Threat Assessment and Threat Management
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Abstract: Threat Assessment

Threat Assessment has become more and more important in workplace and intimate partner violence (IPV). There is always a path to violence where interventions are possible. Neither threats nor violence are static phenomenons; therefore threat assessment must be updated periodically according to new developments. The integration of collateral information is a crucial point in any threat assessment. Often relatives or co-workers are well aware about possible threats (target, capability and willingness to carry out); suicidal or homicidal intentions, access to weapon and substance abuse. This presentation provides knowledge and expertise based on cases studies. Threat assessment is the base for threat management; which offers a strategy that moves away from the prediction of danger to the identification and handling of risk.

"*Threat Management offers a strategy that moves away form the prediction of danger to the identification and handling of risks"* (Turner and Gelles, 2003; p. 3).

This paper provides an exploration of current approaches when dealing with violent and/or threatening offenders. It is based on numerous assessments including treatment experiences and training seminars given by the author. Health care professionals have to enlarge their knowledge when dealing with this subject in at least three areas. (1) Threat assessment is directed more by behavioral aspects than by diagnostic concepts. The path to violence is used to decide whether or not an individual poses a serious threat. Actuarial tools are not very helpful due to the low base rates of targeted violence; and traditional clinical investigations often fail due to the nature of targeting violence (2) In threat management mental health issues play a completly different role than in traditional clinical settings – interventions in targeted violence are not primarily based on mental health issues, but on behavioral aspects. The threat assessment is an ongoing process, as targeted violence is not considered as a static phenomenon. (3) Mental health care professionals can no longer claim confidentiality when dealing with potential violent offenders – they have the duty to balance different legal requirements, and to inform targeted persons following legal procedures.

Historical Considerations: The path to violence.

Since the ancient Greeks mankind was attempting to understand determinants and causes of violent behavior. During the time of the Enlightenment the century long conviction that criminal behavior is a sin against God was finally overcome, and scientific approaches prevailed. However, today's concept of the behavioral based approach using the model of the "path to violence" (Calhoun and Weston 2003) various stages of understanding can now be identified.

I. Biological Markers

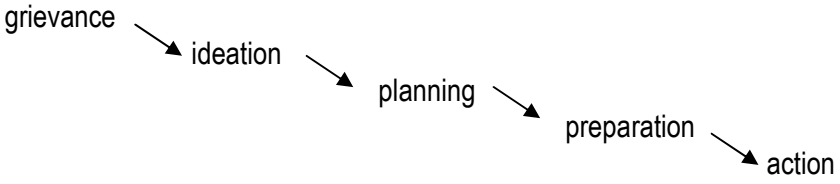
Individuals showing violent and criminal behavior had been identified by their body shape and expressions – you only had to assess corresponding signs to detect a criminal. This approach first started with what was known as PHRENOLOGY (Johan Caspar Lavater: "Criminalphysiognomy" = the facial expression indicates the true criminal; Franz Josef Gall = the cranial shape indicates the true criminal). This approach culminated in Cesare Lombroso's cultural anthropology: violent and criminal behavior is caused by inborn biological dispositions. He stipulated that violent offenders are different from other human beings. The criminal could easily be identified by the following signs: sloping forehead, prominent chop bones, curly hair, cruelty, lack of inhibitions, immunity to pain. Enrico Ferri and Raffaele Garfalo conducted further research on this matter. Violent behavior was therefore seen as a simple product of a set genetic profile. This approach stimulated the research until today. "*The literature on the biological determinants of physically aggressive behaviors is remarkable in three ways. First, the technologies for measuring the biological variables have developed rapidly in recent years, resulting in a high degree of precision, while the definitions of the behaviors of interest and of the subject selection criteria remain rather vague. Second, findings resulting from animal studies are usually stronger than those resulting from investigations of humans. While this difference is usually thought to result from the complexity of the determinants of human behavior, it may be due at least in part to the precision with which the behaviors of interest are described in the animal studies. Third, the investigation of the biological determinants of physical aggression often lack theoretical justification. It is as if subjects were studied because researchers have access to them, or biological variables were measured because the technology was available*" (Hodgins, von Grunau, 1988).

