

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 86-2643

LINDA GLENN CURRIE, etc.

Appellant,

v.

UNITED STATES OF AMERICA,

Appellee,

v.

INTERNATIONAL BUSINESS MACHINES CORPORATION,

Third-Party Defendant.

BRIEF AMICUS CURIAE
OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

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INTEREST OF AMICUS

The American Psychological Association (APA) is a voluntary, nonprofit, scientific, and professional organization with more than 60,000 members. It has been the major association of psychologists in the United States since 1892, and includes the vast majority of psychologists holding doctoral degrees from accredited universities in this country.

APA considers this case to be of unsurpassed importance to psychologists and to the public they serve. A decision to impose the dual

duty to assess a patient's future dangerousness and to take steps to protect victims from their patients' future dangerousness will drastically alter the nature of mental health care in North Carolina and other any jurisdiction that chooses to follow the court below in imposing such duties. APA believes that any judicial decision to impose such duties should be informed by a clear sense of both their effect on the provision of mental health care and the present state of scientific knowledge respecting the capacity of mental health professionals to predict future dangerousness. APA represents the professionals most directly affected by the legal standards of liability adopted by the court below. Also, the data informing the decision has been developed by members of this profession, including APA members.

APA's purpose, as reflected in its Bylaws, is to "advance psychology as a science and profession, and as a means of promoting human welfare." The most effective way to ensure adequate mental health care is to allow for early and preventive treatment on a voluntary basis. Thus APA wishes to foster an atmosphere that will encourage professionals to provide and patients to seek therapeutic assistance. The threat of substantial tort liability posed by the rule the court below adopted is certain to deter many psychologists from treating potentially dangerous patients. The duties imposed by the court below also require psychologists to breach their ethical obligation not to disclose confidences communicated by the patient. And patients' knowledge that therapists are under a legal duty to disclose confidences and initiate involuntary commitment proceedings is certain to undermine therapeutic relationships. Effective therapy requires the assurance of confidentiality because patients are required to disclose intimate and embarrassing acts,

thoughts, feelings and fantasies. These revelations include material that belongs to people's irrational and primitive selves--including intimations of violent impulses. People often quite appropriately decline to share such sentiments even with their closest loved ones. In the therapeutic process this intimate and painful material is brought to consciousness and articulated only because it is essential for treatment. If, however, this material were disclosed to family, colleagues or friends, or if revelations to the therapist were to create a risk of involuntary commitment, the results would be devastating both to the patient and to the possibility of effective therapy.

A central issue in this case is whether mental health professionals are sufficiently capable of predicting future dangerousness in a patient that tort liability is justified for their failure to do so under certain circumstances. A substantial body of empirical social science data--much of it generated by APA members--has been developed respecting the possibility of accurate predictions of future dangerousness. Because APA believes consideration of the relevant social science data is essential to just resolution of the substantive issues raised in this case, APA wishes to provide the Court with an objective analysis of this evidence.

Thus, APA believes that it can offer this Court relevant data and other information that will contribute to a thoughtful resolution of the serious questions confronting it in this appeal.

SUMMARY OF ARGUMENT

Amicus supports the District Court's ultimate decision not to impose tort liability upon Veterans Administration (VA) psychotherapists in this case for their failure to institute involuntary commitment proceedings against

Leonard Avery in North Carolina. Amicus believes, however, that the federal district court adjudicated numerous crucial, unsettled issues of North Carolina tort law in a way that is both unnecessary to the just disposition of this case, inappropriate as a matter of federalism, and unsound as a matter of law and policy.

Applying North Carolina law in this Federal Tort Claims Act (FTCA) suit, 28 U.S.C. § 1346(b), the District Court imposed upon psychotherapists a broad zone of liability for the violent acts of patients in their care. Specifically, the court held that North Carolina would recognize a duty on the part of psychotherapists to warn potential victims of the violent acts of patients, District Court Opinion (Dist. Ct. Op.) at 8; that this duty should extend to all foreseeable victims and not merely to clearly identified victims, id. at 10; that North Carolina would recognize a duty to institute involuntary commitment proceedings against potentially dangerous patients, id. at 20; and that psychotherapists would fulfill this legal obligation if they manifested good faith, independence, and thoroughness in their professional judgment, id. at 23.

These sweeping holdings threaten to revolutionize the relationship between mental health professionals and their patients in North Carolina. No organ of state authority in North Carolina--judicial, legislative or executive--has recognized the bases of tort liability the federal court adopted in this case. This lawmaking by the federal court was entirely unnecessary because North Carolina provides statutory immunity for the conduct of the VA psychotherapists in this case. Even if immunity were inapplicable, the vast majority of the District Court's lawmaking would have been

unnecessary to a just resolution of this case. The facts presented raised no issue of any potential duty to warn and were insufficient to justify the imposition of liability under any reasonable understanding of a duty to commit. In rendering gratuitous pronouncements on these issues, the District Court failed to accord sufficient respect to the primacy of North Carolina's authority over its own tort law. Cf. Erie Railroad Co. v. Tompkins, 304 U.S. 64 (1938). Amicus urges that the opinion below be disapproved for this reason alone. (Point I).

Should this Court decide to adjudicate the merits of North Carolina law, amicus believes that the proper way to resolve this appeal is to reject the basic tort claim appellant Currie asserts. This case presents an opportunity to halt a trend of ill-advised, unsound and empirically unsupportable judicial lawmaking in other states concerning mental health professionals' duty to diagnose a patient's dangerous condition and take preventive measures to protect third parties. Imposition of such a duty is an unfair, ineffectual and counterproductive means of dealing with the problem of violent actions by mentally disabled persons. (Point II).

