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Assessing Violence Risk in *Tarasoff* Situations: A Fact-Based Model of Inquiry

Randy Borum, Psy.D.,*
and Marisa Reddy, Ph.D.†

Although significant advances in risk assessment research and practice have been made in recent years, there has not been any analysis in the professional literature regarding how and whether the emerging practice recommendations apply in *Tarasoff*-type situations. We suggest that, when faced with a *Tarasoff*-type situation, the appraisal of risk should be guided by a method that is primarily fact-based and deductive, rather than by the more inductive risk assessment approach for general violence recidivism, which is guided primarily by base rates and historical risk factors. We review the principles underlying a fact-based, or threat assessment, approach and outline six areas of inquiry that can guide the appraisal of risk: A—attitudes that support or facilitate violence, C—capacity, T—thresholds crossed, I—intent, O—other's reactions, and N—noncompliance with risk reduction interventions.
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The prospect of having to manage a patient who may pose a risk of harm to others evokes considerable anxiety among many clinicians. Mental health professionals who specialize in forensic services often have specific training in violence risk assessment, and may even conduct evaluations where risk is the central, explicit question (Melton, Petrila, Poythress, & Slobogin, 1997). However, many non-forensic clinicians are posed with questions of violence risk in their regular clinical practices (Bednar, Bednar, Lambert, & Waite, 1991; Otto, 2000; VandeCreek & Knapp, 1993). Indeed, these were the circumstances surrounding the now infamous case of *Tarasoff v. Regents of the University of California* (1976).

In that case, a psychologist at a university counseling center was conducting a counseling session with a student, Prosenjit Poddar. During the session Poddar informed him of his wish or intent to harm a woman who was not mentioned by name, but was ostensibly identifiable as Tatiana Tarasoff. At the time, Ms. Tarasoff

*Correspondence to: Randy Borum, Psy.D., Department of Mental Health Law & Policy, University of South Florida, 13301 Bruce B. Downs Boulevard, Tampa, FL 33612, USA. Tel: 813-974-7947 E-mail: borum@fmhi.usf.edu
†National Threat Assessment Center, U.S. Secret Service, Washington, DC 20223, U.S.A.
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was in Brazil. The psychologist and his supervising psychiatrist called the campus police, who questioned Poddar and released him because he seemed rational and reportedly promised them that he would not harm Ms. Tarasoff. When Ms. Tarasoff returned to California two months later, however, Mr. Poddar killed her. Clearly, this was not a case of inaccurate prediction. The psychologist was concerned about Poddar's potential for violence, and did take some action. The legal question was whether that action was reasonable and sufficient.

Although the basic facts of this case are fairly well known, the duty it created for mental health professionals is often less clear. Many, for example, still associate this case with the "duty to warn." The Supreme Court of California (not the US Supreme Court) originally heard this case in 1974 (*Tarasoff* I), and indeed, at that time, ruled that mental health professionals had a duty to warn third parties about potential risk that their clients presented. However, the case was reheard in 1976 (*Tarasoff* II, *Tarasoff v. Regents of the University of California*, 1976) at which time the court redefined the duty as "a duty to protect." *Tarasoff* II preempted the 1974 decision and is the case with binding authority in California.

Thus, the *Tarasoff* duty is not merely to warn. The ruling was that, when a mental health professional determines or, pursuant to the standards of his or her profession, should determine that a client presents a serious danger of violence to another, the mental health professional incurs a duty to use reasonable care to protect the victim. In *Tarasoff* the court ruled that the duty to protect may require the mental health professional to take one or more steps, depending on the particular facts of the case and governing state statutes. Possible actions that can discharge the duty to protect include warning the intended victim or others who might be able to notify the potential victim of the danger; notifying law enforcement; or taking other steps that might be reasonable given the particular circumstances (e.g., pursuing hospitalization or other forms of intervention).

The *Tarasoff* ruling and its attendant doctrine have subsequently been interpreted in a variety of ways in different jurisdictions (Buckner & Firestone, 2000). Some states have adopted it identically and explicitly; others have modified the duty (more broadly or more narrowly); and, some have rejected completely the notion that a mental health professional should have any duty to protect third parties from harm—foreseeable or not—by a client or patient. Practicing clinicians should, of course, be aware of the applicable law in the state where they practice to avoid unnecessary or inappropriate breaches of confidentiality, but the essence of the prescriptions outlined in *Tarasoff*—regardless of whether it is regarded as a legal duty—is, in our view, not unreasonable, nor inconsistent with ethical practice (Beck, 1990, 1998; Bersoff, 1999).

