

**THERAPISTS BEHAVING BADLY:
WHY THE *TARASOFF* DUTY IS NOT ALWAYS
ECONOMICALLY EFFICIENT**

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ABSTRACT

In 1976, the California Supreme Court revolutionized medical

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privacy law when it held, in Tarasoff v. Regents of the University of California, that a psychotherapist counseling a dangerous patient has an affirmative duty to protect a third party against whom the patient makes serious, credible threats. Discharging this duty necessarily requires breaching the confidentiality inherent in the therapist-patient relationship. The consequences of this ruling have been studied using traditional legal analysis, medical disclosure principles, and ethical and moral philosophy. However, a search of the relevant literature reveals that the behavioral incentives produced by the decision have never been critically examined from the perspective of economic efficiency. This article attempts to fill that void.

After introducing the basic principles of the economic analysis of tort law, this article constructs a framework for investigating the “dangerous patient” scenario. It surveys several current versions of the Tarasoff duty and demonstrates that no version induces both the therapist and the potential victim to behave in a socially desirable

held that, in such a situation, the psychotherapist has a “duty to protect the threatened victim.”² How this duty is discharged depends on the facts of the case at hand.³ The court explained that in some cases, merely warning the intended victim may suffice, whereas, in other cases, committing the would-be attacker to a secure mental facility might be required.⁴

The *Tarasoff* case sparked a firestorm of controversy among psychotherapists, lawyers, academics, and judges regarding the status of the therapist-patient privilege. Since the ruling was handed down, the literature has burgeoned with medical and psychological commentary,⁵ case law analysis,⁶ extensions to other disclosure scenarios,⁷ analogies to the lawyer-client privilege,⁸ and even

2. *Id.* at 346.

3. *Id.* at 340.

4. *Id.* at 346 (mentioning “warning” and “incarcerat[ion]” as “some of the alternatives open to the therapist”).

5. See, e.g., Ebrahim J. Kermani & Sanford L. Drob, *Tarasoff Decision: A Decade Later Dilemma Still Faces Psychotherapists*, 41 AM. J. PSYCHOTHERAPY 271 (1987) (approving the *Tarasoff* ruling itself, but criticizing expansions of J/T9dMtyas “San5 0 0 8.52(ruling)-7.1(itself, but criticizin)-7.8(g expansions of)]

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Dr. Lawrence Moore, a psychologist affiliated with the university.¹⁹ After several sessions, he confided in Dr. Moore that he was going to kill an unnamed female, readily identifiable as Tarasoff, when she returned from a vacation in Brazil.²⁰ Dr. Moore notified the campus police, explaining that Poddar suffered from “paranoid schizophrenia, acute and severe,” and made a recommendation for civil commitment.²¹ The police took Poddar into custody but released him shortly after judging him to be rational and not harmful.²² They also made Poddar promise to stay away from Tarasoff.²³ In the meantime, Dr. Moore’s request for civil commitment was denied.²⁴ Poddar was never restrained further, and he never returned to therapy.²⁵

On October 27, 1969, after Tarasoff had returned to the university, Poddar entered Tarasoff’s home and chased her into the backyard, where he shot her with a pellet gun and fatally stabbed her with a kitchen knife.²⁶ Poddar then re-entered the house and called the police.²⁷

Vitaly and Lydia Tarasoff, Tatianna’s parents, brought suit against the University of California, the therapists who treated Poddar at the student health center, and the police.²⁸ The Tarasoffs argued that the therapists and police acted negligently in failing to secure Poddar’s commitment.²⁹ The Tarasoffs said that these failed attempts to commit Poddar deterred him from returning to therapy and indirectly made his attack on Tatiana possible.³⁰ Tatiana’s parents also claimed that Dr. Moore and the campus police negligently failed to warn them “that their daughter was in grave danger. . . .”³¹ In a five to two decision (known as *Tarasoff I*), the California Supreme Court found that both the police and psychotherapists had an affirmative duty to warn Tarasoff, “or those who reasonably could

19. *Tarasoff*, 108 Cal. Rptr. at 880.

20. *Id.*

21. *Poddar*, 518 P.2d at 345.

22. *Tarasoff*, 108 Cal. Rptr. at 880.

23. *Tarasoff II*, 551 P.2d at 341.

24. *Id.*

25. *Tarasoff*, 108 Cal. Rptr. at 880.

