In The

SUPREME COURT OF THE STATE OF CALIFORNIA

ERIK GALEN MENENDEZ, JOSEPH LYLE MENENDEZ, Petitioners, v. THE SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR THE COUNTY OF LOS ANGELES, Respondent. - - - - - - - - - - - - - - - - - THE PEOPLE OF THE STATE OF CALIFORNIA By Ira Reiner, Los Angeles County District Attorney, Real Party In Interest.	No. S017206 (2nd Dist., Div. V, No. B052293) (L.A. Super. Ct. No. SA 002728)

APPLICATION OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION AND THE CALIFORNIA PSYCHOLOGICAL ASSOCIATION FOR LEAVE TO FILE A BRIEF AMICUS CURIAE IN SUPPORT OF PETITIONERS

The American Psychological Association and its affiliate, the California Psychological Association, seek leave to file the accompanying brief amicus curiae in support of the Petitioners.

INTEREST OF AMICI CURIAE

The American Psychological Association ("APA") has been the principal professional association of psychologists in the United States since 1892. Its membership numbers more than 100,000 nationwide. The California Psychological Association ("CPA") is

a state affiliate of APA, and has a membership of more than 5,000 licensed psychologists in California. APA and CPA members in clinical practice treat hundreds of thousands of patients each year who are willing to enter treatment only because they expect -- and rely on -- confidentiality of the patient-therapist relationship. APA and CPA members therefore have a substantial interest in legal rules that preserve the patient's right to confidentiality -- the right that is at issue in this appeal. The scope of confidentiality and evidentiary privilege also is important in defining psychologists' professional obligations to their patients.

Likewise, APA and CPA members have a concrete interest in judicial decisions that may require termination of their therapeutic relationship with some patients. By holding in this case that the therapeutic relationship terminates automatically by operation of law prior to the time when patients and therapists actually decide to discontinue treatment, the Court of Appeal stripped patients of significant rights, divested therapists of their duties, and dictated an end to therapy. APA and CPA members have a vital interest in ensuring that if such termination is legally mandated, it be done under appropriate rules.

APA and CPA are familiar with the questions involved in this case. They believe there is a need for additional argument on the following points, which APA and CPA address in their proposed brief amicus curiae, which is submitted with this application.

SUMMARY OF POINTS TO BE ARGUED

The Court of Appeal made two important rulings in this case: (1) that therapy, by definition, always terminates whenever a patient threatens to harm his or her therapist, and therefore (2) that whenever a patient threatens to harm the therapist, all subsequent communications with the therapist lose their confidentiality. If this Court affirms these rulings, the "chilling effect" on potentially dangerous patients and their therapists will be so strong that few -- if any -- such patients will continue treatment following their voicing a threat. Therapists will be professionally obligated to inform these patients that confidentiality has ceased, and most such patients will leave. Therapy that could avoid future violence will not be provided and future warnings will not be given. By abruptly aborting therapy to these dangerous patients, such a rule would result in more -- not less -- danger to patients, therapists and the public. Equally important, public awareness of this rule would deter from even entering treatment large numbers of people who are not sure what they may say in therapy or how the legal rules will be applied. Finally, the Court of Appeal standard substitutes for the relatively clear rules under existing decisions a vague rule that requires a court to reconstruct and divine the "primary" intentions of mentally ill people and their therapists.

In People v. Wharton, 53 Cal.3d 522, 280 Cal.Rptr. 631 (1991), this Court struck a delicate balance between the

compelling state interest in protecting citizens from harm and the constitutional, statutory, and common law rights of privacy in the patient-therapist relationship. The Wharton decision held that only the content of actual warnings to third parties, and the statements that triggered those warnings, are non-privileged under the "dangerous patient" exception to the patient-psychotherapist privilege. 53 Cal.3d at 562-63, 280 Cal. Rptr. at 655 (1991). In Wharton, two justices dissented, believing that even this waiver of confidentiality went too far and construed the dangerous patient exception too broadly. But at least the Wharton rule embodied some balanced, common sense standard: confidentiality is breached only to the extent necessary to protect the public.

Now, however, the Real Party in Interest seeks to sweep aside the Wharton rule in favor of a total disregard for confidentiality any time that a patient credibly voices a threat. Because of the large number of patients who threaten a therapist or another person at some time, this new proposed rule would end confidentiality and perhaps therapy itself in large numbers of cases. This Court should reject the invitation to so radically move beyond Wharton, to discard confidentiality, and to create a rule that will increase, rather than decrease, the public's exposure to dangerous people.

The APA and CPA request that the proposed brief amicus curiae accompanying this Application be received and filed.

Dated: October 8, 1991

Respectfully submitted,

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THE PEOPLE OF THE STATE OF CALIFORNIA By Ira Reiner, Los Angeles County District Attorney, Real Party In Interest.	

BRIEF OF AMICI CURIAE THE AMERICAN PSYCHOLOGICAL ASSOCIATION AND THE CALIFORNIA PSYCHOLOGICAL ASSOCIATION IN SUPPORT OF THE PETITIONERS

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INTEREST OF AMICI CURIAE

The American Psychological Association ("APA") has been the principal professional association of psychologists in the United States since 1892. Its membership numbers more than 100,000 nationwide. The California Psychological Association ("CPA") is a state affiliate of APA, and has a membership of more than 5,000 licensed psychologists in California. APA and CPA members in clinical practice treat hundreds of thousands of patients each year who are willing to enter treatment only because they expect -- and rely on -- confidentiality of the patient-therapist relationship. APA and CPA members therefore have a substantial interest in legal rules that preserve the patient's right to confidentiality -- the right that is at issue in this appeal. The scope of confidentiality and evidentiary privilege also is important in defining psychologists' professional obligations to their patients.

Likewise, APA and CPA members have a concrete interest in judicial decisions that may require termination of their therapeutic relationship with some patients. By holding in this case that the therapeutic relationship terminates automatically by operation of law prior to the time when patients and therapists actually decide to discontinue treatment, the Court of Appeal stripped patients of significant rights, divested therapists of their duties, and dictated an end to therapy. APA and CPA members have a vital interest in ensuring that if such termination is legally mandated, it be done under appropriate rules.

STATEMENT OF ISSUES

1. Whether the "dangerous patient" exception to the usual privilege protecting patient-therapist communications is limited to the content of warnings given to third parties and the communications that "triggered" such warnings, or the exception voids confidentiality for the entire content of therapy.

2. Whether the patient-therapist relationship automatically terminates by operation of law whenever a patient threatens the therapist, or whenever either the therapist or the patient is no longer "primarily" motivated by a desire to engage in therapy.

STATEMENT OF FACTS

On August 20, 1989, Jose and Mary Louise Menendez were murdered in their home. In March 1990, petitioners Erik Galen Menendez and Joseph Lyle Menendez (the "Menendez brothers") were arrested and charged with killing their parents. For some time after the murder and before they were arrested, petitioners were treated in therapy by a psychologist, Dr. Jerome Oziel. Redacted Factual Findings of the Superior Court (hereinafter "Super. Ct. Findings") ¶¶ 7-8. During a therapy session on October 31, 1989, petitioners allegedly threatened the life of Dr. Oziel. Super. Ct. Findings ¶ 10. As a result of this threat, Dr. Oziel concluded that his family and loved ones were in danger. Later that day, he warned his wife, Dr. Laurel Oziel, and his "girlfriend," Ms. Judalon Smyth. Super. Ct. Findings ¶¶ 10-11. Dr. Oziel apparently relayed additional warnings to his wife in the next few days. Super. Ct. Findings ¶ 15.

After the October 31 session, Dr. Oziel made a number of audio tapes relating to his treatment of petitioners. Super. Ct. Findings ¶ 16. One tape contains Dr. Oziel's notes from his October 31 and November 2, 1989 sessions with petitioners. Court's Exhibit 1. A second tape contains Dr. Oziel's notes from his November 28, 1989 session with petitioner Erik Menendez. Court's Exhibit 2. A third tape is an actual recording of the therapy session between Dr. Oziel and petitioners held on December 11, 1989. Court's Exhibit 3. At all times during the four sessions at issue, petitioners intended and expected that their communications with Dr. Oziel would be kept confidential, as communications made in the course of therapy. Super. Ct. Findings ¶ 21.

