THE AUSTRIAN PSYCHOTHERAPY ACT: NO LEGAL DUTY TO WARN

SHALL THE UNITED STATES FOLLOW THE LEADER IN THE FIELD OF PSYCHOTHERAPY?

I. INTRODUCTION

The Austrian Psychotherapy Act provides no exceptions to patient confidentiality.[1] It is the only one of its kind, internationally.[2] The Act runs directly counter to the law in the United States, which provides for numerous exceptions to patient confidentiality.[3] In addition, the American "*Tarasoff* rule"[4] creates a duty of therapists to warn potential victims when patients communicate to therapists the intent to cause serious bodily harm to those victims.[5] The crux of the debate is the weight to be given two interests: (1)

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1. *See* Karen Gutierrez-Lobos, et al., *Wrapped in Silence: Psychotherapists and Confidentiality in the Courtroom*, 44 INT'L J. OF OFFENDER THERAPY & COMP. CRIMINOLOGY 33 (2000), 2000 WL 13918460.

2. *See id.*

3. *See infra* notes 98-135. *See also* Tarasoff v. Regents of University of Cal., 551 P.2d 334, 339-40 (Cal. 1976) (establishing therapists' duty to warn third parties of imminent danger posed by patients); Jaffee v. Redmond, 116 S.Ct. 1923, 1931-32 (1996) (recognizing psychotherapist-patient privilege, but indicating that the privilege is not absolute); *In re* Lifschutz, 467 P.2d 557, 561 (Cal. 1970) (holding that a litigant-patient exception to the statutory psychotherapist-patient privilege does not unconstitutionally infringe rights of privacy of either psychotherapists or their patients); People v. Stritzinger, 668 P.2d 738, 742-45 (Cal. Ct. App. 1982) (holding that psychologist's report of suspected child abuse based upon communication from patient's child fulfilled reporting obligation, and that psychologist was not thereafter required to disclose related communications from patient); Ritt v. Ritt, 238 A.2d 196, 198-99 (N.J. Ct. App. 1967) (holding that communications between plaintiff-wife and psychiatrist were not protected from disclosure during depositions, and reasoning that the patient only had a limited right to confidentiality, subject to exceptions created by supervening interests of society. Here, the supervening interest was the fact that institution of litigation by the patient constituted vitiation of her right to absolute confidentiality), *rev'd*, 244 A.2d 497, 499 (New Jersey Supreme Court held that the issue had been subsequently decided because the New Jersey legislature had enacted a statute creating the physician-patient privilege that would cover the psychiatric relationship here).

4. This rule arose from the case of *Tarasoff*, 551 P.2d at 339-40. In that case, police officers and therapists failed to warn a victim of a patient's intention to kill her. *Id.* at 340. The patient killed the victim. *See id.* at 339. The victim's parents filed suit against the police officers and therapists for failure of their duty to warn the victim and failure to confine the patient. *See id.* at 340. The court rejected all claims against the police officers. *See id.* at 353. The court also rejected the claim against the therapists for failure to confine the patient. *See id.* at 351. However, the court held that the therapists' special relationship with the patient transferred to the victim. *See id.* at 344. Therefore, the court held, the therapists had a duty to use reasonable care in warning the victim of danger. *See id.* at 340.

5. *See id.*

the patient's right to confidentiality and therapist's need to maintain the trust of his patient, and (2) the public's right to be protected from dangerous individuals.[6] Austria places greater emphasis on the former;[7] the United States assigns higher value to the latter.[8]

Because tort claims for therapist misfeasance are frequently litigated in the United States, it may be time for America to look at its international contradiction. This Note will compare the U.S. and Austrian systems. Part II discusses the basis of the debate between patient rights and public safety. Part III explains the Austrian Psychotherapy Act's rationale, provisions, and effects. Part IV explains the U.S. system, including a discussion of the general right of patients to confidentiality and exceptions to this right. Part V compares the Austrian and American systems. Finally, Part VI proposes a change in the status of American law.

II. THE DEBATE: PATIENT RIGHTS VS. PUBLIC SAFETY

The debate centers on the relative weight of two interests: (1) the patient's right to confidentiality and therapist's need to maintain the trust of his patient, and (2) the public's right to be protected from dangerous individuals.[9]

A. *The Patient's Right to Confidentiality[10] & the Therapist's Need to Maintain the Trust of the Patient*

Numerous arguments have been asserted in favor of retaining patient confidentiality.[11] First, without a confidentiality right, prospective patients in need of treatment will be deterred from seeking help.[12] Second, absent a

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6. *See id. See also* Catherine Agnello, *Advocating for a Change in the Massachusetts HIV Statute: Putting an End to Physician Uncertainty*, 2 SUFFOLK J. TRIAL & APP. ADVOC. 105, 105-06 (1997).

7. *See* Karen Gutierrez-Lobos, et al., *supra* note 1.

8. *See Tarasoff*, 551 P.2d at 347.

9. *See id.* at 340; Agnello, *supra* note 6, at 105-06.

10. *See In re* Lifschutz, 467 P.2d 557, 567-68 (Cal. 1970). *See also* Ellen W. Grabois, *The Liability of Psychotherapists for Breach of Confidentiality*, 12 J. L. & HEALTH 39, 49-53 (1998) (discussing the nature of the confidentiality relationship between patient and therapist).

11. *See infra* notes 12-20 and accompanying text.

12. *See Tarasoff*, 551 P.2d at 359 (Cal. 1976) (Clark, J., dissenting). *See also* Matthew Carmody, *Mandatory HIV Partner Notification: Efficacy, Legality, and Notions of Traditional Public Health*, 4 TEX. F. ON C.L. & C.R. 107, 135 (1999) (suggesting that mandatory disclosure of HIV seropositivity will deter potential patients from being tested and receiving treatment necessary to curb the spread of the disease); Roger Doughty, *The Confidentiality of HIV-Related Information: Responding to the Resurgence of Aggressive Public Health Interventions in the AIDS Epidemic*, 82 CAL. L. REV. 113, 165 (1994) (suggesting that the stigma and potential discriminatory effects surrounding HIV seropositivity will deter patients from being tested and receiving treatment). *But see Tarasoff*, 551 P.2d at 346 (arguing that such predictions are entirely speculative).

guarantee of confidentiality, patients will be discouraged from making full disclosures necessary to their treatment.[13] Third, confidentiality is necessary to maintain the trust of the patient,[14] which is essential to any therapeutic relationship.[15] Fourth, by decreasing effectiveness of treatment, imposition of a duty increases danger to society of violence by the mentally ill.[16] Fifth, the duty to warn may deprive patients of two of their constitutionally protected rights, namely, the right of privacy and the right to receive treatment.[17] Sixth, imposition of liability for failure to warn will discourage therapists from treating patients with violent tendencies.[18] Seventh, potential liability may discourage therapists from testifying on behalf of patients because disclosures

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13. *See Tarasoff*, 551 P.2d at 359 (Clark, J., dissenting). *See also Lifschutz*, 467 P.2d at 567-68 (discussing potential for patient deterrence, but holding that patient's right to confidentiality is not absolute); AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS § 5.05 (2000) (discussing importance that patient feel free to disclose information to physician); Donald H.J. Hermann & Rosalind D. Gagliano, *Symposium on AIDS and the Rights and Obligations of Health Care Workers: AIDS, Therapeutic Confidentiality, and Warning Third Parties*, 48 MD. L. REV. 55, 69 (1989) (suggesting that the threat of liability may deter therapists from inquiring into dangerous activities of patients with HIV).

14. *See Tarasoff*, 551 P.2d at 359-60 (Clark, J., dissenting). *See also* Gutierrez-Lobos, et al., *supra* note 1 (suggesting that confidentiality is important for effective psychotherapy); Vanessa Merton, *Confidentiality and the "Dangerous" Patient: Implications of Tarasoff for Psychiatrists and Lawyers*, 31 EMORY L.J. 263, 306-08 (1982) (arguing that informing the patient of the limitations of confidentiality may destroy the necessary trust relationship between patient and therapist). *But see id.* at 271 (suggesting that informing the patient of the potential need to disclose information may actually make the trust relationship between the patient and therapist stronger).

15. *See generally supra* note 14.

16. *See Tarasoff*, 551 P.2d at 360 (Clark, J., dissenting).

17. *See* Wyatt v. Stickney, 325 F.Supp. 781, 784 (M.D.Ala. 1971). *See also* People v. Feagley, 535 P.2d 373, 386-87 (Cal. 1975) (discussing constitutional right of involuntarily committed patients to receive treatment); *Lifschutz*, 467 P.2d at 567-68 (discussing right to privacy); *Tarasoff*, 551 P.2d at 360 (Clark, J., dissenting) (suggesting that imposition of a duty to warn will increase the risk of civil commitment of those who should not be confined, thus increasing the risk that the right to personal liberty will be violated); Nason v. Superintendent of Bridgewater State Hosp., 233 N.E.2d 908, 913 (Mass. 1968) (discussing the right to receive treatment).

18. *See, e.g.*, Allison L. Almason, *Personal Liability Implications of the Duty to Warn are Hard Pills to Swallow: From Tarasoff to Hutchinson v. Patel and Beyond*, 13 J. CONTEMP. HEALTH L. & POL'Y 471, 495 (1997); Gutierrez-Lobos, et al., *supra* note 1; Hermann & Gagliano, *supra* note 13, at 69; Ginger Mayer McClarren, *The Psychiatric Duty to Warn: Walking a Tightrope of Uncertainty*, 56 U. CIN. L. REV. 269, 284 (1987); Merton, *supra* note 14, at 311. *See also* Judy E. Zelin, J.D., Annotation, *Physician's Tort Liability for Unauthorized Disclosure of Confidential Information about Patient*, 48 A.L.R.4th 668 (1986). The author notes that most states provide a private cause of action against licensed health care providers who impermissibly disclose to third parties confidential information obtained in course of treatment relationship. *See id.* Depending on the jurisdiction, the claim may be filed as breach of contract, malpractice, breach of fiduciary duty, act of fraud/misrepresentation, or breach of specific civil statute permitting award of damages. *See id.* In addition, licensed health care providers who breach confidentiality of patients run risk of professional disciplinary action. *See id.*

made while testifying may form the basis for lawsuits against therapists.[19] Finally, the duty is not practical because predictions of dangerousness are unreliable, thus the duty may result in unnecessary warnings being given or necessary warnings not being given.[20]

B. Public's Right to be Protected from Dangerous Persons

On the contrary, numerous arguments have been advanced in favor of a duty to warn.[21] The most prevalent of these arguments is that "[t]he protective privilege ends where the public peril begins."[22] The *Tarasoff* court stated,

> [T]here now seems to be sufficient authority to support the conclusion that by entering into a doctor-patient relationship the therapist becomes sufficiently involved to assume some responsibility for the safety, not only of the patient himself, but also of any third person whom the doctor knows to be threatened by the patient.[23]

The relationship between the therapist and patient is comparable to that of a medical doctor and patient because therapists receive training to treat patient disorders just as medical doctors are trained to treat patient diseases.[24] Thus, patient dependence on a therapist's judgment in diagnosing emotional disorders and predicting dangerousness is as justified as is patient dependence on a medical doctor's prognosis.[25]

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19. *See* Merton, *supra* note 14, at 311.

20. *See, e.g., Tarasoff*, 551 P.2d at 354 (Mosk, J., dissenting); People v. Burnick, 535 P.2d 352, 365 (Cal. 1975) (en banc); Donna Dickinson, *Ethical Issues in Long Term Psychiatric Management*, 23 J. MED. ETHICS 300, 302-03 (1997); Simon A. Hill, *The Man Who Claimed to Be a Paedophile* [sic], 26 J. MED. ETHICS 137, 137-38 (2000); The Honorable Robert J. Kane & George Sigel, *Violence Prediction: Revisited*, 20 N.ENG. J. ON CRIM. & CIV. CONFINEMENT 63, 64-70 (1993); Merton, *supra* note 14, at 296-301; Joshua M. Weiss, *Idiographic Use of the MMPI-2 in the Assessment of Dangerousness Among Incarcerated Felons*, 44 INT'L J. OF OFFENDER THERAPY & COMP. CRIMINOLOGY 70 (2000), 2000 WL 13918463. *But see Tarasoff*, 551 P.2d at 346 (concluding that professional inaccuracy in predicting violence does not negate a therapist's duty to protect the threatened victim and that the risk of unnecessary warnings being given is a reasonable price to pay for the lives of victims saved).

