Violence Risk Assessment and Management in Outpatient Clinical Practice

Aaron J. Kivisto

University of Indianapolis

Objective: The aims of this review were to highlight fundamental distinctions between risk assessment in forensic versus therapeutic settings, review the best available evidence regarding key risk and protective factors for violence of particular relevance to clinicians in outpatient therapeutic settings, and describe an approach to evaluating and managing violence risk in outpatient treatment.

Method: An integrative literature review was undertaken to examine violence risk and protective factors most relevant to outpatient clinicians in therapeutic settings.

Results: Based on the available research, the Integrative Outpatient Violence Risk Assessment and Management (IVRAM) model, a 5-step strategy for evaluating and managing violence risk in therapeutic contexts, is introduced. The IVRAM emphasizes the integration of nomothetic and idiographic data through a focus on empirically derived dynamic risk and protective factors in the context of an individualized anamnestic analysis.

Conclusion: Clinicians working in forensic and therapeutic settings will increasingly benefit from the contributions of the other as the distinctions between risk assessment and risk management continue to decrease.


Keywords: violence; violence risk; risk assessment; risk management; dangerousness

On May 23, 2014, 22-year-old Elliot Rodger e-mailed his therapist a link to his 137-page “manifesto” outlining his numerous grievances and plans for retribution. Under California’s recently amended duty to protect law, the therapist was required to take “immediate” action—clarified only the previous year as action within 24 hours (California Civil Code § 43.92, 2013). Well before this 24-hour window had expired, Rodger had killed 6 and injured 13 others in Isla Vista, California.

Rodger’s case—which occurred exactly 40 years after the landmark Tarasoff I (Tarasoff v. Regents of University of California, 1974) decision held that psychologists have a duty to warn third parties identified by patients as targets for imminent violence—shared many similarities with the Tarasoff fact pattern. In both cases, college-aged males in California made a threat to their treating psychologist that they intended to kill female students in the University of California system. Despite the tragic outcomes, neither perpetrator’s level of risk was apparently missed or ignored by mental health or law enforcement professionals. To the contrary, police made in-person contact with both perpetrators before the homicides, and the treating mental health professionals in both cases reportedly breached confidentiality because of their apparent concern over these individuals’ threats. Unfortunately, both perpetrators were also able to reassure law enforcement that they did not pose an immediate risk and no further action was taken. That both Prosenjit Poddar, Tatiana Tarasoff’s killer, and Elliot Rodger had been identified, initially at least, as presenting a high risk of serious violence highlights the difficulty of not only evaluating but also managing violence risk in individuals in outpatient psychotherapy.

Although these two cases provide tragic and high profile bookends, the four decades between these events have seen the legal and clinical considerations related to working with potentially dangerous patients become a routine aspect of outpatient mental health practice. From a legal standpoint, most states followed California in enacting some variant of duty to protect laws.
creating novel responsibilities to third parties that would affect confidentiality with dangerous patients. In the 40 years since Tarasoff I, the risk management responses available to clinicians have generally expanded. What was once a relatively narrow duty to warn is now more broadly a duty to protect (Weinstock, Bonnici, Seroussi, & Leong, 2014), allowing greater clinical judgment in how best to mitigate risk.

Empirically, considerable progress has been made in the field of violence risk assessment since Tarasoff (Tarasoff v. Regents of University of California, 1974/1976), with key shifts in the field from violence prediction to violence risk assessment to the current evolution toward violence risk management (Douglas & Skeem, 2005; Skeem & Monahan, 2011). These developments, which have by and large come of age in the risk assessment literature published in forensic specialty journals, are of particular relevance to clinicians practicing in outpatient treatment settings who are responsible for identifying, evaluating, and managing violence risk yet might not have much exposure to this specialized body of research, resulting in an informational silo that potentially impedes optimal risk management practice.

The purpose of this article is to review the current state of the science in evaluating and managing violence risk with potentially dangerous patients in outpatient treatment settings. Differences between risk assessment in forensic versus therapeutic settings are highlighted and an overview of the best available evidence regarding key risk and protective factors is presented. It is suggested that certain risk factors consistently identified in the risk assessment literature are of particular relevance to treating clinicians, whereas others are of lesser relevance. The status of threats as a risk factor, which has generally been ignored in the forensic risk assessment literature while remaining central to most states’ duty to protect jurisprudence, is considered in detail. Similarly, the empirical status of fantasies of extreme physical or sexual violence, such as those not uncommonly expressed in psychotherapy, is evaluated as a risk factor. A five-step process of evaluating risk in outpatient treatment settings is presented, with particular attention to the integration of nomothetic and idiographic information, which aids in the identification of avenues for intervention to mitigate risk.

