In the more than 30 years since Tarasoff, U.S. states have responded to the ruling in a variety of ways—in part because there is no unifying federal law.

Tarasoff and Duties to Protect and to Warn

In 1969, Prosenjit Poddar, a student at the University of California, Berkeley, murdered a fellow student, Tatiana Tarasoff, two months after having made threats to do so to a counseling center psychologist. The victim's parents sued the university, claiming they or their daughter should have been warned of the threats. In 1976, the California Supreme Court ruled in Tarasoff v. Regents of the University of California that clinicians have a duty to “protect” unknowing victims from potential harm. In this case, the court sided with the victim’s father, who argued that the fact that the psychologist reported the threat to campus police officials was insufficient to protect their daughter, and that the victim herself or her parents should have been warned. 2

In the more than 30 years since Tarasoff, U.S. states have responded in varying ways to the ruling—in part because there is no unifying federal law. 3

As of 2002, 13 states had not addressed the “duty to warn” at all. 3 Some state laws make breaches of confidentiality to protect others discretionary—they allow but do not require the therapist to break privilege. 3 Most states have adopted some statutes that require some variation of the Tarasoff duty to protect but not necessarily the duty to warn. 4 Generally, states follow one of three approaches: a mandated duty to warn the endangered party; a duty to protect, but not warn the endangered party (for example, the clinician may seek civil commitment for the client or report the threat to law enforcement officials); or a unified duty to protect and to warn as outlined in Tarasoff.

Like the courts, clinical professional associations have responded to the “duty to protect” and “duty to warn” mandates in a variety of ways. For example, the American Medical Association and American Psychiatric Association support taking steps to inform unknowing partners of possible HIV transmission as long as doctors have first disclosed the limits of confidentiality to clients. 1 The American Psychological Association, on the other hand, opposes the legal duty to warn and has been very specific in outlining the limited situations warranting a breach of confidentiality. 15


Scarano VR, Baily CM, Banfield JR. The Texas Supreme Court speaks: Mental health professionals have no duty to warn or protect third parties. Texas Medicine. 2002; 98(11): 61-64.


Contacts
Zita Lazzarini, JD, MPH, Division of Medical Humanities, Health Law and Ethics, University of Connecticut Health Center, 263 Farmington Ave. MC-625, Farmington, CT 06030-6225, 860-579-5494 (phone), lazzarini@nso.uuchc.edu (e-mail).

Tiffany Chenneville, PhD, Department of Psychology, University of South Florida St. Petersburg, 140 7th Avenue South, DAV 258, St. Petersburg, Florida 33701, 727-873-4585 (phone), chennevi@stpt.usf.edu (e-mail).

See also references cited in articles in this issue.
Problems Applying Tarasoff to HIV

The evolving nature of the law around the duty to protect and the duty to warn, and the variation in states’ acceptance and interpretation of these duties can complicate therapists’ understanding of appropriate versus inappropriate breaches of confidentiality in even the most classic Tarasoff cases (those that involve a threat of serious physical violence to another). Since the onset of the HIV epidemic, some therapists have wondered if these duties could also apply to cases involving potential HIV transmission. For example, what of the case in which a clinician learns that an HIV-positive client has not revealed his or her HIV status to a sexual partner?

If “traditional” Tarasoff situations involving threats of violence create ethical and legal dilemmas for therapists, the question of a therapist’s responsibility to protect unknown sexual partners from potential HIV infection is much murkier. While some courts have applied the duty to warn to cases involving HIV, these cases have typically not involved the therapist-c1ient relationship, and have varied tremendously in both the facts and outcomes of the cases, making it difficult to draw clear legal conclusions. Some cases involving health care organizations or providers have been resolved in favor of maintaining confidentiality, while other courts have ruled in favor of breaching it for the purpose of protecting third parties. For Tarasoff to apply, it is critical that a foreseeable harm to an identifiable victim exist—a standard that is especially difficult to apply to HIV-related cases.

There are several other distinctions between “traditional” Tarasoff cases and those involving HIV. First, the danger of HIV transmission and the timing of that danger is unclear because transmission risk is based on medical probabilities, and the assessment of these probabilities could fall outside the clinician’s scope of practice. Even if the determination of dangerousness is considered a behavioral, rather than a medical judgment, such predictions are both difficult and uncertain.

