PSYCHOTHERAPY: THEORY, RESEARCH AND PRACTICE
VOLUME 20, #3, FALL, 1983

MALPRACTICE RISKS WITH SUICIDAL PATIENTS

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ABSTRACT: *The suicide of a patient is one of the most difficult events that a psychotherapist will ever experience. In addition to the emotional turmoil, a psychotherapist may encounter legal complications because patient suicides are potentially the basis of a malpractice suit. This article explores the malpractice risks when treating suicidal patients in inpatient and outpatient settings. The legal principles of abandonment and duty to warn are reviewed and related to suicide. Recommendations are made to psychotherapists who treat suicidal patients.*

INTRODUCTION

Psychotherapists experience few events which evoke such intense emotional pain as the suicide of a patient. Even the most capable and self-assured psychotherapists are likely to feel guilt or temporarily to doubt their therapeutic judgment. Also, a patient's suicide assaults the therapist's self-image as a protector of life and healer of the sick.

In addition to the emotional pain, a psychotherapist may encounter legal complications in that suicide can be a basis for a malpractice suit (Slawson, 1970; Trent, 1978; Wright, 1981*a*). In a two-year period in Los Angeles, lawsuits followed one-third of the suicides in the hospitals (Litman, 1967). In addition, malpractice suits may occur when the patient is harmed in an unsuccessful suicide attempt.

This article will explore the malpractice risks in treating suicidal patients. The case law will be reviewed and precautions to reduce the legal risks to psychotherapists will be suggested. Although most malpractice suits have been against hospitals or physicians working within hospitals, they have established precedents which apply to other therapists as well. Nevertheless, psychotherapists with specific questions are urged to consult an attorney.

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Definition of Malpractice

Malpractice is an act or the omission of an act by a mental health professional which is inconsistent with reasonable skill and care used by other professionals and which results in injury to the patient. Also, the failure to use reasonable standards in the diagnosis or treatment of the patient must be a contributing cause to the patient's harm. Although most malpractice suits have involved physicians, the malpractice criteria apply to other mental health professionals as well (Knapp, 1980).

The courts do not assume that the psychotherapist acted in a negligent manner merely because the patient committed suicide. A psychotherapist may have used sound therapeutic procedures in diagnosing or treating the patient, and a suicide may still occur. The courts recognize that the diagnosis and treatment of mental distress are inexact sciences. No psychotherapist can be perfect at predicting human behavior or curing a psychological disorder.

A central issue in a malpractice claim is the determination of the accepted standard of care. This standard rests on a reasonableness test—did the psychotherapist behave as would a "reasonably prudent psychotherapist" under similar circumstances (DeLeon & Borreliz, 1978)? The courts will not typically establish legal standards in specialized areas like psychotherapy. Instead, the courts will rely on expert witnesses from the mental health field to determine what constitutes ac-

ceptable practice. The jury will listen to the expert testimony and determine if the defendant's behavior fell below the level expected of psychotherapists. When expert witnesses disagree, the jury will act as a fact-finder and determine who is correct (Knapp & VandeCreek, 1981*a*).

Depending on the jurisdiction, the determination of the standards may vary according to the geographical location of the defendant's practice, the type of practice, or the theoretical orientation (DeLeon & Borreliz, 1978). Rural psychotherapists who do not have access to professional libraries or expert consultants may be held to a lower standard of practice than urban psychotherapists who do have access to large professional libraries, frequent seminars, and experts for referral and consultation.

Also, psychotherapists who claim to be specialists may be held to a higher standard of practice than "general practitioner" psychotherapists. A therapist who specializes in health psychology or child psychotherapy would be held to the minimum standards of specialists in health psychology or child psychotherapy. A general practitioner would not be expected to have the degree of skill or knowledge found in specialists (Knapp & VandeCreek, 1981*b*).

Finally, psychotherapists would be evaluated according to their own system of therapy. For example, a behaviorist would be measured according to the accepted practices of behavior therapy, not psychoanalysis. The court is cognizant of, and respectful of, the well-known and important schools of psychotherapy. Generally speaking, the courts will accept any school as legitimate if a substantial minority of psychologists practice it.