Since the California Supreme Court's seminal decisions in Tarasoff v. Regents of the University of California, 13 Cal. 3d 177, 529 P.2d 553, 118 Cal. Rptr. 129 (1974), vacated, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976), a number of courts have imposed upon mental health professionals the duty to assess the future dangerousness of their patients and, in certain circumstances, to take reasonable care to protect intended

victims from such dangers.¹ This duty has been construed, variously, to require therapists to seek commitment of their patients whom they determine, or "under applicable professional standards reasonably should [] determine[]," present a danger of violence to others, to notify appropriate law enforcement authorities, or to warn potential victims of their patients' dangerousness. Tarasoff, 551 P.2d at 345. See generally Note, Psychotherapists and the Duty to Warn: An Attempt at Clarification, 19 New Eng. L. Rev. 597, 598 (1984). The District Court's opinion in this case extends the ambit of tort liability in North Carolina farther than that presently recognized in any other State.²

Notwithstanding the laudatory public safety goals that the imposition of a broad duty to protect is intended to serve, legal recognition of the duty in this case and all others has been premised on faulty assumptions about the abilities of mental health professionals. Substantial and virtually uncontradicted empirical data show that mental health professionals are unable to predict with any acceptable degree of reliability or validity the future dangerousness of their patients. Nor have psychotherapists arrived at any professional consensus respecting useful guidelines for assessing dangerousness. Accordingly, the rule adopted by the District Court threatens to impose liability upon psychotherapists for failure to perform a duty they

¹ See, e.g., Jablonski v. United States, 712 F.2d 391 (9th Cir. 1983); Hicks v. United States, 511 F.2d 407 (D.C. Cir. 1975); Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185 (D. Neb. 1980); Knight v. State of Michigan, 99 Mich. App. 226, 297 N.W.2d 889 (1980); McIntosh v. Milano, 168 N.J. Super. 466, 403 A.2d 500 (1979).

² The District Court imposed a duty to warn, declined to follow many states in limiting that duty to clearly identified victims, and imposed a duty to commit despite recognizing that the "vast majority of courts have dismissed claims brought against therapists for failure to commit." District Court Opinion at 16.

are incapable of performing. And because psychotherapists cannot predict dangerousness accurately, imposition of a duty to protect third parties will not measurably advance the goal of public safety. (Point II.A.).

Imposition of such a duty will, however, have several deleterious policy consequences. A risk of liability will disincline therapists from treating potentially dangerous individuals. Patients' knowledge that therapists are under a legal duty to disclose confidences and institute commitment proceedings to protect third parties will undermine existing therapeutic relationships and deter potentially dangerous individuals from obtaining the therapy they need. In these ways, the rule the District Court adopted will impede the successful treatment of the potentially dangerous and thereby exacerbate the very risk the legal duty was designed to diminish. (Point II.B.).

Imposition of a duty to protect third parties will also result in unnecessary deprivations of individual liberty. Because mental health professionals do not know which of many patients will commit violent acts, they will react to the threat of tort liability by overpredicting violence and taking preventive steps in a large number of cases. The imposition of a duty to institute involuntary commitment proceedings will inevitably lead to an increase in unnecessary involuntary hospitalization in contravention of North Carolina's express policy of "favor[ing] a less restrictive mode of treatment than involuntary commitment whenever appropriate." In re Farrow, 41 N.C. App. 680, 255 S.E.2d 777, 782 (1979). (Point III).

Accordingly, Amicus urges this Court to affirm only the judgment of the court below and specifically to disapprove the reasoning supporting that judgment.

ARGUMENT

I. THE DISTRICT COURT'S EFFORT TO PRESCRIBE BROAD RULES OF TORT LIABILITY UNDER NORTH CAROLINA LAW WAS UNNECESSARY AND INAPPROPRIATE.

Amicus believes that the substantive legal duties imposed on psychotherapists by the District Court in this case are profoundly misguided as a matter of law and public policy. The opinion below suffers, however, from a more fundamental flaw. The District Court's adjudication of numerous issues of North Carolina tort law was unnecessary to the complete and just resolution of this case. For this reason, the opinion below was a wholly inappropriate intrusion on the sovereignty of the State of North Carolina.

The FTCA abrogates sovereign immunity for damages against the United States Government for negligent or wrongful acts or omissions of its employees to the extent that "a private person would be liable to the claimant in accordance with the law of the place where the act or omission occurred." 28 U.S.C. § 1346(b). Applying this standard, the District Court properly concluded that North Carolina law governs Currie's claim against the United States. North Carolina courts have not yet had occasion to address the extent, if any, to which a psychotherapist should be under a duty to protect third parties from the dangerous acts of a patient. The District Court in the present case nonetheless undertook a comprehensive resolution of these novel issues of tort liability. With no more than fleeting reference to present North Carolina law, the District Court imposed a duty to warn, Dist. Ct. Op. at 8, suggested that the duty to warn should extend to all foreseeable victims, id. at 10, imposed a duty to commit, id. at 20, and decided upon the standard for imposition of liability for breach of the duty to commit, id. at 23.

All of this lawmaking was unnecessary to the decision of the only issue properly before the court: whether the United States should be liable for the failure of VA psychotherapists to institute involuntary commitment proceedings against Avery. North Carolina statutory law definitively resolves this case. Section 122C-210.1 of the North Carolina General Statutes states:

"No facility or any of its officials, staff, or employees, or any physician or other individual who is responsible for the examination, management, supervision, treatment, or release of a client and who follows accepted professional judgment, practice and standards is civilly liable, personally or otherwise, for actions arising from these responsibilities or for actions of the client."

Under 28 U.S.C. § 1346(b), state immunity law as well as state liability law governs tort actions brought against the United States. See Ewell v. United States, 579 F. Supp. 1291 (D. Utah 1982). Section 122C-210.1 is thus fully applicable to the present case.

By its terms, section 122C-210.1 applies to any psychotherapist--public or private--and provides immunity for acts of a client if the therapist has followed accepted professional judgment, practice and standards. See also N.C. Gen. Stat. § 122C-3(14)(h) (VA hospitals included in "facilities" for which section 122C-210.1 provides immunity). In declining to impose liability for the failure to institute commitment proceedings against Avery in this case, the District Court made factual findings that VA psychotherapists had followed accepted professional judgment, practice and standards. Dist. Ct. Op. at 27 (emphasis added). Accordingly, the VA psychotherapists would not have been liable to Currie under North Carolina law given the facts found by the District Court. Under the explicit terms of the FTCA, therefore, the United States cannot be held liable in this case.

Whatever the status of the duty to warn or the duty to institute commitment proceedings under North Carolina law--issues on which the North Carolina courts have never spoken--the conduct challenged in this case was shielded with a statutory immunity. To have resolved this case, therefore, the District Court needed to do no more than conclude that the qualified immunity granted in section 122C-210.1 protected the challenged conduct.

