement of the identifiable victim requirement occurred in the context of negligent release from custody by a county.

47. *Lipari v. Sears Roebuck*, 497 F. Supp. 185 (D. Neb. 1980).

48. The shotgun blast killed Dennis F. Lipari and seriously injured his wife, Ruth Ann Lipari. Mrs. Lipari brought suit against Sears for the shooting. Sears then joined the United States as a third-party defendant. The assailant had been receiving psychiatric care from the V.A. hospital immediately prior to the shooting.

49. *Lipari*, 497 F. Supp. at 195.

50. See *Currie v. United States*, 836 F.2d 209, 213 (4th Cir. 1987).

daughter were the result of an accident rather than an intentional act. Despite these differences, *Lipari* remains the closest company to *Altenberg's* blanket rejection of the *Thompson* identifiable victim requirement.

### B. Imminence of Danger Required for Liability

Prior to *Altenberg*, imposition of liability in an out-patient context had always been accompanied either by specific threats of violence or by a demonstrated propensity for violence.<sup>51</sup> *Altenberg*, however, recognizes a cause of action for failure to warn a third party victim absent these factors. This is in sharp contrast to other courts' requirements that specific threats be voiced. *Brady v. Hopper*<sup>52</sup> stated the requirement as follows:

Unless a patient makes specific threats, the possibility that he may inflict injury on another is vague, speculative, and a matter of conjecture. However, once the patient verbalizes his intentions . . . the possibility of harm to third persons becomes foreseeable.<sup>53</sup>

In *Altenberg*, plaintiffs made no allegation that the patient either voiced threats or subjectively intended to harm anyone.<sup>54</sup> Yet the court left open the possibility that the harm caused was foreseeable. In *Altenberg* then, harm is deemed to become foreseeable even before any intent to harm is verbalized or otherwise suggested by the defendant's behavior.<sup>55</sup> This indicates that the Wisconsin Court deems foreseeability to arise from bare pos-

51. See e.g., *Brady v. Hopper*, 570 F. Supp. 1333 (D. Colo. 1983) (no specific threat); *Doyle v. United States*, 530 F. Supp. 1278 (C.D. Cal. 1982) (no liability absent specific threat or identifiable victim); *Hasenei v. United States*, 541 F. Supp. 999 (D. Md. 1982) (no specific threat); *Leedy v. Hartnett*, 510 F. Supp. 1125 (M.D. Pa. 1981) (no liability absent a specific threat); *Furr v. Grove State Hosp.*, 53 Md. App. 474, 454 A.2d 414 (Ct. Spec. App. 1983) (no specific threats or victim); *Bardoni v. Kim*, 151 Mich. App. 169, 390 N.W.2d 218 (1986) (victim should have been specifically identified); *McIntosh v. Milano*, 168 N.J. 466, 403 A.2d 500 (Law Div. 1979) (specific threat to victim and past history of violence); *Schrempf v. State*, 66 N.Y.2d 973, 487 N.E.2d 883, 496 N.Y.S.2d 973 (1985) (no liability based on propensity for violence because release was within standards of the profession).

52. 570 F. Supp. 1333 (D. Colo. 1983).

53. *Id.* at 1338 (emphasis added).

54. Brief of Defendant, *supra* note 23, at 14.

55. For cases imposing liability absent specific threats in a negligent release context see *Naidu v. Laird*, 539 A.2d 1064 (Del. 1988); *Peterson v. State*, 100 Wash. 2d 421, 671 P.2d 230 (1983). For cases imposing liability absent specific threats but with patients having demonstrated violent propensities see *Jablonski v. United States*, 712 F.2d 391 (9th Cir. 1983).

sibilities of harm rather than probabilities of harm.<sup>56</sup> Though foreseeability of harm must be proven, *Altenberg* places new and far-reaching demands on the powers of foreseeability exercised by psychotherapists.

Significantly, because the element of intent to harm is not present in *Altenberg*, the court implies that the psychotherapist is not only liable for failure to foresee and protect third parties from *intentional* violent acts of the patient,<sup>57</sup> but also for foreseeable *negligent* acts of the patient. This virtually dissolves the previous threshold of imminence of danger at which liability for dangerousness is triggered.