The courts can make an exception to the expert witness requirement if the alleged negligence falls into the common knowledge of laypersons. Under the doctrine of *res ipsa loquitor* ("the thing speaks for itself"), the jury can determine negligence without the aid of expert witnesses. Traditionally, there are three prerequisites for applying the doctrine: a) the event must not ordinarily occur in the absence of negligence, b) it must be caused by an instrumentality or agency under the sole control of the defendant, and c) it must not have been due to any voluntary action by the plaintiff. This has been applied to medical cases where a surgeon cut off the wrong leg (DeLeon & Borreliz, 1978; Prosser, 1971).

The common-knowledge doctrine has also been applied to cases of suicide. For example, in *Meier* v. *Ross General Hospital*,[1] the court found the physician negligent for placing a suicidal patient in a room with an open window. The patient was obviously suicidal, as evidenced by a recent suicide attempt, and expert witnesses were not needed to show that the psychiatrist's actions violated the norms for treating suicidal persons.

According to traditional rules of medical malpractice, patients are responsible for their own behavior. When medical patients fail to cooperate with the physician's treatment plan and contribute to their own harm, their award in a malpractice suit is affected. Their award could be nullified or decreased by the proportion to which they contributed to their own harm (King, 1977).

By definition, suicidal patients contribute to their own harm. However, liability is not lessened or removed in suicidal cases. Suicide is believed to occur in the context of "diminished capacity," and traditional notions of individual responsibility do not apply. The responsibility is taken away from the patient and placed onto the parties who have assumed care for the patient. Consequently, psychotherapists or hospitals can be held to a standard of care in treating the patient, although they can never guarantee that suicide will be prevented (Slawson *et al.*, 1974).

Specific Liability for Suicide: General Rules

Schwitzgebel & Schwitzgebel (1980) have offered three criteria for assessing professional liability in cases of suicide. The first criterion involves the foreseeability of a suicide attempt. No liability has been found when cooperative or cheerful patients suddenly initiated self-destructive behavior (*Dahlberg* v. *Jones*;[2] *Dalton* v. *State*[3]), or

[1] *Meier* v. *Ross General Hospital*, 445 P.2d 519 (1968).

[2] *Dahlberg* v. *Jones*, 285 N.W. 841 (1939).

[3] *Dalton* v. *State*, 308 N.Y.S.2d 441 (Sup. Ct. of N.Y. App. 1970).

when a patient who had not previously exhibited suicidal tendencies suddenly jumped from an unguarded window (*Carlino* v. *State*[4]). Similarly, no liability was assessed when an aggressive patient failed to reveal suicidal potential (*Paradies* v. *Benedictine Hospital*[5]). However, when the treatment plan overlooks, ignores, or neglects evidence of suicidal tendencies, then courts have found practitioners or hospitals culpable (*Dinnerstein* v. *U.S.*;[6] *Eady* v. *Salter*[7]).

The second criterion is reasonableness of professional judgment in treatment. Severely depressed patients require more precautionary care and planning than do less severely depressed patients. The failure to take reasonable precautions when suicidal intent is recognized would be grounds for liability. The more obvious the suicidal intent, the greater will be the practitioner's liability for failure to take this into account in the treatment plan. No single, specific precaution will be required by the court. The court will likely recognize many acceptable precautions (hospitalization, closer observation by ward personnel, locked doors, involvement of family, etc.). As discussed below, the acceptable forms of treatment have become more varied in recent years.

The third criterion involves the thoroughness with which the treatment plans are implemented. Thus, the government was judged to be liable when a nurse ignored the physician's instructions and allowed a depressed patient (who later committed suicide) to leave the ward without an escort (*Abille* v. *U.S.*[8]). Also, in *Comiskey* v. *State of New York*,[9] a hospital (but not the physician) was found at fault for failure to observe closely a patient as the physician had ordered. In contrast, the failure of a psychotherapist to notify other staff members about an increase in suicidal potential would likely leave the therapist liable but absolve the uninformed staff (Perr, 1978).

[4] *Carlino* v. *State*, 294 N.Y.S.2d 30 (1968).

[5] *Paradies* v. *Benedictine Hospital*, 431 N.Y.S.2d 175 (1980).

[6] *Dinnerstein* v. *U.S.*, 486 F.2d 34 (2d Cir. 1973).

[7] *Eady* v. *Alter*, 380 N.Y.S. 2d 737 (1976).

[8] *Abille* v. *U.S.*, 482 F. Supp. 703 (Cal. 1980).