Violence Risk Assessment in Therapeutic Versus Forensic Contexts

Several authors have described overarching differences between the therapeutic and forensic role (Greenberg & Shuman, 1997; Strasburger, Gutheil, & Brodsky, 1997). There are also key differences in the therapeutic versus forensic practice of violence risk assessment and management. Six general distinctions are highlighted below.

Identifiable Victims

Legal considerations related to the clinical practice of evaluating patients’ risk for violence generally requires an “identifiable victim,” something relatively atypical in forensic risk assessment. Most state statutes require an identifiable victim to trigger a duty to protect (Johnson, Persad, & Sisti, 2014), and case law finds no duty to investigate the identity of or warn potential but unknown victims (Thompson v. County of Alameda, 1980; Tarasoff v. Regents of University of California, 1976). Given this, actions that compromise dangerous patients’ confidentiality almost always require relatively unambiguous evidence of either an explicit threat targeting a specific person or actual violence (Friedman, 2006).

Clinical reality, however, is indeed ambiguous, and it is the exception rather than the rule that a clearly identifiable victim is named, even by those threatening homicidal violence (Warren, Mullen, & Ogloff, 2011). When a specific target is identified, it is not uncommon for a different individual to be the eventual victim (Warren, Mullen, Thomas, Ogloff, & Burgess, 2008). Because most standardized risk assessment measures are designed to evaluate an individual’s general level of risk for violence, relative to an appropriate normative comparison sample and against any target, the relevance of these instruments to the specific requirements for targeted violence in outpatient treatment settings warrants consideration.
Imminent Versus Time Unlimited Risk

Risk assessment by treating clinicians typically involves a circumscribed, albeit ill-defined, time frame for violence risk consideration. The window of time typically considered in forensic risk assessment, by contrast, is relatively open-ended (Melton et al., 2007). Central to risk assessment in outpatient treatment settings is the requirement, codified in most states, that the risk of violence be “imminent” (Johnson et al., 2014). Empirical research and relevant case law, however, has failed to reach a consensus as to what “imminent” constitutes. Early research included definitions of “within three days” (Monahan, 1981), “within seven days” (Werner et al., 1990), and within “days or a week or so” (Tardiff, 1992); case law has supported a case of negligence against a psychiatrist whose decision to discharge a patient was determined to be the proximate cause of a fatal motor vehicle accident 5 months later (Naidu v. Laird, 1988); and contemporary research examining those who make threats, likely triggering a duty to protect, has examined rates of subsequent violence over 12 months (Warren et al., 2011). Depending on the time frame considered, research suggests that clinical versus historical risk factors become more or less predictive of violence (Bonta, Law, & Hanson, 1998; McDermott, Edens, Quanbeck, Busse, & Scott, 2008).

The Role of Mental Illness

The presence of mental illness typically carries less legal relevance to the risk management responses of outpatient treatment providers. As articulated by the California Supreme Court in Tarasoff I (Tarasoff v. Regents of University of California, 1974), treatment providers’ obligations to third parties are premised on (a) foreseeable risk to a specific third party (b) in the context of the “special relationship between doctor and patient.” If treatment providers foresee risk, they have a legal duty to protect regardless of whether their patient meets diagnostic criteria for a mental disorder. In contrast, forensic risk assessment often requires both dangerousness and mental illness to permit commitment as a risk management response. For example, dangerousness alone, in the absence of mental illness, has been found insufficient for the continued commitment of insanity acquittees (Foucha v. Louisiana, 1992) and the civil commitment of sex offenders (Kansas v. Hendricks, 1997).

Nature of the Professional Relationship

The nature of the professional relationship differs between the examinee and the treating mental health professional evaluating risk versus that of the forensic evaluator (Greenberg & Shuman, 1997; Strasburger et al., 1997). One aspect of this distinction involves expectations of privacy. As described by Greenberg and Shuman (1997), the foundations of privilege differ in therapeutic versus forensic settings, with treatment providers’ disclosure governed by therapist–patient privilege and forensic evaluators’ disclosure governed by attorney–client and attorney work–product privilege. So long as the potentially dangerous patient does not trigger a duty to protect or consent to breaching confidentiality, treatment providers can be limited in their ability to involve third parties to mitigate risk. In contrast, there are often no such expectations of confidentiality in a forensic risk assessment (Melton et al., 2007). Although this generally allows clinicians in forensic settings to communicate findings to relevant third parties via the court, forensic clinicians themselves should generally avoid intervening therapeutically to avoid “wearing two hats” (Strasburger et al., 1997).