26. *Poddar*, 518 P.2d at 345.

27. *Id.*

28. *Tarasoff II*, 551 P.2d at 340-41.

29. *Id.* at 341.

30. *Id.*

31. *Id.*

have been expected to notify her,” of the threat Poddar posed.³² However, a dissenting opinion urged that the court not encourage violations of the psychotherapist-patient privilege by requiring disclosure of facts learned in the course of therapy.³³

Surprisingly, the court agreed to rehear the case.³⁴ This time the court released the police from all liability but extended the scope of the psychotherapists’ liability.³⁵ According to the second decision (known as *Tarasoff II*), therapists must exercise “that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of that professional specialty under similar circumstances” to predict violence in patients.³⁶ Moreover, once a therapist predicts danger, he “incurs an obligation to use reasonable care to protect the intended victim against such danger.”³⁷ Justice Tobriner, who wrote the majority opinion in both cases, concluded with a far-reaching and ominous declaration of when a psychotherapist must breach confidentiality: “The protective privilege ends where the public peril begins.”³⁸

B. The Duty: Its Scope and Its Triggers

Though *Tarasoff* is only binding in California, a majority of jurisdictions have adopted some form of the *Tarasoff* duty by common law development or by statute.³⁹ But, not all of those states

apply the California Supreme Court's ruling wholesale. The states have generally taken one of three approaches. First, some states retain a duty only to warn, stopping short of full protection.⁴⁰ In a warn-only jurisdiction, a therapist is not obligated to initiate involuntary commitment proceedings or take other protective measures which do not involve actually warning the potential victim. The second approach involves imposing a duty to take measures that are purely protective, but not to warn the potential victim.⁴¹ Therefore, involuntary commitment—but not a verbal warning—would count towards satisfying the duty. Finally, many states embrace the *Tarasoff* court's approach which, though styled a "duty to protect," actually includes a duty to warn.⁴² This approach, therefore, represents a duty to warn and protect. A therapist must meet a due care standard of warning and a due care standard of protection to satisfy the duty in any particular case. Part IV examines

Once a court or legislature decides how to allow a therapist to discharge the duty, it must address which conditions trigger the duty in the first place. On this point, the California Supreme Court, just four years after *Tarasoff*, held (with Justice Tobriner dissenting) that the duty is triggered only when the patient threatens a “specific” or “readily identifiable” victim.⁴³ Under this approach, the identity of the victim must be determinable at the time of the threat. Significantly this approach does not support a blanket duty to protect the public at large. Rather, the duty follows the identifiable victim. This approach will be referred to as the “victim-centered” approach. Many jurisdictions follow this holding.⁴⁴

However, some jurisdictions impose a stricter standard on the therapist by providing an easier to activate trigger. Different opinions have produced textual variants, but the general approach tracks a recent draft of the Restatement (Third) of Torts: “[W]hen reasonable care requires confining a patient who poses a real risk of harm to the community, the duty of the mental health professional ordinarily extends to those members of the community who are foreseeably put at risk by the patient.”⁴⁵ The Wisconsin Court of Appeals emphasized that this approach “flatly reject[s] any distinction between a psychotherapist’s duty to warn on the basis of whether the patient particularizes potential victims of his or her violent tendencies or makes generalized statements of dangerous intent.”⁴⁶ This approach triggers a duty in a larger set of circumstances than does the victim-centered approach.

To see this, suppose that a therapist is treating a patient who exhibits violent tendencies to the degree that he is clearly a danger to anyone with whom he might come into contact. However, suppose

43. *Thompson v. County of Alameda*, 614 P.2d 728, 738 (Cal. 1980).

44. RESTATEMENT (THIRD) OF TORTS:

also that this patient has not specified a particular person whose path he plans on crossing. It is eminently foreseeable that this patient will harm someone—his lover, his child, patrons at his regular bar, customers at a store he frequents—but the identity of the potential victim is not determinable at the time of the threat. The therapist's duty is triggered under the Restatement approach quoted above, but not under the victim-centered approach. The duty, under the Restatement approach, can be thought of as following the attacker, since the therapist has a duty to protect those in the attacker's vicinity. That is to say, it is foreseeable that anyone in the vicinity of a generally violent person will be harmed. This approach will be referred to as the "attacker-centered" approach. The shorthand phrase "foreseeable victim" will be used to indicate someone owed a duty under the attacker-centered approach but not under the victim-centered approach. Conversely, observe that a credible threat to an identifiable individual certainly makes that individual a foreseeable target of the attacker's harm. Thus, danger to an identifiable person triggers a duty under either approach. Part IV examines the economic significance of choosing one of the above triggers over the other.⁴⁷