Even if Section 122C-210.1 were for some reason inapplicable to this case, the vast majority of the District Court's lawmaking would still have been unnecessary. Having properly decided that the facts would not support liability, the court needed only to have held that North Carolina would not impose tort liability under the circumstances of this case. It was not necessary for the court to decide whether North Carolina law would impose liability for failure to commit under any other circumstances.

And even if the District Court thought some definitive resolution of North Carolina law respecting a duty to commit was necessary to the just disposition of this case, the court's resolution of issues respecting the existence and scope of a duty to warn in North Carolina was wholly gratuitous. The District Court apparently thought that the duty-to-commit issue hinged on whether North Carolina would recognize a duty to warn. This assumption was erroneous. Once a court decides that the so-called "special relationship" between therapist and patient creates a duty to protect third parties from the dangerous acts of the patient--a step the wisdom of which amicus vigorously disputes--then the issue of whether to recognize a duty to commit involves a balancing of interests largely distinct from that involved in deciding whether to impose a duty to warn all foreseeable victims. To

decide whether a duty to commit is appropriate, the court must weigh--as did the District Court in this case--the public safety gains from increasing involuntary commitments against the risk to treatment involved in requiring breaches of confidence and the risk of unnecessary deprivations of individual liberty. To decide whether a duty to warn is appropriate, the court must weigh the public safety gains, if any, from increased warnings, against the risk to treatment in breaches of confidence and the burden imposed on psychotherapists in having to foresee and warn possible victims. The District Court could have resolved the former balancing without infringing on North Carolina's right to decide the latter balance for itself in the proper case. And a fortiori the court need not have resolved issues concerning the scope of any such duty to warn.

The District Court thus had no proper occasion to indulge in comprehensive speculation about the possible existence and scope of a psychotherapist's duty to warn and duty to commit under North Carolina law. Such a sweeping and gratuitous exegesis was particularly inappropriate because the federal court did not sufficiently respect State competency to make law in a realm of social relations presumptively at the core of state power.

The issues with which the District Court grappled in this case are, as the court's opinion repeatedly acknowledged, pregnant with important questions of state policy. The Court noted that "policy considerations justified imposing a duty to warn as a component of reasonable care," Dist. Ct. Op. at 8; that extending a psychotherapist's duty to all foreseeable victims and not merely to readily identifiable victims was based on "policy considerations," id. at 11; and that "[d]efining the parameters of [a] 'duty'

[to commit] necessarily involves a balancing of policy considerations," id. at 15.

Were resolution of these issues necessary to do justice as between the parties to a lawsuit authorized by 28 U.S.C. § 1346(b), then a federal court would be obliged to make full use of the tools of the judicial process--including policy analysis--to resolve them. See P. Bator, D. Shapiro, P. Mishkin, H. Wechsler, Hart & Wechsler's The Federal Courts and The Federal System 708-710 (1973); Corbin, The Laws of the Several States, 50 Yale L.J. 762, 775-776 (1941). Amicus has demonstrated, however, that resolution of the difficult policy issues raised in the District Court opinion was wholly unnecessary to full and just disposition. Under such circumstances, respect for the dual sovereignty of the state system counsels strongly for a narrow ground of decision that "leave[s] development of doctrine to the State, which has primary concern for it." Essex Universal Corp. v. Yates, 305 F.2d 572, 585 (2d Cir. 1962) (Friendly, J., concurring).

If left undisturbed, the District Court's sweeping lawmaking threatens to alter drastically the nature of mental health care in North Carolina. Yet neither the courts nor the legislature of North Carolina will have acted to bring about this dramatic change. The change will result from unnecessary federal court pronouncements that have no grounding in the expressed state policies of North Carolina. Amicus urges this Court to rectify the intrusion on State sovereignty by affirming only the judgment below and explicitly rejecting the reasoning supporting that judgment.

II. THE IMPOSITION OF LIABILITY ON THERAPISTS FOR FAILING ACCURATELY TO PREDICT AND CONTROL THEIR PATIENTS' FUTURE DANGEROUSNESS IS UNSOUND AS A MATTER OF LAW AND PUBLIC POLICY.

Should this Court decide to reach the merits, amicus urges a straightforward holding that mental health professionals are not, by virtue of that status alone, potentially liable under North Carolina law to third parties for the violent conduct of their patients. Rigorous examination of the issue makes clear that any such rule of third-party liability (a) is empirically unsupportable and therefore imposes unfair and unworkable obligations upon psychotherapists; (b) undermines the laudatory public safety objectives it is meant to advance; and (c) risks unnecessary deprivation of patient liberty in a significant number of cases, thereby frustrating important State policies expressed by the legislature of North Carolina.

A. Because Mental Health Professionals Can Neither Reliably Nor Validly Predict Dangerousness, Imposition of Tort Liability For Their Failure To Do So Is Unwarranted.

Many recent decisions, in this and other contexts, have recognized the difficulties inherent in therapists' efforts to predict dangerousness.³ For this reason, courts have generally held--as did the District Court in this case--that therapists seeking to predict patient violence must stay "within the broad range of reasonable practice and treatment in which professional

³ See, e.g., Ake v. Oklahoma, 105 S. Ct. 1087, 1096 (1985) ("Psychiatry is not . . . an exact science, and psychiatrists disagree widely and frequently on what constitutes mental illness, on the appropriate diagnosis to be attached to given behavior and symptoms, on cure and treatment, and on likelihood of future dangerousness."); Barefoot v. Estelle, 463 U.S. 880, 899, n.7 (1983); White v. United States, 244 F. Supp. 127, 131 (E.D. Va. 1965), aff'd, 359 F.2d 989 (4th Cir. 1966) (hospital not negligent when it failed to guard patient who escaped and stood in front of train); Tarasoff v. Regents of University of California. See also Barefoot v. Estelle, 463 U.S. at 921 & n.2 (Blackmun, J., dissenting).

opinion and judgment may differ." Tarasoff, 551 P.2d at 345.⁴ See Dist. Ct. Op. at 23. The problem with this approach is that the existence of such a "range" of "reasonable professional judgment" is negated by the empirical evidence. The consistent research finding is that mental health professionals fail to predict accurately future violence in two out of three cases,⁵ and that there is no consistent professional standard for predicting violence.⁶ In light of these findings, the "standard of the profession" or the "range of reasonable practice and treatment" is inherently unreliable, and ultimately

⁴ The Tarasoff court stated:

Obviously we do not require that the therapist, in making th[e] determination [of dangerousness], 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."