In the 25 years since the *Tarasoff* ruling, there have been substantial advances in research and practice regarding violence risk assessment (Borum, 1996, 2000; Borum, Swartz, & Swanson, 1996; Douglas, Cox, & Webster, 1999; McNiel, Borum, Douglas, Hart, Lyon, Sullivan, & Hemphill, in press; Monahan & Steadman, 1994; Otto, 2000). While as recently as 1980 scholarly reviews concluded that mental health professionals were usually wrong when predicting that a client would be violent (Monahan, 1981), a subsequent generation of research has produced much more optimistic findings (Otto, 1992; Mossman, 1994).

A relevant question, however, is whether and how these advances in science and practice affect a clinician's responsibility when confronted with a *Tarasoff*-type

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situation. That is, a clinical encounter in which a client says something or reveals some behavior that raises some initial concern that the client may pose a risk of harm to an identifiable victim. In the sections that follow, we argue that *in situ* assessments of risk relating to a potential duty to protect are distinguishable from other types of formal, comprehensive risk assessments. Specifically, differences are evident in the standard of care, the nature of the decision required, and the type of inquiry needed. We suggest that when a clinician is faced with whether the client in his or her office poses a risk of serious harm to an identified or identifiable victim, the ensuing assessment should be primarily fact-based and deductive, rather than being focused primarily on base rates and risk factors (Reddy, Borum, Vossekuil, Fein, Berglund, & Modzeleski, 2001). Drawing on principles from the threat assessment approach developed by the U.S. Secret Service (Borum, Fein, Vossekuil, & Berglund, 1999; Fein & Vossekuil, 1998; Fein, Vossekuil, & Holden, 1995), we outline six areas of inquiry (with an acronym to facilitate retrieval) that might guide the appraisal of risk.

STANDARD OF CARE FOR ASSESSMENT

When considering what procedures might be appropriate for appraising risk in a variety of circumstances, it is useful to identify the objective of the assessment and to specify the type of violence about which one may be concerned (Borum *et al.*, 1996; Buchanan, 1997). Formal risk assessments, such as those conducted for purposes of determining a patient's suitability for release to the community from an inpatient unit or correctional facility, the objective often focuses on some appraisal of probability and the outcome of interest is typically general violent behavior (Andrews & Bonta, 1995; Douglas *et al.*, 1999; Harris & Rice, 1997; Otto, 2000; Quinsey, Harris, Rice, & Cormier, 1998). Thus, the question is whether, given the patient's current condition, situation, and discharge circumstances, he or she has a reasonably high likelihood of committing a violent act toward anyone over some specified period of time (Andrews & Bonta, 1995; Borum *et al.*, 1996; Harris & Rice, 1997; Otto, 2000; Towl & Crighton, 1997).

In contrast, when confronted with a *Tarasoff*-type situation, the objective of a risk appraisal is simply to determine whether there is a reasonable clinical concern about violence toward an identified or identifiable person(s) (Mulvey & Lidz, 1995)[1]. The question is whether the client is on a pathway toward a violent act toward the target, and, if so, where he or she is on that path and how quickly he or she is moving (Borum *et al.*, 1999; Fein & Vossekuil, 1998; Fein *et al.*, 1995; Reddy *et al.*, 2001). If the clinician is concerned that the client is on a pathway to violence, then a statistical estimate of the probability of violence among some reference group is a less critical factor in determining whether or not some action is required. The focus shifts quickly from assessment to thinking about options for interventions that would have a reasonable likelihood of reducing the risk of harm to the intended victim (Appelbaum, 1985; Mulvey & Lidz, 1995). The assessment of clinical concern,

[1]Although there have been a few far-reaching legal cases that have defined a very broad duty to protect (e.g., 497 F.Supp. 185 (D.Neb. 1980)), a majority of jurisdictions that prescribe such a duty for mental health professionals have limited that duty to identifiable victims.

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however, should be conducted in a way that informs one's understanding of the types of intervention that may be helpful or necessary.