21. *See Tarasoff*, 551 P.2d at 347.

22. *Id.* at 347.

23. *Id.* at 344.

24. *See id.* at 345.

25. *See id.*

III. AUSTRIA: "THE HOME OF MODERN PSYCHOLOGY"[26]

Austria has spawned cutting-edge psychological scholars and theories. Sigmund Freud,[27] Anna Freud,[28] Alfred Adler,[29] and Viktor Frankl[30] are but a few. Perhaps Austria is still ahead of its time with its Austrian Psychotherapy Act. Or perhaps the rest of the world is smart to remain skeptical.

A. The Austrian Psychotherapy Act

The home of modern psychology is protecting its creation. In 1991, Austria enacted the Austrian Psychotherapy Act.[31] The Austrian Psychotherapy Act provides that "[p]sychotherapists, as well as their auxiliary staff, shall be obliged to keep confidential all secrets shared with them or becoming known to them in the exercise of their profession."[32] Even information obtained from children or juveniles is generally protected under the Act.[33] Children's legal representatives are only given information regarding the nature, extent, and cost of psychotherapy, not the children's personal secrets.[34] This requirement of confidentiality is not without its penalties. Section 23 of the Act provides that professionals who violate Section 15 of the Act shall be subject to a maximum monetary fine of fifty thousand Austrian shillings,[35] or shall be punished in the criminal courts if the

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26. Sigmund Freud began the era of "modern psychology" in the late 1800s with his development of psychoanalysis. LESTER A. LEFTON & LAURA VALVATNE, MASTERING PSYCHOLOGY (3rd ed. 1988). For an interesting discussion of the atmosphere of Vienna in which psychoanalysis was born, see FREDERIC MORTON, A NERVOUS SPLENDOR: VIENNA 1888/1889, 54 (1979).

27. Sigmund Freud developed the theory of psychoanalysis. *See* LEFTON & VALVATNE, *supra* note 26. He focused on the unconscious and on how it directs human behavior. *See id.* "Almost a century ago, Freud pointed out the importance of the therapist's duty of discretion about the insights emerging from access to the unconscious. Since then, privacy and confidentiality have been the cornerstones of the psychotherapeutic relationship." Gutierrez-Lobos, et al., *supra* note 1.

28. Anna Freud, Sigmund Freud's daughter, is a renowned psychologist in the area of developmental psychology of children. *See* LEFTON & VALVATNE, *supra* note 26, at 475-77.

29. Alfred Adler was heavily influenced by Sigmund Freud, and many psychologists consider his theory an extension of Freud's. *See id.* Adler believed that social interaction is an important factor that influences personality development. *See id.*

30. Viktor Frankl developed what is generally known as the Third School of Viennese Psychiatry, the school of logotherapy. *See* VIKTOR FRANKL, MAN'S SEARCH FOR MEANING: AN INTRODUCTION TO LOGOTHERAPY (3rd ed. 1984). Logotherapy stresses man's freedom to transcend suffering and find a meaning to his life regardless of his circumstances. *See id.* Frankl's survival of concentration camps at Dachau and Auschwitz was the basis for his formulation of the theory. *See id.*

31. Bundesgesetz vom 7. Juni 1990 über die Ausübung der Psychotherapie (Psychotherapiegesetz) (1991).

32. *Id.* § 15.

33. *See* Gutierrez-Lobos, et al., *supra* note 1.

34. *See id.*

35. Bundesgesetz vom 7. Juni 1990 über die Ausübung der Psychotherapie

deed meets the elements of a criminal offense.[36] The Act is currently the only law that provides for strict confidentiality by psychotherapists with no exceptions.[37]

The Act does, however, allow—but does not mandate—breach of confidentiality in emergency situations.[38]

> In the case of the imminent threat of a criminal act involving the life, physical integrity, or freedom of the victim, the possible disadvantages as a result of the criminal act will generally have precedence over the breach of confidentiality, in which case the psychotherapist has a reporting obligation protected by law. The danger must be direct or imminent, and the occurrence of damage must be certain or highly probable. Public interests (legal proceedings or the health system in general) are not regarded as emergencies.[39]

In addition, breach of confidentiality is only allowed if other measures are insufficient to prevent the act of violence.[40]

B. *Rationale for the Act*

The Austrian Constitution and the European Convention on Human Rights protect personal privacy in general.[41] This protection encompasses individual privacy as well as the relationship with certain professionals such as clergy, attorneys, physicians, and therapists.[42] The Austrian Psychotherapy Act furthers these rights to privacy.[43] Professionals explain that the "duty of confidentiality is intended to protect people who seek psychotherapeutic treatment and accept the special and confidential relationship that this involves."[44] The Act further "contributes to a clearly defined

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(Psychotherapiegesetz) § 23 (1991). This penalty provision will likely be updated in January 2002 to include an amount of 3,634 Eurodollars instead of Austrian shillings. *See* Bundesgesetz über die Niederlassung und die Ausübung des freien Dienstleistungsverkers von Psychotherapeuten aus dem Europäischen Wirtschaftsraum (EWR-Psychotherapiegesetz) § 10 (1999). Three thousand six hundred and thirty-four Eurodollars is roughly equivalent to 50,000 Austrian schillings or 3,427 American dollars. *See* Expedia Currency Converter, *available at* http://www.expedia.com/pub/agent.dll?qscr=curc (last visited Jan. 21, 2001).

36. *See* Bundesgesetz vom 7. Juni 1990 über die Ausübung der Psychotherapie (Psychotherapiegesetz) § 23 (1991).

37. *See* Gutierrez-Lobos, et al., *supra* note 1.

38. *See id.*

39. *Id.*

40. *See id.* Examples of alternative measures include an increase in the frequency of therapy sessions, drug treatment, hospital referral, or civil commitment. *See id.*

41. *See id.*

42. *See id.*

43. *See id.*

44. *Id.*

psychotherapeutic relationship, thus acknowledging the importance of confidentiality for psychotherapy to be effective."[45]

C. *Definition of "Psychotherapist" under the Act*

The Act defines psychotherapy as:

> the comprehensive, deliberate and planned treatment, on the basis of a general and a special training, of disturbances in behaviour and states of disease conditions, due to psycho-social or also psycho-somatic causes, by means of scientific, psychotherapeutic methods, in an interaction between one or several treated persons and one or several psychotherapists, with the objective of mitigating or eliminating the established symptoms, to change disturbed patterns of behavior and attitudes, and to promote a process of maturing, development and sanity in the treated person.[46]

The Act applies to all individuals who complete the full psychotherapy training as defined by the Act[47] and those who engage in the listed activities with a patient, regardless of their respective professions.[48] Thus, social workers, probation officers, and others may be protected by the Act.[49] A professional who may also be subject to other laws may find greater protections under the Act.[50] Thus, a psychiatrist who qualifies under the law as a psychotherapist and defines his relationship as psychotherapist-patient rather than physician-patient is subject to the Act and not to the Austrian Medical Practice Act (Osterreichisches Arztegesetz).[51]

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45. *Id.*

46. Bundesgesetz vom 7. Juni 1990 über die Ausübung der Psychotherapie (Psychotherapiegesetz) § 1(1) (1991).

47. *See id.* §§ 2-8.

48. *See id. See also* Gutierrez-Lobos, et al., *supra* note 1.

49. *See* Gutierrez-Lobos, et al., *supra* note 1.

50. *See id.*

51. *See id.* The authors point out that the Austrian Medical Practice Act, unlike the Austrian Psychotherapy Act, includes reporting obligations when "there is a suspicion of a punishable offense that has resulted in death or serious bodily harm, or if there is a suspicion of torture or neglect of a minor, juvenile, or defenseless person, even where minor bodily harm or health impairment results." *Id.* These exceptions to confidentiality are strictly governed: "Disclosure may be required for criminal proceedings, to insurance companies (in the case of specific, legally defined reporting obligations), or to government officials for certain diseases." *Id. See also* Osterreichisches Arztegesetz §§ 26-27 (1994).

D. Training Requirements & Prerequisites to Become a Psychotherapist

The Act specifies training requirements for psychotherapists.[52] These requirements include completion of a general preparatory instruction in psychotherapy and special training in psychotherapy, taught in theory and in practice.[53] The general training consists of a minimum of 765 hours of instruction in a variety of basic principles[54] and 550 hours of practical experience.[55] The special training consists of a minimum of 300 hours of instruction in a variety of areas,[56] with a minimum of 50 hours in one of the priority areas provided under the Act.[57] In addition, the special training requires 1600 hours of practical experience, with a minimum of 100 hours in one of the priority areas provided under the Act.[58] The Act also sets forth requirements for the training facilities.[59] In addition to these training requirements, the Act sets forth prerequisites for training to become a psychotherapist[60] and prerequisites for the independent exercise of

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52. *See* Bundesgesetz vom 7. Juni 1990 über die Ausübung der Psychotherapie (Psychotherapiegesetz) §§ 2-8 (1991).

53. *See id.* § 2.

54. *Id.* § 3(1). These basic principles include information regarding psychotherapy, somatology and medicine, methodological principles of research and science, questions of ethics, and framework conditions for the exercise of psychotherapy. *See id.*

55. *Id.* § 3(2). The practical instruction includes individual or group self-experience, practical exercise in management of persons with behavior disturbances or with diseased persons, and attendance at practical exercises in supervision. *See id.*

56. *Id.* § 6(1). The areas include the theory of sound and psychopathological personality development, methods and techniques, personality and interaction theories, and psychotherapeutic literature. *See id.*

57. *Id.*

58. *Id.* § 6(2). These subject areas include teaching therapy, teaching analysis, and individual or group self-experience; practical psychotherapeutic knowledge gained from relations with persons with behavioral disturbances or disease, under the supervision of a psychotherapist; attendance at practical exercises with supervision; and psychotherapeutic activity with persons with behavior disorders or diseases. *See id.*

59. *See id.* §§ 4, 5, 7, 8.

60. *See id.* § 10. The Act requires that persons seeking preparatory psychotherapy training have legal capacity; have passed the completion examination of an upper-level secondary school; have completed special training for the sick nursing services or the medical-technical services; and have been admitted to attend preparatory psychotherapy instruction by decree of the Federal Chancellor, on account of aptitude, after obtaining an expert opinion of the Psychotherapy Advisory Council. *See id.* The Act requires that persons seeking special psychotherapy training have legal capacity; be at least twenty-four years of age; submit a written statement by a teaching facility that a training position will be available; have completed the preparatory instruction in psychotherapy and either have completed special training for the sick nursing services or the medical technical services, or have been admitted to attend special training in psychotherapy by way of decree by the Federal Chancellor; have completed a training course at an academy for social workers, a previous teaching institute for advanced social occupations, an academy of pedagogy, or a teaching institute with public teaching authorization for marriage and family counseling, or have completed the short study course in music therapy or a university training course in music therapy; or have completed studies of medicine, pegagogy, philosophy, psychology, publishing and communication science, theology,

psychotherapy.[61]

E. Prison Psychotherapists

Psychotherapists who treat patients in institutions such as prisons are not expressly mentioned in the Act.[62] However, some Austrian practitioners suggest that the Act protects even psychotherapists who treat inmates; thus, these psychotherapists generally do not have a duty to protect third parties.[63] The rationale for this inclusion is:

> Offenders released from prison need to be able to talk freely about their criminal intentions so that they can be prevented from actually committing crimes. If this protection [of confidentiality] were not granted, the therapist or probation officer would become an informer rather than someone capable of bringing about a change.[64]

However, the strict measure of confidentiality cannot realistically apply where the offender's sentence is determined by his success in therapy.[65] Despite this problem, many prison psychotherapists in Austria still invoke their strict duty of confidentiality under the Act and refuse to give an opinion as to whether authorities should change the conditions of detention.[66]

F. Psychotherapists Are Not Witnesses or Experts in Civil or Criminal Trials

Under the Act, courts cannot compel Austrian psychotherapists to serve as witnesses or experts in civil or criminal cases.[67] In addition to the Act, the

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or studies for the teaching profession at upper-level secondary school; or can prove completion of a full study course at an officially-recognized international university. *See id.*

61. *See id.* § 11. The Act requires that persons who wish to be authorized to independently practice psychotherapy shall have successfully completed the preparatory and special instruction in psychotherapy, have legal capacity, be at least twenty-eight years of age, have submitted evidence of their physical fitness and reliability as required to carry out professional duties, and have been admitted to the List of Psychotherapists after the Psychotherapy Advisory Council has been heard. *See id.*

62. *See* Bundesgesetz vom 7. Juni 1990 über die Ausübung der Psychotherapie (Psychotherapiegesetz) (1991).