### C. Civil Commitment of Patients

The original *Tarasoff* formulation required the psychotherapist to protect his patient's intended victim by warning or "whatever other steps are reasonably necessary under the circumstances."<sup>58</sup> This left open the question of whether a legal obligation existed on the therapist's part to commit potentially dangerous patients. The *Tarasoff* court stated, however: "Within the broad range of reasonable practice and treatment in which professional opinion and judgment may differ, the therapist is

56. See 57 AM. JUR. 2D *Negligence* § 54 (1971). The Wisconsin Supreme Court's position in *Altenberg* contradicts earlier Wisconsin statements suggesting that duty to use due care arises from probabilities and not bare possibilities. "The duty to use due care arises from probabilities, rather than from bare possibilities of injury. Failure to guard against the bare possibility of injury is not actionable negligence." Brief of Defendant, *supra* note 23, at 14 (citing *Grube v. Moths*, 56 Wis. 2d 424, 202 N.W.2d 261 (1972)).

57. If a psychotherapist fails to foresee the violence of his patient because of negligent diagnosis a cause of action will stand on independent grounds. *Altenberg* demonstrates that a cause of action exists for negligent diagnosis if it can be shown that proper diagnosis and treatment would have avoided the harm caused to the third person. *Altenberg*, 144 Wis. 2d at 230, 424 N.W.2d at 162. This is congruent with the California Supreme Court's determination in *Hedlund*: "A negligent failure to diagnose dangerousness in a *Tarasoff* action is as much a basis for liability as is a negligent failure to warn a known victim once such diagnosis has been made." *Hedlund*, 34 Cal. 3d at 704, 669 P.2d at 45, 194 Cal. Rptr. at 809.

58. *Tarasoff II*, 17 Cal. 3d at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20. Though phrased as a duty to protect or "to take whatever steps are reasonably necessary under the circumstances," *Id.*, much of the psychotherapeutic community failed to understand that their new duty was to protect and not merely to warn.

A study by Daniel Givelber demonstrated that over 92% of California psychiatrists thought their duty under *Tarasoff* was discharged merely by warning. Givelber, Bowers & Blitch, *Tarasoff, Myth and Reality: An Empirical Study of Private Law in Action*, 1984 Wis. L. REV. 443, 467 (1984). Only 30% of the same class believed *Tarasoff* required them to exercise reasonable care to protect the victim.

free to exercise his or her own best judgment without liability."<sup>59</sup> With this statement the judiciary conceded to psychotherapists the freedom to choose among the broad range of clinical alternatives available to deter violence without exposure to liability.<sup>60</sup> It is reasonable to assume that civil commitment represented one example within this broad range of clinical alternatives which could be exercised by choice—not by duty. This is wholly appropriate given the fact that lawyers and judges tend to think legally and therefore frequently fail to give full consideration to the kinds of clinical alternatives psychotherapists may employ to reduce a patient's violence.<sup>61</sup>

### 1. *Civil commitment: clinical choice or legal duty*

Recently, however, *Tarasoff* type plaintiffs have alleged claims of failure on the therapist's part to exercise a *duty* to commit the patient along with failure to exercise a duty to warn the victim.<sup>62</sup> *Currie v. United States*<sup>63</sup> represents the most comprehensive treatment of the subject to date. In *Currie*, Leonard Avery, a Vietnam veteran and ex-employee of an IBM plant, had articulated to his therapist specific threats to blow up the IBM plant. A team of therapists concluded that Avery was not subject to involuntary commitment under the applicable North Carolina Statute.<sup>64</sup> To fulfill their duty under *Tarasoff*, the psychiatrists then gave explicit warnings of Avery's threats to the United States Attorney General, the Veterans Administration District Counsel, the Federal Bureau of Investigation, the Durham County Police Department and IBM. Despite the warnings, Avery was able to enter the IBM facility, where he shot and killed an IBM employee.