As noted above, the basic premise of *Tarasoff* is that, when a mental health professional determines or, pursuant to the standards of his or her profession, should determine that a client presents a serious risk of violence to another, the mental health professional incurs a duty to use reasonable care to protect the victim. This duty poses for the clinician two potential challenges: the first in determining whether a given client poses a serious risk of violence to another, and the second in determining what steps might reasonably be necessary to protect an intended victim. Stated differently, the clinician must ask "Is this a situation where I should do something, and if so, what should I do?" (Borum, 1998a, 1998b).

If a decision must be made concerning "what to do," there is a range of interventions that may be considered, but clearly part of what makes these situations particularly complex is that they occur in the context of a fiduciary, therapeutic relationship where the promise and duty of confidentiality to the patient may conflict with the objective of preventing harm to others. A thorough discussion of response options and risk reduction strategies is beyond the scope of this article (see Bednar *et al.*, 1991; Borum, 1998a, 1998b; Borum *et al.*, 1996; Harris & Rice, 1997; Otto, 2000; VandeCreek & Knapp, 1993). Instead, we focus on helping the clinician to reasonably answer the first part of the question (whether to be concerned) in a way that will help to inform a decision about the second (what to do).

ASSESSING CLINICAL CONCERN

In evaluating whether to be concerned, the *Tarasoff* language suggests that the clinician should be held to the existing standards of his or her profession, despite the fact that no such explicit standards for these situations currently exist (Borum, 1996). Nevertheless, if the clinician's judgment is challenged, the question posed will be whether she or he considered information that most similarly trained professionals would (or should) consider, and in light of that information whether the conclusion reached was one that a reasonable professional could have made.

Given the recent advances in risk assessment research and practice, it may be tempting to argue that the current standard of practice dictates, in a *Tarasoff*-type situation, that the clinician should consider the array of historical, clinical, and contextual factors that have demonstrated a robust, empirically based relationship to violence risk recidivism, with knowledge of the base rate for violent behavior among people who share some characteristics with the client and use a structured assessment tool to guide the assessment. Indeed, these elements would appear to be consistent with practice recommendations that are appearing in the professional literature and that are advocated in continuing education training (Borum, 2000; Otto, 2000; McNiel *et al.*, in press). However, these recommendations typically pertain to formal risk assessments where the clinician is on notice of the assessment question prior to contact with the patient, and has adequate time to collect relevant information and conduct the evaluation. The objective is typically to appraise the likelihood that the patient will engage in some type of *general violent behavior* over a specified period of time. Additionally, in many instances the patient is already in

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some type of secure confinement and the results of the assessment are to be used to inform a decision about a *less* restrictive placement or intervention.

In contrast, in the office-based *Tarasoff*-type assessment, and arguably in other emergency assessment contexts, the clinician is typically not given advanced notice that a risk assessment will be required and the assessment must be made fairly quickly in the context of therapeutic discourse, and perhaps with limited collateral information. The objective is typically to appraise whether the patient poses a serious risk of harm to an identified or identifiable person, not just whether he or she may be violent generally. This situation shares elements of the definition of "targeted violence" —a term developed by the U.S. Secret Service to refer to circumstances in which an identified person chooses a target in advance of an attack and consequently poses a risk to an identified or identifiable victim (Borum *et al.*, 1999; Fein & Vossekuil, 1998; Fein *et al.*, 1995; Reddy *et al.*, 2001). Additionally, the patient is typically not in a secure setting or under supervisory control and the results of the assessment are to be used to inform a decision about a *more* restrictive placement or intervention. In our view, these distinctions argue for a different type of risk appraisal (as discussed below) and a different standard of care. This discussion is not intended to pose a dichotomy between a fact-based and a more traditional inductive approach; rather, it is designed to highlight some of the distinctions and relative areas of emphasis.