63. *See* Gutierrez-Lobos, et al., *supra* note 1.

64. *Id.*

65. *See id.* In Austria, the release of offenders adjudged to be responsible and mentally disordered is conditioned upon the success of therapeutic measures. *See id.*

66. *See id.* This problem has led prison officials to circumvent the effects of the Act by organizing their own treatment groups and social learning programs. *See id.*

67. *See id.* This limitation presumably stems from Section 15 of the Act. *See* Bundesgesetz vom 7. Juni 1990 über die Ausübung der Psychotherapie (Psychotherapiegesetz) § 15 (1991). *See* Gutierrez-Lobos, et al., *supra* note 1. In general, however, Austrian

reporting obligation of therapists is limited by the Amendment to the Criminal Procedure Act (Gesetzesmaterialen) of 1993.[68] According to the Criminal Procedure Act, reporting is not required if doing so would be detrimental to the performance of an official duty, the effectiveness of which depends on a personal trust relationship.[69] The Criminal Procedure Act encompasses the work of psychosocial professions, i.e., social workers and probation officers, within the arena of criminal proceedings.[70]

The Austrian Psychotherapy Act does not expressly clarify whether patients themselves may release psychotherapists from the duty of confidentiality.[71] This question is disputed.[72] However, it is generally accepted that a patient's release is not binding on a psychotherapist.[73] "In a leading case, the Austrian Supreme Court opined that the protective object of the discretionary right to withhold testimony concerns the therapist-patient relationship rather than the patient and that this right cannot, therefore, be waived by the patient alone."[74] When a patient attempts to release this right, the therapist must consider whether the patient has the ability to assess the consequences of the release on the basis of medical rather than legal interests.[75] In these situations, only the therapist can decide if disclosure would harm the patient.[76]

The rationale for limiting psychotherapists' testimony is not only to protect the psychotherapist-patient relationship, but also because psychotherapists are poorly suited to give legal testimony:

> Clinical and forensic undertakings are dissimilar in that they are directed at different (although overlapping) realities, which they seek to understand in correspondingly different ways. The process of psychotherapy is a search for meaning more than for facts. The therapist accepts the patient's narrative as representing an inner, personal reality. . . . In court, therapists can describe only impressions, countertransference reactions, and assumptions regarding the underlying psychic conflicts. The truth emerging in therapy is subjective and selective; its objective validity cannot be

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physicians may be compelled to testify in criminal proceedings. *See id.*

68. *See* Gutierrez-Lobos, et al., *supra* note 1.
69. *See id.*
70. *See id.*
71. *See id.*
72. *See id.*
73. *See id.*
74. *Id.*
75. *See id.*
76. *See id.*

> assessed without data about external circumstances. Psychotherapists, therefore, cannot produce proof in the legal sense.[77]

The Act does not differentiate between psychotherapists as fact witnesses or as paid experts because the difference is not important—psychotherapists are inadequate witnesses in either vein.[78]

G. *Do Austrian Psychotherapists Have a Duty to Protect the General Public?*

Under the strict provisions of the Act, a breach of patient confidentiality may be excusable in the case of a highly probable danger.[79] However, the "danger must be direct or imminent, and the occurrence of damage must be certain or highly probable."[80] The Act does not regard public interests such as legal proceedings or the health system in general as emergencies that merit breach of patient confidentiality.[81] However, some Austrian practitioners note that, although Austrian law does not include an equivalent of the *Tarasoff* rule, Austrian psychotherapists still have a duty to the general public.[82]

IV. UNITED STATES

The United States, on the other hand, chose to create a duty of therapists to warn potential victims when patients voice threats of serious bodily harm.[83] The United States also prioritizes the well being of its children by requiring psychotherapists and others to report child abuse.[84] In so choosing, the United States places greater value on the right of the public to be protected from dangerous persons.[85] In addition, the United States uses mental health service providers as fact witnesses and experts in trials.[86] The argument has been made that the United States' exceptions threaten to swallow the confidentiality rule.[87]

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77. *Id.*
78. *See id.*
79. *See id.*
80. *Id.*
81. *See id.*
82. *See id.*
83. *See Tarasoff*, 551 P.2d at 339-40.
84. *See* John R. Murphy III, *In the Wake of Tarasoff: Mediation & the Duty to Disclose*, 35 CATH. U. L. REV. 209, 218 (1985).
85. *See id.*
86. *See* Merton, *supra* note 14, at 284-88.
87. "[T]he exceptions and implied waivers are so many and so broad that it is difficult to postulate a case in which the privilege applies." Gutierrez-Lobos, et al., *supra* note 1.

A. *General Right of Patients to Confidentiality*

In the United States, courts have held that a patient's right to confidentiality stems from the Constitution.[88] Courts have cited the right to privacy and right to receive treatment as constitutional bases for this confidentiality right of patients.[89] However, courts have held that this confidentiality right is not absolute.[90] In addition, the right inheres in the patient; a psychotherapist may not override a patient's waiver of the privilege to psychotherapeutic communication.[91]

The medical profession in the United States also acknowledges the value of patient confidentiality. The American Code of Medical Ethics provides:

> The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential communications or information

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88. *See, e.g.*, Whalen v. Roe, 429 U.S. 589, 599-603 (1977) (discussing constitutional right to privacy of patient information, but upholding statute against constitutional attack); Doe v. City of New York, 15 F.3d 264, 269 (2d Cir. 1994) (holding that individuals have a constitutional right of privacy in their medical information and that courts should apply a balancing test to determine whether the government's interest in disclosure is substantial enough to outweigh the privacy interest); Wyatt v. Stickney, 325 F.Supp. 781, 784 (M.D.Ala. 1971) (discussing right to receive treatment); People v. Feagley, 535 P.2d 373, 386-87 (Cal. 1975) (discussing constitutional right of involuntarily committed patients to receive treatment); *In re* Lifschutz, 467 P.2d 557, 567-68 (Cal. 1970) (reasoning that the confidentiality of the psychotherapeutic relationship falls within the zones of privacy created by the Bill of Rights, as discussed in *Griswold v. Connecticut*, 381 U.S. 479 (1965)). *See also Tarasoff*, 551 P.2d at 347 (Mosk, J. dissenting) (suggesting that imposition of a duty to warn will increase the risk of civil commitment of those who should not be confined, thus increasing the risk that the right to personal liberty will be violated).

89. *See, e.g.*, *Wyatt*, 325 F.Supp. at 784 (discussing right to receive treatment); *Feagley*, 535 P.2d at 386-87 (discussing constitutional right of involuntarily committed patients to receive treatment); *Lifschutz*, 467 P.2d at 567-68 (reasoning that the confidentiality of the psychotherapeutic relationship falls within the zones of privacy created by the Bill of Rights, as discussed in *Griswold v. Connecticut*, 381 U.S. 479 (1965)).

90. *See, e.g.*, *Whalen*, 429 U.S. at 602; *Lifschutz*, 467 P.2d at 568 (holding that not all state interference with such confidentiality is prohibited).

91. *See Lifschutz*, 467 P.2d at 573 (rejecting psychotherapists claims that compulsion of privileged information violated his right to privacy, constituted an unconstitutional taking of his property right in his profession, unconstitutionally constricted the practice of medicine, and denied him equal protection under the law); R.P. Davis, Annotation, *Who May Waive Privilege of Confidential Communication to Physician by Person Since Deceased*, 97 A.L.R.2d 393 (1999) (noting that generally only the patient may waive privilege).

> without express consent of the patient, unless required to do so by law.[92]

In addition, commentators suggest that breaches of confidentiality may hinder a client's relationship with his therapist.[93] Because the treatment of potentially dangerous offenders, by its nature, encourages the disclosure of violent fantasies, a duty to warn of these disclosures creates a quandary for therapists.[94] In this vein, the *Tarasoff* court stated:

> Certainly a therapist should not be encouraged routinely 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.[95]

Thus, the line between the need to disclose a threat and the need to maintain patient confidentiality is a dim one, offering little guidance for therapists.[96]

B. Exceptions to Confidentiality

Although the United States recognizes the value of a patient's right to confidentiality, it allows numerous exceptions to the right.[97] The duty to warn third parties of danger presented by patients and the duty to report child abuse are among these exceptions. In addition, there are numerous exceptions to the psychotherapist-patient privilege in court cases.[98]

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92. AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS § 5.05 (2000).

93. *See* Merton, *supra* note 14, at 306-08. In addition to this discussion, the author addresses the possibility that disclosure of potential weaknesses of treatment will allow a deeper trust in the professional relationship. *See id.* at 271.

94. *See id.* at 306-08.

95. *Tarasoff*, 551 P.2d at 347.

96. *See* Scott Rogge, M.D., J.D., *Liability of Psychiatrists Under New York Law for Failing to Identify Dangerous Patients*, 20 PACE L. REV. 221, 224 (2000).

97. *See, e.g.*, Robert Sadoff, *Ethical Obligations for the Psychiatrist: Confidentiality, Privilege, and Privacy in Psychiatric Treatment*, 29 LOY. L.A. L. REV. 1709, 1710-11 (1996) (noting that the privilege may be overcome by statutory exceptions or where necessary to protect the public or a third party).

98. *See id. See also* MIL. R. EVID. 513. This military rule deals with the psychotherapist-patient privilege in military tribunals and sets forth eight exceptions to the privilege: (1) when the patient is dead; (2) when the communication involves evidence of spouse or child abuse, or

C. *Duty to Warn*

Prior to *Tarasoff*, therapists were not held responsible for the violent acts of their patients unless they had a special relationship with the patient or the victim. This responsibility was generally limited to situations where the "clinician had physical control or custody of the patient . . . , knew in advance of the patient's violent intentions, and failed to exercise appropriate control."[99] In other words, therapists "previously risked liability for negligently allowing patients with violent histories and intentions to be released or to escape from their custody and control when those patients later caused harm to other people."[100]

However, in 1976, the status of the common law changed with the case of *Tarasoff v. Regents of University of California.*[101] This landmark case established the duty to warn in the United States.[102] In *Tarasoff*, police officers and therapists failed to warn a victim of a patient's intention to kill her.[103] The patient killed the victim.[104] The victim's parents filed suit against the police officers and therapists for failure of their duty to warn the victim and failure to confine the patient.[105] The court rejected all claims against the police officers.[106] The court also rejected the claim against the therapists for failure to confine the patient.[107] However, the court held that the therapists' special relationship with the patient transferred to the victim.[108] Therefore, the court held, the therapists had a duty to use reasonable care in warning the victim of danger.[109] In so holding, the court set forth the following rule:

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neglect, or in a proceeding in which one spouse is charged with a crime against the person of the other spouse or child of either spouse; (3) when there is a duty to report under federal or state law, or service regulation; (4) when the service provider believes that the patient's mental or emotional condition makes the patient a danger to any person, including the patient; (5) if the communication clearly contemplates future commission of a fraud or crime, or if the services of the provider were sought to aid the patient in such activity; (6) when necessary to insure the safety and security of military personnel, military dependents, military property, classified information, or accomplishment of a military mission; (7) when an accused offers statements or evidence concerning his mental condition in defense, extenuation or mitigation, as necessary in the interests of justice; and (8) when constitutionally required. *See id.* 513(c)(1)-(8).