The claim for relief in *Currie* centered entirely on the psy-

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59. *Tarasoff II*, 17 Cal. 3d at 438, 551 P.2d at 345, 131 Cal. Rptr. at 24.

60. Mills, *supra* note 8, at 246. Clinical remedies available include reassessment, consultation, changes in medication, or civil commitment.

61. *Id.*

62. *Currie v. United States*, 836 F.2d at 209; *See also, Lipari*, 497 F. Supp. at 185. At the time of *Currie*, *Lipari* was the only case clearly authorizing a claim for a duty to commit patients.

63. *Currie*, 836 F.2d at 209.

64. Each time Avery's case was discussed the participating team of psychotherapists concluded Avery could not be committed because he was lucid and in touch with reality. His danger was determined to be a product of anger and not mental illness. The North Carolina statute required mental illness and dangerousness in order to commit involuntarily. *Id.* at 211.

chiatrists' alleged affirmative duty to seek involuntary commitment. The Fourth Circuit Court of Appeals, ruling under North Carolina law, refused to recognize such a duty.<sup>65</sup> Apparently persuaded by arguments by the American Psychological Association<sup>66</sup> in its amicus brief, the court found that the policy considerations involved in finding a duty to warn were distinct from the policy considerations in finding a duty to commit.<sup>67</sup> The court found that involuntary commitment involved considerations of the patient's constitutionally protected liberty interest,<sup>68</sup> and that involuntary commitment would have a great likelihood of destroying the psychiatrist's potential for constructive influence over the patient.<sup>69</sup>

The *Altenberg* court, unpersuaded by *Currie*, found failure to commit as a companion cause of action to failure to warn.<sup>70</sup> Contrary to *Currie*, the court satisfied itself that civil commitment proceedings were less disruptive to the therapist-patient relationship than warnings to third parties.<sup>71</sup> Based on this determination the court found it puzzling that the court in *Currie* would recognize a cause of action for failure to warn but not failure to commit.<sup>72</sup> Moreover, the court believed that warnings alone were frequently ineffective in satisfying the duty to protect the potential victim.<sup>73</sup> This cause of action was limited,

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65. *Id.* at 210. This conclusion overruled the Federal District Court's ruling that an affirmative duty to seek involuntary commitment should be recognized. The district court found *Lipari* persuasive in finding that "it would be improper to rule that psychotherapists would never have a duty to institute commitment proceedings against a patient." *Currie v. United States*, 644 F. Supp. 1074, 1081 (M.D.N.C. 1986). The court believed that to rule otherwise would allow a psychotherapists to act in careless disregard of members of the public known to be endangered by his patient.

66. The American Psychological Association is a voluntary, nonprofit, scientific, and professional organization with more than 60,000 members. It has been the major association of psychologists in the United States since 1892, and includes the vast majority of psychologists holding doctoral degrees from accredited universities in the United States. Brief of Defendant, *supra* note 23 at 1.

67. *Currie*, 836 F.2d at 213.

68. Commentators have noted that the infiltration of law into the mental health profession with its focus on individual rights has made it increasingly difficult to commit a person involuntarily. See Kelleher, *supra* note 32, at 601 (citing NATIONAL INSTITUTE OF MENTAL HEALTH, CIVIL COMMITMENT AND SOCIAL POLICY: AN EVALUATION OF THE MASSACHUSETTS MENTAL HEALTH REFORM ACT OF 1970 at 47 (1981)).

69. *Currie*, 836 F.2d at 213.

70. *Schuster v. Altenberg*, 144 Wis. 2d at 234, 424 N.W.2d at 165.

71. *Id.* at 257-58, 424 N.W.2d at 173; see also Stone, *The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358, 377 (1976).

72. *Altenberg*, 144 Wis. 2d at 258, 424 N.W.2d at 173.