131 Cal. Rptr. at 20, 551 P.2d at 345 (citations omitted).

⁵ See, e.g., J. Monahan, The Clinical Prediction of Violent Behavior (1981); Ennis & Litwack, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 Cal. L. Rev. 693, 713 (1974) (hereafter Flipping Coins); Kozol, Boucher, & Garofalo, The Diagnosis and Treatment of Dangerousness, 18 Crime & Delinquency 371 (1972). See also Monahan, The Prediction of Violent Behavior: Toward a Second Generation of Theory and Policy, 141 Am. J. Psychiatry 10, 11 (1984).

⁶ See Steadman, The Right Not To Be a False Positive: Problems in the Application of the Dangerousness Standard, 52 Psychiatric Quarterly 84, 96 (1980) ("Nowhere in the research literature is there any documentation that clinicians can predict dangerous behavior beyond the level of chance."). See also Wenk, Robinson & Smith, Can Violence Be Predicted? 18 Crime & Delinquency 393, 394 (1972) (finding it impossible to identify any subclass of offenders "whose members have a greater-than-even chance of engaging again in an assaultive act.").

unworkable, as a standard by which to judge the assessments of particular therapists and to impose liability based on those judgments.⁷

Social scientists, psychiatric authorities, and legal commentators are overwhelmingly in agreement that dangerousness cannot be predicted with any acceptable degree of reliability or validity.⁸ Scientific studies clearly demonstrate that predictions of dangerousness of mentally disabled persons are extremely inaccurate and are largely based on speculation.⁹

7/ Commenting on the decision in Tarasoff to examine "the therapist's prediction of dangerousness" under the ordinary malpractice criterion of "conformity to standards of the profession." Professor Stone writes: "One can only wonder what it means to apply standards to skills which do not exist. As Justice Mosk noted, dependence on such standards 'will take us from the world of reality into the wonderland of clairvoyance.'" Stone, The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society, 90 Harv. L. Rev. 358, 371 (1976) (quoting Tarasoff v. Regents of the University of California, 551 P.2d 334, 354 (1976) (Mosk, J., dissenting in part and concurring in part)) (hereafter Stone). See also Tarasoff, 551 P.2d at 361 n.6 (Clark, J., dissenting) ("The majority's reliance on the traditional standard of care for professionals . . . is seriously misplaced. The standard of care assumes that to a large extent, the subject matter of the specialty is ascertainable. One therapist cannot accurately predict dangerousness, which in turn, means that the standard is inappropriate for lack of a relevant criterion by which to judge the therapist's decision. . . . The majority's attempt to apply a normative scheme to a profession which must be concerned with problems that balk at standardization is clearly erroneous."); Note, Imposing a Duty to Warn on Psychiatrists--a Judicial Threat to the Psychiatric Profession, 48 U. Colo. L. Rev. 283, 290-91 (1977) (same).

8/ "Reliability" refers to the degree of correlation or correspondence of judgment between professionals using the same method. Thus, if representative pairs of therapists, interviewing a representative sample of prospective patients, usually agree that each individual is or is not "dangerous," the judgment of "dangerousness" is said to be reliable. "Validity," by contrast, refers to how accurate the judgment in question is, without regard to the likelihood of agreement among therapists as to that judgment.

9/ See J. Monahan, The Clinical Prediction of Violent Behavior (1981); B. Ennis & R. Emery, The Rights of Mental Patients 20 (1978); Morse, Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law, 51 S. Cal. L. Rev. 527 (1978); Report of the American Psychological Association Task Force on the Role of Psychology in the Criminal Justice System, 33 Am.

The American Psychiatric Association Task Force on Clinical Aspects of the Violent Individual (1974) (hereafter Task Force) concluded after exhaustive review of the literature that judgments concerning the long-run potential for future violence and the "dangerousness" of a given individual are "fundamentally of very low reliability." Task Force at 23. The Task Force found that efforts to predict violence of particular individuals resulted in an unacceptably high rate of false positives--i.e., violent behavior was predicted for individuals who did not demonstrate any violence within the period of study. Id. at 23-24.¹⁰

9 Cont'd.

Psychology 1099 (1978); Steadman, Predicting Dangerousness Among the Mentally Ill, 6 Int'l. J. L. & Psychiatry 381-90 (1983); American Psychiatric Association Task Force Report, Clinical Aspects of the Violent Individual 28 (1974) (90 per cent error rate "unfortunately . . . is the state of the art"). See generally D. Shapiro, Psychological Evaluation and Expert Testimony (1984); Wettstein, The Prediction of Violent Behavior And The Duty To Protect Third Parties, 2 Beh. Sciences and the Law 291 (1984); Scott, Violence in Prisoners and Patients, Medical Care of Prisoners And Detainees, 123 U. Pa. L. Rev. 439 (1979); Flipping Coins, supra note 5, at 750-51; Rector, Who Are the Dangerous? Bull. Am. Acad. Psych. & L. 186 (July 1973); Rosenhan, On Being Sane In Insane Places, 13 Santa Clara L. Rev. 379 (1973); Justice & Birkman, An Effort to Distinguish the Violent from the Nonviolent, 65 So. Med. J. 703 (1972); Kozol, Boucher & Garofalo, The Diagnosis and Treatment of Dangerousness, 18 Crime & Delinquency 371 (1972); Rubin, Prediction of Dangerousness in Mentally Ill Criminals, 27 Arch. Gen. Psychiatry 397 (1972); United States Department of Health, Education and Welfare, HEW News (News Release, August 8, 1974).