Despite *Tarasoff's* celebrity status, recent decisions confirm that the scope and triggers articulated by the California Supreme Court are not universally accepted.⁴⁸ Further, it is possible that, in jurisdictions with a common law *Tarasoff* duty rather than a statutory one, the duty might be susceptible to judicial erosion. That is, in no uncertain terms, the status of the *Tarasoff* duty—the form of the solution to the dangerous patient problem—is very much a live controversy. Many supporting and detracting arguments have been made using theories

47. For a particularly insightful doctrinal separation of the victim-centered approach from the attacker-centered approach, see Alan R. Felthous & Claudia Kachigian, *To Warn and to Control: Two Distinct Legal Obligations or Variations of a Single Duty to Protect?*, 19 BEHAV. SCI. & L. 355 (2001).

There are other components of the triggering conditions that are not dealt with in this article. One of these is the requisite seriousness of the confidential therapist-patient relationship. Many dangerous patient cases—including *Tarasoff* itself—have arisen under facts demonstrating an intense, one-on-one relationship between therapist and patient lasting more than a few counseling sessions. See, e.g., *Kolt v. United States*, No. 94-CV-0293E(H), 1996 U.S. Dist. LEXIS 15786, at *2-*3 (W.D.N.Y. Oct. 1, 1996) (regular psychotherapy sessions at Veterans Administration facility for nearly four years). But, courts have found the requisite relationship after only two cursory outpatient encounters, *Jablonski v. United States*, 712 F.2d 391, 393-94 (9th Cir. 1983), or a week's worth of periodic observation, *Leonard v. Latrobe Area Hosp.*, 625 A.2d 1228, 1229 (Pa. Super. Ct. 1993).

48. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 355 (5th ed. 2004) (citing Texas and Virginia as explicitly rejecting *Tarasoff*).

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party knows that the other party knows the information, and so on.⁶²

Next, a measure of economic efficiency must be selected. For the purposes of this article, a liability regime is “efficient” if the simultaneous exercise of optimal care by both injurer and victim is a Nash equilibrium.⁶³ This is perhaps the most widely used measure of efficiency in game theory literature.⁶⁴

A particular strategy combination⁶⁵ is a Nash equilibrium if it is not possible for either player, acting unilaterally, to vary his strategy

B. The Basic Model of Simultaneous Torts

Consider an accident involving two risk-neutral parties, each of whom selects his care level independently, without the other's knowledge.⁷¹ That is, victim and injurer take care simultaneously.⁷² An ordinary traffic accident involving two cars approaching each other on a highway is an illustrative example. Let x and y

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additional care unit will cut damages by more than one dollar.⁷⁸ But beyond this level, the cost of additional care exceeds the additional savings in damages.

Let τ represent the total social cost of the accident. Since total social cost is the sum of the parties' care and the expected damages, it follows that $\tau = \tau(x, y) = x + D(x, y) + y$.⁷⁹ The properties of D noted above ensure that there actually exist values of injurer's and victim's care that minimize total social cost.⁸⁰ Call the optimal levels of injurer's and victim's care x^*

damages.⁸³ “Threshold” comparative negligence differs from pure comparative negligence in that when both injurer and victim are negligent, liability is only borne jointly if the victim takes at least as much care as the injurer.⁸⁴ This article will follow the tradition of law and economics literature by adopting a generalized form of comparative negligence, the features of which can be adjusted to mimic either a pure or a threshold scheme.⁸⁵