73. *Id.*

however to situations where it could be established that the patient was a proper subject of involuntary commitment under statutory standards.<sup>74</sup>

## 2. *Legally required commitment: risk factors for the therapist*

Wisconsin's willingness to recognize a cause of action for failure to commit poses a serious dilemma for psychotherapists. The *Altenberg* court fails to balance the duty a psychotherapist owes to her patient with the duty owed to potential victims of her patient. The psychotherapist stands in a fiduciary relationship with her patient, but not with her patient's potential victim. The patient's well-being is the psychotherapist's foremost consideration. The problem faced by practitioners then is that the necessity of focusing attention on escalating threats of legal liability outside the fiduciary relationship renders the likelihood of legal liability from within the fiduciary relationship more threatening.<sup>75</sup> This dilemma is not reflected in any balancing considerations by the court.

The recognition of an affirmative duty to commit indicates that the initial buffer zone of a "broad range of reasonable practice," which could be employed by psychotherapists to avoid liability in *Tarasoff*, is becoming less real. It seems, at least in Wisconsin, that the courts are losing touch with what was initially recognized in *Tarasoff*—that judges are not yet qualified to be instructing psychotherapists on how to discharge their duty to protect.

In addition, recognition of a cause of action for failure to commit is especially burdensome to psychotherapists because of the increasing difficulty in successfully committing patients involuntarily. The current trend toward recognizing and establishing the rights of mental health patients has led to the following potential complications with regard to commitment: (a) it is increasingly difficult to commit an individual involuntarily; (b) more and more people are being released from hospitals and treated on an out-patient basis, and (c) patients are more aware

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74. *Id.* at 248, 424 N.W.2d at 169.

75. The energy and consideration a practitioner is now required to focus on outside of the fiduciary relationship in order to avoid legal liability from third parties will often come at the expense of the patient. The psychotherapist will find it more difficult to put the well-being of his patient first when his attention is consistently drawn outside that relationship.

of their rights and are exercising them, particularly the right to refuse treatment.<sup>76</sup>

The Wisconsin statute for involuntary commitment provides a prime example of the new and more stringent requirements for involuntary commitment. A patient must not only exhibit a "substantial probability" of dangerousness, but must also be mentally ill.<sup>77</sup> Needless to say, not all patients of psychotherapists which have the potential for violence are mentally ill. Yet mere anger, or even a strong propensity for violence will not serve as grounds for commitment absent a mental illness.<sup>78</sup> Dangerous propensities coupled with the fact that the person happens to be seeing a psychotherapist will not provide a finding of mental illness. Furthermore, psychotherapists frequently disagree among themselves as to what constitutes mental illness.<sup>79</sup> Psychotherapists can only hope that the evaporating buffer zone of *Tarasoff* will not be replaced by dogmatic lawyers and judges assuming too quickly their own competence in a discipline subject to significant controversy and ambiguity.

### 3. *Legally required commitment: deprivation of liberty and least restrictive treatment*

A fear shared by commentators and the American Psychological Association is that recognition of a duty to commit potentially dangerous patients will result in significant and unneces-

76. Kelleher, *supra* note 35, at 602.

77. Wis. STAT. § 51.20 (1987) provides in relevant part as follows:

Involuntary commitment for treatment.

(1) PETITION FOR EXAMINATION. (a) Except as provided in pars. (ab), (am) and (ar), every written petition for examination shall allege that the subject individual to be examined:

1. Is mentally ill, drug dependant, or developmentally disabled and is a proper subject for treatment; and

2. Is dangerous because the individual:

...

b. Evidences a substantial probability of physical harm to other individuals as manifest by evidence of recent homicidal or other violent behavior, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt or threat to do serious physical harm . . .

*Id.*

78. *Id.*

79. See, e.g., *Ake v. Oklahoma*, 470 U.S. 68, 81 (1985) ("Psychiatry is not an exact science, and psychiatrists disagree widely and frequently on what constitutes mental illness, on the appropriate diagnosis to be attached to given behavior and symptoms, on cure and treatment, and on [the] likelihood of future dangerousness.")

sary deprivations of liberty to mental patients.<sup>80</sup> It is contended that a duty to commit will result in an increase in the number of commitment proceedings based on therapists' fear of patient violence.<sup>81</sup> Because therapists are unable to accurately predict violence, the unnecessary detention of numerous patients is a substantial possibility.