NATURE OF DECISION AND RISK INQUIRY

As best practice recommendations for formal risk assessments have emerged in the professional literature, practitioners are often advised to identify and utilize relevant base rates and to focus on empirically established risk factors, often with the guidance of a structured assessment instrument, in appraising the level of risk (Borum, 2000; Borum, Otto, & Golding, 1993; Otto, 2000; Monahan, 1981; McNiel *et al.*, in press). However, these recommendations do not apply equally to *Tarasoff*-type assessments. Consideration of base rates is not likely to assist in determining clinical concern in such cases for at least two important reasons. First, the concern in duty to protect situations is typically narrowly specified toward an identified or identifiable victim. Prevalence rates of violence toward a specific victim are typically unknown, but would necessarily be extremely low and therefore unlikely to contribute to the determination of reasonable clinical concern. Second, that the clinician is faced with this decision usually means that the client has already engaged in some threatening or otherwise concerning communication or behavior that has raised the specter of potential harm to a third party. Although some literature exists on the relationship between threats and subsequent violence, base rates of violent behavior for people who have engaged in foreboding, troublesome, or menacing behavior in the community and have not been subject to any intervention are typically not well documented. Even if they were, however, the portentous communication or behavior combined with other indications of intent or planning could—as a matter of legal foreseeability—pose a *prima facie* suggestion that the clinician "should" be concerned and take appropriate action. A clinician could not dismiss a client's statement that he intended to leave the office and shoot his business partner at his place of work simply because the base rate of homicide is

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statistically low. Base rates, even if they are known, often may not be the most critical factor in appraising clinical concern.

Similarly, exclusive reliance on traditional, empirically established risk factors—particularly those that are historical in nature—is also unlikely to be helpful in determining clinical concern in a *Tarasoff*-type assessment. While mental health professionals should generally be familiar with the research literature on risk factors for violent behavior (Borum *et al.*, 1996; Monahan & Steadman, 1994; Otto, 2000), using them as a *primary* basis for an inquiry and decision is more appropriate for determining the risk of general community violence than for determining whether a given client is on a pathway to harming a specific victim. Most of the empirical research on risk factors for violence has used a general violence criterion. This is not to suggest, for example, that knowing a client is currently paranoid and actively abusing substances is irrelevant to appraising risk; rather, that relying exclusively on empirical risk factors could lead a clinician not to consider or inquire about factors that might indicate intent or planning, and the relative absence of traditional risk factors in a given case might lead the professional inappropriately to under-estimate risk.

GUIDING PRINCIPLES FOR DUTY TO PROTECT SITUATIONS

As noted above, the fundamental holding in *Tarasoff* was that, when a mental health professional determines or, pursuant to the standards of his or her profession, should determine that a client presents a serious risk of violence to another, the mental health professional incurs a duty to use reasonable care to protect the victim. In some circumstances, a clinician's concern is raised because the client makes a specific, verbal threat of harm toward the intended victim. However, the first guiding principle we would suggest is that threats should not be regarded as a necessary or exclusive factor for precipitating an inquiry about clinical concern. Although the duty to protect statutes in some states only impose a legal *requirement* to act in situations where a threat is made, as a clinical and ethical matter there may be circumstances where a professional is legitimately concerned about potential violence and would be permitted to act to prevent harm, even if not mandated to do so by statute or case law. Fein and Vossekuil (1998) have suggested that, in assessing risk for targeted violence, it is important to distinguish between *making* a threat (i.e., communicating an intent to harm) and *posing* a threat (i.e., engaging in behavior that indicates furthering a plan or building capacity for a violent act). Although some people who make threats ultimately pose threats, many do not. Similarly, a client may pose a threat of harm to an identifiable victim, even if he or she has not made a direct threat. Persons who appear to pose a threat provoke the greatest level of concern.

The second guiding principle for *Tarasoff*-type risk assessments is that a clinician should inquire about, and focus upon, the behaviors that would likely precede any planned violent act. These are referred to in the targeted violence literature as "attack-related behaviors", and may include developing an idea and plan to engage in a violent act toward a target; acquiring the means or capacity for the violent act (such as a weapon or other means of inflicting harm); selecting a target or targets; and determining the time, place, and manner in which to approach or otherwise gain access to the target (such as discovering the target's work schedule). These

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behaviors indicate planning and preparation for an attack. They are significant markers of the client's movement on the pathway from idea to action (Borum *et al.*, 1999; Fein & Vossekuil, 1998; Fein *et al.*, 1995; Reddy *et al.*, 2001). They are the foundation of the inquiry that we present below and recommend for these assessments.