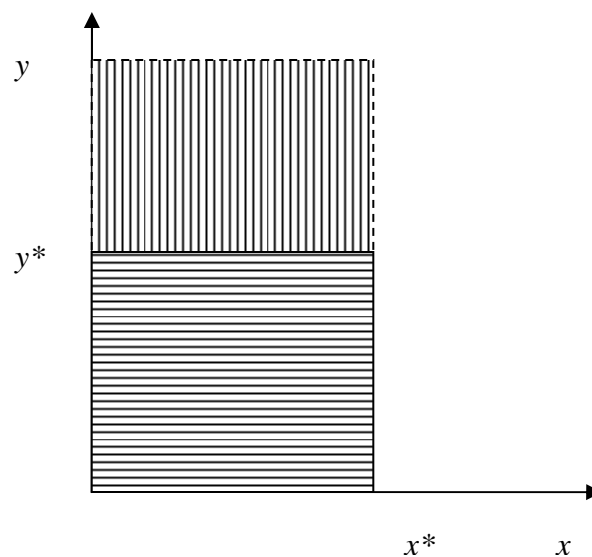
To describe this system, let β represent the fraction of damages borne by the injurer when both parties are negligent. This fraction increases as the injurer exercises less care or the victim exercises more care.⁸⁶ Let u_i denote the function describing the injurer’s total liability.⁸⁷ Further, suppose that the court (or the legislature) has set all the relevant due care standards equal to the optimal care values derived above. Then, the injurer’s liability is described by

$$\begin{aligned}
 & u_i(c_i, c_v) && \text{if } c_i < c_v && * \\
 & \beta u_i(c_i, c_v) + (1-\beta)u_v(c_i, c_v) && \text{if } c_i \geq c_v \text{ and } c_v < c_v^* && * \\
 & u_v(c_i, c_v) && \text{if } c_i \geq c_v \text{ and } c_v \geq c_v^* && *
 \end{aligned}$$

The graph below shows the different regions of liability.⁸⁸ The lined regions represent zones where the injurer is liable for more than just his own care expenditure. The vertically-lined region represents the zone where the injurer is liable for full damages, while the horizontally-lined region represents the zone where the injurer is liable for partial damages.

Figure 1

Comparative Negligence: Regions of Injurer Liability



Comparative negligence has a unique Nash equilibrium of optimal care in the case of a simultaneous tort.⁸⁹ To see this, suppose that the victim believes the injurer will select optimal care. According to the rules articulated above, the victim will then be fully liable for any damages that ensue, plus her own cost of care.⁹⁰ Her task, then, is to minimize the sum of damages and care.⁹¹ Until the victim reaches her optimal level of care, every dollar spent on care will cut damages by more than one dollar, but, after she reaches this

88. This graph is adapted from Haddock & Curran, *supra* note 82, at 52.

89. MICELI, *supra* note 50, at 19-20.

90. Her liability is described by $u_V(x^*, y) = D(x^*, y) + y$.

91. That is, she must minimize $u_V(x^*, y) = D(x^*, y) + y$.

level, each additional care dollar will only cut damages by some amount less than one dollar.⁹² It follows that the victim should spend until she reaches optimal care. Thus, optimal care is the victim's best response.

Conversely, suppose that the injurer believes that the victim will select optimal care. If the injurer exercises optimal care, he will have to pay only for the cost of that care.⁹³ However, if the injurer selects a negligent level of care, he will also be fully liable for damages.⁹⁴ The question then becomes whether taking optimal care is cheaper than taking some lesser level of care but also incurring damages.⁹⁵ The answer is "yes." To see this, note first that optimal care alone is cheaper than optimal care plus damages resulting from optimal care.

the defining feature of comparative negligence—fractional damages apportionment—never came into play.¹⁰² In equilibrium, the comparative negligence regime ends up not performing the cost-spreading function its supporters often cite for its superiority over “all or nothing” negligence regimes.¹⁰³ This irony has served as the centerpiece of arguments against comparative negligence.¹⁰⁴

C. *The Basic Model of Sequential Torts*¹⁰⁵

Consider an accident involving two risk-neutral parties but, unlike a simultaneous tort, one party selects his level of care before the other.¹⁰⁶ Moreover, the second party observes the first party’s care selection.¹⁰⁷ The venerable English case of *Butterfield v. Forrester* is illustrative: the defendant, while repairing his house, negligently left a large pole on the street, obstructing the roadway. Later that evening, the plaintiff’s horse, while galloping down that street, tripped and fell on the pole, leaving the plaintiff injured.¹⁰⁸ The total social cost is not altered by the sequential nature of the

102. Indeed, the solution steps in the proof are actually identical to those in the proof of efficiency of simple and contributory negligence—systems without fractional damage apportionment. MICELI, *supra*

accident.¹⁰⁹ That is: $\tau = \tau(x, y) = x + D(x, y) + y$. Therefore, the optimal care values are again given by x^* and y^* . The expressions for victim's and injurer's liability are also the same as those derived above for a simultaneous tort.