This point is best illustrated by a hypothetical statistical analysis. Assume that one patient out of 1,000 will in fact carry out a dangerous threat. Further assume that all psychotherapists could predict with 95% accuracy which one out of the 1,000 is dangerous. If 100,000 patients are examined for dangerousness, 95 of the 100 dangerous patients would be isolated. Disappointingly, however, even a margin of error of only 5% means that of the 99,900 patients who are harmless, almost 5,000 would be unnecessarily deprived of their liberty.<sup>82</sup> The point raised by the American Psychological Association is that because therapists will fear liability where a duty to commit is imposed, more patients falling within the margin of error, which in fact greatly exceeds five percent, will be involuntarily committed.

A general guideline imposed by most states is that psychotherapists pursue the least restrictive treatment for their patients. If the American Psychological Association is right in its belief that imposition of a duty to commit will increase the number of commitment proceedings, then the policy of least restrictive treatment has encountered a hostile enemy. American criminal principles suggest that it is better that ten guilty people go free than one innocent person be deprived of his liberty. How then can we explain a legal policy which suggests that in the area of civil commitment it is better that fifty-four harmless people be committed, lest one dangerous person be free?<sup>83</sup>

#### D. Predicting Dangerousness

The *Tarasoff* court's axiomatic statement, "[t]he protective

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80. See Amicus Curiae Brief of the American Psychological Association at 28, *Currie v. United States* 826 F.2d 209 (4th Cir. 1987) (No. 86-2643).

81. *Id.*

82. Stone, *supra* note 71 at 363-64 n.23 (citing Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 84 (1968)).

83. Comment, *Tarasoff and Psychotherapists' Duty to Warn*, 12 SAN DIEGO L. REV. 932, 942-43, n.75 (1975). It is further significant that these numbers are based on an assumed accuracy of 95% in predicting violence. Actual precision is in fact much lower.

privilege ends where the public peril begins,"<sup>84</sup> is not contested. The well-recognized problem for courts and psychotherapists, however, is determining where the public peril in fact begins. Prior to *Altenberg*, the recognized difficulty of psychotherapists' ability to predict dangerousness had served as the fundamental justification for granting a buffer zone of conduct within a broad professional range of reasonably accepted practice. Though the *Altenberg* court continues to pay lip service to the buffer zone established in *Tarasoff*,<sup>85</sup> the justification for the buffer zone appears to be attenuated. In its opinion, the *Altenberg* court stated:

Of further significance is the fact that a survey of psychotherapists suggests that practitioners are quite confident of their ability to assess dangerousness: "[T]he task of assessing dangerousness is not viewed as being beyond the competence of individual therapists or as a matter upon which therapists cannot agree."<sup>86</sup>

This statement is based largely on the results of a survey in which psychotherapists were asked to rate themselves as to their ability to predict dangerousness.<sup>87</sup> More than 75 percent of the therapists surveyed believed they could predict patient violence within a range of "probable" to "certain."<sup>88</sup> In addition, 70 percent of the responding therapists believed that 90-100 percent of their colleagues would agree with their conclusion as to whether or not the patient was dangerous.<sup>89</sup>

It is disquieting that the Wisconsin Supreme Court would place stock in the results of this study in light of the overwhelming academic and empirical evidence to the contrary. Virtually every jurisdiction dealing with the predictability of violence has

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84. 17 Cal. 3d at 442, 551 P.2d at 347, 131 Cal. Rptr at 27.

85. The court's literal wording of the established standard is reminiscent of the "broad range" standard established in *Tarasoff*.

[W]e emphasize that in determining whether harm was foreseeable, the psychotherapist is not held to a standard of omniscience, but merely to that degree of care and skill which is exercised by the average practitioner in the class to which he belongs, acting in the same or similar circumstances.

*Altenberg*, 144 Wis. 2d at 238, 424 N.W.2d at 165.

86. *Id.* at 248, 424 N.W.2d at 169 (emphasis added) (quoting Givelber, Bowers & Blitch, *supra* note 58).