Origin of Violence Risk Question

The evaluation of violence risk is triggered by different mechanisms in therapeutic versus forensic settings. Like other types of forensic evaluation, risk assessments in forensic contexts generally arise from a court order or attorney referral. Forensic practice guidelines emphasize the need for the clinician to clearly articulate the referral question and report only the data relevant to it (Grisso, 2010). In other words, forensic risk assessment originates with a clear referral to
conduct a forensic risk assessment. Clinical evaluations of violence risk, by contrast, almost never originate with a clear referral question; clinicians generally have to recognize the need to evaluate risk in the context of a different referral question. Whereas forensic evaluators should avoid addressing questions unrelated to the referral question, treatment providers must go beyond the presenting issue when a foreseeable risk arises. Most states’ duty to protect laws include an articulated threat toward an identifiable third party as one trigger for a duty to protect, and therefore for the clinician to fully evaluate and attempt to manage risk. However, an articulated threat is not necessary to trigger a duty, so clinicians should be aware that they are also responsible for evaluating risk in situations without such a threat so long as the risk was foreseeable (Jablonski v. U.S., 1983).

Use of Standardized Instruments

Clinicians rarely use standardized risk assessment instruments in therapeutic contexts (Higgins, Watts, Bindman, Slade, & Thornicroft, 2005; Tolman & Mullendore, 2003), despite meta-analytic research suggesting that the risk factors identified in criminal populations, which provide the foundation for these instruments, appear to generalize to other populations (Bonta et al., 1998).

Comparing utilization rates in forensic versus therapeutic settings, Tolman and Mullendore (2003) surveyed 200 randomly selected psychologists and 182 board-certified forensic psychologists and found that forensic psychologists used standardized risk assessment measures with far greater frequency. Whereas 63%, 31%, and 27% of forensic psychologists had used the Psychopathy Checklist-Revised (PCL-R; Hare, 2003), Historical Clinical Risk-20 Version 3 (HCR-20 V3; Douglas, Hart, Webster, & Belfrage, 2013), and Violence Risk Appraisal Guide (VRAG; Harris, Rice, & Quinsey, 1993), respectively, only 7%, 2%, and 9% of general practice psychologists had. Higgins and colleagues’ (2005) survey of 66 general adult psychiatry trusts in England found that although most were not using standardized risk assessment measures, a majority were using protocols developed by their agency. The perceived availability of standardized instruments appears to represent one barrier to their use, and access to relevant historical information has also been identified as a challenge in inpatient and other time-limited practice settings (Elbogen, Huss, Tomkins, & Scalora, 2005).

Risk and Protective Factors: Two Sides of the Same Coin

Although a vast majority of the risk assessment literature has focused on the identification of risk factors that increase the likelihood of future violence, it has recently been emphasized that protective factors—those associated with a decreased risk of violence—complement and enhance the clinical utility of risk assessment and management (de Ruiter & Nicholls, 2011; de Vries Robbé, de Vogel, & Douglas, 2013). Both risk and protective factors can be broadly categorized as falling into one of two group: (a) Static factors, which are associated with the probability of future violence but are generally unchangeable, and (b) dynamic factors, which are associated with the likelihood of future violence and can change over time, whether naturally or as the result of some intervention (Douglas & Skeem, 2005). The following sections outline a variety of risk and protective factors that have received considerable empirical attention and that have been integrated into many standardized risk assessment instruments. Also included are two risk factors more specific to therapeutic settings that tend to receive minimal attention in the field of forensic risk assessment: the relations between (a) homicidal threats and future violence and (b) fantasies of physical and sexual violence and risk for enacting such fantasies.