Second, because the potential danger is unclear, the sense of urgency is often lower in HIV-related cases, allowing a longer time frame in which the partner might be warned. This usually allows for the option of the client’s self-disclosure to the partner, thus preserving the client-therapist bond of confidentiality while still warning the partner.

Third, in some cases, transmission may already have occurred, in which case “protection” (if necessary at all, since the “danger” of transmission is past) is focused on affording the partner the right to be tested and treated, which can often be accomplished through partner notification services. Finally, in most cases, consensual sex implies a shared responsibility for communication and negotiation, which may relieve the client (and his or her therapist) of sole responsibility for the possibility of HIV transmission.

Considerations to Guide Decision Making

Are a client’s actions likely to pose such a strong danger of HIV transmission to an unknowing third person that a breach of therapeutic confidentiality is justified? Therapists can approach this question by considering several factors. These include: the applicable mandates governing the provider’s profession; the foreseeability of harm; the identifiability of the victim; and whether viable alternatives to warning the potential victim exist.

Legal, Ethical, and Regulatory Mandates. Since laws vary so widely from state to state, and can change suddenly, it is critical for clinicians to understand how the laws of their own states apply to them. Similarly, an awareness of the professional standards and ethics that govern the therapist’s practice is helpful, although in some situations state law and professional guidelines may conflict. Finally, some organizations have their own regulations regarding acceptable breaches of confidentiality for staff in different roles, and it is crucial for employees to seek supervision about their agencies’ policies. The more clinicians know about each of these three sets of mandates, the better they can understand their professional responsibilities in a given situation.

Foreseeability of Harm. Several factors may influence whether it is likely that a sexual activity will result in HIV transmission to an unknowing partner. The type of the sexual activity (oral sex versus anal...
or vaginal sex), whether or not the partners use protection, and how frequently the partners have sex all relate to potential danger (although clearly HIV transmission could occur in a single sexual encounter). The questions of intention and imminence also may influence decisions about how dangerous the client is to the unknowing partner: does the client have an intention to harm a third party, and HIV is merely the means to do so? A client with a malicious intent represents a far different situation clinically (and, perhaps, legally) than a client who is simply unsure how to tell his or her partner. In such very rare cases where there is a clear intention to harm others, civil commitment may be an appropriate alternative. When is the next time the partner is likely to be at risk? And how strongly opposed to disclosure is the client? Is the client willing to consider any risk reduction measures?

Identifiability of the Victim. Is the identity of the client’s partner or partners known to the clinician? Attempting to discover the identity of unknowing partners is usually considered to be outside the clinician’s role. For example, if a client reports exclusively anonymous sex, potential victims are not identifiable.

In the case of couple’s counseling, of course, the partner’s identity is known to the therapist. This may present the most difficult situation for clinicians, because the therapist has a duty to the unknowing partner not only as a potential victim but also as a client, and because one of the main objectives of couple’s counseling is to facilitate honest communication.

Alternatives to Warning. If a clear risk of HIV transmission exists to an unknowing, identifiable, HIV-negative partner, in a state in which the clinician is bound by a “duty to protect,” the clinician can and should investigate whether such a duty might be discharged in ways other than breaking confidentiality. It is nearly always preferable for clients to disclose their own HIV status to partners themselves than to have a therapist disclose without client consent. Clinicians can explore clients’ willingness to work toward telling partners—either by themselves or with the coaching or actual assistance of the clinician. Clients who choose to disclose in the clinician’s presence offer the added benefit of certainty that the disclosure has taken place. When clients do not feel able to disclose immediately, therapists can help them explore other ways to effectively reduce risk prior to disclosure, including abstinence, using condoms, or switching from anal or vaginal sex to oral sex. Clinicians also can investigate whether partner notification services, if available, would sufficiently discharge their duty to warn current partners.