On March 9, 1990, police seized from Dr. Oziel the three audio tapes mentioned above, along with other documents. The prosecution seeks the right to introduce those tapes -- and transcripts of their contents -- into evidence at petitioners' pending murder trial. See Menendez v. Superior Court, 228 Cal. App. 3d 1320, 1323-25, 279 Cal. Rptr. 521, 522-23 (1991). Dr. Oziel, and Petitioners, seek to exclude these tapes from evidence, on the grounds that they constitute or contain privileged patient-therapist communications. Petitioners' Opening Brief ("Pet. Brief") at 4-5.

After conducting in camera hearings on the issue, the Superior Court ruled that all "the referenced communications were intended by the brothers to be confidential within the meaning of the psychotherapist-patient privilege," but that they lost their

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After conducting in camera hearings on the issue, the Superior Court ruled that all "the referenced communications were intended by the brothers to be confidential within the meaning of the psychotherapist-patient privilege," but that they lost their

confidential status because Dr. Oziel reasonably concluded that disclosure was necessary to warn third parties of the danger posed by the Menendez brothers. See Menendez v. Superior Court, 279 Cal. Rptr. at 527.

Subsequently, after various rulings by the Court of Appeal and this Court, the Menendez brothers petitioned the Court of Appeal for a writ of mandate. The Court of Appeal acknowledged that the tapes contain "confidential communications," as defined in the California Evidence Code. Menendez, 228 Cal. App. 3d 1320, 1323, 279 Cal. Rptr. 522. It further acknowledged that such confidential communications fall within the psychotherapist-patient privilege codified in the Evidence Code, and that the holders of the privilege, the Menendez brothers, could prohibit the disclosure of these communications, absent some exception to the privilege. Id.

The Court of Appeal held, however, that since certain statements made during the October 31 and November 2 sessions between Dr. Oziel and the Menendez brothers prompted Dr. Oziel's warnings to his wife and Ms. Smyth, everything said during those sessions fell under the "dangerous patient" exception to the general privilege rules and were, therefore, not privileged. Id. at 1324.

The Court of Appeal also held that the tapes relating to the November 28 and December 11 sessions were not privileged because, it said as a sort of quasi-factual finding, those sessions were not held "for the purpose of therapy." Id. The Court of Appeal seemingly based this holding on its conclusion that the therapeutic

relationship between the Menendez brothers and Dr. Oziel must, as a matter of law, have "disintegrated once petitioners threatened Dr. Oziel's life." Id. at 1333. The Court of Appeal also based its holding on its inference that, following petitioners' threats, neither Dr. Oziel nor the petitioners were "primarily" motivated by a desire to give or receive therapy. Id.

Following the Court of Appeal's decision, petitioners were granted review by this Court.

ARGUMENT

SUMMARY OF ARGUMENT

The facts of record in this case do not paint a very appealing picture, either of the petitioners or of Dr. Oziel. The Menendez brothers are charged with a heinous crime; it is not surprising that a court might incline toward admissability of potentially highly probative evidence. The record indicates that Dr. Oziel had an extra-marital relationship with Ms. Smyth, and employed her to eavesdrop on therapy sessions. Reportedly, Dr. Oziel's psychology licensure is now on probationary status.

The Court of Appeal's ruling in this case rests upon two conclusions: (1) that therapy, by definition, always terminates when a patient communicates a serious threat against his or her therapist, and (2) that whenever a patient threatens a therapist, all post-threat communications with the therapist lose their confidentiality. If this Court affirms these conclusions, the "chilling effect" on potentially dangerous patients and their therapists will be so strong that few -- if any -- such patients

will continue treatment following their voicing a threat. Therapists will be professionally obligated to inform these patients that confidentiality has ceased, and most such patients will leave. Therapy that could avoid future violence will not be provided and future warnings will not be given. By abruptly aborting therapy to these dangerous patients, such a rule would result in more -- not less -- danger to the patients themselves, to therapists and to the public. Equally important, public awareness of this rule would deter from ever entering treatment large numbers of people who are not sure what they may say in therapy, or how the legal rules will be applied. Finally, the Court of Appeal opinion substitutes for the relatively clear rules under existing decisions, a vague rule that requires a Court to reconstruct and divine the "primary" intentions of mentally ill people and their therapists.

In People v. Wharton, 53 Cal.3d 522, 280 Cal. Rptr. 631 (1991), this court struck a delicate balance between the compelling state interest in protecting citizens from harm, and the constitutional, statutory, and common law rights of privacy in the patient-therapist relationship. The Wharton decision held that only the content of actual warnings to third parties, and the statements that triggered those warnings, are non-privileged under the "dangerous patient" exception to the patient-psychotherapist privilege. 53 Cal. 3d at 562-63, 280 Cal. Rptr. at 655 (1991). The Wharton decision was decided by a 4-3 vote, with at least two justices believing that even this waiver of confidentiality went

too far and construed the dangerous patient exception too broadly. But at least the Wharton rule embodied a balanced, common-sense standard: confidentiality is breached only to the extent necessary to protect the public.

Now, however, spurred perhaps by the lurid facts in this case, the Real Party in Interest seeks to sweep aside the Wharton rule in favor of a total disregard for confidentiality any time that a patient threatens the therapist. Because of the large number of patients who threaten a therapist or another person at some time (see Section II.A below), this would end confidentiality and perhaps therapy itself in large numbers of cases. This Court should reject the invitation to so radically move beyond Wharton, to discard confidentiality, and to create a rule that will increase, rather than decrease, the public's exposure to dangerous people.

I. THE COURT OF APPEAL CONSTRUED TOO BROADLY THE "DANGEROUS PATIENT" EXCEPTION TO THE GENERAL CONFIDENTIALITY OF PSYCHOTHERAPIST-PATIENT COMMUNICATIONS.

A. Exceptions to the Evidentiary Privilege Protecting Psychotherapist-Patient Communications Should Be Construed Narrowly.

California Evidence Code §1014 provides in relevant part that a "patient, whether or not a party, has a privilege to refuse to disclose, and to prevent another from disclosing, a confidential communication between patient and psychotherapist." The Code defines such a "confidential communication" as "information . . . transmitted between a patient and his psychotherapist in the course of that relationship and in confidence by a means which, so far as

the patient is aware, discloses the information to no third persons . . . ." Cal. Evid. Code Ann. §1012 (Deering 1986) (emphasis added).

Of course, there are exceptions to this broad privilege. But the history of these Code provisions, as well as subsequent case law, show clearly that the privilege was intended to be applied broadly and that any exceptions were intended to be applied narrowly.

For example, the comment of the Senate Law Revision Commission to §1014 emphasizes that the psychotherapist-patient privilege "provides much broader protection than the physician-patient privilege." Cal. L. Rev. Comm'n Comments, Evid. Code Ann. at 194-95 (Deering 1986). The Commission stressed that "[u]nless a patient . . . is assured that [intimate and embarrassing details] will be held in utmost confidence, he will be reluctant to make the full disclosure upon which diagnosis and treatment . . . depends." Id. The Commission acknowledged that "the granting of the privilege may operate in particular cases to withhold relevant information," but concluded on balance that "the interests of society will be better served if [therapists] . . . are able to assure patients that this confidence will be protected." Id.

Consistent with this legislative intent, California courts have consistently respected the breadth of the psychotherapist-patient privilege. For example, in Scull v. Superior Court, 206 Cal. App. 3d 784, 788, 254 Cal. Rptr. 24, 26 (1988), the court refused to compel a psychotherapist, who was accused of sexually

molesting a patient, to release a list of his other female patients. The Court stated that §1014 "affords a broad privilege" to prevent disclosure of confidential information, and that this privilege is "founded upon the notion that certain forms of antisocial behavior may be prevented by encouraging those in need of treatment for emotional problems to secure the services of a psychotherapist." Id.

This Court has itself acknowledged the need for near-absolute confidentiality in treatment, as well as the benefit to society of encouraging potentially dangerous persons to seek treatment. See, e.g., People v. Stritzinger, 34 Cal. 3d 505, 511, 194 Cal. Rptr. 431, 435 (1983); Tarasoff v. Regents of University of California, 17 Cal. 3d 425, 459-60, 131 Cal. Rptr. 14, 39-40 (1976); In re Lifschutz, 2 Cal. 3d 415, 437, 85 Cal. Rptr. 829, 843-44 (1970).

In addition to being founded in the statutes, patient-therapist confidentiality is a constitutionally protected privacy interest that can only be overridden by a "compelling" state interest. In re Lifschutz, 2 Cal. 3d at 431-32, 85 Cal. Rptr. at 839-41; Cutter v. Brownbridge, 183 Cal. App. 3d 836, 842-43, 228 Cal. Rptr. 545, 548-49 (1986); Scull v. Superior Court, 206 Cal. App. 3d at 791, 254 Cal. Rptr. at 27.