[9] *Comiskey* v. *State of New York*, 418 N.Y.S.2d 233 (1979).

Liability for Inpatient Suicides

The malpractice law regarding hospitals is a complex and ever-changing field which will not be reviewed in detail here. Thorough descriptions of hospital liability may be found in Health Law Center (1974) and King (1977). However, psychotherapists should know that malpractice actions for inpatient suicides could be directed against either the therapist or the hospital. Generally speaking, malpractice suits can be levied against physicians or psychotherapists within the hospital if they have staff or hospital privileges. Although they use the hospital facilities, these professionals are assumed to be independent and responsible for their behavior.

However, in some situations the hospital could be sued. The hospital could be liable if it negligently hired or trained its employees, supervised them inadequately, or permitted hazardous conditions to exist. In addition, if the hospital employed the physician or psychotherapist, then the hospital could be sued for their negligent actions under the doctrine of vicarious liability. However, negligent employees may not be entirely free from liability because the hospital could, in turn, sue them for the financial loss incurred by their actions (King, 1977).

In considering malpractice actions for inpatient suicides, the courts have slowly but steadily changed the standards of liability from an earlier "custodial model" to a more recent "open door" model. In the earlier custodial model, the purpose of the hospital was to diagnose suicidal intent and then to watch the patient so closely that an attempt would be impossible. The standard of supervision was so strict that Perr commented that "therapy was imprisonment by a jailor in a white coat" (1965, p. 637).

But even when the custodial model was being applied, the courts would find liability only for reasonably foreseeable suicide attempts. In *Moore* v. *U.S.*,[10] the hospital was not found negligent when the patient pried open the detention screen from the third floor and jumped out. Although the patient had delusions and paranoid ideation, he had shown no evidence of suicidal intent. Similarly, in

[10] *Moore* v. *U.S.*, 222 F. Supp. 87 (Mo. 1963).

Hirsh v. *State*,[11] the hospital was absolved of blame when a patient committed suicide with capsules that he had hoarded. He had been stripped naked and searched and no one had reason to suspect that he was still concealing barbiturates.

Davidson (1965) aptly described the basic dilemma of the custodial model. A suicidal person is likely to have low self-esteem. If this patient is then deprived of a belt, trousers, shirt, and pajamas (to prevent hanging), eyeglasses (to prevent cutting with glass), and dentures (to prevent them from being swallowed), then the patient has also been deprived of many forms of possible pleasures and sources of dignity such as eating solid foods, reading, and appearing respectable as a person.

In addition, patients who are hospitalized for long periods of time under strict conditions may underestimate their potential for recovery. Patients may become dependent on the hospital, family, or friends. The hospitalization may greatly impair their ability to effect positive change on their environment (Halleck, 1980).

Over the years, changes have occurred in the therapeutic standards regarding the required degree of supervision of suicidal patients. Mental health professionals recognized that some of the traditional restrictive policies harmed the patient because they engendered feelings of helplessness. Consequently, hospitals implemented an open-door model which loosened the restrictions and encouraged patients to assume more responsibility for themselves. Contrary to the fears of some mental health professionals, the suicide rate within hospitals actually decreased when more liberal policies were introduced (Perr, 1965). The open-door policy does not deny the risks of suicide. Rather, it acknowledges that the effective treatment of suicide may involve some short-term risks (Slawson *et al.*, 1974).

In addition, there was a move toward more outpatient treatment. Brief psychotherapy became more popular and crisis intervention services developed. Advances in psychopharmacology also permitted the outpatient treatment of many patients who were previously treated within hospitals. Also, as civil commitment laws became more stringent, many patients could not be forced into hospital treatment merely because they threatened suicide or needed treatment. Some patients insisted on outpatient treatment or no treatment at all.

The standards required by the courts in treating suicidal patients changed with the prevailing judgment of mental health experts. Courts would no longer require strict observation in all suicidal cases. This philosophy was expressed in *Dinnerstein* v. *U.S.* (see footnote 6): "Not every potential suicide must be locked in a padded cell. The law and modern psychiatry have now both come to the belated conclusion that an overly restrictive environment can be as destructive as an overly permissive one" (436 F.2d 34 at 38). Now the courts recognize that the therapist must balance the benefits of treatment against the risks of freedom.