The sequential nature of the accident does, however, require a slight reformulation of the concept of Nash equilibrium. This can be done easily (and without disturbing the earlier results). Instead of defining the Nash equilibrium in terms of care values selected by each party, it must be defined in terms of courses of action which incorporate the fact that the parties act sequentially. The strategies

IV. MODELING THE DANGEROUS PATIENT SCENARIO

A. *Assessing the Basic Models*

The dangerous patient scenario, from start to finish, encompasses an extensive sequence of events: (1) a prospective patient—either dangerous or non-dangerous—begins therapy; (2) the therapist treats the patient and attempts to diagnose dangerousness; if the therapist finds the patient to be dangerous; (3) the therapist takes affirmative steps, such as seeking involuntary commitment, to protect potential victims; (4) the therapist warns the victim that she might be in danger; (5) the victim tries to avoid a violent encounter; but nevertheless (6) an attack occurs.¹¹³ Independently, and in parallel with this sequence, the victim gathers knowledge of her attacker's violent tendencies, perhaps in anticipation of a confrontation or simply as part of her daily routine.¹¹⁴ The bulk of the academic controversy and judicial and legislative disagreement regarding the dangerous patient problem focuses on how to frame the therapist's duty once he diagnoses dangerousness. Therefore, this article takes the diagnosis of dangerousness as a starting point and analyzes the subsequent events, including the victim's knowledge-gathering.

Which of the above tort models is best suited to this analysis? It seems right to say that, at least in most cases, the victim will make her care selection without observing the therapist's expenditure on protective measures such as the initiation of commitment proceedings. In this sense, each party exercises care simultaneously, and the simultaneous-tort model is appealing. However, if the therapist decides to warn the victim, he exercises care before the victim does. Since the warning is necessarily conveyed directly to the victim, the victim observes the therapist's care level. Thus, therapist's warning care and victim's care are taken sequentially, suggesting the use of the sequential-tort model. It is apparent, then, that restricting the analysis to one or the other of the above two models does not accurately capture the dangerous patient scenario.

The deficiency of either model used alone becomes more apparent when the relationship between each party's precautionary expenditures and the expected damages is scrutinized. In both of the

113. See generally Ginsberg, *supra* note 6 (discussing cases involving dangerous patients).

114. *Id.*

basic models, the entirety of a party's precautionary expenditures directly affects expected damages.¹¹⁵ That is, expected damages always vary as injurer's or victim's care changes. However, in the

Lastly, consider the expression for expected damages. As in the basic models, damages depend on the level of care exercised by the parties that actually and directly result in their protection. Therefore, expected damages can be written as $D(p, v)$.¹²⁷ Victim's knowledge and therapist's warning care do not figure into damages since, although they make the prospect of taking care more attractive to the victim, they do not conclusively determine that the victim will indeed take more care.

The total social cost of the dangerous patient problem is the sum of therapist's costs, victim's costs, and damages, and can therefore be written

$$\tau = \tau(w, p, v, k) = \underbrace{w + p}_{\text{therapist's costs}} + \underbrace{D(p, v)}_{\text{expected damages}} + \underbrace{C(v; k, w) + k}_{\text{victim's costs}}.$$

The above observations and assumptions guarantee that there exists a unique optimal minimizing value of each precautionary variable.¹²⁸ Call these optimal values w^* , p^* , v^* , and k^* .

C. Describing the Liability Regime and Achieving the Social Optimum

The comparative negligence system analyzed above can be used in the dangerous patient problem, but the ultimate form of the negligence rules in any given jurisdiction will necessarily depend upon (1) whether that jurisdiction allows the duty to be satisfied by warning only, protection only, or requires both warning and protection, and (2) whether the jurisdiction adopts the victim-centered trigger or the attacker-centered trigger.¹²⁹ The following analysis examines the various implementations of the *Tarasoff* rule and

care, and victim's knowledge—contribute to the total social cost of a *Tarasoff* dangerous patient attack. Moreover, these quantities interact in ways more complex than injurer's and victim's care in the basic tort scenarios studied earlier. For this reason, the foregoing analysis will focus chiefly on the conditions under which the social optimum is a Nash equilibrium point, and less so, if at all, on ancillary questions—such as the possible existence of non-optimal Nash equilibria—that were able to receive more attention in the context of the basic models.¹³⁰