Because of the social and legal importance of this patient-therapist privilege, courts have consistently held that exceptions to the privilege apply only in "narrowly circumscribed situations" where "the government seeks to promote a compelling interest and where there is no less intrusive means of accomplishing its

purpose." Scull v. Superior Court, 206 Cal. App. 3d at 791, 254 Cal. Rptr. at 27. See also In re Lifschutz, 2 Cal. 3d at 432, 85 Cal. Rptr. at 839-40 (even when the patient voluntarily sues, there is not a "complete waiver of privilege;" rather, "the patient-litigant exception allows only a limited inquiry into the confidences . . . directly relevant to the [matters] ... the patient has voluntarily disclosed and tendered in his pleadings); Cutter, 183 Cal. App. 3d at 843, 228 Cal. Rptr. at 549 (court must balance a "compelling need for discovery against the fundamental right of privacy," and "even where the balance tips in favor of disclosure, constitutional concerns require a strict circumspection of the scope of the disclosure"); Stritzinger, 34 Cal. 3d at 511, 194 Cal. Rptr. at 435 ("the psychotherapist-patient privilege has been broadly construed in favor of the patient"). Thus, even where the legislature has identified a "compelling" state interest that justifies an exception to the general privilege, the courts must shape the exception so that it is "intrusive" on confidentiality as little as possible.

B. Wharton Properly Limited the "Dangerous Patient" Exception to the Therapist's Actual Warnings to Third Parties and Statements That Triggered Such Warnings.

California Evidence Code §1024 provides that:

> There is no privilege under this article if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger.

This "dangerous patient" exception to the privilege has been applied narrowly by the courts. In Wharton, this Court recently acknowledged that the exception should be applied "only when the patient's case falls squarely within its ambit." 53 Cal. 3d at 554, 280 Cal. Rptr. at 649, quoting Stritzinger, 34 Cal. 3d at 513. Moreover, Wharton restated the well-settled rule that "constitutional concerns require a strict circumscription of the scope of the disclosure." Id., quoting Cutter, 183 Cal. App. 3d at 843, 229 Cal. Rptr. at 549.

In Wharton, the lower court required a murder defendant's therapists to testify to the content of certain statements made by the defendant during therapy. This Court reiterated that under Evidence Code §1024, there was no privilege for those statements which were communicated to a third party pursuant to Tarasoff v. Regents of University of California, 17 Cal. 3d 425, 131 Cal. Rptr. 14 (1976).[1] The Court also ruled that there was no privilege as to the statements made in therapy that "triggered" the Tarasoff warnings. Wharton, 53 Cal. 3d at 554, 280 Cal. Rptr. at 649. That holding sought to "vindicate the Legislature's [intent]" by striking a "careful balance between the need for confidentiality in the psychotherapeutic relationship on the one hand, and public safety concerns on the other." Id. at 652. (Emphasis added.) The

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[1] Under Tarasoff, when a patient communicates to his or her therapist a serious threat to a readily identifiable individual, the therapist has a duty to take reasonable steps to protect that individual. Tarasoff, 17 Cal. 3d at 434-43, 131 Cal. Rptr. at 22-28. Often, such duty will be fulfilled, as in Wharton, by warning the individual target of the threat.

Court struck that balance explicitly by affirming that the privilege continued to apply to "statements that did not trigger the . . . warning." Wharton, 53 Cal. 3d at 554, 280 Cal. Rptr. at 649 (emphasis in original). The Court found that limiting disclosure to "triggering" remarks "circumscrib[es] the scope of the exception" and thus acts "in accordance with both the intent of the Legislature and this court's prior pronouncements on the subject." Id. This limitation on the scope of §1024 was crucial to this Court's holding in Wharton.[2] It is also consistent with this Court's original ruling in Tarasoff that even when disclosure of confidences is required, it must be done "discreetly, and in a fashion that would preserve the privacy of the patient to the fullest extent compatible with the prevention of the threatened danger." 17 Cal. 3d 442, 131 Cal. Rptr. 14 at 27.

The Court of Appeal decision in this case would destroy Wharton's carefully balanced rule and expand §1024 far beyond its intent. The Court of Appeal ruled that "Dr. Oziel had reasonable cause to believe that petitioners posed a danger to him, his wife, and his paramour," and that Dr. Oziel needed to do more than issue a vague warning; he needed to provide his wife and Ms. Smyth with some reasons in order to convince them that the threat was real. Menendez, 228 Cal. App. 3d at 1332, 279 Cal. Rptr. at 528.

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[2] Justices Broussard and Kennard dissented in Wharton, believing that the "language and purpose" of §1024 indicated that the waiver of confidentiality should be limited to only the content of the warning itself -- and should not go so far as to include prior "triggering" statements. Whether or not Wharton went too far, the Court of Appeal ruling in this case surely goes miles beyond Wharton.

However, the Court of Appeal provides no rationale for concluding that, as a result of Dr. Oziel's Tarasoff warnings, two entire therapy sessions should become non-privileged. The Court of Appeal leaped from deciding that bare warnings were inadequate in this case to deciding that two entire sessions which preceded the warnings were non-privileged. It bypassed or ignored the balancing required by Wharton.

The Court of Appeal decision is inconsistent with the constitutional right to privacy, the legislative intent of §1024, and the previous holdings of this Court. This Court stated in Wharton that limiting the waiver of confidentiality to the warnings themselves and the statements that "triggered" them was consistent with legislative intent and previous holdings because such a rule judiciously "circumscribes the scope of the exception to the [patient-therapist] privilege . . ." Wharton, 53 Cal. 3d at 554, 280 Cal. Rptr. at 649. Such circumscription -- or indeed any line drawing -- is missing from the Court of Appeal ruling.

The Court of Appeal ruling is both unreasonable and unworkable. It is unreasonable because it would destroy confidentiality even as to patient-therapist communications that have nothing to do with the subject of the threats or warnings. It is unworkable because it fails (unlike Wharton) to provide any pragmatic way of distinguishing what is privileged from what is not.

Consider, for example, a patient who agrees to undergo therapy because of depression over job-related stress. Assume further that

during the course of the therapy sessions, the patient also discusses his marital problems and financial troubles. After several months, the patient communicates to his therapist a threat against the patient's supervisor, who he feels is "pushing me too hard," and that the therapist warns the supervisor. Finally, assume that the patient later becomes involved in a divorce. Under the Court of Appeal ruling, confidentiality is destroyed not only for the patient's statements in therapy about his supervisor -- but for <u>everything</u> he has said in prior sessions. The therapist presumably can testify in the divorce action about what the patient said about his wife; can testify in a creditor suit about what the patient said about his unpaid bills; and so on. This is a truly bad rule of law.

In therapy sessions, patients do not usually discuss a neatly organized sequence of subjects. They jumble together a lot of concerns. The Court of Appeal ruling means that if a patient discusses not only subject A (the threat to harm someone) but also subject Z -- which is totally irrelevant to subject A -- confidentiality is lost as to subject Z as well as subject A.[3] The Court of Appeal's ruling gives little guidance for determining what nexus -- if any -- between statements made in previous sessions and the threat made in a later session is necessary to justify the

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[3] This is not a speculative inference about the Court of Appeal ruling. The Court of Appeal itself cited the Superior Court's finding that "each session was related to and inextricably intertwined with the one that preceded and followed it." 279 Cal. Rptr. at 521. On this theory, virtually everything said in therapy is "intertwined" with the subject of later testimony.

disclosure of the content of the prior therapy sessions. The Court of Appeal seems to accept the ruling of the Superior Court in this case -- that all sessions are a seamless part of a single whole and that §1024 therefore authorizes the disclosure of all communications made during any session for a patient who at any time voices a threat. Menendez, 228 Cal. 3d at 1330, 279 Cal. Rptr. at 527. Many patients continue in therapy for years. This would mean that if a threat was made in 1991, sessions from 1987 might no longer be privileged if they were "intertwined" in the "seamless web" of therapy. This is hardly the "narrow" exception intended by the Legislature. Such a rule also violates the constitutional right to privacy. It contravenes the well-settled rule that a statutory exception to such an established privilege is constitutional only when it is narrowly limited to disclosure of directly relevant information. Cutter, 228 Cal. at 551; Lifschutz, Board of Trustees v. Superior Court, 119 Cal. App. 3d 516, 174 Cal. Rptr. 160 (1981).