II. Personality Markers

Under the influence of psychology and psychiatry violent and criminal behavior is and has been seen to be caused by certain personality traits such as antisocial personality. "*There is, however, a growing area of research suggesting that myriad physical health conditions may be causally related to antisocial behavior through the mediating factor of central nervous system dysfunction*" (Brennan et al. 1997). Various violence risk assessment tools were created based on this approach, on one hand the actuarial risk assessment instruments, on the other hand the clinical interview based instruments. However, as static concepts they *lose their utility when applied to investigations of stalking, workplace violence, school violence, and other threat assessment crimes* (Palarea 2007). The use of violence is determined much more by dramatic moments than by personality traits (Meloy 1998). Most violent offenders are not violent most of the time. However, some of those with psychological problems are more prone to violent outbursts. According to recent media reports, the 22 year old offender of the Kauhajoki School Shooting in Finland (2008), Mr. Saari, was planning his action for six years. He was investigated by the police on the Monday, finding no evidence of violent behavior, and the next morning of Tuesday, September 23 he killed 10 people and himself. Now it turned out, that after having killed the 10 people Mr. Saari called a friend and told him, that he had planned the shooting for over two years. After this call, Mr. Saari killed himself. However, since then the police found some notes at his home disclosing Mr. Saari's plan dating back to 2002.

III. Path to Violence

Contemporary threat assessment tools use the concept of the "path to violence" to decide whether someone is on that path and at which stage. The original description is based on a six step model used for public security purposes, and it is slightly modified for general use in targeted violence. The escalation of violence is taking place in a step by step process:



In the Kauhajoki School Shooting case we have learned that the initial grievance started six years previouly; the shooter had communicated with other school shooting offenders in order to find out the best ways in causing the most harm and fatalities. He purchased a semiautomatic handgun at the same shop where the first Finnish school shooter had bought his weapon – if the police had known these facts during the investigation which took place the day prior to the shooting, they would have realised that Mr. Saari was almost at the end of the path to violence: the outcome would certainly have been different. The concept of the "path to violence" is based on the modus operandi of these offenders and helps to identify those who could pose a serious threat.

From a preventive aspect it is important to realise, that in most cases their is plenty of time for interventions – somebody must put the dots together and collecting the information. We should not forget, that often classmate or co-workers spent hours and hours together with the offender – often they realise that something is going wrong long before the final escalation takes place. When we consider the amount of time, men hours, and money, which is now investigated into such events like the Kauhajoki Shooting, we should also think about spending more time and money for the prevention of such crimes.

Mental health care professionals are now more and more confronted with targeted violence

When the first stalking cases were reported two decades ago, the problem was associated to topranking officials and celebrities. However, in the meantime, it turned out that stalking is part of domestic and workplace violence, and that it affects many more people then ever thought before. Stalking is one type of targeted violence. Depending on the definition of stalking between 15% and 20% of the entire population become a victim of stalking during their lifetime. The average duration of stalking is approximately two years ranging from a couple of days to decades. And it is not the unknown stranger who commits stalking – empirical facts show that in 70% of all stalking cases the offender is known to the victim; and in approximately half of all stalking cases the stalking behavior emerges out of a former intimate relationship. To make it even more complicated: stalking is not a singular type of behavior, rather it is a chain of actions targeted towards the victim. In a quarter to a third of all cases the stalking behavior includes physical violence, ranging from a slap to life-threatening attacks.

Homicidal behavior is often strongly related to domestic violence and it constitutes another form of targeted violence. When health care professionals have to assess suicidal people they have the duty to

simultaneously assess the risk for homicidal actions – again the concept of the path to violence can be used for a comprehensive threat assessment. The threat assessment is an ongoing process and must be up-dated whenever new information is available.