Psychotherapists must use reasonable professional judgment in assessing the therapeutic risks of freedom. They must carefully assess decisions to reduce the supervision of suicidal patients, whether it involves a transfer to a less restrictive ward or a discharge out of the hospital. Of course, when the patient is dangerously suicidal, the hospital must still provide close supervision. As noted earlier, an open-door policy does not mean an open-window policy for highly suicidal patients.

Liability for Outpatient Suicide

Although only a few cases deal with outpatient suicides, the principles are the same as for inpatient cases. Psychotherapists must use reasonable standards of care in the diagnosis of suicidal intent and the development and implementation of a treatment plan. In *Runyon* v. *Reid*,[12] a psychiatrist and a mental health foundation were sued because their patient had taken a lethal dose of sleeping pills which had been prescribed for him. The court found that the patient's suicidal intent was not foreseeable; hence the psychiatrist and clinic were exonerated. Although this case involved a psychiatrist, it illustrates a principle which applies to nonmedical psychotherapists who treat outpatients: a psy-

[11] *Hirsh* v. *State*, 168 N.E.2d 372 (1960).

[12] *Runyon* v. *Reid*, 510 P.2d 943 (Okla. 1973).

chotherapist using acceptable diagnostic procedures would not be liable for unforeseen suicide attempts.

When the suicide attempt is foreseeable, the treatment provided must be consistent with professional standards. In *Speer* v. *U.S.*,[13] a psychiatric outpatient hoarded pills and took a fatal dose of medication. The psychiatrist was exonerated because he had followed acceptable medical procedures in the prescription of medication for this patient. Although nonmedical psychotherapists would not be treating patients through medication, they would have to follow acceptable procedures in their treatment of suicidal outpatients.

Standards of treatment in psychotherapy are hard to establish and may vary according to the locality or school of the psychotherapist. Also, it is often difficult to establish a causal link between the therapist's behavior and subsequent psychological harm (Fishalow, 1975). Nevertheless, in nonsuicidal cases, courts have found psychotherapists liable for blatantly negligent acts such as hitting clients, having sexual relations with them, or gossiping about them. Although the authors found no cases of this in the legal literature, it is conceivable that a psychotherapist could be liable for negligent acts which preceded (and presumably caused) a patient's suicide (DeLeon & Borreliz, 1978).

Psychotherapists may also be liable for the negligence of employees, whether professional or clerical. Psychotherapists who hire obviously incompetent employees or who fail to supervise them properly may be liable when such employees contribute to the suicide of a patient.

Abandonment

The legal concept of abandonment may apply to psychotherapists who work in outpatient settings. This concept, which has received increasing attention in the medical literature, states that unless limited by the understanding of both parties, the relationship may not be terminated unilaterally by the physician unless treatment is no longer needed, the relationship is ended by the patient, or suitable notice is given by the physician that affords the patient ample opportunity to engage other services. Abandonment could involve two types of legal action. First, if the psychotherapists err in their judgment and terminate the relationship when it should have been known that further treatment was needed, they may be liable for negligence under a malpractice criterion. Expert witnesses would likely be needed to determine the standard of reasonable care. Secondly, if psychotherapists willfully terminate or withhold treatment knowing that further care is needed or that a referral is essential, then they may be liable for intentional abandonment. When intentional abandonment is alleged, a low burden of proof may be required. The fact of termination may be sufficient to establish guilt and expert witnesses may not be needed (Furrow, 1980; King, 1977).

Although no cases of abandonment by psychotherapists have appeared in the legal literature, it is likely that psychotherapists could be vulnerable to such charges under several circumstances. In cases involving physicians, abandonment has been found to occur when the covering physician was too busy to attend to the emergency needs of the patients of a vacationing colleague. Also, abandonment was found when a physician was too busy with his/her own patients to attend to the emergency needs of another of his/her own patients. Clearly, psychotherapists should provide emergency after-hour services for their clients. Psychotherapists should not overload their schedules so that they deny availability to needy clients, and they should provide adequate coverage on vacations. The press of business is not an adequate defense.

Abandonment has also been found where a physician refused to continue treatment because of the patient's inability to pay for services and where the physician failed to discover and treat the patient's illness (Furrow, 1980). Psychotherapists must also exercise reasonable care in deciding when to terminate the relationship. Psychotherapy may pose unusual dilemmas because of its emotional nature. Furrow (1980) suggested that therapists may react to client dependency or other intense emotions by denying the seriousness of the situation or by fear and backing off from the relationship, leaving the client feel-

[13] *Speer* v. *U.S.*, 512 F. Supp. 670 (1981).

ing rejected. Terminating treatment at such stormy times may be especially risky even if an attempt to refer the client is made (King, 1977).