In stark contrast to the Court of Appeal's "all or none" approach, Wharton provides a far more judicious, reasonable rule. Under Wharton, the therapist is permitted to disclose those things -- and only those things -- that are needed to achieve protection of society: the warnings themselves and certain statements that are closely related to the threat because they helped "trigger" the warning. This should be sufficient to protect potential victims and society. If a therapist warns a patient's supervisor saying, "John Smith can't control his anger and has

threatened to shoot you," ordinarily this is sufficient to allow the supervisor, or the police, to take protective action. But it would not increase safety for the therapist to add disclosures such as, "Would you like to know what he said about his wife?" or "He has poor control of his impulses because his parents . . . ."

The Wharton rule does not depend on rigid criteria such as whether two subjects happened to be discussed in a single therapy session. The rule permits the disclosure of all "trigger" statements, and prohibits the disclosure of all statements that do not trigger a Tarasoff warning, regardless of when the statements were made. The Wharton rule is consistent with the legislature's intent, because it permits the disclosure only of those statements that are in fact necessary to ensure public safety.

Surely this is the outer bounds of what can be read into a statutory exception that permits "disclosure of the communication" that is "necessary to prevent the threatened danger." Cal. Evid. Code §1024. The communication referred to in the statute is the threat itself, or the statement of how it will be implemented. The statute does not refer to "the content of all prior therapy sessions." Thus, the plain language of § 1024 limits the dangerous-patient exception to the actual content of Tarasoff warnings themselves. While, as Wharton holds, public safety concerns may provide a rationale for extending the exception to include "triggering" statements, it is clear that the Court of Appeal ruling pushes the language of §1024 beyond its breaking point. This Court should vacate the Court of Appeal's decision and

instruct the lower court to make appropriate factual findings pursuant to Wharton.

In its Answer Brief, the Real Party in Interest raises a side-argument. It argues that Wharton was wrongly decided because it could not be applied in cases where no warning is actually given, even though in retrospect a psychotherapist had "reasonable cause to believe" that the patient was dangerous. It assumes that one cannot identify statements that "trigger" a warning that should have been -- but never was -- given. See Ans. Brief at 7-12.

Even assuming, arguendo, that §1024 was intended to provide an exception to the privilege where no warning actually is given -- which is doubtful[4] -- the Real Party in Interest's arguments do not discredit the Wharton analysis. If the therapist is determined to have had reasonable cause to issue a warning, but did not do so, the court can first determine that the therapist had reasonable cause to believe a warning was necessary, and then ascertain which statements of the patient triggered such reasonable cause.

In Mavroudis v. Superior Court of San Mateo County, 102 Cal. App. 3d 603, 604-06 162 Cal. Rptr. 724, 732-34 (1980), the Court described the mechanism for determining whether §1024 applies in

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[4] Reading §1024 narrowly, as is mandated by law (see above), it is likely that the exception to the privilege was meant to apply only in cases where a warning actually was given. The Real Party in Interest suggests that the phrase "reasonable cause to believe" was intended to mean that it is irrelevant whether a warning actually was given. But it is far more likely that this language was designed to ensure that §1024 covered situations where a warning was actually given, but the patient ultimately proved not to be dangerous. This is the reason §1024 did not say that "there is no privilege if the patient proves to be dangerous."

cases where no warning actually is given. In such cases, a trial court should examine the evidence in camera to determine if the factual predicates of §1024 are satisfied, i.e., whether the therapist had reasonable cause to believe that the patient was dangerous and that the disclosure of privileged communications was necessary to prevent the danger. Mavroudis, 102 Cal. App. 3d 603, 604-06, 162 Cal. Rptr. 724, 732-34 (1980). The Wharton ruling extends this analysis by requiring the court to determine which statements by the patient should have "triggered" such a warning. For example, if a patient said to a therapist that he was going to kill his wife, and the therapist failed to warn the wife, and testimony was later sought concerning this, the court would first decide whether the threat gave the therapist "reasonable cause" to believe that the patient was dangerous. If so, the court would then determine which statements triggered the reasonable cause.

Of course, trial courts should be reminded that hindsight is always "20-20," and that therapists frequently will not have "reasonable cause" in advance to believe that a patient is dangerous, or to know whom they may harm. See Thompson v. County of Alameda, 27 Cal. 3d 741, 614 P.2d 728 (1980). In any event, the Real Party in Interest's argument in no way discredits Wharton.

C. Unnecessary Expansion of the Scope of §1024 Would Harm Many Non-Dangerous Patients And the Public.

The Real Party In Interest in this case seeks to protect the public. Yet ironically, the judicial ruling it seeks would inevitably have the opposite effect. If potentially dangerous,

mentally ill persons knew that if they say anything in therapy that gives their therapist "reasonable cause" to believe that they may harm the therapist or someone else, then confidentiality will be lost as to everything they have said or may say in the future, many of these patients either will never enter therapy or will try to hide their real thoughts and feelings. In either event, there will be less effective therapy and more danger to society.

As this Court has acknowledged, psychotherapists cannot predict with reliable accuracy whether patients will be dangerous.[5] The scientific literature contains copious empirical evidence that given the current state of scientific development, psychologists, psychiatrists, and other therapists are not able reliably to predict future dangerous conduct -- especially for people without a prior record of such violence.[6] One of the leading experts who

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[5] See, e.g., Tarasoff v. Regents of University of California, 17 Cal. 3d at 438, 131 Cal. Rptr. at 25 ("[w]e recognize the difficulty that a therapist encounters in attempting to forecast whether a patient presents a serious danger of violence"); Hedlund v. Superior Court of Orange County, 34 Cal. 3d 695, 669 P.2d 41, 48-49, 194 Cal. Rptr. 805 (1983) (Mosk, J. dissenting); People v. Burnick, 14 Cal. 3d 306, 325-27, 121 Cal. Rptr. 488 (1975) (describing as "unequivocal" the evidence that therapists are unable to predict accurately future violence or dangerousness).

[6] See generally Krakowski, et al., "Psychopathology and Violence: A Review of the Literature," 27 Comp. Psychiatry 131 (1986); Motto, et al, "Development of a Clinical Instrument to Eliminate Suicide Risk," 142 Amer. J. Psychiatry 680 (1985); Mulvey and Lidz, "A Critical Evaluation of Dangerousness Research in the New Legal Environment," 9 J. Law and Human Behavior 209 (1985); Tardiff and Koenigsburg, "Assaultive Behavior Among Psychiatric Outpatients," 142 Amer. J. Psychiatry 960 (1985); Note, "Psychotherapists' Duty to Warn: Ten Years After Tarasoff," 15 Golden Gate L. Rev. 271 (1985); Monahan, "The Prediction of Violent Behavior: Toward a Second Generation of Therapy and Policy," 141 Am. J. of Psychiatry, 10-15 (1984); Monahan, "The Clinical

has exhaustively surveyed the literature concludes that even when it is possible to use the most sophisticated multi-variate analysis, predictions of violence are accurate only 10% to 30% of the time.[7] Another leading expert concludes that "nowhere in the research literature is there any documentation that clinicians can predict dangerous behavior beyond a level of chance."[8]

Research also demonstrates that psychotherapists tend to over-predict dangerousness. For every case in which they do not predict violence and it occurs, there are several cases where they do predict violence and it does not occur.[9] (In the parlance of the

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Prediction of Violent Behavior," (NIMH Monograph, 1981): Dix, "Clinical Evaluation of the 'Dangerousness' of 'Normal' Criminal Defendants," 66 Va. L. Rev. 523 (1980); Steadman, "The Right Not To Be a False Positive: Problems in the Application of the Dangerousness Standard," 52(2) Psychiatric Quarterly 84-99 (1980); Cocozza and Steadman, Prediction in Psychiatry: An Example of Misplaced Confidence in Experts, 271-73 (1977); Roth and Meisel, "Dangerousness, Confidentiality, and the Duty to Warn," 134 Am. J. Psychiatry 508-11 (1977); Cocozza and Steadman, "The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence," 29 Rutgers L. Rev. 1084 (1976); Diamond, "The Psychiatric Prediction of Dangerousness," 123 U. Penn. L. Rev. 439 (1974); Wenk, et al., "Can Violence Be Predicted?" 18 Crime and Delinquency 393 (1972).

[7] Monahan, "The Prediction of Violent Behavior: Towards a Second Generation of Theory and Policy," 141 Am. J. Psychiatry 10 (1984).

[8] Steadman, "The Right Not to Be a False-Positive: Problems in the Application of the Dangerousness Standard," 52 Psychiatric Quarterly 84, 96 (1980).