99. Rogge, *supra* note 96, at 222. *See also Tarasoff*, 551 P.2d at 335.
100. Rogge, *supra* note 96, at 222. *See also Tarasoff*, 551 P.2d at 335.
101. *See Tarasoff*, 551 P.2d at 339-40.
102. *See id.*
103. *See id.* at 340.
104. *See id.* at 339.
105. *See id.* at 340.
106. *See id.* at 353.
107. *See id.* at 351.
108. *See id.* at 344.
109. *See id.* at 340.

> 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.[110]

The court went on to clarify a therapist's duty by stating that the therapist must exercise "that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [that professional specialty] under similar circumstances."[111] Within this range, the court continued, "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."[112] The standard used to determine the adequacy of the therapist's conduct is the traditional negligence standard of reasonable care under the circumstances.[113]

In the twenty-five years since the California Supreme Court decided *Tarasoff*, more than twenty-five states have recognized the duty to warn, by statute or case law.[114] Other jurisdictions explicitly reject the *Tarasoff* doctrine.[115] Still other courts have distinguished *Tarasoff* from certain factual situations.[116] Yet another line of cases applies the *Tarasoff* doctrine to new

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110. *Id.*

111. *Id.* at 345 (quoting Bardessono v. Michels, 478 P.2d 480 (Cal. 1970)).

112. *Tarasoff*, 551 P.2d at 345.

113. *See id.*

114. *See* Bradley v. Ray, 904 S.W.2d 302, 307-09 (Mo. Ct. App. 1995) (discussing the status of *Tarasoff* legal developments nationwide). *See, e.g.*, Almonte v. New York Med. College, 851 F. Supp. 34 (D. Conn. 1994); Naidu v. Laird, 539 A.2d 1064, 1072 (Del. 1988) (holding special relationship between mental health professional and patient supports duty to take steps to protect third parties); Estates of Morgan v. Fairfield Family Counseling Ctr., 673 N.E.2d 1311, 1313 (Ohio 1997), *reconsid. denied*, 676 N.E.2d 534 (Ohio 1997); Hembree v. State, 925 S.W.2d 513 (Tenn. 1996).

115. *See, e.g.*, Green v. Ross, 691 So.2d 542, 543-44 (Fla. Dist. Ct. App. 1997) (finding that Florida legislature had not established a cause of action for failure to warn); Lee v. Corregedore, 925 P.2d 324, 336-37 (Haw. 1996) (limiting the *Tarasoff* holding to cases involving potential victims of violent assault, while declining to extend it to risks of self-inflicted injury); Thapar v. Zezulka, 994 S.W.2d 635, 640 (Tex. 1999) (holding psychiatrist not liable for death of third party killed by patient because psychiatrist had no duty to warn victim and had duty to maintain patient's confidentiality); Nasser v. Parker, 455 S.E.2d 502, 502 (Va. 1995) (finding patient did not have special relationship with psychiatrist and hospital so psychiatrist and hospital not liable for patient's murder of third party).

116. *See, e.g.*, Riley v. United Health Care of Hardin, Inc., 165 F.3d 28, 1998 WL 598733, **4 (6th Cir. 1998) (patient made non-specific threats); Boulanger v. Pol, 900 P.2d 823, 834-35 (Kan. 1995) (holding psychiatrist had no duty to warn where the victim was already aware of

situations, new classes of health providers, and other defendants who may be held responsible for an individual's conduct.[117]

In addition to changes in case law, states have changed confidentiality and malpractice laws to limit, permit, or mandate the duty to warn.[118] These statutes often include immunity from *Tarasoff*-type lawsuits in return.[119] Several states extend the duty to warn to new classes of professionals in new situations.[120] For example, health care workers have a duty to warn third-party contacts of risks of exposure to a patient's transmissible disease, such as HIV/AIDS or active tuberculosis.[121] Despite clarifying statutory or case law, *Tarasoff* has "arguably become the de facto standard of care in the mental health community."[122]

The American Code of Medical Ethics incorporates the *Tarasoff* duty to warn by suggesting that confidentiality, although important, is "subject to

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the danger posed by the patient and because no special relationship existed between psychiatrist and voluntary mental patient); Bishop v. South Carolina Dept. of Mental Health, 473 S.E.2d 814, 816 (S.C. App. 1996), *aff'd as modified*, 502 S.E.2d 78 (S.C. 1998) (victim had prior knowledge of the patient's dangerousness); Limon v. Gonzaba, 940 S.W.2d 236, 241 (Tex. App. 1997) (victims neither identifiable nor foreseeable).

117. *See, e.g.*, Garamella v. New York Med. College, 23 F. Supp.2d 167, 174 (D. Conn. 1998) (psychiatric resident's supervisor liable for failing to notify resident's medical school that resident was a pedophile); Valentine v. On Target, Inc., 727 A.2d 947, 948 (Md. 1999) (holding gun dealer owed no duty to third parties to exercise reasonable care in the display and sale of handguns to prevent the theft and illegal use of handguns against third parties); Popple v. Rose, 573 N.W.2d 765 (Neb. 1998) (holding parents may be sued for failure to warn babysitter of their son's known dangerous sexual propensities, but holding that son's dangerous sexual propensities were not known in that case); J.S. v. R.T.H., 714 A.2d 924, 936 (N.J. 1998) (spouse may be held liable because she had reason to know of her husband's sexually abusive behavior against neighbor's children yet did nothing to stop it); Ludlow v. City of Clifton, 702 A.2d 506, 509 (N.J. Super. Ct. 1997) (applying Tarasoff to suit against school board and child study team, but holding defendants not liable because statutory discretionary duty fulfilled); Cain v. Rijken, 717 P.2d 140, 140 (Or. 1986) (*en banc*) (mental health provider may be liable for failure to warn of patient's inability to drive safely); Schuster v. Altenberg, 424 N.W.2d 159, 175 (Wis. 1988) (recognizing duty of psychiatrist to inform police where patient exhibits generalized dangerous tendencies, but no readily identifiable target); State v. Agacki, 595 N.W.2d 31, 38 (Wis. Ct. App. 1999) (applying public safety exception to confidentiality although the threat was not particularized). *See also* JAMES C. BECK, CONFIDENTIALITY VERSUS THE DUTY TO PROTECT: FORESEEABLE HARM IN THE PRACTICE OF PSYCHIATRY (James C. Beck ed. 1990); LEON VANDECREEK & SAMUEL KNAPP, TARASOFF AND BEYOND: LEGAL AND CLINICAL CONSIDERATIONS IN THE TREATMENT OF LIFE-ENDANGERING PATIENTS (rev. ed. 1993). *See generally* Michael L. Perlin, *Tarasoff at the Millennium: New Directions, New Defendants, New Dangers, New Dilemmas*, PSYCHIATRIC TIMES, Nov. 1999.

118. *See* Rogge, *supra* note 96, at 225. *See also* CURRAN ET AL., HEALTH CARE LAW AND ETHICS 193-99 (5th ed. 1998).

119. *See, e.g.*, Hutchinson v. Patel, 637 So.2d 415, 418-19 (La. 1994). *See generally* Michael R. Geske, *Statutes Limiting Mental Health Professionals' Liability for the Violent Acts of Their Patients*, 64 IND. L.J. 391, 403 (1989).

120. *See* Geske, *supra* note 119, at 398-400.

121. *See* Lawrence O. Gostin & James G. Hodge, Jr., *Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification*, 5 DUKE J. GENDER L. & POL'Y 9, 41-44 (1998).

122. Rogge, *supra* note 96, at 229.

certain exceptions which are ethically and legally justified because of overriding social considerations."[123] Threat of serious harm to another is one of these considerations:

> Where a patient threatens to inflict serious bodily harm to another person or to him or herself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities.[124]

The duty to warn exception has numerous proponents, both in the United States and internationally.[125]

Yet, the *Tarasoff* duty to warn has also been criticized because its holding leaves several questions unanswered, thus offering little guidance to therapists.[126] For instance, which threats are "serious and imminent"? If not mentioned by name, when is a threatened victim "identifiable"? One author recounts a case study that exemplifies the difficulty of victim identification.[127] The case study involves a man who therapists found to be a general danger to women.[128] However, the therapists could not determine a particular woman or group of women subject to the danger.[129] Thus, the therapists could not

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123. AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS § 5.05 (2000).

124. *Id.*

125. *See, e.g.*, Perreira v. State, 768 P.2d 1198, 1201 (Colo. 1989) (holding that there are situations in which the need to protect an individual or the community from the threat of harm from a patient may outweigh the strong policy in favor of non-disclosure of patient confidences); Rocca v. Southern Hills Counseling Center, Inc., 671 N.E.2d 913, 917-19 (Ind. Ct. App. 1996) (holding that, while free and frank communication should be promoted to aid proper diagnosis and treatment, public policy supports disclosure of confidential information when appropriate); Estates of Morgan, 673 N.E.2d at 1332 (held a psychotherapist liable for failing to control a schizophrenic patient despite pleas of patient's parents when the patient subsequently killed his parents); Emerich v. Philadelphia Center for Human Development, Inc., 720 A.2d 1032, 1045 (Pa. 1999) (found a duty to warn in accord with *Tarasoff*, but found that the mental health center had fulfilled its duty by warning the victim not to go to the patient's apartment); Agacki, 595 N.W.2d at 38 (applying public safety exception to confidentiality although the threat was not particularized); Charles E. Cantu, *Bitter Medicine: A Critical Look at the Mental Health Care Provider's Duty to Warn in Texas*, 31 ST. MARY'S L. J. 359, 379-405 (2000) (discussing Texas's rejection of the *Tarasoff* doctrine, and suggesting that the doctrine should be adopted in Texas); Vittorio Fineschi, et al., *The New Italian Code of Medical Ethics*, 23 J. OF MED. ETHICS 239, 243 (1997) (suggesting that the new Italian Code of Medical Ethics provides for an exception to patient confidentiality when there is potential for harm to a third party); Dr. Thaddeus H. Jozefowicz, *The Case Against Having "Professional Privilege" in the Physician-Patient Relationship*, 16 MED. & L. 385, 391 (1997) (arguing in favor of the trend toward allowing exceptions to patient confidentiality rights in order to protect the public).

126. *See* McClarren, *supra* note 18, at 293.

127. *See* Dickinson, *supra* note 20, at 302.

128. *See id.*

129. *See id.*

realistically fulfill the duty to warn.[130] Another question unanswered by the *Tarasoff* holding is what "reasonable steps" should a therapist take to protect the threatened party. Exactly what are the "standards of the profession" by which therapists are to measure their activity?[131]

D. Duty to Report Child Abuse

A duty to report child abuse exists to some degree in all fifty states.[132] The status of this duty in the psychotherapist-patient relationship is unclear. Some courts have held that statutes requiring the reporting of actual or suspected child abuse expressly make the psychotherapist-patient privilege inapplicable.[133] However, other jurisdictions have completely nullified the privilege.[134] These jurisdictions have protected therapists' discretion by suggesting that the question of whether to disclose suspected child abuse is a matter left to the individual therapist's professional and moral judgment.[135]

E. Use of Mental Health Service Providers as Witnesses or Experts in Trials

The United States uses psychotherapists as fact witnesses and experts in civil and criminal trials.[136] American courts rely upon mental health professionals to predict offender dangerousness in sentencing hearings.[137] In addition, despite a general psychotherapist-patient evidentiary privilege, courts may compel therapists to testify in a variety of situations.[138] In Austria,

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130. *See id.*

131. This problem was suggested in *Tarasoff*, 551 P.2d at 354 (Mosk, J., dissenting).

132. *See* Murphy, *supra* note 84, at 220.

133. *See* People v. Stritzinger, 668 P.2d 738, 742-45 (Cal. Ct. App. 1982).

134. *See, e.g.*, Maryland Att'y Gen. Op., 1977 Md. AG LEXIS 107, 9 (1977) (holding that privilege applies despite child abuse reporting statute). *See also* Wisconsin Att'y Gen. Op. 10-87, 1987 Wisc. AG LEXIS 60, 11 (1987) (holding that if a report is made in good faith, the physician will be immune from civil or criminal liability).

135. *See supra* note 133.