Finally, as a guiding principle, we suggest that the clinician conceptualize and gauge the client's risk as a dynamic pathway from idea to action. This is consistent with our suggestion that the basic questions in *Tarasoff*-type situations should be (a) "Is the client on a pathway toward a violent act?" and (b) "If so, how fast is he or she moving and where could one intervene?". We recommend that the clinician look at the client's communications and behaviors, taking particular note of the progression of any behaviors toward action, as well as any collateral information in answering these questions (Borum *et al.*, 1999; Fein & Vossekuil, 1998; Fein *et al.*, 1995; Reddy *et al.*, 2001). These questions underscore the fact-based nature of this inquiry because they encourage the clinician to ask what conclusion the facts in the particular case suggest.

PROPOSED INQUIRY FOR DUTY TO PROTECT SITUATIONS

Because the fundamental task in a *Tarasoff*-type situation is determining whether there is a reasonable basis for concern that the client is on a pathway toward a violent act, the key factors for the clinician to weigh and consider shift away from static, research-based correlates of violence to ideas, behaviors, and situational influences that might indicate intent, planning, or preparation for a violent act. As we have already noted, we refer to this type of focus as a "fact-based" inquiry. While many previously published suggestions for managing *Tarasoff* situations, such as the advisability of seeking professional consultation (Monahan, 1993), still apply, in the section below, we propose six factors that a clinician might consider in a fact-based inquiry of risk. As a potential mnemonic device, the acronym ACTION can be used to recall these factors: A—attitudes that support or facilitate violence, C—capacity, T—thresholds crossed, I—intent, O—other's reactions, and N—non-compliance with risk reduction interventions. These factors are not presented in any particular order of importance, nor is the list intended to be all inclusive. Rather, they are intended only to serve as a framework for guiding a fact-based risk inquiry arising in the context of an otherwise routine clinical encounter.

Attitudes that Support or Facilitate Violence

It is a well established principle in social psychology that one important consideration in determining whether an individual will engage in a particular behavior is the nature and strength of his or her attitude toward that behavior (Azjen, 1985). For example, certain antisocial attitudes have been associated with increased risk for criminal and violent behavior (Andrews & Bonta, 1995); and, misogynistic, patriarchal attitudes and attitudes that support the use of violence have been found among men who engage in partner-directed violence (Saunders, 1992; Straus,

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Gelles, & Steinmetz, 1980). Practically speaking, if some inappropriate communication or behavior has raised concern about whether a client may intend violence toward a particular third party, it is helpful to know about the nature and strength of the client's attitude toward that behavior. Specifically, does the client believe that the use of violence is justified under the circumstances? This implies, of course, that one must understand the client's appraisal of his or her "circumstances", because it is the client's perception, not the professional's perception, that will most influence whether violence will occur. In general, the stronger the perceived justification, the greater the likelihood of action. In addition to knowing whether the client believes that he is justified in using violence, it may be useful to assess his or her appraisals of provocation or intentionality from others (hostile attribution bias), violent fantasies, self-statements, expectations about success of violence, and whether the client thinks it will accomplish or further his or her goal.

Capacity

As part of a deductive, fact-based inquiry of risk, it is important to consider whether the client has the capacity or means to carry out the type of violent act that the client has threatened or suggested might occur. This would include physical and intellectual capabilities, access to means (weapons or materials necessary to effect the violent act), access to the target, and opportunity to commit the act. Clearly, the issue of access to the target is differently considered if the target is continuously monitored and accompanied by an armed protective detail, as is the case with protectees of the U.S. Secret Service. However, the clinician may still consider how well the subject knows the target's routines, whereabouts, and security precautions, the subject's physical proximity to the target, the target's degree of sophistication about the need for self-protective measures, and whether the target or subject may currently be under law enforcement surveillance or scrutiny.

Thresholds Crossed

As previously noted, one key indicator of whether an individual is on a pathway toward some violent act is whether the individual has already engaged in behaviors in furtherance of a plan for that act (i.e., attack-related behaviors), particularly behaviors that require breaking laws and rules. Acts committed in violation of law are particularly noteworthy since they indicate a willingness and ability to engage in antisocial behavior to accomplish one's objective. In conducting a risk inquiry, it is helpful to ask not only about the existence of a plan, but also about what steps the client may have taken to further that plan.