87. Givelber, Bowers, & Blitch, *supra* note 58. The study involved a survey sample of 2,875 psychiatrist psychologists and social workers located in major cities across the United States.

88. *Id.* at 463.

89. *Id.* at 464.

cited persuasive studies consistently showing that psychotherapists are not able to successfully predict violence.<sup>90</sup> Consistent research findings, in fact, show that mental health professionals fail to accurately predict future violence in two out of three cases<sup>91</sup> and that there is no consistent professional standard for predicting violence.<sup>92</sup> In addition, mental health has been proven to be the most significant *noncorrelate* of violence.<sup>93</sup>

That mental health professionals' undocumented self-appraisals show practitioners are confident in their ability to predict violence does nothing to discredit the overwhelming empirical evidence to the contrary.<sup>94</sup> It does show, however, that psychotherapists' confidence in themselves, though undeniably self-flattering, is sorely misplaced. One wonders why society would trust psychotherapists to accurately diagnosis dangerous propensities in their patients when they are demonstrably unable to accurately perceive themselves.

For psychotherapists, the importance of all this lies in the expertise and knowledge the judiciary stands poised to impute to them. If psychotherapists are seen as expert predictors of violence, then courts are likely to find therapists negligent in more instances for failing to foresee the violent acts of their patients. It is this trend that threatens to destroy the "broad range of reasonable practice" buffer zone that *Tarasoff* first conceded to psychotherapists.

### III. SUMMARY AND CONCLUSION

*Tarasoff* was the first case to extend psychotherapist's obligations beyond the confines of the therapist's fiduciary relationship with his patient. The therapist first incurred a duty to warn targeted victims of his patient's violence. This duty was subsequently recouched in terms of a duty to protect. Compliance with this duty is measured by conformity to the standards of the profession, but because psychotherapeutic standards are difficult

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90. See, e.g., J. MONAHAN, *THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR* (1981); Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693, 713 (1974) (cited in A.P.A. Brief, *supra* note 80).

91. *Id.*

92. See Steadman, *The Right Not To Be a False Positive: Problems in the Application of the Dangerousness Standard*, 52 PSYCHIATRIC QUARTERLY 84, 96 (1980) ("Nowhere in the research literature is there any documentation that clinicians can predict dangerous behavior beyond the level of chance") (cited in A.P.A. Brief *supra* note 80.)

93. J. MONAHAN, *supra* note 90 (quoted in A.P.A. Brief, *supra* note 80, at 18-19).

94. See *supra* notes 89-91, and accompanying text.

to define, the judiciary initially conceded a "broad range" of reasonable practice as a buffer zone from liability.

However, emerging trends, as displayed in *Altenberg*, have revealed a pattern of expanding liability. This trend is evidenced by the following:

1. The requirement of a specific and identifiable victim appears to be losing strength.

2. The imminence of danger required to trigger the duty to protect appears to be lessening.

3. The initially broad buffer zone of reasonable practice is beginning to erode as clinical choices, such as civil commitment, become legal duties.

4. The judiciary appears to be generating more confidence in psychotherapist's ability to predict dangerousness. Nevertheless, it remains to be seen if *Altenberg* represents a prototype of emerging legal logic, a mere aberration, or the arrival at a brief pinnacle in a reactionary trend of expansive liability.

The degree of *Altenberg*'s deviation from previous *Tarasoff* type actions is largely attributable to the fact that Wisconsin purports to follow the minority position in *Palsgraff*. This, coupled with Wisconsin's refusal to limit its impact on policy grounds has produced a new dimension to the *Tarasoff* doctrine. Nevertheless, it remains to be seen whether *Altenberg* represents an aberration in *Tarasoff* reasoning or is in fact indicative of the maturing form of the controversial doctrine. What can be counted on, however, is that the forces representing the policy interests on both sides of the controversy will become increasingly organized. The substance and scope of *Tarasoff* in the future will be largely determined by society's and judicial reaction to the new and more vigorous personality now emerging.

Steven Craig Bednar