

CASES THAT TEST YOUR SKILLS

Mr. Z, an engineering student who works with explosives, says he plans to 'rid the world of nonbelievers.' He suffers delusions but repeatedly refuses psychiatric treatment. How would you react?

When a patient threatens terrorism

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Mr. Z, age 38, came to the United States from a predominantly Islamic country to study science and engineering. While in graduate school, he was seen by a primary care physician for complaints of hypersomnia; reduced appetite with an approximate 15-lb weight loss; impaired concentration and memory, which hurt his academic performance; low energy; and occasional thoughts about dying.

Mr. Z's physical examination and lab results were unremarkable, and he reported no psychiatric history. He was diagnosed with depression and was prescribed sertraline, 50 mg/d, but he refused to take it. He declined referral to a psychiatrist but agreed to weekly psychotherapy with a psychology intern at the student mental health center.

During therapy, Mr. Z said he constantly felt lonely. He feared being ostracized because of his Islamic beliefs and lifestyle, yet reported tremendous guilt over violating Islamic codes forbidding premarital sex. He told his therapist that his longing

for a romantic relationship was "contaminating" his soul, and fantasized that death would free him of impure, sexual thoughts.

The severity of Mr. Z's depression and his preoccupation with death alarmed the therapist. She referred him to a clinic psychiatrist, but Mr. Z refused to see him, saying that his depression was a punishment from God for his sexual sins. He vowed to repent by undergoing psychotherapy.

CONTINUED THERAPY A 'religious awakening'

During the first 4 months of therapy, Mr. Z's Beck Depression Inventory score fell from 32 to 17, indicating mild depression.

Mr. Z then reported that he experienced a "religious awakening" and began describing his mood and experiences in religious terms. He thanked his therapist for "saving his soul."

The therapist was stunned by Mr. Z's sudden transformation in mood and affect. He slept 7 to 8

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hours a night, and his academic performance improved dramatically. He exhibited stable (though bright) affect and no thought disorder. His therapist viewed his use of religious terminology, though significant, as a cultural artifact because there were no signs of psychosis. Although no objective signs of mania or hypomania were apparent, the therapist suspected he might have bipolar disorder. She again tried unsuccessfully to refer him to a psychiatrist.

Then came Sept. 11, 2001.

Mr. Z was traumatized by the terrorist attacks on the World Trade Center and the Pentagon. He feared a backlash against Muslims in the United States but showed no signs of paranoia.

A few months later, however, Mr. Z became preoccupied with the attacks and harbored conspiracy theories alleging that the United States government had committed them. His speech was rapid and pressured, and he slept only 2 to 3 hours nightly. We later learned that he had not attended class for months and only sporadically showed up for lab work.

Mr. Z then began to fear he was under surveillance and that his visa would be revoked. His affect became increasingly intense during psychotherapy, and he frequently used religious metaphors and concepts. His therapist realized he was suffering a worsening manic episode, although suicidal or homicidal thoughts were not present.

DOWN WITH 'NONBELIEVERS'

During a subsequent session, Mr. Z reported that he had become engaged to marry a well-known supermodel. He also announced a plan to "rid the world of nonbelievers"—people who were not devout Christians, Jews, or Muslims. His three-stage plan called for:

- gently persuading nonbelievers to change their beliefs and lifestyles
- threatening nonbelievers who did not repent after polite persuasion
- "eliminating all the nonbelievers" who did not respond to intimidation.

Mr. Z viewed his therapist as "commander of

the believers" and considered the three-phased plan to be her will. She questioned Mr. Z extensively about how, when, and against whom he intended to carry out this plan. He identified no specific targets, but did say, "I'll know what do to when the time comes. I am an engineer, and I know a lot about explosives."

The therapist then recommended an emergency psychiatric evaluation, which Mr. Z declined. She immediately notified the mental health clinic's attending psychiatrist.

What are the therapist's options? Can Mr. Z be involuntarily committed based on his threats of violence against "nonbelievers?"