Intent

Once a client has made a statement or revealed some behavior that causes initial concern, it is helpful for the clinician to distinguish whether the client simply has an idea of violence or if he intends to commit the act. Just as making a threatening

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statement does not necessarily mean the client poses a risk, so it is that having an idea of harming a third party is not dispositive of intended action. Level of intent may be inferred indirectly from the specificity of the plan and the access to means to carry it out, or more directly from behaviors that indicate a commitment to action. This commitment may be reflected in the client's prior consideration of potential consequences, and consideration—and rejection—of alternative ways to accomplish his or her objective. Individuals who are considering violence and who believe that they have no other available options or that they have "nothing to lose" would be expected to have more resolute intent and commitment to the violent act. Attitudes, as noted above, can also influence intent.

Others' Reactions and Responses

Often with in-session risk assessments it is not possible to review external records or obtain collateral information. However, to the extent that information from other people who know the client is available, either directly or from the client's report, such data may be potentially helpful in appraising the client's risk. The theory of planned behavior posits that a key factor in determining a person's attitude toward a behavior is the reactions he/she anticipates or expects from others (Azjen, 1985). Thus, knowing about the reactions of others can help the assessment in two ways. First, it can help to gauge the direction of the client's own attitude toward the act. For example, if a client reports that when he told his girlfriend he was so angry with his boss that he thought of killing him she said "Well somebody ought to," the clinician could infer that the strength of the client's perceived justification for a violent act may be stronger, or that perceived barriers or discouragements may be fewer. Second, knowing how others are responding to the client helps the clinician to understand the social context in which the client's ideas about violence exist. If the client has talked to anyone about his ideas or plans for violence, it would be probative to know whether significant others have discouraged or condemned the ideas, offered no judgment, supported or escalated the violent ideas, or even facilitated the development of capacity or movement from idea to action. Statements from others that they are concerned that the client might actually follow through with his or her idea or plan ("I'm scared he might actually do it.") might also increase a clinician's index of concern regarding the propensity for violence.

Noncompliance with Risk Reduction

A final critical factor in assessing the nature and degree of risk that a client may pose to a potential target is his or her interest and willingness to participate in interventions to reduce or mitigate risk. In this regard, a clinician might consider the client's motivation to prevent or avoid a violent act, the client's other beliefs about the efficacy of the treatment weighed against any potential side effects, trust/alliance with the provider, and history of adherence and willingness to comply with medication and other therapeutic regimens. The likelihood of compliance or participation in an intervention may also be related to "insight"—or the extent to which an individual understands and appreciates the severity of his or her own

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disorder, need for treatment, and/or potential for violence. Many individuals who pose a risk of harm to others will not have a major mental disorder. The issue of insight, however, as we have broadly defined it here, is still relevant as it includes an understanding or acknowledgement of one's risk of harm and the conditions that may affect that risk. If a client appreciates that he or she may be at risk for harming a third party and is motivated to take action to avoid that outcome, then his or her movement on a pathway toward violence has a greater likelihood of being slowed or re-directed.

CONCLUSION

When a clinician is aware that a client has engaged in some threatening or otherwise concerning communication or behavior that has raised the specter of potential harm to an identified or identifiable third party, there is arguably an ethical obligation, and in some cases a legal duty, to inquire further to determine whether there is a reasonable basis for clinical concern. These assessments typically must be made immediately and in the context of therapeutic discourse. Thus, the nature and purpose of the risk appraisal in these cases is fundamentally different than in formal risk assessment. The central question in these cases is typically not whether the client has a certain statistical probability of violence toward any third party over a specified time period; rather it is whether the client's ideas and behaviors should give rise to a reasonable clinical concern about potential harm to a specific identifiable target, whether those indications suggest that the client is on a pathway toward a violent act, and, if so, what interventions have a reasonable likelihood of reducing the risk of harm.

Drawing on principles from the threat assessment approach developed by the U.S. Secret Service, we have proposed that the appropriate inquiry to address these questions should be primarily fact-based, and, accordingly, that primary reliance on empirically based historical risk factors and on base rates will be less helpful. A fact-based inquiry focuses on patterns of thinking and behavior that may reflect planning and preparation for an attack. Specifically, we have suggested that this inquiry could include an examination of attitudes that support or facilitate violence, capacity, thresholds crossed, intent, other's reactions, and noncompliance with risk reduction interventions. The clinician may draw on this information to determine what conclusions these facts may suggest and to decide whether the client poses a serious risk of violence to an identified or identifiable target. We would emphasize that the goal in these situations is not to optimize statistically the *prediction* of future violent acts, but to *prevent* what is potentially more foreseeable violence from occurring.

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