

Virtual Mentor

American Medical Association Journal of Ethics
March 2008, Volume 10, Number 3: 144-149.

CLINICAL CASE

Duty to Warn and Dissociative Identity Disorder

Commentary by Michael A. Norko, MD

As a fourth-year student doing a psychiatry rotation, Alana had been researching dissociative identity disorder. She'd worked with a couple of patients with that diagnosis over the month, and one patient had given her permission to sit in on the therapy sessions with the psychiatrist, Dr. Carpenter.

The patient was a woman who appeared to have five distinct personalities. Of average height and build, this patient, whose name was Mary, alternately appeared to be a frightened child, a sexually provocative adult, a male writer, an accountant, and a violent, unrestrained person called "Sam." "Sam" routinely threatened to assault physicians and staff, threw chairs and other objects with great force, and often cursed at anyone who came near him. Dr. Carpenter made certain that restraints were available when "Sam" appeared. He believed that this personality was an unconscious identification with the men who had abused Mary viciously when she was a child and that it would disappear when Mary was successfully treated.

During the last week of Alana's rotation, "Sam" was the primary mode in which Mary presented. He repeatedly made threats about a specific person—the owner of a grocery store near where the patient lived. Midway through one session, "Sam" stated, "I'll kill that guy. You know I will. I've already made a plan and bought a gun. I'm going to shoot him tonight when he gets off work."

Dr. Carpenter tried to calm "Sam," and, after a few minutes, Mary the accountant resurfaced. After about 10 minutes of conversation, Mary left, acting calm and relaxed, with no recollection of "Sam" and his threats.

Remembering the famous *Tarasoff* case, after which the courts decided that psychologists and psychiatrists had legal and ethical duties to inform the police of a threatening patient's plan, Alana asked Dr. Carpenter whether the *Tarasoff* ruling applied to Mary and whether they should inform the police.

Dr. Carpenter seemed hesitant. "I've been working with this patient for 18 months. If I were to turn her over to the police, it would undo all our work, and quite possibly she would not return to therapy."

Commentary

There are many fascinating aspects of this case worthy of discussion, but the place to start is with the ethical dilemma between, as Dr. Carpenter characterizes it, doing

good therapy and “turning the patient over to the police.” I will discuss the issues of police notification and *Tarasoff* duties further, but my first observation is that solving difficult problems is often a matter of finding alternatives early and intervening before a dilemma arises. In this case, Dr. Carpenter not only had earlier opportunities to avoid the decision Alana’s question poses, but probably the responsibility to do so.

Dr. Carpenter has a worthy goal in mind for long-term therapy with Mary—the re-integration of her ego and resolution of negative effects of past traumatic experiences. He is probably right that “Sam” will “disappear” with a successful treatment. The problem is that “Sam” is very real behaviorally, and the presence of this violent tendency within Mary should not be ignored, though it seems that Dr. Carpenter may be doing so.

When Dr. Carpenter attempts to calm the patient and Mary responds to him, it’s not the psychological equivalent of a successful tumor resection. Mary is not “cured” of her “Sam” personality. Just because it was the Mary personality who left Dr. Carpenter’s office and was no risk to others does not mean that Mary—the person—is not a danger. Dr. Carpenter is well aware of the risk that “Sam” poses; he has taken the extraordinary measure to have restraints available when he conducts therapy with Mary.

Unless Dr. Carpenter can somehow feel certain that “Sam” has never appeared outside of a therapy session and never will, he has knowingly allowed a person capable of violence to leave his office after making a specific threat to an identified third party. Were the grocer to be injured or killed by Mary, Dr. Carpenter would have a hard time explaining his rationale for taking precautions to protect his own safety but not considering the safety of an identified potential victim in the community or the risk to his own patient’s well-being should violence or attempted violence occur. This is not to say that Dr. Carpenter’s primary duty is to public safety, but he has done no service to Mary by allowing her to leave without further exploration of the risk and appropriate precautions.