[9] For example, several studies have tracked patients who were institutionalized in maximum security correctional mental hospitals because they were considered dangerous but were released because of deficiencies in the prior proceedings. One study found that only 20% of these patients -- all of whom had been labelled as dangerous -- committed violent acts following their release (i.e., there were four false positives for every true positive). A second study found that only 14% of released patients committed violent

scientific literature, there are several "false positives" for every "false negative.") An American Psychiatric Association Task Force stated that "every study performed in this area has demonstrated that mental health professionals have strikingly high false positive ratios (in the neighborhood of 4:1 to 3:1)."[10] Thus, any rule ending confidentiality for those who are predicted to be violent (and for whom warnings are given), will end confidentiality for many more people who are not in fact dangerous.

As one expert notes, suppose 0.2% of all patients are in fact dangerous, and suppose further that psychotherapists could in the future develop a test that could predict dangerousness with 95% accuracy (an overly optimistic assumption). Under these circumstances, out of 10,000 patients, 20 would in fact be dangerous, and psychotherapists would correctly identify 19 of these patients. However, psychotherapists also would falsely over-predict that 499 other patients would be dangerous. Thus, "[t]o prevent 19 episodes of major violence, the psychiatrist will attempt to protect the potential victim in over 500 cases. [19 +

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acts (i.e., six false positives for every true positive). Steadman, "The Right Not To Be a False Positive: Problems in the Application of the Dangerousness Standard," 52 Psychiatric Quarterly at 88; see also S.A. Shah, "Dangerousness: A Paradigm for Exploring Some Issues in Law and Psychology," American Psychologist, 227-28 (March 1978) ("[i]nvariably such predictions are accompanied by rather huge rates of 'false positive' errors; that is, the great majority of the persons predicted as likely to engage in future violent behavior will not display such behavior.").

[10] Appelbaum, Position Statement on the Duty to Protect of the Task Force on Psychiatry and Law of the American Psychiatric Association 15 (1985).

499 = 518]." Beck, The Potentially Violent Patient and the Tarasoff Decision in Psychiatric Practice 87-89 (1985).

This bedeviling problem of prediction is not just a theoretical one. It is a practical limitation that has been acknowledged by this Court. See, e.g. Thompson v. County of Alameda, 27 Cal. 3d 741, 754, 167 Cal. Rptr. 70, 77 (1980) (requiring warnings in the case of each person "who has a history of violence and who has made a generalized threat [to unidentified persons] at some time ... would in our view, require a cacophony of warnings that by reason of their sheer volume, would add little to the effective protection of the public"); Tarasoff, 17 Cal. 3d 441, 131 Cal. Rptr. 27 ("psychotherapeutic dialogue encourages patients to express threats of violence, few of which are ever executed)" (emphasis added).

Given the inherent limitations of trying to predict violent conduct, the Court of Appeal's interpretation of Evidence Code §1024 in this case would result in disastrous consequences for many people. In the example above, the therapist would predict harm and would warn the victims in 518 cases. In 19 cases, the therapist would predict correctly. But, in addition, 499 people who posed no risk would totally lose confidentiality of their therapy records.

This bad result would be multiplied, because under People v. Clark, 50 Cal. 3d 583, 619-20, 268 Cal. Rptr. 399, mod., 50 Cal. 3d 1157a, cert. denied, 111 S. Ct. 442 (1990), any statement revealed to a third party in a non-privileged communication (such as a warning) loses its confidential status for any purpose. Once

patient statements have been disclosed pursuant to §1024, the statements are no longer confidential, and arguably, other parties could thereafter spread the statements without fear of legal repercussion. Thus, not only does the patient who unwittingly is a "false positive" lose the privilege to keep confidential information out of court proceedings, but he or she also might lose the right to have such information kept confidential in out-of-court contexts, such as employment or insurance.[11] This is an intolerable result.

In sum, this Court should reject the Court of Appeal's novel creation of a truck-sized hole in the general rule of confidentiality, because it would harm large numbers of innocent and harmless patients.

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[11] APA believes that Clark went too far in declaring broadly that "The reason for the privilege -- protecting the patient's right to privacy and promoting the therapeutic relationship -- and thus the privacy itself, disappears once the communication is no longer confidential." 268 Cal. Rptr. at 423. For example, suppose two therapists, Dr. Smith and Dr. Jones, both are treating patient Brown, who is having marital problems. At a party, Smith reveals intimate and embarrassing details of Brown's personal life to a visitor from out of town. The visitor is not interested, and leaves town without repeating the disclosure. Under Clark, such details are no longer confidential, and although Dr. Smith may be liable for the initial disclosure, Dr. Jones may now repeat the disclosure to anyone he wishes. Even though the patient is not at fault for the initial disclosure; even though the initial disclosure by Dr. Smith was unethical; and even though the initial damage to the patient was slight because the third party was an uninterested stranger; the patient forfeits forever his crucial right to confidentiality. The dictum in Clark should be disavowed because the confidentiality of a patient communication should depend on the patient's reasonable expectations, not the actions of the therapist. See Cal. Evid. Code §1012 (communications are confidential if transmitted by a patient in such a manner that "so far as the patient is aware" discloses the communication only to the therapist).

II. THE COURT OF APPEAL ERRED IN HOLDING THAT THE PATIENT-THERAPIST RELATIONSHIP TERMINATED AS SOON AS DR. OZIEL FELT THREATENED.

The Court of Appeal ruled that the November 28 and December 11 sessions that occurred subsequent to Dr. Oziel's Tarasoff warnings were not privileged because the therapist-patient relationship instantaneously ceased to exist at the moment of petitioners' threats against Dr. Oziel. Menendez, 228 Cal. App. 3d at 1333, 279 Cal. Rptr. at 529. This ruling is not grounded in law, is contrary to the established facts of clinical practice, and could have potentially disastrous consequences for both therapy patients and the general public.

A. Patients' Threats Against Therapists Are Relatively Common and Do Not Always Foreclose Successful Therapy.

Research on clinical practice has shown that many therapy patients express threats of violence against their therapists. The psychotherapeutic relationship often results in "negative transference" directed by patients toward the therapist, i.e., many patients begin to view the therapist in the form of other authority figures in the patient's life and begin to have strong (and sometimes negative) feelings toward the therapist reflecting the patient's true feelings toward these other individuals.[12]

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[12] See, e.g., State v. Leiding, 812 P.2d 797, cert. denied, 811 P.2d 575 (N.M. App. 1991) (describing transference as "the emotional response that the patient in therapy has toward the therapist [in which] the patient unconsciously attributes to the therapist those feelings that may have been supposed toward others close to the patient, such as parents."). See also Campbell, Psychiatric Dictionary 661 (1981) (transference is the "projection of feelings, thoughts and wishes onto the [therapist] who has come

Obviously, therapists do not encourage patients to threaten or commit acts of violence. However, in certain cases such "acting out" against the therapist is an emanation of the negative feelings experienced by the patient. Moreover, such threats do not always signal the end of successful treatment. On the contrary, for some patients, this is an unavoidable part of the therapeutic process. The expression of previously suppressed anger can signal a breakthrough in therapy and can be an important stepping stone to achieving therapeutic goals. As one therapist has noted, if too little negative transference is mobilized, "the patient is deprived of the opportunity to relive crucial relationships and experiences." Kirman, "The Management of Aggression in Modern Psychoanalytic Treatment," Modern Psychoanalysis 39 (1986).

It is not surprising, then, that threats by patients against therapists are fairly common (although carrying out such threats may be rare). In one recent study of 150 psychiatrists in Oregon, 61% of the respondents had experienced direct verbal threats of physical harm at some point in their career; 30% had received written threats; and 35% had received phone threats. However, only 7% had actually experienced the threatened assault. Nevertheless, the author concludes that "threats and assaults are relatively

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to represent an object from the patient's past. The [therapist] is reacted to as though he were someone from the patient's past. ... Transference may be positive ..., or it may be negative, as when the patient dislikes or hates the [therapist]"); Kirman, "The Management of Aggression in Modern Psychoanalytic Treatment" in Modern Psychoanalysis at 38 (describing treatment of patients suffering from narcissistic disorders, the author notes that "it is clear that [the therapist's] treatment plan must sooner or later release the powerful hatred of such patients toward the analyst").

frequent occurrences in the careers of responding psychiatrists." Faulkner, et al., "Threats and Assaults Against Psychiatrists," 18 Bull. Am. Acad. Psychiatry & Law, 41, Table 3 (1990). Another survey of 300 psychotherapists revealed that 81% experienced at least one episode of physical attack, verbal abuse or other harassment from patients. Tryon, "Abuse of Therapists By Patients: A National Survey," 17 Prof. Psychology: Research and Practice, 358 (1986). A review of the literature in the same article revealed that approximately 40% of all therapists feel physically threatened by their patients at one time or another. Id. at 357. See also Guy, et al., "Who Gets Attacked? A National Survey of Patient Violence Directed at Psychologists in Clinical Practice," 21 Prof. Psychology: Research and Practice 493-95 (1990) (survey finding that 49% of all therapists had been threatened with physical attack by their patients and 40% had actually been attacked); Madden, et al., "Assaults on Psychiatrists By Patients," 133 Am. J. Psychiatry 422 (1976) (more than 40% of psychiatrists had been assaulted by a patient); Whitman, et al., "Assault on the Therapist," 133 Am. J. Psychiatry 426 (1976) (21% of patients pose a threat to a therapist and one in 160 actually assault the therapist). In fact, while "[n]o one knows how often psychologists are physically attacked by their patients, [e]xtensive underreporting makes it likely to be more frequent than is currently believed." Guy, supra.