136. *See* Merton, *supra* note 14, at 284-88. *See also* William M. Grove & R. Christopher Barden, *Protecting the Integrity of the Legal System: the Admissibility of Testimony from Mental Health Experts Under Daubert/Kumho Analyses*, 5 PSYCHOL. PUB. POL'Y & L. 224, 238 (1999) (suggesting that much expert testimony by mental health professionals should be excluded under reigning case law).

137. *See id.*

138. *See, e.g., In re* Lifschutz, 467 P.2d 557, 561 (Cal. 1970) (holding that a litigant-patient exception to the statutory psychotherapist-patient privilege does not unconstitutionally infringe rights of privacy of either psychotherapists or their patients); *Stritzinger*, 668 P.2d at 742-45 (holding that a psychologist's testimony regarding patient's admission of sexual conduct was not properly admitted since psychologist had previously fulfilled reporting obligation under statute when he reported suspected child abuse based on communication from patient's child); Ritt v. Ritt, 238 A.2d 196, 198-99 (N.J. Ct. App. 1967) (holding that communications between plaintiff-wife and psychiatrist were not protected from disclosure and reasoning that the patient only had a limited right to confidentiality, subject to exceptions created by supervening interests

however, courts may not compel psychotherapists to testify in trials.[139] Even if an Austrian patient waives his right to confidentiality, he may not do so alone.[140] The Act deems the psychotherapist-patient relationship an entity in and of itself, so that one party may not waive the privilege without the cooperation of the other party.[141]

In 1996, the U.S. Supreme Court first recognized the psychotherapist-patient privilege in *Jaffee v. Redmond*.[142] In *Jaffee*, a police officer received extensive counseling from a licensed clinical social worker after the police officer shot and killed a man.[143] The family of the deceased brought suit against the officer and wanted to compel disclosure of the content of the therapy sessions.[144] The Court recognized the privilege under Federal Rule of Evidence 501.[145] That Rule states, " . . . the privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of common law as they may be interpreted by the courts of the United States in the light of reason and experience."[146] The Court described the common law principles underlying the recognition of testimonial privileges:

> For more than . . . three centuries it has now been recognized as a fundamental maxim that the public has a right to every man's evidence. When we come to examine the various claims of exemption, we start with the primary assumption that there is a general duty to give what testimony one is capable of giving, and that any exemptions which may exist are distinctly exceptional, being so many derogations from a positive general rule. Exceptions from the general rule

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of society. Here, the supervening interest was the fact that institution of litigation by the patient constituted vitiation of her right to absolute confidentiality), *rev'd*, 244 A.2d 497, 499 (the New Jersey Supreme Court held that the issue had been subsequently decided because the New Jersey legislature had enacted a statute creating the physician-patient privilege that would cover the psychiatric relationship here); AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS § 5.06 (2000) (providing that physicians may communicate with a patient-plaintiff's attorney with patient consent, and may testify in court in any personal injury or related case); John C. Williams, J.D., Annotation, *Liability of One Treating Mentally Afflicted Patient for Failure to Warn or Protect Third Persons Threatened by Patient*, 83 A.L.R.3d 1201 (2000) (discussing state rules of evidence pertaining to the physician-patient privilege).

139. *See* Gutierrez-Lobos, et al., *supra* note 1. Physicians in Austria, however, may be compelled to testify. *See id.*

140. *See id.*

141. *See id.*

142. Jaffee v. Redmond, 116 S.Ct. 1923, 1930 (1996). The Court also extended the privilege to include licensed social workers. *See id.* at 1931.

143. *See id.* at 1925.

144. *See id.*

145. *See id.* at 1930.

146. FED. R. EVID. 501.

> disfavoring testimonial privileges may be justified, however, by a ['Jpublic good transcending the normally predominant principle of utilizing all rational means for ascertaining the truth.['][147]

The Court then weighed the benefit of requiring testimony against the benefit of allowing a psychotherapist-patient privilege.[148] The Court noted that the privilege serves the public interest by "facilitating the provision of appropriate treatment for individuals suffering the effects of a mental or emotional problem."[149] The Court further reasoned

> . . . the likely evidentiary benefit that would result from the denial of the privilege is modest. If the privilege were rejected, confidential conversations between psychotherapists and their patients would surely be chilled, particularly when it is obvious that the circumstances that give rise to the need for treatment will probably result in litigation. Without a privilege, much of the desirable evidence to which litigants such as petitioner seek access—for example, admissions against interest by a party—is unlikely to come into being. This unspoken "evidence" will therefore serve no greater truth-seeking function than if it had been spoken and privileged.[150]

In adopting the psychotherapist-patient privilege, the Court was reassured by the fact that all fifty states and the District of Columbia had enacted some form of the privilege.[151] In adopting the rule, the Court further rejected a case-by-case balancing of interests test, reasoning that making confidentiality "contingent upon a trial judge's later evaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the privilege."[152]

Justice Scalia dissented in *Jaffee*, arguing that application of the privilege would create injustice, including loss of evidence of possible wrongdoing.[153] Justice Scalia further questioned the psychotherapist's ability

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147. *Jaffee*, 116 S.Ct. at 1928 (internal citations omitted). *See also* Kathleen J. Cerveny & Marion J. Kent, *Recent Decision: Evidence Law—The Psychotherapist-Patient Privilege in Federal Courts*, 59 NOTRE DAME L. REV. 791, 815-16 (1984) (advocating for a federal psychotherapist-patient privilege and discussing the benefits of the privilege in light of the court's need for evidence).

148. *See Jaffee*, 116 S.Ct. at 1929.

149. *Id.*

150. *Id.*

151. *See id.*

152. *Id.* at 1932.

153. *Id.* (Scalia, J., dissenting).

to maintain the public's mental health.[154] In addition, Justice Scalia suggested that fear of later litigation would not likely deter a patient from seeking psychological counseling or being completely truthful to his therapist.[155] Justice Scalia also thought it unjust that a patient could seek the benefit of honesty in counseling and still have the benefit of dishonesty in court.[156] Finally, Justice Scalia took issue with the Court's extension of the privilege to licensed social workers, arguing that such professionals are not as highly skilled as psychotherapists.[157] Therefore, urged Scalia, the Court should not encourage consultation with a social worker to the extent it encourages consultation with a psychotherapist.[158]

Although the Supreme Court adopted a psychotherapist-patient privilege, its limits are not clear.[159] For instance, where a psychotherapist divulged privileged information to prevent harm to a third party, but the third party is harmed anyway, may a court then compel the psychotherapist to testify in a civil or criminal proceeding after the harm has occurred?[160] In addition, the privilege is subject to exceptions.[161]

The American Medical Association Code of Medical Ethics also recognizes that physicians may breach patient confidentiality for litigation

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154. *See id.* at 1934.

155. *See id.*

156. *See id.* at 1935. However, it could also be argued that persons who seek help for their mental distress should not be punished for doing so. In Justice Scalia's scenario, the person who seeks aid for his problem would be treated worse in court than the person who did not seek help. *See id.*

157. *See id.* at 1937.

158. *See id.*

159. *See* George C. Harris, *The Dangerous Patient Exception to the Psychotherapist-Patient Privilege: The Tarasoff Duty and the Jaffee Footnote*, 74 WASH. L. REV. 33, 33 (1999).

160. *See id.* The author suggests that, although mental health professionals should be compelled to testify in restraining order proceedings or hearings regarding involuntary commitment of dangerous patients, the professionals should not be compelled to testify against their patients after the threat has been carried out because public policy safety concerns are not met by breaching the privilege once the threat has been fulfilled. *See id.*

161. *See Jaffee*, 116 S.Ct. at 1923. *See also In re* Lifschutz, 467 P.2d 557, 561 (Cal. 1970) (holding that a litigant-patient exception to the statutory psychotherapist-patient privilege does not unconstitutionally infringe rights of privacy of either psychotherapists or their patients); People v. Stritzinger, 668 P.2d 738, 742-45 (Cal. Ct. App. 1982) (holding that a psychologist's testimony regarding patient's admission of sexual conduct was not properly admitted since psychologist had previously fulfilled statutory reporting requirement by reporting suspected child abuse based on communication from patient's child); Ritt v. Ritt, 238 A.2d 196, 198-99 (N.J. Ct. App. 1967) (holding that communications between plaintiff-wife and psychiatrist were not protected from disclosure during depositions, and reasoning that the patient only had a limited right to confidentiality, subject to exceptions created by supervening interests of society. Here, the supervening interest was the fact that institution of litigation by the patient constituted vitiation of her right to absolute confidentiality), *rev'd*, 244 A.2d 497, 499 (the New Jersey Supreme Court held that the issue had been subsequently decided because the New Jersey legislature had enacted a statute creating the physician-patient privilege that would cover the psychiatric relationship here).

purposes.[162] The Code provides that physicians may communicate with a patient-plaintiff's attorney with patient consent or may testify in court in any personal injury or related case.[163]

V. COMPARISON OF AUSTRIAN AND AMERICAN LAWS

Austria places great emphasis on confidentiality as a tool to encourage open discourse within treatment.[164] But is it really possible to know why a patient would not tell a psychotherapist about a violent tendency? Perhaps he did not trust his psychotherapist, perhaps he did not premeditate the act, or perhaps he was unwilling to share his fantasy. These inherent problems in measuring the subjective state of patients make it difficult to measure the relative success of the Austrian and United States programs. However, discussion of the two different systems in light of several concerns offers some insight.

A. *Ability of Psychotherapists to Accurately Predict Dangerous Behavior*

A major concern relating to psychotherapists' treatment of dangerous patients is lack of ability to accurately predict dangerous behavior.[165] The United States addresses this issue by erring on the side of caution and requiring psychotherapists to break confidentiality when serious bodily injury to a third person is probable.[166] Austria addresses the problem by giving psychotherapists the discretion to determine whether or not they must take action to avert injury to a third party.[167] However, Austrian professionals concede that psychotherapists are incapable of offering reliable evidence for

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162. AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS § 5.06 (2000). This is not unlike Austrian law, wherein physicians may be compelled to testify. *See* Gutierrez-Lobos, et al., *supra* note 1. However, physicians who are also covered by the Austrian Psychotherapy Act may not be compelled to testify. *See id.*

163. AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS § 5.06 (2000).

164. *See* Gutierrez-Lobos, et al., *supra* note 1.

165. *See* People v. Burnick, 535 P.2d 352, 365 (Cal. 1975). The Court in *Burnick* suggests that psychiatric predictions of violence are inherently unreliable. *See id. See also* Hill, *supra* note 20, at 137-38 (discussing a case in which prediction of dangerousness was especially problematic); Kane & Sigel, *supra* note 20, at 75-78 (addressing the difficulty in predicting dangerousness and suggesting that evaluations are often inconsistent due to different approaches to examinations, different methodologies followed, and different perspectives in collecting and interpreting data); Merton, *supra* note 14, at 296-301 (discussing in depth the difficulty of predicting dangerousness); Weiss, *supra* note 20 (suggesting a particular assessment method to more accurately assess inmate dangerousness, but conceding that accurate assessment of dangerousness is difficult).

166. *See Tarasoff*, 551 P.2d at 339-40.

167. *See* Gutierrez-Lobos, et al., *supra* note 1.

court proceedings, thus courts should not call them as fact or expert witnesses.[168]

Courts and commentators have criticized the American *Tarasoff* rule largely because it depends upon therapists' ability to predict dangerousness:

> ['']In the light of recent studies it is no longer heresy to question the reliability of psychiatric predictions. Psychiatrists themselves would be the first to admit that however desirable an infallible crystal ball might be, it is not among the tools of their profession. It must be conceded that psychiatrists still experience considerable difficulty in confidently and accurately *diagnosing* mental illness. Yet those difficulties are multiplied manyfold when psychiatrists venture from diagnosis to prognosis and undertake to predict the consequences of such illness[.']. . . Predictions of dangerous behavior, no matter who makes them, are incredibly inaccurate, and there is a growing consensus that psychiatrists are not uniquely qualified to predict dangerous behavior and are, in fact, less accurate in their predictions than other professionals.[169]

Judge Mosk went on to state that a duty to warn "will take us from the world of reality into the wonderland of clairvoyance."[170]

Judge Mosk's prediction is not without support. For example, one psychiatrist recounts a case that exemplifies the difficulty of predicting dangerousness.[171] The case involved a man with severe depression who admitted himself to a psychiatric hospital in September, 1998.[172] On admission, the man claimed that he had, several years before, sexually abused several children and his pet dog.[173] He further claimed a continuing urge to go after children.[174] Unfortunately, the day after admission, the man was missing.[175] The psychiatrist explains the hospital's quandary:

> At this stage, we had no clear evidence on which to assess whether he was a child abuser or not. It was decided initially to inform the police that our patient had absconded, was considered to be a risk to himself, and should be returned to

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168. *See id.*

169. *Tarasoff*, 551 P.2d at 354 (quoting People v. Burnick, 535 P.2d 352 (Cal. 1975); Murel v. Baltimore City Criminal Court, 407 U.S. 355, 364-65 (1972)) (emphasis in original).