So let’s re-examine the session and its antecedents to see what else Dr. Carpenter might have done when “Sam” appeared in the session and made what seemed to be a credible threat. “Sam” spoke of a particular victim who works in a location near Mary’s home, whom Mary knows and to whom she has access. “Sam” also provided a specific time frame (tonight) and method of killing (gun). In an attempt to calm the patient down, Dr. Carpenter seemed most interested in making “Sam” go away, and, in doing so, he missed an opportunity to probe further the extent and seriousness of the situation so that he might form an appropriate treatment plan with his patient.

Had this been an oral board examination in psychiatry, Dr. Carpenter might well have failed for not assessing homicidality. Why does “Sam” want to kill the grocer? Is this desire based on a paranoid, delusional belief? Is “Sam” angered over some recent offense or slight, or is the grocer a random or symbolic target? Does “Sam” actually have a gun? Can he obtain one? Has “Sam” used a gun in the past? Is there

some meaning to the timing of the threat? Is tonight important for some reason? Because these questions were not asked, we know very little about how serious a threat Mary (the one person) poses to the grocer—even outside of her own awareness.

The American Psychiatric Association, for example, in its *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors* recommends asking the question, “Do you have guns or other weapons available to you?” [1] The situation in this case scenario would seem to call for the same inquiry.

Perhaps these questions seemed irrelevant to Dr. Carpenter because, after all, “Sam” is only a portion of a fractured ego, and not a separate, physical person. But Dr. Carpenter knows how real the phenomenology of “Sam” is. He has already engaged in 18 months of hard work to help Mary re-integrate these components of her personality.

The fact that Mary does not recall what takes place when “Sam” is present will not prevent her from being arrested when witnesses report her shooting the grocer, nor is it likely to relieve her of all the criminal consequences of her act. The criminal justice system will not get caught up in thinking of “Sam” as the perpetrator and thus be stymied in efforts to prosecute Mary. Mary’s mental state at the time of the crime will be relevant and may permit her to offer an insanity or diminished capacity defense in many jurisdictions, and her amnesia about the events may well complicate determination of Mary’s competency to stand trial and her criminal responsibility [2]. But even a successful insanity defense or a mitigated sentence is not a desirable outcome for Mary. Juries are suspicious of both amnesia claims and the insanity defense, and an outcome less serious than a murder conviction would not be certain.

Dr. Carpenter is right not to have had a knee-jerk response to call the police when hearing a threat during a therapy session. In fact, there are known negative consequences to mandated warnings, including harm to the therapy [3] and criminal prosecution of the patient [4]. Nevertheless Dr. Carpenter needed to gain more information from “Sam” after the threat was made in order to determine an appropriate course of action. He needed to have further discussion with Mary after she responded to him. Mary should have been made aware of the threat that “Sam” made, so that she and Dr. Carpenter could formulate a plan together for keeping her and the grocer safe from harm. If Mary has a gun or access to one, what steps can she take to protect herself since she does not recall what “Sam” does? Mary may also be unaware of a gun obtained or hidden by “Sam,” and Dr. Carpenter and Mary should have also made plans for this possibility.

If there is any substantial risk of “Sam” making an appearance outside of therapy—especially that very night—it might be necessary to hospitalize Mary. Or perhaps she merely needs to be with people she can trust to monitor her behavior on a constant basis. Is it possible to make such arrangements? If it is possible for Mary’s friends and family to assist her, is it safe for them? Would it be an effective plan? What we

don't know from this narrative is whether Mary (in any mental state) has elsewhere engaged in the kind of violent behavior that Dr. Carpenter has observed. If there are no reliable clinical interventions to prevent this possible homicide, then notifying the grocer and the police must at least be considered.

But all of this should have been talked about before Mary left the session. In fact, it should have been discussed after “Sam’s” first display of chair-throwing and violent threats. To some extent it was considered, because Dr. Carpenter has arranged to restrain his psychotherapy outpatient if necessary. Again, the inconsistency of Dr. Carpenter’s behavior will bedevil him if the grocer is attacked.

It seems likely that Dr. Carpenter was not prepared to respond to this sudden turn of events because he had not contemplated the range of possible adverse consequences of Mary’s violent behavior. Dr. Carpenter was doing precisely what the California Supreme Court was critical of in the *Tarasoff v. The Regents of the University of California* case; he was considering his clinical activity during therapy sessions in isolation from the rest of his patient’s experience and interactions in the world.