Risk Factors for Violence

Static Risk Factors

Gender. Male gender is consistently associated with heightened rates of violence in the general population, but the presence of severe mental illness appears to mitigate these gender differences (Binder & McNiel, 1990; Krakowski & Czobor, 2004; Lam, McNiel, & Binder, 2000). Nationally representative data from the Epidemiologic Catchment Area (ECA) survey,
for example, found that males overall had higher rates of violence in the community in the previous year (Swanson, Holzer, Ganju, & Jono, 1990). Consistent with this, data from the Federal Bureau of Investigation (FBI) Uniform Crime Reports show that males are arrested at approximately four times the rate of females for violent crimes (FBI, 2013). However, these gender differences tend to become less pronounced in samples with severe mental illness. Findings from the longitudinal MacArthur violence study of 1,136 discharged civil psychiatric patients, for example, found that although males had a higher prevalence of violence immediately after discharge, these differences dissipated over one year (Robbins, Monahan, & Silver, 2003).

Similarly, no gender differences in rates of violence were observed in Swanson et al.’s (2002) sample of 802 treatment-seeking adults with psychotic or mood disorders or Krakowski and Czobor’s (2004) prospective study of hospitalized psychiatric patients. Whereas Otto (2000) concluded that clinicians working with more disturbed patients should not consider sex to be a salient risk factor for violence—a conclusion that appears to remain valid—clinicians in outpatient settings should keep in mind that gender remains a robust risk factor for violence in the general population and is likely associated with violence risk in less disturbed outpatient samples.

**Age.** Younger age is consistently found to be associated with higher rates of violence in the general population (Swanson et al., 1990), violent offender populations (Bonta et al., 1998), and mentally ill offenders (Snowden, Gray, Taylor, & MacCulloch, 2007). These findings are reflected in several formal risk assessment instruments. For example, age is the second most heavily weighted risk factor in the VRAG (Harris et al., 1993), a widely used actuarial violence risk assessment instrument. Regarding age ranges at highest risk of violence, Bonta et al.’s (1998) meta-analytic findings indicated that violence risk peaks for male offenders between their late teens and early 20s.

Data from the FBI Uniform Crime Report (2013) show that arrest rates for each of the four crimes categorized as violent (murder/non-negligent manslaughter, rape, robbery, and sexual assault) peak among men aged 25–29 years and then decrease rapidly within a decade. Comparing arrest rates between the 25–29 and 40–44 age ranges, aggravated assault drops by 49.8%, robbery drops by 67.9%, murder/non-negligent manslaughter drops by 68.6%, and rape by 35.3%. Elbogen and Johnson’s (2009) finding that adults younger than 43 years old were approximately five times more likely to commit a violent act in the next 3 years compared with those aged 43 years and older are consistent with these FBI data, as is Harris and Rice’s (2007) conclusion that aging is inversely related to recidivism. Although some research has suggested that age is less strongly linked to violence in acutely mentally ill individuals (Beck, White, & Gage, 1991), meta-analytic findings have not supported this and suggest that age remains a significant predictor of violence even in acute psychiatric settings (Dack, Ross, Papadopoulos, Stewart, & Bowers, 2013).

**Age at first offense.** The age at which individuals commit their first serious act of violence is inversely associated with risk for future violence. In a study including three nonoverlapping offender samples, Harris and Rice (2007) found that young age at first offense was a consistent predictor of both general and sexual violence. The average age at first offense in their samples was 23, and nearly one in four had been arrested before the age of 16. Cottle, Lee, and Heilbrun’s (2001) meta-analysis of 23 studies examining risk factors for general juvenile recidivism, which included but was not limited to violent recidivism, identified earlier age of first contact with the legal system and earlier age of first commitment as predictors of recidivism.

**History of violence.** A history of violent behavior consistently emerges as a robust predictor of future violence across community, offender, and psychiatric samples. In a meta-analysis that included eight studies from offender samples (N = 2,878), Bonta et al. (1998) found that violence history emerged as one of the single strongest predictors of future violence from among a variety of demographic, clinical, and criminal variables. Very similar results were found in a complementary meta-analysis specific to psychiatric inpatient samples (Dack et al., 2013).

Longitudinal data from a nationally representative community sample of 34,653 adults from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC; Elbogen &
Johnson, 2009) found that 9.42% of those with a history of violence \( (n = 5,923) \) engaged in a violent act in the next 3 years, compared with only 1.42% for those without a history of violence \( (n = 27,571) \)–more than a sixfold increase in rates of violence among those with a history of violence. Preliminary data also suggest that the type of previous violence perpetrated might moderate the association between previous and future violence. For example, in a sample of 91 offenders in pretrial diversion, past violence overall was found to predict violence within 12 months. However, when premeditated violence was distinguished from impulsive violence, the latter was found to be unrelated to future violence, whereas the former was strongly associated with future violence (Swogger, Walsh, Christie, Priddy, & Conner, 2014).