¹⁰ This tendency to overpredict violence results only from the difficulty of identifying factors that suggest future violence but also from the extremely low incidence of violence as a societal phenomenon:

Predictions of dangerousness, like those of suicide, are, with few exceptions, predictions of rare or infrequent events This means that even if the characteristics of such future violent patients could be specified with fairly great accuracy, predictions based upon such characteristics will identify far more "false positives"

Subsequent research unequivocally confirms the Task Force findings.¹¹ Professor Monahan,¹² in The Clinical Prediction of Violent Behavior (1981) (hereafter Clinical Prediction), reported that no procedures used by psychotherapists had succeeded in reducing the high rate of "false positive" predictions of violent behavior. Even allowing for possible distortions in certain of the research data, Monahan concluded that "it would

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than "true positives." Even if an index of violence proneness could be developed so as to correctly identify prior to release fifty percent of those individuals who will violate parole by committing violent offenses, the actual employment of such an index would identify eight times as many "false positives" as "true positives." This means that eight of the nine persons retained in prison as a result of application of the index would not have committed such offenses if released.

Task Force at 23-24 (footnotes omitted).

¹¹ See, e.g., Schwitzgebel, Prediction of Dangerousness and its Implications for Treatment in Modern Legal Medicine, Psychiatry, and Forensic Medicine 784 (W. Curran, A. McGarry & C. Petty, eds. 1980); Steadman & Cocozza, Psychiatry, Dangerousness, and the Repetitively Violent Offender, 69 J. Crim. Law & Criminology 226 (1978). See generally supra note 9. See also Steadman & Cocozza, Stimulus/Response: We Can't Predict Who Is Dangerous, 8 Psych. Today 32, 35 (Jan. 1975):

Because psychiatrists cannot accurately predict who will become violent, they frequently err. Rather than random errors, however, their inaccurate predictions are consistently on the safe side. They overpredict. They assume that since some patients are dangerous, the one under consideration might be. The result of this practice is that as many as twenty harmless persons are incarcerated for every one who will commit a violent act.

^{12/} Professor Monahan, a research psychologist on the faculty of the University of Virginia Law School, has been described as the "leading thinker on [the] issue" of the prediction of violence. Barefoot v. Estelle, 463 U.S. 880, 920 (1983) (Blackmun, J., dissenting).

be fair to [state] that the 'best' clinical research currently in existence indicates that psychiatrists and psychologists are accurate in no more than one out of three predictions of violent behavior over a several year period." Id. at 47.¹³

The notion that mental health professionals have expertise in predicting dangerousness is based largely on popularly-held stereotypes that mentally disordered individuals are more likely than is the general population to engage in violent acts, and that the presence of a mental disorder, per se, makes the prediction of violence easier and more accurate than would otherwise be the case. There is no empirical support for these propositions. See D. Shapiro, Psychological Evaluation and Expert Testimony 157-160 (1984) (hereafter Shapiro); Flipping Coins, supra note 5, at 716 (and citations contained therein). Professor Monahan has observed that "[t]he most relevant

¹³ The studies above refer primarily to the inability of psychotherapists to make medium to long-term predictions of the violent behavior of their patients. Although there are very few studies of the reliability and validity of short-term predictions, Professor Monahan has observed that short-term emergency commitment of mentally ill persons predicted to be imminently violent may be exempt from the systematic inaccuracy found in the current research. Monahan, Prediction Research and the Emergency Commitment of Dangerous Mentally Ill Persons: A Reconsideration, 135 Amer. J. Psychiatry 198 (1978). This difference is due, in part, to the fact that short-term predictions are usually made in the context of specific, and usually acute, mental disorders. See generally Roth, Clinical and Legal Considerations in the Therapy of Violence-prone Patients, in 18 Current Psychiatric Therapies 55, 58 (J. Masserman ed. 1978). However, even the few studies that exist regarding short-term predictions of "imminent" violence limit the ability to predict to several days. Id.

In any event, even extremely short-term predictions of violence cannot be made with a degree of accuracy that would justify imposition of tort liability for the failure accurately to make such predictions. And the duties imposed by the District Court make no distinction on the basis of short or long term predictions.

noncorrelate of violence is 'mental illness'." Clinical Prediction at 77 (emphasis added). Indeed, "schizophrenics and other psychotic persons ha[ve] a history of lower violence and fewer incarcerations than [do] other accused persons." Menzies, Webster & Sepejak, The Discovery of Dangerousness in a Pre-trial Forensic Clinic, Paper presented at the Annual Meeting of the American Psychiatric Association (1982).¹⁴

The best predictor of future violence is past violence--a factor having nothing to do with a mental disorder for which a patient is being treated and a factor about which even the most thorough therapist may be unaware. See Shapiro at 157; Shah, Dangerousness: A Paradigm for Exploring Some Issues in Law and Psychology, 33 Am. Psychologist 224-238 (1978); Clinical Prediction at 71.¹⁵ And in circumstances such as those presented by this case, where there is no history of violent actions by the patient, predictions of dangerousness simply cannot be accurately made.¹⁶

¹⁴ Although therapy patients often express thoughts of violence, they rarely carry them out--the very nature of psychotherapy actuates clients to voice such ideation. Bersoff, Therapists as Protectors and Policemen: New Roles as a Result of Tarasoff, 7 Prof. Psychology 267 (1976). However, such ideation should not be confused with impulse. Many studies on aggression demonstrate that frequently, expressing violent thoughts in fantasy is precisely what prevents the person from acting on that fantasy. Shapiro at 160.

^{15/} But see T. Blau, The Psychologist as Expert Witness 49-50 (1984) ("Some have suggested that 'the past is prologue' and that dangerousness can be best predicted from a history of violence. Recent evaluation of the violent history paradigm does not support this concept. It is suggested that violence is frequently due to transitory psychological state[s] that emerge in response to atypical circumstances and is a fairly poor indicator of future violence."). (Citations omitted.)