It is useful to review the strategies open to each party that result in optimal care. The therapist chooses his level of care without being privy to the victim's level of knowledge of her attacker's dangerousness and before the victim selects her level of care. Thus, the only therapist strategy corresponding to optimal care is “*warn optimally and protect optimally.*” In particular, the therapist's strategy does not incorporate any notion of sequence; he is the “first mover.”¹³¹ The victim, on the other hand, moves in part before (or simultaneously with) and in part after the therapist. To wit, she gathers knowledge independently of any interaction with the therapist, but she selects her level of precautionary care after observing the therapist's warning. Strategies for the victim that result in optimal care are therefore: “*gather optimal knowledge; take optimal care in all cases*” and “*gather optimal knowledge; take optimal care in response to optimal warning care, but take negligent care in response to negligent warning care.*”¹³² Thus, there are two possible strategy combinations that ultimately result in the social optimum: (1) the therapist takes optimal care in warning and protection, and the victim gathers optimal knowledge and takes optimal care in all cases; or (2) the therapist takes optimal care in warning and protection, and the victim gathers optimal knowledge and takes optimal care whenever she observes the therapist's optimal warning, but takes negligent care otherwise.

130. See, e.g., Parts III.B-C.

131. To this extent, the therapist is in the same position as the sequential-tort injurer. See *supra* Part III.C.

132. Observe that, for the purposes of establishing that the optimal values form a Nash equilibrium, the victim's strategy “*Gather optimal knowledge; take optimal care in response to negligent care, but take negligent care in response to optimal care*” need not be considered. This is so because, if it were selected, either the victim or the therapist would have to select a non-optimal care value. This would defeat the aim of constructing a Nash equilibrium consisting only of optimal values of the precautionary variables.

There are six duty-trigger permutations in which to test the above strategy pairings, depending upon whether the duty involves warning, protection, or both, and whether the trigger is victim-centered or attacker-centered. Also, for each duty-trigger combination, the analysis can be carried out with respect to an identifiable victim or a victim of harm which is merely foreseeable. This doubles the total number of possibilities to 12. This might seem daunting, but several preliminary observations considerably simplify the situation.

First, observe that, for a victim of harm which is merely foreseeable, neither of the two optimal strategy pairings can actually be achieved. This victim is not identifiable at the time of the threat. Such a victim likely has never had any previous contact with her attacker, and thus cannot gather optimal knowledge. Further, such a victim likely cannot be readily identified before the encounter, thus preventing the therapist from delivering an optimal warning. The chance customer at a store visited by the dangerous patient is an illustrative example of such a victim. Therefore, under any duty, a dangerous patient scenario involving a merely foreseeable victim never possesses a realizable Nash equilibrium consisting of optimal values of all precautionary variables. This cuts the total number of

basic tort models in that a court assesses the care of each party on one dimension only, as opposed to a unified duty regime where both warning and protection are analyzed. If the therapist warns optimally, he pays only for his warning and protection costs. If the therapist warns negligently and the victim takes optimal care, the therapist incurs his warning and protection costs, plus damages. If the therapist warns negligently and the victim takes negligent care, the therapist incurs his warning and protection costs, plus only a portion of the damages. In this regime, the precise fraction of damages borne by the therapist is a function of his warning care and the victim's protective care. Thus, the therapist's liability, denoted here by u_T , is described by

$$u_T = \begin{array}{ll} w + p & \text{if } w \geq w^* \\ w + p + D(p, v) & \text{if } w < w^* \text{ and } v \geq v^* , \\ w + p + \beta(w, v)D(p, v) & \text{if } w < w^* \text{ and } v < v^* \end{array}$$

and victim's liability is described by

$$u_V = \begin{array}{ll} D(p, v) + C(v; k, w) + k & \text{if } w \geq w^* \\ C(v; k, w) + k & \text{if } w < w^* \text{ and } v \geq v^* . \\ [1 - \beta(w, v)]D(p, v) + C(v; k, w) + k & \text{if } w < w^* \text{ and } v < v^* \end{array}$$

Neither of the two possible optimal care combinations is a Nash equilibrium. This is because the therapist's strategy of optimal care in both warning and protection will never in practice be selected.¹³³ Suppose, for the sake of contradiction, that the therapist did select this strategy. According to the liability functions given above, this strategy results in the therapist bearing the cost only of his own care.¹³⁴ But, regardless of the victim's strategy choice, the therapist can unilaterally improve his lot by warning optimally but exercising zero protective care.¹³⁵ Since the definition of a Nash equilibrium requires that neither party be able to unilaterally improve his lot by

133. Game theoretically, the therapist's strategy of dual optimal care is strictly dominated by the strategy of optimal care in warning only.