It is surprising perhaps but true that such threats can be absorbed and deflected by dedicated therapists -- who can continue

to help the patient. In one study of actual attacks against therapists (which obviously are more serious than mere threats), in only 5% of the cases did the attack against the therapist result "in refusal to see the patients on an ongoing basis." Bernstein, "Survey of Threats and Assaults Directed Toward Psychotherapists," 35 Am. J. of Psychotherapy 546-548 (1981). Another survey noted that "usually the therapists continued to see the patients after [experiencing physical] assaults" and that a number of practitioners "indicated subsequent positive treatment outcomes." Tryon, 17 Prof. Psychology: Research and Practice, at 362.

In sum, the Court of Appeal's quasi-factual assertion that the therapeutic relationship necessarily "disintegrates," and that successful therapy is impossible following a threat of physical attack, simply is not true. It is contradicted by the experience learned day by day and year by year by tens of thousands of therapists. On the contrary, the empirical evidence establishes that patients' threats are common and that successful therapy is possible -- even in some extreme cases in which patients carry through on their threats to attack the therapist.

B. The Appellate Court Erred in Holding That There Was No Ongoing Therapeutic Relationship Despite The Extensive Contact Between Petitioners and Dr. Oziel.

The therapist's duty of care to patients and to third parties arises when the therapeutic relationship is formed. Absent such a relationship, there is no duty of care to the patient or to others. Tarasoff, 17 Cal. 3d at 435, 131 Cal. Rptr. at 23; Rainer v.

Grossman, 31 Cal. App. 3d 539, 543, 107 Cal. Rptr. 469, 471 (1973). Perhaps because of the sensitivity of therapy and the vulnerable nature of therapy patients, courts have found that a patient-therapist relationship begins with the earliest contacts, and continues so long as there is any professional contact. See e.g., Bunce v. Parkside Lodge of Columbus, et al., No. 90AP-1106 slip op. (Ohio App. April 23, 1991) (therapist-patient relationship "clearly" existed between a patient at a drug rehabilitation clinic and a senior counselor at the facility even though he was not the patient's primary counselor); Moskowitz v. MIT, No. 14786/79 (N.Y. Co. Supr. Ct. 1982), judgment reduced 474 N.Y.S.2d 742 (App. Div. 1984), app. denied 471 N.E.2d 463 (N.Y. 1984) (psychologist-patient relationship may have existed where a patient called therapist for an appointment and the therapist referred the patient to another psychologist).

One treatise concludes from the case law that the following acts by a therapist may create a therapist-patient relationship sufficient to impose certain professional obligations: giving advice; making psychological interpretations; conducting lengthy phone conversation with a prospective patient; giving a patient an appointment; telling walk-in patients that they will be seen; and providing psychological diagnostic opinions to neighbors and friends. Smith, Medical Malpractice Psychiatric Care, 1991 Cum. Supp. at 31.

In defining the evidentiary privilege, the California legislature has adopted a similarly expansive view of the

therapist-patient relationship, by defining "patient" as any person who "consults a psychotherapist . . . for the purpose of securing a diagnosis or preventive, palliative, or curative treatment of his mental or emotional condition." Cal. Evid. Code §1011. Clearly petitioners continued to meet this definition even after they allegedly threatened Dr. Oziel. As the Superior Court properly found, petitioners were seeking therapy during the November 28 and December 11 sessions, regardless of whether they harbored thoughts of killing Dr. Oziel at that time. By confessing to their parents' murder and discussing the possible reasons behind their acts, defendants were trying to relieve their guilt and seeking palliative treatment for their "emotional or mental condition." Even the Court of Appeal has acknowledged that large portions of the November 28 and December 11 sessions were devoted to discussing not the murders, but petitioners' emotional condition. During the November 28 session, Erik Menendez expressed remorse and discussed his suicidal thoughts with Dr. Oziel. Menendez, 228 Cal. App. 3d at 1328, 279 Cal. Rptr. at 526. It is thus clear that Erik Menendez was seeking palliative treatment at the November 28 session, and was therefore a "patient" under the California Evidence Code.

It makes no sense to rule, as did the Court of Appeal, that no therapeutic relationship existed despite the facts that: Dr. Oziel continued to schedule appointments and hold therapy sessions with petitioners; these sessions continued to be held in his office; petitioners continued to discuss their psychological problems;

Dr. Oziel continued to advise petitioners; and petitioners continued to assume that these sessions were protected by confidentiality.[13] Menendez, 228 Cal. App. 3d at 1325-32, 279 Cal. Rptr. at 523-28. The APA is unaware of a single case, and neither the Court of Appeal nor the Real Party in Interest has cited any, in which courts have ruled that despite all these factors, a patient-therapist relationship does not exist. The unsupported statement of the Court of Appeal that "therapy" must have ceased should be disavowed by this Court.

C. The Court of Appeal Ruling Would Lead to Absurd and Dangerous Results.

In holding that the therapeutic relationship terminates, ipso, at the instant a patient communicates a serious threat to a therapist, the Court of Appeal apparently did not consider fully certain implications of its ruling. If there is no longer a therapeutic relationship, some (though not all) professional obligations may cease. See Rainer, 31 Cal. App. 3d at 543, 107 Cal. Rptr. 471. Thus, under the Court of Appeal ruling, after a threat, the therapist would be under no duty to give competent advice to the "non-patient," even if sessions continue and both parties believe that a therapeutic relationship continues to exist. The therapist would have no duty to refer the patient to others if needed for specialist care. As the Court of Appeal held, the

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[13] In addition, there does not appear to be any evidence that Dr. Oziel altered his charging practices after October 31, when petitioners allegedly issued their threats. Presumably, Dr. Oziel continued to expect payment for services provided after that date.

therapist also would have no duty to maintain the confidentiality of what is said by the person who is no longer a patient. Menendez, 228 Cal. 3d at 1333, 279 Cal. Rptr. at 529. The therapist would not even have a duty to take adequate notes or to keep records of subsequent sessions. These are the consequences of ending the therapy relationship by "operation of law."

Even apart from these disastrous collateral results, and with respect to only factor that apparently concerned the Court of Appeal -- protecting the public -- its decision would backfire. The therapist in such circumstances would have no ongoing duty to warn or protect third parties. Tarasoff, 131 Cal. Rptr. at 23. For example, if after threatening Dr. Oziel, the Menendez brothers had communicated a threat to kill their grandmother, under the Court of Appeal's ruling, Dr. Oziel would have had no duty to warn or protect the grandmother, since Dr. Oziel was no longer acting as a therapist. Thus, ironically, in seeking to fashion a rule that would broaden disclosure of relevant information in cases involving dangerous patients, the Court of Appeal ruling would terminate the obligation to make essential future disclosures. As noted above, potentially dangerous patients can become angry at a wide array of people. Often therapists may have to warn different people of different risks at different times. But the Court of Appeal ruling would short-circuit this whole process. It would end therapy, therapeutic obligations, and public safety obligations at the first threat, regardless of any future dangers of which the therapist

becomes aware. This would result in less protection for the public.

D. Whether a Patient-Therapist Relationship Exists Depends on the Reasonable Expectations of the Patient.

Most therapeutic relationships terminate eventually. After termination, most (but not all) of the parties' rights and duties are diminished. Legally, therefore, the question of when therapy terminates is a crucial one. APA believes that courts should examine the totality of the circumstances in each case and decide whether therapy was ongoing. However, a court's analysis should be based principally on the same factor which warranted the judicial recognition of confidentiality in the first instance -- the reasonable expectations of the patient. A therapeutic relationship should be considered ongoing if -- under all the circumstances -- the patient reasonably expects that the relationship exists. This standard reflects the legislature's conclusion that patient expectations and intentions generally determine whether a therapeutic relationship is formed and communications are confidential. See Cal. Evid. Code §§1011, 1012.