^{16/} See Kozol, Boucher, & Garofalo, The Diagnosis and Treatment of Dangerousness, 18 Crime & Delinquency 371 (1972):

The difficulty involved in predicting dangerousness is immeasurably increased when the subject has never actually

Other demographic variables that correlate positively with violent behavior include age (a disproportionate amount of crime is committed by persons between the ages of fifteen and twenty);¹⁷ gender (almost 90% of those arrested for violent crimes are male);¹⁸ environmental circumstances (family, peer, jobs), as well as the availability of victims, weapons, and alcohol or other drugs. Lanyon, Psychological Assessment Procedures in Court-Related Settings, 17 Prof. Psychology 260, 264 (1986). It is not surprising that much of the research in this area has found that psychotherapists have no greater ability than laymen to predict future dangerousness.¹⁹

Although an occasional rare study does advance the view that psychotherapists can employ objective professional standards for evaluating

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performed an assaultive act We submit that to properly assess indications of possible dangerousness in the absence of an actual instance of dangerous acting out requires the highest degree of psychiatric expertise and may well exceed the present limits of our knowledge No one can predict dangerous behavior in an individual with no history of dangerous acting out.

17/ See F. Zimring, Confronting Youth Crime: Report of the Twentieth Century Fund Task Force on Sentencing Policy Toward Young Offenders (1978).

18/ See W. Webster, Crime in the United States--1977 (Federal Bureau of Investigation, 1978).

19/ See, e.g., Flipping Coins, supra note 5, at 707, n.43 ("There are a few studies comparing the diagnostic reliability of psychologists and laymen, most of which report no significant difference."). See generally 1 J. Ziskin, Coping with Psychiatric and Psychological Testimony 263 (3d ed. 1981).

the potential likelihood of dangerousness,²⁰ this view is in the extreme minority. See Small, Psychotherapists' Duty to Warn: Ten Years After Tarasoff, 15 Golden Gate U. L. Rev. 271 (1985). Reflecting the consensus view of responsible professionals, Professor Monahan states:

No one thinks that the prediction of violence is on the verge of attaining a validity comparable to that of the prediction of the weather. ... There may indeed be a ceiling on the level of accuracy that can ever be expected of the clinical prediction of violent behavior. That ceiling, however, may be closer to 50% than to 5% among some groups of clinical interest.

Monahan, The Prediction of Violent Behavior: Toward a Second Generation of Theory and Policy, 141 Am. J. Psychiatry 10, 11 (1984). Thus, at best, the development of more accurate and successful techniques may permit psychotherapists to predict violence successfully in half the cases. Given these odds, however, there is little justification for holding therapists liable for failing to predict accurately their patients' dangerousness.

In essence, legal recognition of a duty to protect third parties threatens to impose liability on psychotherapists for failing to perform a function that, according to all available empirical evidence, they are incapable of performing. As a profession, psychotherapists make no claim to the ability to predict dangerousness with any acceptable degree of accuracy; there does not exist within the profession any generally accepted "standard of care" against which particular efforts to assess potential dangerousness can be measured. Under the rule of liability the District Court adopted, psychotherapists cannot--save perhaps by seeking commitment for all who

^{20/} See Givelber, Bowers & Blitch, Tarasoff, Myth and Reality: An Empirical Study of Private Law in Action, Wis. L. Rev. 443 (1984) (hereafter Givelber, et al.).

exhibit the slightest urge to violence--conduct their professional affairs in a way that assures protection from ruinous tort liability.²¹ Because no generally accepted standard of care exists, imposition of tort liability in any given case under the rules the District Court adopted is a matter of chance.²² The tort law of North Carolina should not be extended to create a situation so fundamentally unfair for psychotherapists seeking to treat the mentally disabled.

B. A Rule Imposing A Duty To Assess Dangerousness And Take Preventive Measures Will Undermine The Goal of Public Safety It Is Meant To Serve.

Courts imposing upon psychotherapists a duty to assess dangerousness in patients and take preventive measures are doubtless motivated by a noble instinct to protect the public from the random or calculated violence of mentally disturbed persons. Unfortunately, for several reasons, the legal rule the District Court adopted will reduce the possibility of effective treatment for such persons.

Because no accepted professional "standard of care" exists for assessing a patient's dangerousness, psychotherapists treating the potentially

²¹ Such a result does not accord with the policies of North Carolina law expressed by courts of the State in analogous settings. See, e.g., Azzolino v. Dingfelder, 315 N.C. 103, 337 S.E.2d 528, 535 (1985) (tort liability for wrongful life rejected because existence of such a tort would "place increased pressure upon physicians to take the 'safe' course").

²²/ That psychotherapists may be required to assess dangerousness in State involuntary commitment proceedings is no justification for imposing liability on them for failing accurately to do so in a therapeutic setting. It is a far different matter for the State to enlist professional assistance in the very difficult task of assessing dangerousness in a commitment hearing to protect the public safety and imposing draconian tort liability upon therapists for their failure to make accurate predictions of dangerousness in the therapeutic setting.

dangerous are left with no course of action sure to protect them from exposure to severe tort liability. They will reasonably assume that, in the event of a lawsuit, the dangerousness of a particular patient who has committed a violent act will seem obvious. With the benefit of hindsight, a court or jury is not likely to be moved by abstract protestations about the difficulties of prediction. Nor will it do much good to describe the many other patients with comparable "violent" tendencies who have been stabilized and integrated successfully into society. Once a homicide or other crime has been committed there will be an almost irresistible temptation in the legal system to conclude that the therapist should have done something more to prevent it.

Faced with such a prospect one rational response for psychotherapists is to avoid altogether the patients that pose such risks. A rule of third-party liability is certain to discourage many mental health professionals from treating any patients whose history or behavior suggests that future violence is a possibility. Even without such a rule, many therapists presently tend to avoid these kinds of patients because they are notoriously difficult to treat.²³ If therapists are now told that they may be held responsible for their patients' violent conduct--despite their acknowledged inability to predict that violent conduct--they will be even more reluctant to begin treatment. This, in turn, will lead to less care for the very patients whose conduct poses the threat recognized by the District Court.

Imposition of a duty to protect will also undermine effective treatment in other ways. One crucial concern in forcing psychotherapists to warn potential victims or institute involuntary commitment proceedings is that

^{23/} See Stone, supra note 7, at 371-372.

such actions necessitate breaches of the confidential treatment relationship between therapist and patient. Effective psychotherapy requires that patients be able to reveal their innermost thoughts and feelings, secure in the knowledge that those thoughts and feelings will be kept confidential. As the Sixth Circuit has noted, a therapist's "'capacity to help his patients is completely dependent upon their willingness and ability to talk freely.'" In re Zuniga, 714 F.2d 632, 338 (6th Cir.), cert. denied, 464 U.S. 983 (1983) (quoting Prop. Fed. R. Evid. 504 note, 56 F.R.D. at 242 (1976)). This fact, in turn, "'makes it difficult if not impossible for [the therapist] to function without being able to assure his patients of confidentiality. ... A threat to secrecy blocks successful treatment.'" Id. Thus the rule adopted by the District Court jeopardizes the treatment process itself.