Steps for Clinicians

Clinicians can reduce the risk of harm to others while preserving the integrity of the therapeutic relationship by taking key steps:

1. Explain the Limits of Confidentiality

Early. Inform clients of the scope and limits of confidentiality at the outset of the relationship. This includes discussing its boundaries in individual therapy, as well as whether secrets of one partner will be held from another by the therapist in couples counseling. Clearly note any mandated reporting responsibilities (for example: child or elder abuse reporting, suicidality, and what will happen “if I hear that you are planning to do something that may physically harm someone else”). Such a discussion sets clear expectations that allow the client to decide what to share in therapy, and allow the therapist to refer back to the discussion if an issue of necessary breach of confidentiality ever arises.

2. Work as Part of a Team.

In many settings, clinicians work as part of a multidisciplinary team with physicians and other providers. Even solo practitioners would be well-advised to obtain their clients’ consent to consult with members of their clients’ health care teams. This can allow clinicians access to more information about whether or not a foreseeable danger exists, and whether it can be addressed in ways other than warning. If warning is necessary, it may be more appropriate for the physician (who, in some capacities, may have more latitude to break confidentiality for this purpose in some states, such as California) to make the disclosure.

3. Work with the Client and Document These Attempts. Discuss with the client...
the benefits and importance of both risk reduction and disclosure, and document these interactions. In the unlikely case that warning is warranted, clinicians can prove that they attempted to take other steps short of warning that proved insufficient. If the clinician does not warn, and is sued by an unknowing partner, he or she can demonstrate that substantial steps were taken to protect the partner. 7

Conclusion
Confusion about the confidentiality versus duty to protect dilemma persists despite the fact that more than 30 years have passed since the Tarasoff ruling. The complexity of defining danger in the context of HIV and of sexual behavior makes the HIV-related application of the duty to protect particularly confusing. It is rare that a situation meets all the necessary criteria to require warning. In the majority of cases, the most appropriate plan is for clinicians to focus on helping clients overcome barriers to self-disclosure and, if necessary, to assist with the self-disclosure process.

While there are no easy solutions, clinicians should attempt to apply a formal decision-making process that includes the types of considerations noted herein when faced with this dilemma. Finally, as stated above, the importance of seeking qualified consultation regarding state law, professional ethics, and employer policies cannot be overemphasized.

Recent Reports

Criminalization of HIV Transmission in the UK

Both of the articles in this issue explore the questions about responsibility for the disclosure of HIV-positive status. The British study below examines this question and others from the perspectives of people living with HIV. The following summary was adapted from the cited article and its abstract:

A study of HIV-positive people in England and Wales found that the criminal prosecution of individuals with HIV for "reckless HIV transmission" has caused concern and criticism among HIV-positive "African" heterosexuals and gay and bisexual men living there.

Researchers recruited and paid 125 HIV-positive participants from nonclinical community sources and conducted focus groups in London, Brighton, and Manchester. From the 188 comments or exchanges, 12 themes emerged. The topics most often discussed were "shared responsibility," the idea that, in consensual sex, HIV prevention is not solely the responsibility of the HIV-positive partner; and "increased stigma," the idea that criminalization leads to societal blame and stigmatization. The single issue most often raised was that criminalization has weakened the public health message that each partner should be responsible for his or her health. Overall, 90 percent of the study participants' comments were critical of criminalizing reckless transmission of HIV. Notably, only 3 percent of comments related to fears that criminalization would lead to fewer individuals testing for HIV.

Next Issue
The next issue of FOCUS marks our transition to a quarterly newsletter. This Summer edition of FOCUS will also be the first available solely online. To ensure that you continue to receive FOCUS, please visit our website at http://www.ucsf-ahp.org/epubs_registration.php and give us your e-mail address. Circumcision is receiving unprecedented attention as an HIV prevention method. In our next issue, Adamson Muula, MBBS, MPH, a physician and lecturer at the University of Malawi, and PhD candidate at the University of North Carolina at Chapel Hill discusses the potential of circumcision to prevent HIV acquisition and transmission in the developing world as well as applications to other areas.

Also in the Summer issue, Andrew Gruulich, MBBS, PhD, head of the Epidemiology and Prevention Program at the University of New South Wales, and David Templeton, MBBS, a sexual health physician practicing in Sydney, Australia, explore what we know about the utility of circumcision as a prevention approach in resource-rich countries.