134. His liability function is $u_T = w^* + p^*$.

135. This would reduce his liability to $u_T = w^* < w^* + p^*$.

varying from the putative Nash strategy,¹³⁶ the therapist's optimal warning and protective care cannot be part of a Nash equilibrium. The therapist's liability is reduced from optimal warning care plus optimal protective care to optimal warning care alone. Since both optimal care combinations require this strategy on the part of the therapist, it follows that the warn-only regime has no Nash equilibrium.

2. *Protect-Only Duty*

In a protect-only jurisdiction, the therapist avoids all damages if he exercises optimal protective care. If he protects negligently, however, he will incur full damages plus his own cost of care if the victim takes optimal care, and he will incur a portion of the damages plus his own cost of care if the victim takes negligent care. The damages apportionment parameter will depend only on the therapist's protection and the victim's care. Therefore, the therapist's liability is given by

$$u_T = \begin{array}{ll} w + p & \text{if } p \geq p^* \\ w + p + D(p, v) & \text{if } p < p^* \text{ and } v \geq v^*, \\ w + p + \beta(p, v)D(p, v) & \text{if } p < p^* \text{ and } v < v^* \end{array}$$

and the victim's is given by

$$u_V = \begin{array}{ll} D(p, v) + C(v; k, w) + k & \text{if } p \geq p^* \\ C(v; k, w) + k & \text{if } p < p^* \text{ and } v \geq v^* \\ [1 - \beta(p, v)]D(p, v) + C(v; k, w) + k & \text{if } p < p^* \text{ and } v < v^* \end{array}$$

optimal protection plus full damages.¹⁴⁶ This relationship may be true, but it need not be. If it is true, the therapist's strategy "*warn optimally and protect optimally*" is indeed a best response.

Conversely, suppose the victim believes that the therapist will exercise dually optimal care. From the definition of optimality, it follows that, until the victim's optimal care level is reached, she will more than offset the marginal cost of taking additional care with marginal savings in expected damages. This establishes that it is in the victim's best interest to take optimal care; optimal care is her best response. As for the victim's best response regarding her level of knowledge, the definition of optimality implies that savings in the cost of care will more than offset additional knowledge gathered until the optimal level of knowledge is reached, but will cease to do so beyond that level.¹⁴⁷ Thus, the victim's strategy "*gather optimal knowledge; take optimal care in all cases*" is a best response to the therapist's strategy "*warn optimally and protect optimally.*"¹⁴⁸

It follows that the strategy combination of "*warn optimally and protect optimally*" on the part of the therapist and "*gather optimal knowledge; take optimal care in all cases*" on the part of the victim may be a Nash equilibrium, but need not necessarily be a Nash equilibrium.

To test the second optimal strategy combination, suppose first that the therapist believes the victim will select the strategy "*gather optimal knowledge; take optimal care in response to optimal warning care, but take negligent care in response to negligent warning care.*" Whether dually optimal care is the therapist's best response depends upon how precipitously the victim's cost of care decreases as she

gains more knowledge from a therapist's warning.¹⁴⁹ This property is not dictated by the terms of the dangerous patient scenario; it may or may not hold in a given case. That is, the therapist's strategy "*warn optimally and protect optimally*" may or may not be the therapist's best response.

Conversely, suppose the victim believes that the therapist will exercise dually optimal care. It is clear, from the above analysis of the first optimal care strategy combination, that the victim's strategy "*gather optimal knowledge; take optimal care in response to optimal warning care, but take negligent care in response to negligent warning care*" is a best response for the victim.

149. If the therapist believes the victim will actually select this strategy, then it must be the case that, for any $w < w^*$ and for any p , the following relationship holds:

$$\min_{v < v^*} [1 - \beta(w, p, v)]D(p, v) + C(v; k^*, w) + k^* < C(v^*; k^*, w) + k^*.$$

The next question is whether dually optimal care is the therapist's best response. Suppose it is not. Then it must be true that there exists some $w_0 < w^*$ and some p_0 such that

$$w_0 + p_0 + B(w_0, p_0, v)D(p_0, v) < w^* + p^*$$

for whatever value of v the victim decides to select. In this scenario, the victim will select the value of v that maximizes the value of $0.87676112.02410$ value of 4

This analysis shows that, while both strategy combinations which minimize the total social cost of the dangerous patient problem *may* be Nash equilibria, neither *need* be. The following table presents a summary of the results proven in this section. The entries in the table describe the number of socially optimal Nash equilibria in a given duty-trigger combination.