However, the concept of abandonment has limits, and there are ways of protecting against abandonment. First, in private practice psychotherapists can typically refuse to accept new clients, and in any setting therapists should limit their caseloads to be able to handle emergency needs of current clients. Second, it is sometimes possible from the outset to limit by contract the nature and duration of treatment. Third, referral to another practitioner with ample opportunity for discussion with the client reduces the risk of client deterioration at termination. Fourth, abandonment would not occur if the psychotherapist saw the client for an initial interview, decided not to accept the person for treatment, and immediately referred the client elsewhere. In *Grubin* v. *Brandt*,[14] a general practitioner physician saw a patient for an interview. The physician correctly diagnosed a mental health problem and referred him to a psychiatric clinic. Although the person accepted treatment at the mental health clinic, he subsequently committed suicide. The court refused to find the referring physician liable, stating that the referral absolved him of subsequent responsibility for the patient.

Duty to Warn

Recently an attempt was made to apply the *Tarasoff* decision to psychotherapists who treat suicidal outpatients. The 1976 case, *Tarasoff* v. *Regents of the University of California et al.*,[15] required psychotherapists to take actions, including possibly breaching confidentiality, to protect the public from violent patients. Because warning the potential victim is the most obvious protective action, this has been called the "duty to warn" (Knapp & VandeCreek, 1982).

In *Bellah* v. *Greenson*[16] a California court refused to extend the duty to protect to suicidal cases. Dr. Greenson was treating a young woman as an outpatient when she committed suicide. Her parents brought suit, alleging that Greenson had the responsibility to warn them of their daughter's suicidal tendencies. The court said that Dr. Greenson was not required to do so. Only the safety of third persons presents a public interest strong enough to override confidentiality; self-inflicted harm does not invoke a duty to warn. The principle was later upheld in a subsequent California case, *Schwarz* v. *U.S.*.[17]

However, note that the suit did not allege that Dr. Greenson was otherwise negligent in his treatment of his patient; only that he failed to warn her parents of her suicidal tendencies. Of course psychotherapists could be liable on other grounds for negligently treating suicidal patients who harm themselves. Also, the court ruled that Dr. Greenson was statutorily permitted to breach confidentiality if he had so desired. However, these cases are only binding precedents in California. Other states with different statutes and different common law precedents may choose not to follow the *Tarasoff* or *Bellah* decisions.

RECOMMENDATIONS TO PSYCHOTHERAPISTS

Of course, psychotherapists should diligently assess the suicidal potential of their patients and carefully implement their treatments. Reevaluation of suicidal potential should be made at several juncture points of treatment: time of hospital admission, transfers to less restrictive wards, home visits, or discharges. In addition reevaluation should be made when friends or family members present new evidence.

Psychotherapists in inpatient settings should work closely with the hospital staff. Nurses and attendants should clearly understand instructions regarding suicidal patients. As with family members, psychotherapists should attend to the information garnered by hospital staff members who observe the patient. Their comments may provide information crucial to modifications of the treatment plan. Additional details on suicide prevention in the hospital have been presented by Farberow (1981).

Psychotherapists working in outpatient

[14] *Grubin* v. *Brandt*, 329 A.2d 82 (1974).

[15] *Tarasoff* v. *Regents of the University of California et al.*, 551 P.2d 334 (1976).

[16] *Bellah* v. *Greenson*, 146 Cal. Rptr. 535 (1978).

[17] *Schwartz* v. *U.S.*, 49 LW 3362.

settings should be certain that they can provide adequate service to suicidal patients. They should have back-up arrangements with a local hospital whereby patients may be hospitalized if necessary (Lesse, 1965). Also, reasonably available coverage during evening hours and weekends is a prerequisite.

The psychotherapist has an obligation to seek a consultation when treatment has reached an impasse or the suicidal potential is dangerously high. Consultation should be sought with other mental health professionals, especially those who have expertise in dealing with suicidal patients. The consultation could provide insights into how to manage the patient and may give support for whatever treatment has already occurred. In addition, it may provide legal evidence for the reasonableness of diagnostic and treatment procedures.