Dr. Kennedy's and Dr. Klafter's observations

Two legal principles justify involuntary commitment of a patient who poses a threat to himself or the public:

Police power refers to the government's role in maintaining public safety. State commitment statutes usually require that a mentally ill person pose a significant and imminent threat to the public. The psychiatrist who files an affidavit alleging danger does not need absolute certainty or perfect information but must act in good faith.¹

Parens patriae, or paternalism, refers to government intervention on behalf of persons incapable of managing their lives.¹

Psychiatric treatment of unwilling patients is possible in some states. Family members and/or mental health professionals can petition the court to compel outpatient psychiatric treatment.

Because an emergency evaluation produces a thorough and controlled psychiatric assessment (and minimal deprivation of personal lib-

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Box 1

**Involuntary commitment:
How the legal process works**

Psychoiatric patients can be involuntarily committed through a two-step process: emergency hospitalization and judicial commitment.

Laws vary from state to state but they usually allow mental health professionals and law enforcement officials to complete a written statement documenting their belief that an individual suffers from a mental illness and poses substantial danger to self or others.

This form allows police to civilly arrest and transport the individual to a hospital for an emergency evaluation. The hospital then must complete the evaluation within a specified period, usually 24 hours.

If the evaluator finds that the individual is mentally ill and dangerous, he or she must then file an affidavit with the probate court, again within a specified period.

A court hearing is then scheduled. The individual is usually granted due-process rights, including the right to an attorney and an independent psychiatric evaluation. The judge then must decide whether the individual is mentally ill and dangerous, usually based on a “clear and convincing” evidence standard.

erty), a psychiatrist with any doubt about the patient’s condition should move toward commitment.

Before resorting to legal coercion, try scheduling more-frequent appointments to monitor symptom progression. This would allow faster response when civil commitment criteria are met.

A psychiatrist or other mental health professional can request an emergency evaluation based on information from a knowledgeable intermediary or family member—even if the clinician did not recently or directly interview

the patient.² For example, a psychologist could receive information from a case manager who encountered the patient decompensating. It would be impractical to require a psychiatrist to see a decompensating patient before an evaluation can be ordered.

HOSPITALIZATION A ‘blood-drinking monster’

With no security staff immediately available, the attending psychiatrist and therapist sent Mr. Z home.

The psychiatrist then submitted an application for involuntary hospitalization—in which the doctor summarized the case—and faxed it to the local psychiatric emergency service. The police were notified and—after verifying that the appropriate paperwork had been completed—arrested Mr. Z at his home and brought him to the emergency service for an assessment. Mr. Z was then hospitalized. (*Box 1*).

Mr. Z was found to be harboring bizarre, grandiose, persecutory, and religious delusions. He claimed that a blood-drinking monster was lurking inside the hospital, and that his hospitalization was part of a conspiracy to persecute Muslims. He considered the Sept. 11 attacks fictitious and claimed that widely broadcast television news footage of the attacks was a computer-animated video. The patient refused all medications while hospitalized.

After 3 days, the court ordered Mr. Z’s discharge, citing lack of evidence that he posed any danger to self or others. At his mental health probate hearing, he managed to conceal his psychotic symptoms while testifying. The court expressed concern over his technical training in explosives but ruled that he was not dangerous because he had never used this knowledge to commit violence.

Upon discharge, Mr. Z declined outpatient psychiatric treatment. The therapist then told Mr. Z that she would terminate psychotherapy after two sessions unless he visited a psychiatrist. Mr. Z again refused, and psychotherapy was terminated.

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Box 2

Terminating patient care: When 30 days' notice is not appropriate

Although 30 days' notice is generally appropriate for terminating a provider-patient relationship, a longer or shorter period may be needed depending on:

- Reason for termination. Immediate termination can be justified if the patient has assaulted or threatened the clinician.
Provider-patient relationship duration. In general, the shorter the relationship, the more leeway there is toward shortening the required notice.
Type of care being provided. Psychiatric care involving medications or highly intensive interventions calls for longer notice to effect a smooth transition to the next caregiver.
Availability of alternatives. The general wait time to obtain a new-intake appointment with another psychiatrist needs to be factored into the length of notice.

Letters and notes regarding termination can be used as evidence in court proceedings. When judging a patient abandonment case, the courts will rely on documentation of the reasons for termination and the process used to end treatment.