Figure 2

Number of Nash Equilibria in Certain *Tarasoff* Duty Versions

<u>Trigger</u> <u>Duty</u>	Victim-centered	Attacker-centered
Warn-only	Identifiable victim: None Foreseeable victim: N/A	Identifiable victim: None Foreseeable victim: None
Protect-only	Identifiable victim: None Foreseeable victim: N/A	Identifiable victim: None Foreseeable victim: None
Warn-and-Protect	Identifiable victim: None by necessity, but potentially as many as 2 Foreseeable victim: N/A	Identifiable victim: None by necessity, but potentially as many as 2 Foreseeable victim: None

V. IMPLICATIONS

A. *Contemporary Controversies in Law and Economics*

The above analysis shows that the *Tarasoff* duty does not

law generally achieves efficient results.¹⁵¹

But more conclusions can be drawn. In fact, this result can serve as somewhat of an ideological Rorschach: different normative views about law and economics yield different interpretations. For example, those who believe in the efficiency hypothesis might contend that the lack of across-the-board efficiency of the *Tarasoff* regime has no bearing on the common law efficiency thesis, since *Tarasoff* has been implemented by statute in a vast majority of states. Inefficiency is no surprise then, because statutes are often regarded as less efficient than the common law.¹⁵² This argument seems weak, however, since many states have codified the unified victim-centered approach—the only version with a chance at efficiency—rather than one of the necessarily inefficient versions. Also, judges have had the opportunity to refine this statutory approach by applying interpretive glosses where justified.¹⁵³

Still other commentators might view the lack of necessary efficiency as support for a theory favoring the use of treble damages to supplement inefficient negligence schemes.¹⁵⁴ Recall that the strategy combination of therapist's optimal care and victim's optimal knowledge and optimal care in all cases is a Nash equilibrium if optimal warning is cheaper than damages resulting from optimal therapist's protection and optimal victim's care. Artificially multiplying the magnitude of the damages function can satisfy this relationship and make the strategy combination efficient.

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Finally, those who believe that the American tort system as a whole is too administrative,⁸ too costly,⁸ or too difficult to deal with⁹ believe that the

greater patient autonomy might note that a protect-only duty disincentivizes warning—since a court does not take warning into account in assigning liability—and encourages confining the patient and restricting his movement.¹⁵⁹ However, a protect-only duty never produces socially optimal results.¹⁶⁰ On the other hand, a warn-and-protect duty is efficient under certain conditions.¹⁶¹ Therefore, the argument might conclude, states should impose a unified duty, which accommodates and incentivizes warning—a precaution less physically restrictive of the patient than confinement—and eschew a protect-only approach, which does not.

Victims' rights advocacy groups can also make positive use of the results proven here to advance their cause in the political arena. In particular, they can observe that the only version of the duty which accommodates (even though it does not demand) an efficient *Tarasoff* regime is that which places the most comprehensive restrictions on the therapist: the warn-and-protect version.¹⁶² Socially optimal results cannot be achieved in the warn-only and protect-only versions; they can only be achieved, if at all, where the therapist is induced to take both types of precautions simultaneously.¹⁶³ Therefore, a victims' rights group can lobby in a principled way for the adoption of the warn-and-protect duty. Such lobbying would advance the group's private motivations by emphasizing the dual measures geared toward victim safety and garnering popular support by justifying the position on broad-based efficiency grounds.

Additionally, mental healthcare providers who support a stronger confidentiality norm can point to the results proven above as a source of support for the very general proposition that current efforts to balance therapist-patient confidentiality with public protection do not always yield optimal results. Thus, they might argue, it is time for legislatures and common law judges alike to reconsider how to best protect potential victims of dangerous psychotherapy patients, opening up the general discussion even if specific alternatives are not suggested. On the other hand, those arguing against such reconsideration can point to the behavior of the warn-and-protect duty in a victim-centered jurisdiction. They can argue that a potentially

159. *See*

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efficient duty has already been found, and subsequent discussion