Between half and three quarters of all victims of targeted violence need professional help due to impairment of their mental health conditions. The symptoms ranging from sleep disturbances and nightmares, to panic-reactions, constant fear leading to avoidance behavior and undermining working capacity; somatic problems such as headaches, chronic fatique syndrome, gastrointestinal disturbances, and chronic pain, just to name the most prominent problems. Therefore health care professionals will see threat-related victims and their relatives, and there is a urgent need to train health care providers in this area. But mental health care professionals will also be confronted with the question: what to do with the offenders? Many may believe that as long as these problems do not arrive at their doorstep there is nothing which must be done – a rather naïve view of the world. Health care professionals may easily become the victim of stalkers themselves, as various studies clearly indicate. 15-20% of health care providers are confronted with stalking; and approximately 50% are confronted with workplace violence (Cooper and Swanson, 2002). The International Labour Organisation in cooperation with the International Council of Nurses, the World Health Organisation and Public Services International have issued guidelines for addressing workplace violence in the health care sector in 2002. The 1st International Conference on Workplace Violence in the Health Sector (Amsterdam 2008) gave an overview on the topic covering various aspects and providing preventive strategies.

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Cooperation with law enforcement

One of the primary goals of law enforcement is to protect its citizens. Various police departments worldwide have implemented specialised threat management units to deal with threats and to prevent violent escalations. Simply knocking at a stalker's door helps in approximately two third of all cases and contributes in bringing the stalking to an end – at least in this particular case. A restraining order can be of help, and of course victim treatment including providing security advice. As you may be aware, stalkers deny that they have a problem – the problem is the victim. If she would not behave in this way, there would be no need for this behavior. It's naïve to expect that they are motivated to undergo therapeutic counselling and to change their behavior. A legal framework is required to bring these types of offenders into treatment.

However, the goals of such an approach must be clarified. What should therapy provide? When you consider it as a kind of a last resort, then this approach will fail. Therapy helps best when implemented early on after the problematic behavior erupts. Stalking, as any other threatening and violent behavior, is not a disease – we estimate that only a third of all cases can be diagnosed at the time of their threatening behavior as having a serious mental health issue. And even in cases, when they are diagnosed with mental health problems, it is often not clear whether the threatening behavior is caused by the mental impairment, or whether it simply co-occurs.

The treatment approach in stalking cases is based on a behavior change rather than treating a mental health problem. This includes problem solving techniques, anger management, and social skills training. Many stalkers suffer from attachment problems and related unresolved grievances – therapy in such cases may by an option in changing someone's life. The dialectic approach of DBT is helpful in overcoming the own tunnel vision that nothing can be changed. The same approach the American President Obama uses

in his speech can be adapted in therapy in order to provide a vision: Yes, we can! The therapeutic alliance is the base for this approach, where therapy goes with the client, and not against him.

Case example

This case is a constructed vignette based on various real case materials.

Friday night at the police headquarters, after finishing his shift Sg. Miller had an argument with a female colleague on duty, during which he became upset and slapped her and grabbed her by the hair, she defended herself by kicking him; he finally he left the building shouting abuse and threats: "*You're gonna get it…!*". She was scared to death and reported the incident to her superior officier and the superintendent investigated the case. Sg. Miller was a member of SWAT, and it later turned out that the two had had an extramarital affair. After the hearing is was unclear whether Sg. Miller would react with a suicidal or even a homicidal action due to the publicity the case had attracted. A threat assessment was carried out, using the model of the path to violence, in order to decide whether or not he was on this path. The WAVR-21 was used as an assessment tool and it clearly turned out, that Sg. Miller was neither suicidal nor homicidal despite the serious grievance he suffered from. He never before had physically attacked his female colleague with the exception of that particular situation, where he was emotionally upset. He apologized for his unacceptable behavior.

One of the particular difficulties in this case was the access to weapons, the training both parties have received and the capability to use their weapons and their knowledge. Sg. Miller was a pillar within the SWAT unit and he was given the chance to hold this position, but he received a clear warning, that personal issues must not interfere with police duties. The superintendent also demanded him to undergo treatment in order to solve his personal problems.

Therapeutic intervention

The therapeutic approach in violent cases are always based on two different avenues: one is the therapeutic intervention per se, the other is the ongoing threat assessment based on the clinical interview. These two aspects have to be dealt with simultaneously during the intervention process. In case of a threat against third parties the responsibility always lies with the treating therapist to warn potential targets, according to the Tarasoff Doctrine. Although this "Tarasoff duty to warn" philosophy was coined by an American Court it is now applicable worldwide, as a recent European Court on Human Rights' decision clearly indicates (Gavaghan 2007). Professionals can no longer claim confidentiality, rather they have to balance rights, especially concerning security aspects of third parties. The threat assessment is not a single event, rather it must be updated periodically, or when new information is available, which leads to a revision of the puzzle. The threat assessment should be done by an interdisciplinary team (Resnick 2007). The information management is crucial and professionals involved in the situation should always consider collateral information. The single most accurate predictor is always the targeted victim!