Source: Slovenko R. Law in psychiatry. New York: Brunner-Routledge, 2002:770-1.

Would you terminate psychotherapy at this point? Could the therapist's actions be viewed as patient abandonment?

Three horizontal lines for writing a response to the first question.

Dr. Kennedy's and Dr. Klaffer's observations

The formation of a professional relationship establishes a duty of care and requires the clinician

to provide reasonable notice of termination and alternative sources of care. Although 30 days' notice is generally appropriate, several factors may dictate the need for more or less notice (Box 2).

In Mr. Z's case, we view the psychologist's behavior as appropriate because:

- Without psychotropics, Mr. Z's psychosis would likely persist. To continue treating him with psychotherapy alone would fall below the standard of care.
By threatening to terminate psychotherapy, the therapist tried to use the patient's transference and desire to maintain the therapeutic relationship as an incentive to accept medication.

CONTINUED OBSERVATION A clue from the past

Mr. Z's brother, who was contacted by the treatment team, reported that the patient had never been violent. He did note, however, that as an adolescent Mr. Z talked about joining a terrorist organization, though he had never followed through. The brother tried to persuade Mr. Z to leave school and live with him on the West Coast, but he instead chose to continue his studies.

Mr. Z's hospital treatment team realized that his continued work in engineering—where he had access to explosive materials—posed a significant risk given his impaired judgment. Acting on a forensic expert's advice, the team warned university officials about Mr. Z's mental state and preoccupation with violence. The FBI was also contacted.

Was the treatment team justified in reporting Mr. Z's behavior to authorities, even though he never identified any potential victims?

Four horizontal lines for writing a response to the second question.

Dr. Kennedy's and Dr. Klafter's observations

Various legislative and judicial remedies—some more restrictive than others—address the psychiatrist's duty to third parties:³

- Some states require psychiatrists to notify or protect third parties when any danger is foreseeable, regardless of threat or victim.
- Other states require specific threats but charge the psychiatrist with foreseeing all potential victims regardless of whether they were named.
- Still other states limit protection to identifiable victims, even if no threat is issued.
- In some states the psychiatrist is responsible only if the patient makes specific threats to identifiable victims.

Again, psychiatrists need to make their best professional judgments in good faith about risk of violence. Hospitalizing a threatening patient provides the most protection to third parties, but this option is intrusive, coercive, and is not always appropriate or feasible. If the threat is directed toward the public rather than specific individuals or groups, law enforcement agencies can reduce the risk somewhat through monitoring and surveillance.

Although it is a judgment call, clinicians should notify:

- all persons or organizations against whom a patient might commit violence
- and those who might be targeted as instruments for violence towards others, such as family members who have guns the patient could obtain.

A terrorist would not likely seek psychiatric help relative to his goals of terrorism because such behavior is not rooted in major mental illness. However, the heightened sense of paranoia and anxiety created by events involving terrorism, religious animosity, and hatred provide patients who struggle with psychosis an outlet

for their paranoia. As such, we should take a patient's terroristic threats seriously.

CONCLUSION Going home

The university granted Mr. Z medical leave and placed him on academic probation for 2 months, during which he returned to his native country to stay with his parents.

The faculty later dismissed Mr. Z from the program, citing poor academic and laboratory performance. His visa expired, with renewal contingent upon enrollment in a full-time academic program.

References

1. Rosner R (ed). *Principles and practice of forensic psychiatry* (2nd ed). New York: Oxford University Press, 2003:108.
2. Ohio Revised Code section 5122.10.
3. Felthous AR, Kachigian CK. The fin de millenaire duty to warn or protect. *J Forensic Sci* 2003;46:1103-12.

Related resources

- ▶ American Academy of Psychiatry and the Law. www.aapl.org.

DRUG BRAND NAMES

Sertraline • Zoloft

DISCLOSURE

The authors report no financial relationship with any company whose products are mentioned in this article, or with manufacturers of competing products.

Terroristic threats from a psychiatric patient should be taken seriously. Clinicians should work toward involuntarily commitment if there is any doubt about the patient's condition. Begin the commitment process by contacting the supervising physician, then notify police.

Bottom Line