**Arrest history.** Longitudinal epidemiologic data from the NESARC study found adults with a history of juvenile detention were nearly six times more likely to commit at least one act of violence in the next 3 years compared with adults without such a history (14.72% vs. 2.48%; Elbogen & Johnson, 2009). In addition to juvenile arrests, recent arrests have also emerged as significant predictors of violence in the large-scale National Institutes of Mental Health (NIMH) Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study of 1,410 adults with schizophrenia (Swanson et al., 2006). Meta-analytic research supports both a history of juvenile delinquency and an adult criminal history as significant predictors of violence (Bonta et al., 1998). Although a nonviolent criminal history also emerged as predictor of future violence, the effect size was small, suggesting, unsurprisingly, that arrests for violent crime are more strongly predictive of subsequent violence than arrests in general.

**Antisocial personality disorder (ASPD) and psychopathy.** The risk for future violence increases with the presence and severity of ASPD, with psychopathy—a severe variant of ASPD—serving as a particularly robust risk factor. The body of research linking psychopathy to violence risk originated in offender samples (Hare, 1980) and is well documented in meta-analytic findings (Fazel, Singh, Doll, & Grann, 2012) and has come to attain substantial support in nonforensic samples. For instance, among civil psychiatric patients in the MacArthur violence study, psychopathy was found to be a robust predictor of future violence even after controlling for a variety of covariates and other personality disorders (Skeem & Mulvey, 2001). Reflecting its empirical status as a powerful predictor of violence, psychopathy is the most heavily weighted risk factor on the VRAG and accounts for a substantial portion of the VRAG’s variance (Edens, Skeem, & Douglas, 2006).

**Dynamic Risk Factors**

**Major mental illness.** Severe mental illness is related to violence, although research converges in suggesting that the strength of this link can be modified by a variety of factors that can be addressed clinically. The most reliable estimates of the overall association between mental illness and violence are likely derived from the nationally representative data from the NIMH ECA study of 17,803 individuals from five U.S. communities. Of the subset of approximately 7,000 individuals from which data on violence were collected, those with severe mental illness—defined as schizophrenia, bipolar, and major depression—were two to three times more likely to be violent compared with those without these diagnoses, with lifetime prevalence rates of 16% versus 7%, respectively (Swanson, 1994). Complimenting epidemiologic research, meta-analytic findings suggest that psychosis is associated with a 49% to 68% increase in the odds of violence (Douglas, Guy, & Hart, 2009).

There are several caveats to this general association of particular relevance to clinicians. First, several large-scale studies have suggested that this link is indirect and explained, at least in part by the fact that individuals with severe mental illness are more likely to possess other modifiable risk factors. For example, longitudinal epidemiologic data from the NESARC study, which obtained a nationally representative sample \( (N = 34,653) \) from the United States, found that severe mental illness predicted future violence but only among those with comorbid substance abuse and/or dependence. Those with severe mental illness were also more likely to possess other dynamic risk
factors, including substance abuse, perceived threats, recent divorce, unemployment, and recent victimization (Elbogen & Johnson, 2009).

Second, the risk of violence conferred by severe mental illness seems to be attributable to specific symptom clusters rather than the presence of a diagnosis per se (Friedman, 2006). The NIMH CATIE study of 1,410 adults with schizophrenia, for instance, found a 6-month 19.1% prevalence rate of general violence and a 3.6% prevalence rate of serious violence (Swanson et al., 2006). However, the increased risk of violence was found to be attributable to the presence of five specific positive symptoms (hostility, suspiciousness/persecution, hallucinatory behavior, grandiosity, and excitement), whereas other positive symptoms (conceptual disorganization and general delusions) were unrelated to violence risk. Related research suggests that delusions accompanied by anger are associated with violence, but not delusions without anger (Ulrich, Keers, & Coid, 2014).

Furthermore, a constellation of negative symptoms of schizophrenia appears to reduce violence risk and offset the increased risk from positive psychotic symptoms (Swanson et al., 2006). Overall, only specific positive symptom clusters appear to increase the risk of violence, negative symptom clusters appear to reduce risk, and the combination of these factors tends to generally negate any increased risk conferred by positive symptoms. These findings are also highly consistent with other large-scale studies that have examined the attributable risk of specific symptom clusters (Steadman et al., 1998).