170. *Tarasoff*, 551 P.2d at 354 (Mosk, J., dissenting).

171. *See* Hill, *supra* note 20, at 137-38.

172. *See id.*

173. *See id.*

174. *See id.*

175. *See id.*

> the ward urgently. It was decided not (at least initially) to discuss his statements about the historical child abuse. In fact, he returned to the ward before it was felt necessary to inform the police.[176]

Upon his return, the man said he no longer had sexual desire for children but still admitted to previously abusing children and his pet dog.[177] Still, the psychiatric staff did not know if these claims were true or were merely delusions of a man seriously depressed.[178] An investigation revealed that neither the police nor social services knew the man, and no complaint had ever been filed against him.[179] The man provided some specific information about the abuse but refused to provide names of any of his claimed victims.[180] Despite the lack of concrete evidence of the man's potential danger to society, the psychiatrist decided that the "duty to protect the public from possible risk was sufficient [enough] that [he] had to involve other agencies."[181] Thus, the psychiatrist disclosed the potential risk to personnel of various social service and police agencies.[182] Interestingly, the psychiatrist was able to do so with the man's consent.[183]

Another problem with prediction of dangerousness is that evaluations are often inconsistent due to different approaches to examinations, different methodologies followed, and different perspectives in collecting and interpreting data.[184] The case of Texas psychiatrist James Grigson is indicative of this problem.[185] Grigson has been nicknamed "Dr. Death" because he has deemed every criminal defendant he has interviewed a danger to society.[186]

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176. *Id.*
177. *See id.*
178. *See id.*
179. *See id.*
180. *See id.*
181. *Id.*
182. *See id.*
183. *See id.* There is no suggestion, however, that patient consent to disclosure under these circumstances is the norm. *See id.*
184. *See* Kane & Sigel, *supra* note 20, at 75-78 (addressing the difficulty in predicting dangerousness and suggesting that evaluations are often inconsistent due to different approaches to examinations, different methodologies followed, and different perspectives in collecting and interpreting data). *See also* People v. Burnick, 535 P.2d 352, 365 (Cal. 1975) (suggesting that psychiatric predictions of violence are inherently unreliable); Grove & Barden, *supra* note 136, at 238 (suggesting that even standardized criteria such as Rorschach tests and disorders listed in the DIAGNOSTIC AND STATISTICAL MANUAL IV would fail to meet the current reliability standards for expert testimony).
185. *See* Merton, *supra* note 14, at 287. The author suggests that "[i]t was the profession's willingness to accept attribution of peculiar expertise in predicting future conduct that landed psychiatrists in the *Tarasoff* quandary." *Id.* at 288.
186. *See id.* at 287.

The result of each determination was a death sentence for the criminal defendant.[187]

In essence, the U.S. rule holds psychotherapists liable for a task they admittedly cannot perform.[188] The *Tarasoff* court disputed this point:

> 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, 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.']'[189]

However, it is not entirely clear that all therapists exercise equal degrees of skill, knowledge, and care under similar circumstances.[190] In addition, despite problems inherent to prediction, American courts rely upon therapists' predictions of dangerousness when sentencing offenders.[191]

Austria, on the other hand, does not hold psychotherapists liable for failing to warn third parties based upon predictions of dangerousness.[192] It does, however, give psychotherapists the discretion to warn third parties in cases of imminent danger.[193] Austria does not utilize psychotherapists as expert witnesses due to the difference between therapeutic reality and forensic reality.[194]

1. Encouragement of Open Discourse Within Treatment

Both the United States and Austria recognize the importance of encouraging open discourse in the treatment relationship:[195]

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187. *See id.*

188. *See Tarasoff*, 551 P.2d at 344-45.

189. *Id.* at 345 (quoting Bardessano v. Michels, 478 P.2d 480 (Cal. 1970)).

190. *See* Kane & Sigel, *supra* note 20, at 75-78. The authors address the difficulty in predicting dangerousness and suggest that evaluations are often inconsistent due to different approaches to examinations, different methodologies followed, and different perspectives in collecting and interpreting data. *See id.*

191. *See* Merton, *supra* note 14, at 284-88.

192. *See* Bundesgesetz vom 7. Juni 1990 über die Ausübung der Psychotherapie (Psychotherapiegesetz) § 23 (1991); Gutierrez-Lobos, et al., *supra* note 1.

193. *See* Gutierrez-Lobos, et al., *supra* note 1.

194. *See id.*

195. *See In re* Lifschutz, 467 P.2d 557, 567-68 (Cal. 1970); AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS § 5.05 (2000); Cerveny & Kent, *supra* note 147, at 796-99; Gutierrez-Lobos, et al., supra note 1.

> ['']The psychiatric patient confides more utterly than anyone else in the world. He exposes to the therapist not only what his words directly express; he lays bare his entire self, his dreams, his fantasies, his sins, and his shame. Most patients who undergo psychotherapy know that this is what will be expected of them, and that they cannot get help except on that condition.[ ] It would be too much to expect them to do so if they knew that all they say—and all that the psychiatrist learns from what they say—may be revealed to the whole world from a witness stand.['']196

However, Austria more strongly encourages this openness.[197] The Austrian Psychotherapy Act[198] provides for patient confidentiality with no exceptions.[199] The Act allows Austrian psychotherapists to warn third parties of the danger posed by patients if no other measures will avert the danger but does not require psychotherapists to do so.[200] In addition, the Act provides that courts may not compel psychotherapists to testify as fact or expert witnesses in civil or criminal trials.[201]

The United States, on the other hand, requires psychotherapists to protect third parties from danger posed by patients, through disclosure of privileged communications if necessary.[202] The United States also utilizes psychotherapists as experts in civil and criminal trials and allows psychotherapists to act as fact witnesses in some situations.[203] Because the

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196. *Lifschutz*, 467 P.2d at 567 (quoting Taylor v. United States, 222 F.2d 398, 401 (U.S. App. D.C. 1955)).

197. *See* Gutierrez-Lobos, et al., *supra* note 1.

198. Bundesgesetz vom 7. Juni 1990 über die Ausübung der Psychotherapie (Psychotherapiegesetz) (1991).

199. *See* Gutierrez-Lobos, et al., *supra* note 1.

200. *See id.*

201. *See id.*

202. *See Tarasoff*, 551 P.2d at 339-40.

203. *See, e.g., Lifschutz*, 467 P.2d at 561 (holding that a litigant-patient exception to the statutory psychotherapist-patient privilege does not unconstitutionally infringe rights of privacy of either psychotherapists or their patients); People v. Stritzinger, 668 P.2d 738, 742-45 (Cal. Ct. App. 1982) (holding that a psychologist's testimony regarding patient's admission of sexual conduct was not properly admitted since the psychologist had previously fulfilled a statutory reporting requirement by reporting suspected child abuse based on communication from patient's child); Ritt v. Ritt, 238 A.2d 196, 198-99 (N.J. Ct. App. 1967) (holding that communications between plaintiff-wife and psychiatrist were not protected from disclosure and reasoning that the patient only had a limited right to confidentiality, subject to exceptions created by supervening interests of society. Here, the supervening interest was the fact that institution of litigation by the patient constituted vitiation of her right to absolute confidentiality), *rev'd*, 244 A.2d 497, 499 (the New Jersey Supreme Court held that the issue had been subsequently decided because the New Jersey legislature had enacted a statute creating the physician-patient privilege that would cover the psychiatric relationship here); AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS § 5.06 (2000) (providing that physicians may communicate with a patient-plaintiff's

United States allows more exceptions to patient confidentiality, one may argue that patients in the United States are not as likely to engage in open discourse during treatment.[204]

2. *HIV/AIDS Infected Patients*

An additional concern relating to confidentiality and treatment of dangerous persons involves HIV/AIDS-infected patients.[205] Unfortunately, some HIV-positive individuals may knowingly engage in conduct likely to spread the virus. Patients with HIV could foreseeably tell their therapists about this conduct. Do the therapists then have a duty to warn the potential victims? On one hand, the disclosure of the contagious disease to public health authorities and/or third parties in danger of transmission may curb the spread of the deadly virus.[206] On the other hand, patients may avoid testing if they know the results will be disclosed.[207]

In the United States, jurisdictions are not in agreement concerning the duty to warn of HIV transmission.[208] Some states impose a duty to protect by

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attorney with patient consent, and may testify in court in any personal injury or related case).

204. *See* Gutierrez-Lobos, et al., *supra* note 1. *See also* David R. Katner, *The Ethical Dilemma Awaiting Counsel Who Represent Adolescents with HIV/AIDS: Criminal Law and Tort Suits Pressure Counsel to Breach the Confidentiality of the Clients' Medical Status*, 70 TUL. L. REV. 2311, 2338-39 (1996) (suggesting that the attorney-client relationship may be hindered by informing client of limitations on right to confidentiality).

205. *See generally* Agnello, *supra* note 6. *See also* Carmody, *supra* note 12, at 107-08 (suggesting that mandatory notification programs are not as effective as voluntary notification programs in the prevention of the spread of HIV because mandatory notification programs may deter people from getting HIV testing done, therefore separating them from medical treatment that could prevent the spread of the disease); Doughty, *supra* note 12, at 122-28 (emphasizing the importance of confidentiality for HIV-infected patients); Fineschi, et al., *supra* note 125, at 243 (indicating that the new Italian Code suggests that there is a duty to inform partners or family of a patient's HIV- positive status despite the fact that this duty is directly counter to a 1990 Italian law that specifically prohibited the revelation to third parties of a patient's HIV infection); Bernard Friedland, *HIV Confidentiality and the Right to Warn: the Health Care Provider's Dilemma*, 80 MASS. L. REV. 3, 3 (1995) (examining the belief of health care providers that they have an ethical obligation to warn partners of HIV-positive patients); Kenneth E. Labowitz, *Beyond Tarasoff: AIDS and the Obligation to Breach Confidentiality*, 9 ST. LOUIS U. PUB. L. REV. 495, 517 (1990) (concluding that health care providers have a duty to breach confidentiality in order to curb the spread of HIV).

206. *See* Agnello, *supra* note 6, at 115 (suggesting that HIV should be disclosed through contact tracing for the protection of third parties); Fineschi, et al., *supra* note 125, at 243 (indicating that the new Italian Code suggests that doctors have a duty to inform partners or family of a patient's HIV-positive status in order to protect these third parties); Friedland, *supra* note 205, at 3 (examining the belief of health care providers that they have an ethical obligation to warn partners of HIV-positive patients); Labowitz, *supra* note 205, at 517 (concluding that health care providers have a duty to breach confidentiality in order to curb the spread of HIV).

207. *See* Carmody, *supra* note 12, at 107-08. *See also* Doughty, *supra* note 12, at 122-28 (emphasizing the importance of confidentiality for HIV-infected patients).