That the patient's expectation is the key factor is evident from the language of the Evidence Code provisions themselves. Section 1012 defines "confidential communication" as a patient-therapist communication transmitted "in confidence, by a means which so far as the patient is aware discloses the information to no third persons. ..." Likewise, §1011 defines "patient" as one who consults a psychotherapist ... for the purpose of securing a

diagnosis or preventative, palliative, or curative treatment." (Emphasis added.) Thus, the patient's purpose in seeking therapy, and the patient's awareness and expectation of confidentiality, are the essential factors in determining whether a communication is privileged. See In Re Lifschutz, 2 Cal.3d 415, 85 Cal. Rptr. 829, 839 (1970) (in interpreting Evidence Code, court was "mindful of the justifiable expectation of confidentiality that most individuals seeking psychotherapeutic treatment harbor").

A therapeutic relationship certainly should be deemed to exist if -- as in this case -- both the patient and the therapist believe that therapy is continuing. A patient should not lose the right to confidentiality regarding embarrassing and intimate details unless he or she should reasonably expect that events have arisen such that confidentiality no longer exists. When the therapist no longer sees the patient in his or her office, no longer sees the patient alone, no longer discusses the patient's problems, and no longer charges the patient, a court could reasonably conclude that the patient should have realized that the therapeutic relationship had terminated. Of course, there may be "grey area" cases, where the reasonableness of the patient's expectations is far less clear. However, courts should be very reluctant to impose, after the fact, an interpretation that no therapy relationship existed -- when all the parties to the relationship at the time believed it did.

In State v. Miller, 709 P.2d 225, 230 (Or. 1985), cert. denied, 475 U.S. 1141 (1986), the Oregon Supreme Court adopted essentially the "reasonable expectation" standard proposed here.

In that case, defendant telephoned his brother and stated that he had just killed another person. The brother advised the defendant to telephone a mental health professional. The defendant then called a state hospital, told the receptionist that he had committed murder, and asked to speak to a psychiatrist. The receptionist summoned a psychiatrist, who spoke to the defendant for 10 to 15 minutes, in an effort to keep him on the line while the police traced the call. During their conversation, the defendant made several incriminating statements to the psychiatrist, which the State later sought to introduce into evidence at the defendant's trial.

The court in Miller first noted that the question of whether a patient's statement is confidential depends on the intent of the patient, which may be inferred from all the circumstances. Id. at 232-33. It also held that whether a patient-therapist relationship exists at all, and whether the patient-therapist privilege applies, is determined by the reasonable expectations of the patient. Id. at 234. Thus, according to the court, if a prospective patient meets a therapist in a supermarket and immediately makes an unsolicited confession, there is no reason for the patient to believe that the therapist has agreed to a therapeutic relationship, and the patient does not have a reasonable expectation that the communication will be confidential. Id. In contrast, "if a prospective patient talks to a licensed psychotherapist in a professional practice setting, such as a mental health clinic or private practice office, the patient could

fairly infer that the psychotherapist has indicated a willingness to enter into a confidential relationship." Id. (emphasis added). Consequently, the court in Miller found that the patient-therapist relationship existed because the defendant reasonably expected that his disclosures would remain confidential. Id.

In contrast, the Court of Appeal erred in this case, because it ignored all of the factors indicating that petitioners had a "reasonable expectation" that their therapeutic relationship with Dr. Oziel was ongoing, and it relied on factors that are irrelevant to the petitioners' expectations. The Court of Appeal based its ruling primarily on its view that petitioners' relationship with Dr. Oziel must have "disintegrated once petitioners threatened Dr. Oziel's life." Menendez, 228 Cal. App. 3d at 333, 279 Cal. Rptr. at 529. Such threats, however, did not alter the petitioners' expectations. As the Superior Court found, all of the sessions "were intended . . . for the purpose of therapy." Super. Ct. Findings ¶ 9 (emphasis added).

As we showed above, the therapeutic relationship does not always terminate upon the issuance of a threat directed at the therapist. Such threats are common, and there is no empirical support for the assumption that a threat always results in the "disintegration" of a therapeutic relationship. On the contrary, threats can be part of a patient's airing and resolving of other problems. Consequently, there was no reason for either petitioners or Dr. Oziel to expect that the relationship was legally deemed "terminated" following the threat.

The Court of Appeal also appeared to base its holding on its inferences as to Dr. Oziel's motives. It said that "the doctor's primary objective was not to provide treatment to petitioners. . . ," and that "Dr. Oziel was motivated by self-preservation . . . ." This apparent finding of fact was substituted for the opposite finding of the Superior Court, and it certainly contradicts the reasonable expectations of the petitioners-patients. Once again, the Court of Appeal went too far. There may be many reasons why a therapist might not feel that therapeutic progress is his or her "primary objective." Suppose the therapist is "burned out" and only wants easy money; or that he continues therapy so he can write a book about "criminal minds I have known;" or that he wants the patient to do harm because the therapist also hates the proposed victim. All of these actions are bad, unethical, and perhaps actionable. But does it make sense, as the Court of Appeal ruling implies, that the patient who is unaware of these motives of his therapist and is still pursuing therapy nevertheless loses his confidentiality rights? We submit that it does not make sense.

Obviously, a patient entering therapy does not have any idea as to the therapist's motives for taking the case. Such motives may be improper or, as in this case, complex and mixed.[14] But

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[14] Dr. Oziel's motives appear to be complicated. The Superior Court which heard the parties' testimony found as a matter of fact that the parties (including Dr. Oziel) intended all of the sessions to be for the purpose of therapy. Super. Ct. Findings ¶ 9. Even the Court of Appeal, which rejected this finding, held only that Dr. Oziel's "primary" objective was not to provide therapy. Menendez, 228 Cal. App. 3d at 1333, 279 Cal. Rptr. at

confidentiality should not depend on divining the subjective motives of the therapist. To hold otherwise would require patients to assess their therapists' motivations at the beginning of each session (surely an impossible and unreasonable task) -- and for Courts to try to reconstruct these motives later.

In Miller, the court faced a situation where the therapist was not motivated at all by a desire to help the patient, but only by a desire to keep him talking until the police could trace his call. Miller, 709 P.2d at 230. Despite this, the court found that the motive of the therapist was irrelevant in determining whether the patient-therapist privilege applied, because:

> where a patient consults a psychotherapist for professional assistance for a mental or emotional problem and reasonably believes that the psychotherapist is willing to embark upon a professional relationship, the fact that the psychotherapist has a secret ulterior purpose for the interview or examination will not prevent the patient from claiming the privilege as to confidential communications. To hold otherwise would effectively transfer the privilege from the patient . . . to the psychotherapist. Such a shift is not supported by the language of the rule, it underlying purpose, or case law.

Id. at 235 (emphasis added). This Court should rule likewise.

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529. This implies that helping petitioners was Dr. Oziel's "secondary" motive. Also, following petitioners' threat, under Tarasoff Dr. Oziel could have informed the police and could have provided the police with as much confidential information as was necessary to secure his own safety and the safety of his loved ones. The fact that Dr. Oziel chose instead to take less drastic measures, and to try and preserve his safety while continuing to treat petitioners, suggests that Dr. Oziel was motivated in part by a desire to provide continued therapy to them.

Finally, when it did consider Petitioners, the Court of Appeal mistakenly focused not on their reasonable expectations, but upon their motives. See Menendez, 228 Cal. App. 3d at 1333, 279 Cal. Rptr. at 529 ("[p]etitioners' primary objective was not to receive therapy, but to provide themselves with a possible psychiatric defense"). This was inappropriate, because a patient's motivation should have no bearing on the duties of the therapist to provide appropriate care or to protect confidential information. For example, a patient seeking therapy may be motivated not by a desire to receive treatment, but rather by a desire to appease his family or his employer, or by an attachment he has formed to his therapist, or by a desire to comply with a court order. In each case, the patient may not really have therapy as his "primary objective." But once he enters into the therapeutic relationship, and he has a reasonable expectation that the therapist will perform competently and not reveal confidential information -- the law must respect that expectation. Whether or not the patient is "sincere," he nevertheless is revealing confidential information.