To be sure, amicus does not suggest that this confidential relationship should be under all circumstances inviolate. Many states, for example, require a report to the authorities whenever a therapist learns about ongoing child abuse.²⁴ And most therapists would acknowledge a moral responsibility to take some discretionary action if convinced that a patient is about to commit a violent crime. But the question here is whether the law should force a large increase in the number of warnings--i.e., whether it is desirable to impose judicially a rule that will certainly lead to warnings and

²⁴ E.g., N.C. Gen. Stat. §§ 110-115.

commitment proceedings motivated, not by the clinical and moral judgment of therapists, but by their fear of being second-guessed in a later tort suit.²⁵

Such a development would significantly impair the ability of psychotherapists to treat the very persons who are causing the problem--those who may have some urge to do violence. As amicus has discussed, the number of persons likely to be affected by such a rule is quite large. These patients will know that if they reveal violent impulses, even in a confidential therapy session, the therapist is likely either to reveal these feelings to the friend, family member or business associate involved or to institute involuntary commitment proceedings. The breach of confidence not only will be painful for patients but will precipitate serious collateral harms as well. Warnings can reasonably be expected to lead to loss of employment, estrangement from family, or rifts with friends. Involuntary commitment proceedings will result in deprivations of liberty.

Faced with such likely consequences, patients will naturally avoid treatment or avoid making the very statements during treatment that may be most essential to their recovery.²⁶ Effective psychotherapy depends upon

²⁵ Note, Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff, 31 Stan. L. Rev. 165, 190 (1978) (distinguishing the effects of "discretionary" disclosures from the effects of a legal duty to warn) (hereafter Stanford Note).

²⁶/ See Tarasoff, 551 P.2d at 359 (Clark, J. dissenting) (majority's rule will deter persons from seeking treatment, prevent full disclosure of patients' thoughts, and interfere with the development of a trusting relationship between therapist and patient); Stone, supra note 7, at 370 ("Anyone who has worked in a therapeutic program serving drug addicts, prisoners, parolees, probationers, or juvenile delinquents can attest that the duty to breach a patient's privacy as required by Tarasoff II would eviscerate whatever possibility of treatment exists with these difficult patients").

the patient's willingness to share his or her most embarrassing and frightening feelings. The importance of this process was eloquently expressed in an analogous context in Hammonds v. Aetna Casualty & Surety Co.:

"When a patient seeks out a doctor and retains him, he must admit him to the most private part of the material domain of man. Nothing material is more important or more intimate to man than the health of his mind and body. Since the layman is unfamiliar with the road to recovery, he cannot sift the circumstances of his life and habits to determine what is information pertinent to his health. As a consequence, he must disclose all information in his consultations with his doctor--even that which is embarrassing, disgraceful or incriminating. To promote full disclosure the medical profession extends the promise of secrecy The candor which this promise elicits is necessary to the effective pursuit of health; there can be no reticence when patients discuss their problems with their doctors."

243 F. Supp. 793, 801-802 (N.D. Ohio 1965). Such reticence, in turn, may well increase the likelihood that patients will "act out" the violent impulses they are afraid to expose and resolve in therapy.²⁷

These dangers are not speculative. In a survey of California psychotherapists by the Stanford Law Review after the Tarasoff decision, a majority of those surveyed "thought that patients will withhold information important to treatment if they believe the therapist may breach confidentiality."²⁸ And fully one-fourth of respondents "reported actually observing their patients' reluctance to discuss their violent tendencies when informed of the possibility of an exception to absolute confidentiality."²⁹

²⁷ See Stone, supra note 7, at 373 (duty to warn "will reduce rather than increase public safety because it will diminish the ability and motivation of therapists to treat effectively mentally disturbed and potentially dangerous people"); Gurevitz, Tarasoff: Protective Privilege Versus Public Peril, 134 Am. J. Psychiatry 289 (1977) (hereafter Gurevitz).

²⁸ Stanford Note, supra note 25, at 183.

²⁹ Id.

This risk might be worth taking if there were reason to believe that the net effect of imposing a broad duty would be significant prevention of violence. Even if psychotherapists were better able to predict dangerous conduct in their patients, it is not clear that a duty to warn would advance the safety objective. Indeed, in many circumstances a warning may precipitate a confrontation and thus "may in fact increase the likelihood of violence."³⁰ In such a case, other options are obviously far preferable. "Most patients will tolerate a variety of other protective forms of crisis intervention by the therapist with much less damage to the therapeutic alliance and with much less rage towards both the therapist and the potential victims because their psychological implications are much less sinister to the patient."³¹

A decision about how to respond to a patient's intimations of violent intention is often complex and difficult. Under the present system therapists can decide on a case-by-case basis whether a given threat is serious enough to outweigh the need for confidentiality or to justify a deprivation of liberty, and whether a warning will improve matters or make them worse. Were the District Court opinion to stand, however, the likely result would be a large number of warnings and involuntary commitments motivated primarily by the risk of tort liability. Such a result serves no good purpose and thwarts the possibility of effective therapy for the very patients whose potential violence motivated the District Court to impose a broad duty to protect.

³⁰ Stone, supra note 7, at 370. Accord Roth, supra note 13, at 58 ("warnings may increase rather than decrease the likelihood of subsequent violence"); Gurevitz, supra note 27, at 290.

³¹/ Stone, supra note 7, at 370-371.

III. IMPOSITION OF A DUTY TO INSTITUTE INVOLUNTARY COMMITMENT PROCEEDINGS WILL RESULT IN THE UNNECESSARY DEPRIVATION OF LIBERTY IN SIGNIFICANT NUMBERS OF CASES.