208. *See* Agnello, *supra* note 6, at 111. *See generally* Paul Barron, et al., *State Statutes Dealing with HIV and AIDS: a Comprehensive State-by-State Summary*, 5 L. & SEXUALITY 1 (1995) (discussing state statutes regarding reporting of HIV and AIDS).

requiring physicians to report the disease to public health authorities or persons at risk of transmission.[209] Other states allow an exception to the duty of confidentiality by authorizing disclosure when necessary to prevent foreseeable danger.[210] Still other states prohibit disclosure to third parties absent consent of the patient.[211] However, all states mandate reporting of AIDS and other communicable diseases to public health officials.[212] In addition, many states implement contact tracing programs to curb the spread of the disease.[213]

The American Medical Association Code of Medical Ethics recognizes the importance of reporting HIV status.[214] Section 2.23 of the Code provides for exceptions to patient confidentiality "when necessary to protect the public health or when necessary to protect individuals[.]"[215] The section sets forth steps a physician should take before notification of the third party occurs.[216]

In Austria, physicians are required to report information regarding AIDS, but psychotherapists are not. The Austrian Medical Practice Act

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209. *See* Agnello, *supra* note 6, at 111. *See also* Christine E. Stenger, *Taking Tarasoff Where No One Has Gone Before: Looking at "Duty to Warn" Under the AIDS Crisis*, 15 ST. LOUIS U. PUB. L. Rev. 471, 490-504 (1996) (discussing the duty to warn third parties of potential HIV infection in terms of the *Tarasoff* rule and setting forth guidelines for physicians); Labowitz, *supra* note 204, at 517 (concluding that health care providers have a duty to breach confidentiality in order to curb the spread of HIV); Tracy A. Bateman, J.D., Annotation, *Liability of Doctor or Other Health Practitioner to Third Party Contracting Contagious Disease from Doctor's Patient*, 3 A.L.R.5th 370 (2000) (noting that courts have recognized liability of doctors to persons infected by a patient if the doctor negligently fails to diagnose contagious disease or for failing to warn third parties who have a foreseeable risk of exposure to the disease).

210. *See* Agnello, *supra* note 6, at 111.

211. *See id. See also* Annotation, *State Statutes or Regulations Expressly Governing Disclosure of Fact that Person has Tested Positive for Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS)*, 12 A.L.R.5th 149 (2000) (noting that information believed to be particularly sensitive or prone to misuse should receive additional protection from disclosure).

212. *See id. See also* Hermann & Gagliano, *supra* note 13, at 56.

213. *See* Agnello, *supra* note 6, at 112. "Contact tracing is a system of notification designed to prevent further transmission of communicable diseases by alerting those who have been exposed to an infected person. It is used in conjunction with reporting procedures and is carried out by public health officials." *Id.* at 112. For further discussion of contact tracing and other public health strategies, *see* CURRAN ET AL., *supra* note 118, at 903-26 and 964-1005. *See also* Carmody, *supra* note 12, at 124 (pointing out that all fifty states have implemented some form of HIV partner notification program).

214. *See* AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS § 2.23 (2000) (dealing specifically with HIV testing). *See also* Friedland, *supra* note 205, at 3 (examining the belief of health care providers that they have an ethical obligation to warn partners of HIV-positive patients).

215. AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS § 2.23 (2000).

216. *See id.* The Code provides that "the physician should, within the constraints of the law: (1) attempt to persuade the infected patient to cease endangering the third party; (2) if persuasion fails, notify authorities; and (3) if the authorities take no action, notify the endangered third party." *Id.*

(Osterreichisches Arztegesetz), unlike the Austrian Psychotherapy Act, includes reporting obligations when "there is a suspicion of a punishable offense that has resulted in death or serious bodily harm, or if there is a suspicion of torture or neglect of a minor, juvenile, or defenseless person, even where minor bodily harm or health impairment results."[217] The Act strictly governs these exceptions to confidentiality: "Disclosure may be required for criminal proceedings, to insurance companies (in the case of specific, legally defined reporting obligations), or to government officials for certain diseases."[218] However, a psychiatrist who qualifies under the law as a psychotherapist, and who defines his relationship as psychotherapist-patient rather than physician-patient, is subject to the Act and not to the Austrian Medical Practice Act.[219] Thus, a psychotherapist who discovers a patient's seropositivity through therapy presumably has no legal duty to disclose this information.[220]

3. *Use/Non-Use of Psychotherapists as Witnesses/Experts in Trials*

In Austria, courts may not compel psychotherapists to testify as witnesses or experts in civil or criminal trials.[221] In the United States, therapists all too often find themselves taking an oath to testify in court. Thus, in Austria the judicial system may be deprived of relevant information. However, in America, "junk science" runs rampant—litigants can find a therapist to testify as an expert on virtually anything. As a result, psychotherapy in Austria has perhaps retained more of its dignity than has psychotherapy in the United States. However, the Austrian psychotherapeutic system has surmounted the Austrian judicial system.[222]

Further, in Austria, the patient alone may not waive the psychotherapist-patient privilege.[223] However, in the United States, the patient may himself waive the privilege.[224] The California Supreme Court has stated:

> We do not believe the patient-psychotherapist privilege should be frozen into the rigidity of absolutism. So extreme a conclusion neither harmonizes with the expressed legislative intent nor finds a clear source in constitutional law. Such an application would lock the patient into a vice which

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217. Gutierrez-Lobos, et al., *supra* note 1. *See also* Osterreichisches Arztegesetz §§ 26-27 (1994).

218. Gutierrez-Lobos, et al., *supra* note 1.

219. *See id.*

220. *See id.*

221. *See id.*

222. *See id.*

223. *See id.*

224. *See In re* Lifschutz, 467 P.2d 557, 567-73 (Cal. 1970); Davis, *supra* note 91.

would prevent him from waiving the privilege without the psychotherapist's consent.[225]

Also unlike the United States, Austria deems psychotherapists poorly suited to give any legal testimony.[226] Thus, Austria does not differentiate between psychotherapists as fact witnesses or as paid experts because the difference is not important—psychotherapists are inadequate witnesses either way.[227]

4. *"Junk Science" vs. Integrity of the Profession?*

One may argue that Austrian psychotherapists have retained more integrity than have psychotherapists in the United States. Commentators suggest that courts should not rely upon therapists as experts because they are incompetent to act in that capacity.[228] In addition, critics have disparaged American mental health professionals for offering forensic assistance.[229] Even American Judge David Bazelon has campaigned against courts' undue reliance on technical expertise, psychiatric and otherwise.[230]

5. *Should the Judicial System Receive All Relevant Information or Is the Patient Right to Confidentiality More Important?*

Both the United States and Austria recognize a psychotherapist-patient privilege.[231] Thus, each system sees the importance of patient confidentiality. However, the Austrian privilege is more absolute than the American privilege.[232] In Austria, a patient alone may not waive the privilege.[233] The psychotherapist-patient relationship is viewed as an independent entity.[234] Thus, one party to the relationship cannot waive the privilege without the

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225. *Lifschutz*, 467 P.2d at 573.

226. *See supra* note 77 and accompanying text.

227. *See id.*

228. *See id. See also* Merton, *supra* note 14, at 296-301.

229. *See supra* notes 185-87 and accompanying text. *See also* Grove & Barden, *supra* note 136, at 238 (suggesting that expert witnesses have an ethical duty to tell the court and opposing counsel when their methods do not meet requisite reliability standards, and that failure to do so brings the profession into disrepute).

230. *See* Merton, *supra* note 14, at 272-73. *See also* People v. Burnick, 535 P.2d 352, 365 (Cal. 1975) (en banc) (suggesting that psychiatric predictions of violence are inherently unreliable); Grove & Barden, *supra* note 136, at 238 (suggesting that even standardized criteria such as Rorschach tests and disorders listed in the DIAGNOSTIC AND STATISTICAL MANUAL IV would fail to meet the current reliability standards for expert testimony).

231. *See* Jaffee v. Redmond, 116 S.Ct. 1923, 1932 (1996); Gutierrez-Lobos, et al., *supra* note 1.

232. *See* Gutierrez-Lobos, et al., *supra* note 1.

233. *See id.*

234. *See id.*

cooperation of the other party.[235] In addition, Austrian courts may not compel psychotherapists to testify as fact or expert witnesses.[236]

In the United States, however, a patient may waive the psychotherapist-patient privilege without the consent of his psychotherapist.[237] Unlike in Austria, a psychotherapist may not override the patient's waiver of the privilege.[238] In at least one American case, a court has imprisoned a psychotherapist for refusing to divulge privileged information despite a court order to do so.[239] In *In re Lifschutz*, the court held that "the historically important state interest of facilitating the ascertainment of truth in connection with legal proceedings" may outweigh a patient's confidentiality interest.[240] This result is inconceivable under Austrian law.[241] "Competent Austrian authorities do not know of any case in which a psychotherapist has been prosecuted as an accomplice to a crime for failing to breach confidentiality."[242]

The Austrian system also avoids the potential for role conflicts of the treating psychotherapist.[243] Psychotherapists, because they are not compelled to testify, are not forced to wear two hats or act as double agents in court.[244] In the United States, however, a psychotherapist may act in his professional capacity to help a patient, but a court may then compel the psychotherapist to speak against his patient in court because of this professional capacity.

In addition, courts may compel American therapists to testify in a variety of situations despite the privilege.[245] This becomes especially problematic if

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235. *See id.*

236. *See id.*

237. *See In re* Lifschutz, 467 P.2d 557, 558 (Cal. 1970).

238. *See id.*

239. *See id.*

240. *Id.* at 568. It should be noted, however, that the exception compelled information only in cases in which the patient's own action initiated the exposure, so intrusion into the patient's privacy remained essentially under the patient's control. *See id.* Thus, the intrusion was constitutional. *See id.*

241. *See* Gutierrez-Lobos, et al., *supra* note 1.

242. *Id.*

243. *See id.*

244. *See id.*

245. *See, e.g., In re* Lifschutz, 467 P.2d 557, 561 (Cal. 1970) (holding that a litigant-patient exception to the statutory psychotherapist-patient privilege does not unconstitutionally infringe rights of privacy of either psychotherapists or their patients); People v. Stritzinger, 668 P.2d 738, 742-45 (Cal. Ct. App. 1982) (holding that a psychologist's testimony regarding patient's admission of sexual conduct was not properly admitted since psychologist had previously fulfilled a statutory reporting requirement by reporting suspected child abuse based on communication from the patient's child); Ritt v. Ritt, 238 A.2d 196, 198-99 (N.J. Ct. App. 1967) (holding that communications between plaintiff-wife and psychiatrist were not protected from disclosure and reasoning that the patient only had a limited right to confidentiality, subject to exceptions created by supervening interests of society. Here, the supervening interest was the fact that institution of litigation by the patient constituted vitiation of her right to absolute confidentiality), *rev'd*, 244 A.2d 497, 499 (the New Jersey Supreme Court held that the issue had been subsequently decided because the New Jersey legislature had enacted a statute creating the physician-patient privilege that would cover the psychiatric relationship here); AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL

psychiatrists are subject to suit based upon disclosures made during testimony.[246] One author suggests that a negative side effect of the *Tarasoff* decision is to discourage therapists from testifying on behalf of their patients in criminal trials because their testimony can then be used against the therapists in civil trials.[247] Because therapists may be concerned about their own liability, the author argues, they will be less likely to aid patients through testimony.[248]

6. *Willingness of Psychotherapists to Treat or Assist Violent Patients*

A further question to be addressed relates to psychotherapists' willingness to treat violent patients. Does the Austrian Psychotherapist Act encourage or discourage therapists from taking on dangerous patients? Likewise, does the United States statutory and common law positively or negatively affect therapists' decisions to treat violent patients?

Several commentators suggest that inconsistent and indefinite liability will lead to a shortage of providers willing to treat dangerous patients.[249] One practitioner suggests that the "possibility that external pressure [due to potential ethical and legal ramifications] on the therapist to disclose such information may be successful will result in mistrust by patients and caution by therapists, to the extent of reluctance to treat clients of this type."[250]

Reverse *Tarasoff* cases exacerbate the quandary of therapists. In one such case, *Oringer v. Rotkin*,[251] the therapist issued a warning and was then sued by the patient for breaching confidentiality.[252] The court granted

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ETHICS § 5.06 (2000) (providing that physicians may communicate with a patient-plaintiff's attorney with patient consent, and may testify in court in any personal injury or related case). *But see In re* Rules Adoption, 540 A.2d 212, 217-18 (N.J. Ct. App. 1988) (invalidating several portions of the Department of Corrections regulations concerning exceptions to privileged communications between psychologist and inmates because the regulations permitted disclosure of confidences that did not present clear and imminent danger to the inmate or others, or failed to identify any intended victim).