As the California Supreme Court famously noted, “[t]he protective privilege ends where the public peril begins” [5]. The solution raised by that first *Tarasoff* court was that the therapist had a duty to *warn* the likely victim of a patient’s threat. When the case was re-heard, the same court—known as the second *Tarasoff* court [6]—restated that the duty was to *protect* the likely victim. Many mental health professionals were more distressed by the second decision than by the first. After reflection, however, the field came to understand that it was possible to protect the victim (e.g., by hospitalizing the patient and treating the etiology of the potential violence) without violating the confidentiality of therapy.

The state of California ultimately modified the legal requirements by statute in 1985 so that the duty to a third party could be fulfilled by “reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency” [7]. California continued to struggle with the precise nature of the requirements in case law, and the legislature modified the statute again in 2006 to attempt to clarify that there was a duty to warn and to protect that could be fully satisfied by a warning to the victim and police [8]. Many other states have adopted legislative mandates about *Tarasoff* duties; most impose a duty to breach confidentiality, some merely permit it, and others are silent on the issue [7]. Because of the state-to-state variation, mental health professionals must be well-informed of the duty in their own states, which can be simultaneously complicated, vague, and difficult to assess.

Dr. Carpenter should have sought consultation with a colleague familiar with forensic psychiatry earlier in the course of Mary’s therapy, certainly upon entertaining the idea of physically restraining an outpatient. That would have allowed him to have the benefit of probing questions and a viewpoint outside of the limited focus of his clinical goals for his long-term therapy patient. Because of Alana’s observations, the right question is being asked, but too late to allow the most

reasonable interventions. Dr. Carpenter will either have to call Mary back in, if possible, to engage in the appropriate immediate care plan, or call the police and hope they can be helpful without hurting Mary or the therapy, or do nothing and hope that serious violence will not erupt that evening.

Professionalism does not permit inaction in the face of such adverse potential consequences. Dr. Carpenter may only choose to do nothing (i.e., call neither Mary nor the police) if he is satisfied through his clinical assessment that Mary and the grocer will be safe without such interventions. Given the potential outcomes, Dr. Carpenter should also seek consultation in making this risk assessment. And, as in all clinical and risk assessments, he should be careful to document his decision making and his consideration of alternatives.

References

1. American Psychiatric Association. *Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors*. Washington, DC: American Psychiatric Association; 2003:10.
http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx. Accessed February 12, 2008.
2. Bourget D, Whitehurst L. Amnesia and crime. *J Am Acad Psychiatry Law*. 2007;35(4):469-480.
3. Herbert PB. The duty to warn: a reconsideration and critique. *J Am Acad Psychiatry Law*. 2002;30(3):417-424.
4. Weiner JR. *Tarasoff* warnings resulting in criminal charges: two case reports. *J Am Acad Psychiatry Law*. 2003;31(2):239-241.
5. *Tarasoff v The Regents of the University of California*, 529 P2d 553 118, Cal Rptr 129 (Cal 1974), at 561.
6. *Tarasoff v The Regents of the University of California*, 551 P2d 334 (Cal 1976).
7. Herbert PB, Young KA. *Tarasoff* at twenty-five. *J Am Acad Psychiatry Law*. 2002;30(2):275-281.
8. Weinstock R, Vari G, Leong GB, Silva JA. Back to the past in California: a temporary retreat to a *Tarasoff* duty to warn. *J Am Acad Psychiatry Law*. 2006;34(4):523-528.

Michael A. Norko, MD, is an associate professor of psychiatry in the Law and Psychiatry Division of the Yale University School of Medicine in New Haven, Connecticut. He is also director of forensic services for the Connecticut Department of Mental Health and Addiction Services and deputy editor of the *Journal of the American Academy of Psychiatry and the Law*.

Related in VM

[In Defense of Exceptions to Confidentiality](#), October 2003

[In Defense of Absolute Confidentiality](#), October 2003

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2008 American Medical Association. All rights reserved.