Therapists cannot identify which of their many patients with potential violent tendencies will actually resort to violence. The only rational response to this lack of knowledge, in the face of a threat of liability, is to assume that every patient who expresses violent emotions will act on those emotions. As a result, therapists will vastly overpredict violence, and will make treatment decisions on that basis. The District Court's effort to temper the impact of the novel legal duty to commit by holding psychotherapists to no more than a generally prevailing standard of care, see Dist. Ct. Op. at 23, does not ameliorate the risk of overprediction of violent behavior. Because there is no acknowledged professional approach to predicting violence--no general standard of care to which therapists can confidently conform--therapists treating potentially violent patients will necessarily be preoccupied with other ways of minimizing their legal exposure.

Therapists willing to treat potentially dangerous patients can be expected to recognize that the personal risks of inaction far outweigh any costs of taking action. In any given case, if the therapist guesses that a patient presents no serious danger of violence and takes no preventive steps, the therapist faces potentially huge tort liability if that judgment proves to be wrong. If, instead, the therapist assumes that the same patient might be violent and the therapist takes appropriate action, the short-term impact on the therapist is minimal but the impact on the patient will be severe. Under

the rules the District Court adopted, the psychotherapists would feel pressure in every case to institute involuntary commitment proceedings.³²

The rules the District Court adopted might, in theory, reduce the number of violent acts by mentally ill persons, but it would do so only by drastically increasing the number and duration of involuntary hospitalizations. Because future violence cannot be predicted with any degree of accuracy, see Point II.A. supra, if violent actions are to be prevented through isolation in a hospital, it will require "preventive detention" of the far larger group of people who exhibit some potential for violence.³³

It follows that a decision to control possible future violent acts by patients in psychotherapy would be effective only if it had a major impact on the existing balance struck in our society between two competing values: the

^{32/} Fulfilling a duty to warn is plainly insufficient under the standards the District Court adopted. The VA psychotherapists warned local, state, and federal law enforcement officials and were nonetheless subjected to possible liability for failing to institute involuntary commitment proceedings. The pressure to institute such proceedings is thus clear. See Tarasoff v. Regents of the University of California, 551 P.2d at 361 (Clark, J., dissenting) (since "the decision not to warn or commit must always be made at the psychiatrist's civil peril, one can expect most doubts will be resolved in favor of the psychiatrist protecting himself"); Stanford Note, supra note 25 at 188.

^{33/} There is evidence that third-party liability rules do promote more hospitalizations of potentially dangerous patients. In the Stanford survey, several responding psychiatrists volunteered that Tarasoff had made them more likely to commit patients who made threats of violence. Stanford Note, supra note 25, at 189 n.24. And a later survey found that therapists are, in fact, more likely to seek involuntary hospitalizations if they feel they are bound by the Tarasoff rule. Givelber, et al., supra note 20, at 478.

The fact that the treating psychotherapist's recommendation of involuntary commitment is not necessarily decisive in official proceedings does not reduce the likelihood of drastic increases in commitment under the District Court's rule. Studies have demonstrated that psychotherapist recommendations "generally control the outcomes" of commitment proceedings in North Carolina. Fitch, 14 N.C. Cent. L.J. 406, 455 (1984); Note 62 N.C. L. Rev. 1158, 1163 (1984).

value of preventing violence against third parties, and the value of allowing many mentally disabled persons to receive appropriate treatment in a nonrestrictive outpatient setting on a voluntary basis. This is no easy balance to strike. Any enthusiasm for the use of physical isolation as a means to control violence by the mentally disabled has to be tempered by due recognition of the costs of such an approach.

One crucial cost is the significant reduction in patients' liberty. "Because of the virtual impossibility of predicting dangerousness, such an approach [i.e. involuntary commitment] would necessarily lead to prolonged incarceration for many patients who could become useful members of society." Johnson v. United States, 409 F. Supp. 1283, 1293 (M.D. Fla. 1976), rev'd on other grounds, 576 F.2d 606 (5th Cir. 1978). The sizeable group of people who intimate some impulse to violence would experience significant restrictions on their freedom, Humphrey v. Cady, 405 U.S. 504, 509 (1972), solely to protect the rest of society from the violent acts that a very few of their numbers would otherwise commit.

The State of North Carolina struck the balance between individual liberty and the protection of society in a manner that strongly favors noninstitutional treatment of the mentally disabled in cases of doubt. The District Court itself recognized that "North Carolina's stated policy . . . is to 'favor a less restrictive mode of treatment than involuntary commitment whenever appropriate.'" Dist. Ct. Op. at 16 (quoting In re Farrow, 255 S.E.2d at 782). Yet the sweeping duty imposed by the District Court contravenes this State policy because it effectively means that psychotherapists who decline to institute involuntary commitment proceedings do so at their peril. As discussed above, see Point II.B. supra, in the context of individual cases,

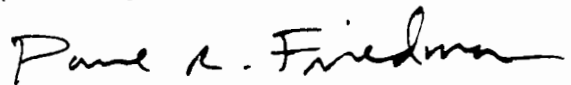
the appropriateness of failing to commit a patient will always be assessed after a patient has in fact proved to be violent and an innocent person has been seriously harmed. Faced with this possibility--and unable to protect themselves by conforming to professional "standards of care" because none exist--mental health professionals will be forced to "indulge every presumption in favor of . . . restraint, out of fear of being sued." Sherrill v. Wilson, 653 S.W.2d 661, 664 (Mo. 1983).

Amicus strongly believes that such a shift in the prevailing balance would disserve society. As the District Court acknowledged, "[t]he vast majority of courts" addressing the duty-to-commit issue have agreed that imposing such a duty on therapists is not sound public policy. Dist. Ct. Op. at 16. At the very least, a federal court should be wary of altering the balance in a crucial area of state policy without guidance from the organs of political authority in North Carolina. For these reasons, amicus urges this Court to reject the District Court's decision to impose on psychotherapists a comprehensive legal duty to protect third parties from patient violence.

CONCLUSION

For all the foregoing reasons, amicus urges this Court to affirm only the judgment of the District Court in this case and specifically to disapprove the reasoning underlying that judgment.

Respectfully submitted,



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CERTIFICATE OF SERVICE

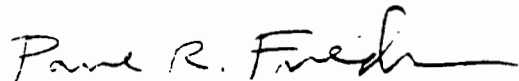
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