Psychotherapists should carefully document all interactions, consultations, and professional judgments (Halleck, 1980). Records should contain the management options that have been considered and their reasons. Not only will thorough records aid in the treatment of the patient, but they would be indispensable if the treatment were ever called into question. Records showing thorough evaluation of the risks and benefits of treatment generally diminish the probability of a successful lawsuit.

Finally, psychotherapists who are threatened with a malpractice suit should follow the suggestions of Wright (1981*b*). Wright, an employee of the APA professional liability (malpractice) program, noted that many psychologists harm their defense through actions taken after receiving a summons. Acting out of indignation, anger, or fear, they may attempt to resolve the case on their own and end up with a judicial foot in their therapeutic mouth. The first step when faced with a malpractice suit cannot be overemphasized: consult an attorney.

REFERENCES

DAVIDSON, H. A. *Forensic Psychiatry*. New York: Ronald Press, 1965.

DELEON, P. & BORRELIZ, M. Malpractice: Professional liability and the law. *Professional Psychology*, 1978, **9,** 467-477.

FARBEROW, N. Suicide prevention in the hospital. *Hospital and Community Psychiatry*, 1981, **32,** 99-104.

FISHALOW, S. E. The tort liability of the psychiatrist. *The Bulletin of the American Academy of Psychiatry and the Law*, 1975, **3,** 191-230.

FURROW, B. *Malpractice in Psychotherapy*. Lexington, Mass.: Lexington Books, 1980.

HALLECK, S. *Law in the Practice of Psychiatry*. New York: Plenum, 1980.

HEALTH LAW CENTER. *Problems in Hospital Law* (2nd ed.). Rockville, Md.: Aspen Systems Corp., 1974.

KING, J. *The Law of Medical Malpractice*. St. Paul, Minn.: West Publishing, 1977.

KNAPP, S. A primer on malpractice for psychologists. *Professional Psychology*, 1980, **11,** 606-612.

KNAPP, S. & VANDECREEK, L. Behavioral medicine: Its malpractice risks for psychologists. *Professional Psychology*, 1981*a*, **12,** 677-683.

KNAPP, S. & VANDECREEK, L. Malpractice as a regulator of psychotherapy. *Psychotherapy: Theory, Research and Practice*, 1981*b*, **18,** 354-357.

KNAPP, S. & VANDECREEK, L. Tarasoff: An update. *Professional Psychology*, 1982, **13,** 511-516.

LESSE, S. Editorial comment. *American Journal of Psychotherapy*, 1965, **19,** 105.

LITMAN, R. Medical-legal aspects of suicide. *Washburn Law Journal*, 1967, **6,** 395-401.

PERR, I. N. Liability of hospital and psychiatrist in suicide. *American Journal of Psychiatry*, 1965, **122,** 631-638.

PERR, I. N. Legal aspects of suicide. *Legal Aspects of Medical Practice*, 1978, **6(1),** 49-55.

PROSSER, W. *The Law of Torts* (4th ed.). St. Paul, Minn.: West Publishing, 1971.

SCHWITZGEBEL, R. L. & SCHWITZGEBEL, R. K. *Law and Psychological Practice*. New York: John Wiley, 1980.

SCHUTZ, B. *Legal Liability in Psychotherapy*. San Francisco: Jossey-Bass, 1982.

SLAWSON, P. F. Psychiatric malpractice: A regional incidence study. *American Journal of Psychiatry*, 1970, **126,** 1302-1305.

SLAWSON, P. F., FLINN, D. & SCHWARTZ, D. Legal responsibility for suicide. *The Psychiatric Quarterly*, 1974, **48,** 50-64.

TRENT, C. Psychiatric malpractice insurance and its problems: An overview. *In* W. Barton and C. Sanborn (Eds.), *Law and the Mental Health Professions: Friction at the Interface*. New York: International Universities Press, 1978.

WEBER, E. The up and coming theory of abandonment. *The Journal of Legal Medicine*, 1975, **3(2),** 19-21.

WRIGHT, R. Psychologists and professional liability (malpractice) insurance. *American Psychologist*, 1981*a*, **36,** 1485-1493.

WRIGHT, R. What to do until the malpractice lawyer comes. *American Psychologist*, 1981*b*, **36,** 1535-1541.