The Court of Appeal's holding also is impractical since it requires a post-hoc divination of motives of mentally ill persons -- a task that the courts will find daunting at best. The Court of Appeal held that petitioners in this case were "primarily" -- not solely -- motivated by self-interest. Menendez, 228 Cal. App. 3d at 1333, 279 Cal. Rptr. at 529. Most individuals probably have "mixed motives" for entering into therapeutic relationships. Not all such motives are articulated, or even conscious, and many

motives may be unrelated to the goal of receiving treatment. But this does not mean that therapy is doomed to failure or that the therapist should not be held to the normal legal duties.[15] This Court should decline to adopt a rule that will entangle courts in endless efforts to sort out psychological motives. Instead, it should rely on the more objective and verifiable standard of patients' reasonable expectations.

E. A Rule That Focuses on the Reasonable Expectations of the Patient Is Practical.

This Court should rule that whether a therapeutic relationship exists (or is ongoing) depends on whether, under the totality of circumstances, the patient reasonably expected that a therapeutic relationship existed. This rule has a number of advantages.

First, such a standard is both flexible and practical. By focusing on reasonable expectations, rather than motivations, courts need not inquire into the unknown (and perhaps unknowable) purposes underlying each party's actions. Rather, courts need only

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[15] The impracticality of the Court of Appeal ruling is also evident if one considers who pays for the therapy sessions. If therapy is deemed to terminate as a matter of law in certain situations where neither party reasonably expects that termination has occurred, patients and practitioners will continue to bill third party payors for ongoing sessions. In order to determine whether therapy is ongoing, and reimbursement appropriate, payors would have to assess the motivations of the parties at all times -- clearly an impossible task. Therapists may be denied payment in a variety of circumstances where "legal termination" has occurred but therapy continued. And therapists and patients might be subject to recoupment for overpayment if the payor learns that a court has ruled -- after the fact -- that therapy had legally terminated because the patient or therapist was not "primarily" interested in therapy.

ask whether the patient had a certain expectation, and whether that expectation was reasonable in light of the facts.

Second, such a rule would preserve the relationship of trust that is the cornerstone of successful therapy. Patients will only retain trust in their therapist when the therapist's actions -- especially regarding confidential communications -- conform to their reasonable expectations.[16] As this Court has recognized, the right to confidentiality "draws its substance primarily from the psychological needs and expectations of the patients . . . ." In re Lifschutz, 2 Cal. 3d at 423, 85 Cal. Rptr at 833 (emphasis added). Consequently, this Court has declined to sanction unknowing waivers of confidentiality by patients, because such

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[16] The importance to patients of having their communications remain confidential cannot seriously be disputed. Numerous studies have found that confidentiality is crucial to the establishment of a trusting relationship between patient and therapist, and thus is crucial to successful treatment outcomes. See, e.g., Miller and Thelen, "Knowledge and Beliefs About Confidentiality in Psychotherapy," 17 Prof. Psychology: Research and Practice, 15-19 (1986) (noting that the majority of patients view confidentiality "as an all-encompassing mandate for the profession of psychology"); McGuire, et al., "The Adult Client's Conception of Confidentiality in the Therapeutic Relationship," 16 Prof. Psychology: Research and Practice 375-84 (1985) (survey results demonstrate that "clients not only value confidentiality in the therapy relationship but . . . they also expect it") (emphasis added); Merluzzi and Brischetto, "Breach of Confidentiality and Trustworthiness of Counselors," 30 Journal of Counseling Psychology, 245-51 (1983) (noting that breached confidentiality "was associated with significantly lower trustworthy ratings [for the therapist]"); Schmid, et al., "Confidentiality in Psychiatry: A Study of the Patient's View," 34 Hospital and Community Psychiatry 353-55 (1983) ("the patients in our sample clearly believed that confidentiality was an important concomitant of their care . . ."); Note, "Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff," 31 Stan. L. Rev. 165, 183 (1978) (majority of surveyed therapists "thought patients will withhold information important to treatment if they believe the therapist may breach confidentiality").

waivers result in the unexpected and unintended forfeiture of a privacy right. Roberts v. Superior Court of Butte County, 9 Cal. 3d 330, 343, 107 Cal. Rptr. 309, 317 (1973).[17] This Court should decline to adopt a ruling that would result in loss of confidentiality in a variety of situations in which patients reasonably expect it.

Finally, the ruling of the Court of Appeal would cause therapists to discontinue therapy to potentially dangerous individuals at the exact time when they are most likely to become violent. Assume, for example, that a patient has just communicated a serious threat to his or her therapist. If the Court of Appeal decision is affirmed, an ethical therapist will have an obligation to inform the patient that therapy may have been terminated in the eyes of the law, and that no subsequent communications will necessarily be confidential.[18] Under these circumstances, "candor and integrity would require the doctor to advise a patient at the outset that he will violate his confidence and inform law enforcement authorities of their discussions." Stritzinger, 34 Cal. 3d at 514, 194 Cal. Rptr. at 438. Under these circumstances, many dangerous patients will simply end therapy.

In Tarasoff, this Court stated that the fears of the mental health community regarding this "chilling effect" of the duty to

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[17] Tarasoff, of course, sanctioned the unintentional waiver of confidentiality, but only in very limited circumstances and only to further the compelling state interest in public safety.

[18] The APA's ethics code provides that "[w]here appropriate, psychologists inform their clients of the legal limits of confidentiality." APA Ethical Principle 5 (1989).

protect were "entirely speculative." Tarasoff, 17 Cal. 3d at 440 n.12, 131 Cal. Rptr. at 26 n.12. Perhaps they were at the time. But an impressive body of research now confirms the importance to patients of strict confidentiality.[19] Moreover, Tarasoff and its progeny created a small exception to the general confidentiality rules; the vast majority of patients' communications to their therapists remain protected even after Tarasoff. In contrast, the Court of Appeal ruling here blasts a gaping hole in the general rule of confidentiality. Following a threat or other "termination by operation of law," everything a patient says may now be disclosed to the public.

The Tarasoff exception differs from the Court of Appeal holding in another respect. Many patients understand and accept the policy underlying the Tarasoff -- because it applies to very specific disclosures. In fact, many dangerous patients seek therapy because they know they are potentially violent and they wish to have appropriate steps taken to prevent harm to others. See, e.g., Wulsin, et al., "Unexpected Clinical Features of the Tarasoff Decision," 140 Am. J. of Psychiatry 602 (1983); Beck, "When the Patient Threatens Violence: An Empirical Study of Clinical Practice After Tarasoff," 10(3) Bulletin of the AAPL, at 199 (1982). Thus, when a therapist gives a specific Tarasoff warning, he or she may sacrifice the patient's confidentiality to a limited degree, but not sacrifice the patient's broader trust. In contrast, it is impossible to retain trust when the patient

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[19] See n. 16, supra, and citations therein.

knows that the therapist is under no obligation to hold any of the patient's communications in confidence. Most patients and therapists therefore would likely choose to discontinue therapy in these situations.

This result would be inhumane (since effective treatment is often possible despite a threat to the therapist); it also would be dangerous. If, as can be reasonably assumed, patients communicating threats have more propensity toward violence than the patient population as a whole, then the likely consequence of automatic termination following a threat is that the most dangerous patients will be terminated from the very therapy that may be needed to avoid harm.[20] Clearly this result does not reflect the Legislature's intent or sound law. This Court should not endorse a ruling that would lead to such disastrous consequences.

CONCLUSION

For the foregoing reasons, the APA respectfully urges that this Court vacate the ruling of the Court of Appeal, and (1) rule that the November 28 and December 11 sessions between Petitioners and Dr. Oziel were conducted with the reasonable expectation of confidentiality, and (2) hold that, pursuant to Wharton, the trial

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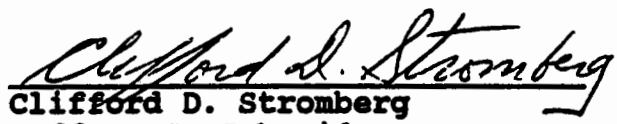
[20] This Court has recently been forced to deal with the tragic consequences that can result from the premature termination of a therapeutic relationship with a dangerous patient. In People v. Clark, 50 Cal. 3d 583, 268 Cal. Rptr. 399 (Cal. 1990), a therapist abruptly terminated treatment after receiving threats from a patient. Distraught by this feeling of abandonment at a crucial point in therapy, the patient set fire to the therapist's house, killing the therapist's husband and permanently disfiguring the therapist. Id. at 406, 418.

court should admit into evidence only those statements from any session that formed the content of, or directly triggered, Dr. Oziel's warnings to others.

Respectfully submitted,



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