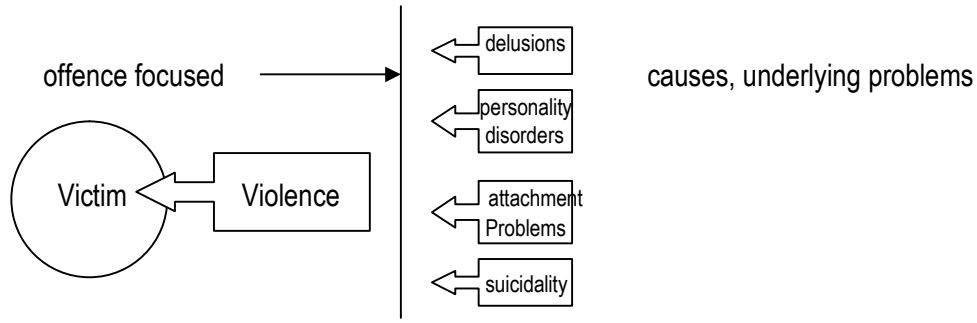
When threat assessment clients are referred for treatment, there are at least four salient psychiatric problems which are a challenge for therapeutic interventions, as illustrated in the following list:

personality disorders
attachment problems
suicidality
other

risk assessment

In offender treatment, the primary goal is focusing on the offence pattern, which means, that we consider the threatening/violent behavior per se as the main reason which brings someone to treatment, and not so much the underlying problems. Mental health professionals tend to rely on psychiatric diagnoses as the first approach for therapeutic interventions, but this is often misleading in cases of targeted violence, as a quotation by Mullen (2007) illustrates: «*Traditionally, most areas of psychiatry have focused on disorders of mental function, with behavior regarded as a mere epiphenomenon*». Behavior in targeted violence is the primary key point for interventions, which are used in a hierarchical way in treatment. The underlying causes are considered, when the threat escalation is under control. This is of importance especially in outpatient treatment approaches, and where is an ongoing risk for further violent actions.

The offence focused treatment is illustrated in the following diagram:



The offence-focused treatment is based on a semistructured cognitive-behavioral intervention approach consistent of 24 moduls (see: http://www.bsgp.ch/userdocs/APA2006%20Stalking.pdf). The specific treatment goals can be divided into offence and personality focused aspects.

offence focused:
- offence reconstruction
- cognitive distorsions
- underlying causes
- impulse control (internal-external)
- offence related personality aspects
- victim empathy
- improving impulse control
- openness
- intimacy and emotionality
- responsibility
- work – life-balance
- crisis-management

personality focussed:
- anger management
- power and powerlessness
- own victimisation
- social skills
- fear-reduction
- substance abuse
- life style problems related to self esteem
- identity and self esteem
- nature and ecology
- ethical concerns
- personal perspectives
- spirituality

In most cases the first goal is to stop the violent behavior, and then to address any underlying problems. In cases of escalation it is of primary importance, to be prepared for violent outbursts, which require a close co-operation with law enforcement authorities. After the offence focused approach we consider the specific therapeutic challenges related to the individual psychopathology.

Conclusion

The aim of this contribution is to provide an overview on threat management and its application within the health care sector, and in other areas, for the handling of targeted violence. Violence is considered as taking place in a step by step process; the model is called "path to violence". In this concept, mental health issues are not the main focus; rather it is the behavior. The "path to violence" helps to identify whether or not someone is on this slippery slope and at which slope. Threat assessment is not a single task, rather it must be updated whenever new information becomes available. Intervention are based on the assessment and consists of a multifaceted approach and interdisciplinary cooperation (police intervention, victim support, offender treatment, cooperate security, etc.). "*Threat Management offers a strategy that moves away form the prediction of danger to the identification and handling of risks"* (Turner and Gelles, 2003; p. 3).

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