246. *See* Merton, *supra* note 14, at 322-25.

247. *See id.*

248. *See id.*

249. *See* Almason, *supra* note 18, at 495. The author argues against extension of the *Tarasoff* rule to include personal liability of therapists who fail to discharge their duty to warn, noting that excessive and inconsistent liability will lead to a scarcity of health care providers willing to treat violent patients. *See id. See also* Hermann & Gagliano, *supra* note 13, at 69 (suggesting that allowing a jury to decide the issue of predictability of dangerousness leads to uncertainty for therapists, who may then be deterred from treating dangerous patients); McClarren, *supra* note 18, at 284 (suggesting that the inconsistency in legislation setting forth requirements regarding psychotherapists' duty to warn may lead psychotherapists to refuse to treat patients who are believed to be potentially dangerous); Merton, *supra* note 14, at 311 (suggesting that therapists will be discouraged from treating potentially dangerous patients).

250. Gutierrez-Lobos, et al., *supra* note 1 (citing H. Gurevitz, *Tarasoff Protective Privilege Versus Public Peril*, 139 AM. J. PSYCHIATRY 289-92 (1977)).

251. Oringer v. Rotkin, 556 N.Y.S.2d 67 (1st Dept. 1990).

252. *See id.* at 68.

summary judgment for the therapist because the therapist fit within the statutory *Tarasoff* exception and had followed the statute's procedures in making the disclosure.[253] This case does not assist those therapists who do not fit within the statutory exception.[254]

7. *Willingness of Patients to Seek Treatment*

Along similar lines, what impact do the American and Austrian laws have on patients' willingness to seek the help of therapists? Both Austrian and American practitioners suspect that lack of patient confidentiality will discourage patients from seeking treatment.[255] Some commentators agree that lack of confidentiality has this deterrent effect.[256] However, others question this suggestion.[257] Some empirical evidence suggests that people still seek care from physicians or therapists without the protection of confidentiality.[258] This evidence, albeit scant, shows that the suspicions of Austrian and American practitioners may be mistaken.

B. *Ramifications of Laws: Remedy for Victims?*

Because the Austrian Psychotherapy Act creates no duty of psychotherapists to warn third parties of impending danger,[259] victims are left with no remedy in Austria. In the United States, however, victims have an available remedy.[260] Austrian practitioners suggest that the lack of a *Tarasoff* rule, in combination with the Act, results in a reduced amount of related litigation in Austria.[261] Thus, court dockets are less crowded and can more

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253. *See id.*

254. *See* Rogge, *supra* note 96, at 228.

255. *See Tarasoff*, 551 P.2d at 359 (Clark, J., dissenting). *See also* Gutierrez-Lobos, et al., *supra* note 1 (suggesting that lack of confidentiality will hinder the psychotherapeutic process).

256. *See Tarasoff*, 551 P.2d at 359 (Clark, J., dissenting). *See also* Carmody, *supra* note 12, at 135 (suggesting that mandatory disclosure of HIV seropositivity will deter potential patients from being tested and receiving treatment necessary to curb the spread of the disease); Doughty, *supra* note 12, at 165 (suggesting that the stigma and potential discriminatory effects surrounding HIV seropositivity will deter patients from being tested and receiving treatment). *But see Tarasoff*, 551 P.2d at 346 (arguing that such predictions are entirely speculative).

257. *See Tarasoff*, 551 P.2d at 346 (arguing that such predictions are entirely speculative). *See also* Jaffee v. Redmond, 116 S.Ct. 1923, 1932 (1996) (Scalia, J., dissenting).

258. *See* Daniel J. Shuman, *The Origins of the Physician-Patient Privilege and Professional Secret*, 39 SW. L. J. 661, 664-65 (1985). *See also* Daniel W. Shuman & Myron F. Weiner, *The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege*, 60 N.C. L. REV. 893, 924-25 (1982) (discussing the impact of the privilege on patient behavior); Myron F. Weiner & Daniel W. Shuman, *The Privilege Study*, 40 ARCHIVES GEN. PSYCHIATRY 1027, 1030 (1983).

259. See Gutierrez-Lobos, et al., *supra* note 1.

260. Potential remedies may include monetary damages or revocation of a mental health provider's license.

261. *See* Gutierrez-Lobos, et al., *supra* note 1.

quickly entertain cases involving other types of victims. In addition, Austrian psychotherapists are not deterred from treating dangerous patients for fear of being held liable later.[262] Therefore, it can be argued, dangerous persons are better able to receive treatment, in turn reducing the number of victims of these dangerous persons. Thus, the need for remedies in Austria may be lessened because its treatment system is more successful.

VI. PROPOSAL

A. *America Should Look to Austria for Guidance: Disclosure of Dangerousness Should Remain Discretionary Rather than Mandatory*

Austria has chosen the better standard for disclosure of dangerousness and has enforced it consistently. The American system is inconsistent in its rules and enforcement.[263] Thus, American psychotherapists are left in a quagmire of uncertainty.[264] By establishing a consistent rule, the legislature will protect the public interest in treating and rehabilitating the mentally ill.[265]

Another reason for a discretionary rule is that psychotherapists are unable to accurately predict dangerous behavior.[266] Courts should therefore not hold psychotherapists liable for a task that they cannot perform. It makes no sense to ask an untrained jury to decide whether a particular danger was predictable when a trained professional, intimately knowledgeable about his patient, is unable to do so.

Along these same lines, courts should not compel psychotherapists to testify in civil or criminal cases. The natures of therapy and court proceedings are not interchangeable:

> Clinical and forensic undertakings are dissimilar in that they are directed at different (although overlapping) realities, which they seek to understand in correspondingly different ways. The process of psychotherapy is a search for meaning more than for facts. The therapist accepts the patient's

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262. *See id.*

263. *See* McClarren, *supra* note 18, at 293.

264. *See* Rogge, *supra* note 96, at 229.

265. *See* McClarren, *supra* note 18, at 293.

266. *See* People v. Burnick, 535 P.2d 352, 365 (Cal. 1975) (en banc). *See also* Hill, *supra* note 20, at 137-38 (discussing a case in which prediction of dangerousness was especially problematic); Kane & Sigel, *supra* note 20, at 75-78 (addressing the difficulty in predicting dangerousness and suggesting that evaluations are often inconsistent due to different approaches to examinations, different methodologies followed, and different perspectives in collecting and interpreting data); Merton, *supra* note 14, at 296-301 (discussing in depth the difficulty of predicting dangerousness); Weiss, *supra* note 20 (suggesting a particular assessment method to more accurately assess inmate dangerousness, but conceding that accurate assessment of dangerousness is difficult).

> narrative as representing an inner, personal reality. . . . In court, therapists can describe only impressions, countertransference reactions, and assumptions regarding the underlying psychic conflicts. The truth emerging in therapy is subjective and selective; its objective validity cannot be assessed without data about external circumstances. Psychotherapists, therefore, cannot produce proof in the legal sense.[267]

Thus, courts and legislatures should construe the psychotherapist-patient privilege recognized by the U.S. Supreme Court in *Jaffee v. Redmond*[268] broadly, like the psychotherapist-patient privilege in Austria.

However, courts should not extend the psychotherapist-patient privilege recognized in *Jaffee* to include social workers and others untrained in the traditional psychotherapeutic areas.[269] Austria's privilege is read broadly because the Austrian Psychotherapy Act sets forth stringent training requirements for anyone who is to claim the protection of the Act.[270] The United States should also require a minimum level of training for the psychotherapists subject to the privilege.

A consistent American scheme will lead to additional benefits. First, a consistent privilege encourages more open discourse within treatment.[271] In addition, a consistent privilege increases the integrity of the psychotherapeutic profession because the public will no longer view psychotherapists as double agents.[272] Psychotherapists will also be more willing to treat dangerous patients under a consistent system.[273] Patients will likewise be encouraged to seek treatment, assured that their disclosures will remain confidential.[274] Each of these added benefits increases the success of psychotherapy and, in turn, contributes to the public health.

B. Disclosure of HIV Seropositivity Should Be Mandatory Because It Is More Readily Definable Than Human Dangerousness

Physicians can readily identify HIV through medical testing. In addition, the HIV virus is inherently dangerous to humans. However, psychotherapists are not as readily able to predict human behavior.[275] In addition, the psychotherapist-patient privilege is

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267. Gutierrez-Lobos, et al., *supra* note 1.
268. Jaffee v. Redmond, 116 S.Ct. 1923 (1996).
269. *See id.* at 1937 (Scalia, J., dissenting).
270. *See supra* notes 52-61 and accompanying text.
271. *See supra* notes 195-204 and accompanying text.
272. *See supra* notes 228-30 and accompanying text.
273. *See supra* notes 249-54 and accompanying text.
274. *See supra* notes 255-57 and accompanying text.
275. *See supra* notes 165-94 and accompanying text.

> "rooted in the imperative need for confidence and trust." Treatment by a physician for physical ailments can often proceed successfully on the basis of a physical examination, objective information supplied by the patient, and the results of diagnostic tests. Effective psychotherapy, by contrast, depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.[276]

Thus, courts and legislatures should not hold psychotherapists to the same duty to warn as physicians.

In Austria, authorities require physicians to report contagious diseases.[277] However, if a patient discloses his HIV seropositivity to a physician who is covered by the Austrian Psychotherapy Act, that physician has no duty to report the HIV status because it was obtained within a psychotherapist-patient relationship and is thus subject to the psychotherapist-patient privilege.[278]

Because HIV seropositivity is medically ascertainable and is often deadly, this information should not be privileged in the United States.[279] The United States should mandate disclosure of HIV seropositivity by psychotherapists to public health authorities.[280] The public health authorities can then implement partner notification or contact tracing programs to curb the spread of the disease.[281] Because courts and legislatures should mandate the

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276. Jaffee v. Redmond, 116 S.Ct. 1923, 1928 (internal citations omitted).

277. *See* Gutierrez-Lobos, et al., *supra* note 1.

278. *See id.*

279. *See generally* Fineschi, et al., *supra* note 125 (indicating that the new Italian Code of Medical Ethics suggests that there is a duty to inform partners or family of a patient's HIV-positive status, although this duty is directly counter to a 1990 Italian law that specifically prohibited the revelation to third parties of a patient's HIV infection).

280. *But see* Hermann & Gagliano, *supra* note 13, at 74 (asserting the desirability of providing therapists with discretionary authority to warn spouses or sexual partners, rather than fixing mandatory duty to warn and pointing out that therapists may not inquire into dangerous activities if there is a mandatory duty).

281. *See* Agnello, *supra* note 6, at 112. The author suggests that HIV should be disclosed through contact tracing for protection of third parties and argues that "[t]he mortal fate awaiting unsuspecting spouses and their unborn children cannot be justified by a policy calculated to preserve the confidentiality and privacy of the individual who is infected. The focus must be on the sanctity of human life." *Id.* at 117. "An individual's privacy is paramount, but human life is sacred." *Id.* at 122.

disclosure of this information, psychotherapists should inform patients of this limitation on confidentiality at the outset of treatment.[282]

VII. CONCLUSION

The United States should follow the leader in the field of psychotherapy. Like the Austrian Psychotherapy Act, American law should make duty to warn third parties of dangerous patients discretionary instead of mandatory. Such a law would eliminate much confusion, uncertainty, and litigation in America. The United States should, however, mandate disclosure of HIV seropositivity to public health officials. Each of these measures is in the interest of public health.

Dana J. Kenworthy[*]

282. *See* Merton, *supra* note 14, at 271. The author notes that informing the patient of the potential need to disclose information may actually strengthen the trust relationship between the patient and therapist. *See id.*

* J.D., 2001, Indiana University School of Law—Indianapolis; B.A., 1998, Ball State University. The author would like to thank Karen Gutierrez-Lobos and Bruce Kleinschmidt for their generous research assistance, and her husband, Alex, for his unconditional love and support. The author would also like to dedicate this work to her mother, Flossie Cantrell, who is her role model and eternal source of inspiration.