Third, patients’ subjective impressions about mental health treatment appear to modify their risk for violence. In a large sample (N = 1,011) of adults receiving outpatient psychiatric treatment across five U.S. states, patients’ risk for community violence was lower when they (a) perceived a need for treatment, (b) adhered to treatment, and (c) endorsed positive perceptions of treatment effectiveness (Elbogen, Van Dorn, Swanson, Swartz, & Monahan, 2006).

Substance abuse. Substance abuse appears to be a stronger risk factor for violence than severe mental illness, although the two often co-occur (Elbogen & Johnson, 2009) and exacerbate the risk-enhancing effects of the other. Data from the NIMH ECA study found that whereas severe mental illness alone increased the odds of violence by two to three times, substance abuse alone increased the odds of violence sevenfold (Swanson et al., 1990). Of particular clinical relevance, individuals with severe mental illness were more likely to abuse substances, and comorbid substance abuse and severe mental illness were associated with higher rates of violence than either risk factor independently.

Lifetime violence prevalence rates from the ECA survey were as follows: 7.3% for those without major mental disorder or substance abuse, 16.1% for those with major mental disorder only, 35.0% for those with substance abuse or dependence only, and 43.6% for those with both major mental illness and substance abuse or dependence (Swanson et al., 1990). These findings were generally replicated by the findings of the MacArthur violence study: Substance abuse increased the risk of violence among both mentally ill participants and community comparison groups and patients reported higher rates of substance abuse than the community sample (Steadman et al., 1998).

Substance abuse as a particularly robust risk factor for violence was further supported in the nationally representative longitudinal NESARC data (Pulay et al., 2008) and in other large-scale longitudinal studies (Swartz et al., 1998). In a recent reanalysis of the MacArthur violence data, it appeared that the interaction between alcohol and severe mental illness might differ across individuals with mood versus psychotic disorders, with alcohol enhancing risk more for those with mood disorders (Yang, Mulvey, Loughran, & Hanusa, 2012).

Anger. Anger is an intuitive risk factor for violence that has also received consistent support in the literature. For example, Wang and Diamond (1999) tested a model that included anger, antisocial personality, current violent offense, ethnicity, and impulsivity as predictors of violence in a sample of 385 mentally ill offenders and found that anger emerged as the single best predictor of institutional violence. Similarly, anger predicted (r = .24) violence in the MacArthur violence study (Skeem & Mulvey, 2001), and Doyle and Dolan (2006) generally replicated this finding in
a smaller U.K. sample \((N = 124)\) of discharged psychiatric patients who were followed in the community for 24 weeks.

Anger also emerges as a risk factor for violence in nonpsychiatric samples. For example, the role of anger in domestic violence has received considerable attention, and meta-analytic research finds that male perpetrators consistently report higher levels of anger than their nonviolent counterparts (Norlander & Eckhardt, 2005), whereas daily diary research has identified anger as proximally related to domestic violence perpetration (Elkins, Moore, McNulty, Kivisto, & Handsel, 2013).

**Social support.** As Swanson et al. (2006) concluded, the linkage between violence, social contact, and social support is a complex one. Using data from the NIMH CATIE study, severely mentally ill individuals who were living with their family were found to engage in more violence than those living elsewhere, which appeared at least partly attributable to the increased opportunities for violence that comes from being around others. In a prior study, Swanson et al. (1998) found that level of impairment moderated the association between social support and violence. Whereas social contact was positively associated with violence in those with the most severe impairments, it was negatively associated with violence in less impaired individuals.

Earlier research also suggests that the nature of the social network might be more important than the presence or absence of a network per se. For example, Steadman (1982) found that some types of social networks were associated with increased rates of violence, whereas others were associated with decreased rates. Having a mental health professional in the social network has been found to decrease risk for violence (Estroff et al., 1994, as cited in McNiel, 1998).

**Weapon availability.** There exists considerable indirect evidence for an association between weapon access and risk of violence (Otto, 2000). Direct evidence linking access to weapons and violence, however, has been minimal and generally limited to domestic violence research. In an influential study examining whether having a firearm in the home provided homeowners protection or risk, Kellerman et al. (1993) analyzed 1,860 homicides across three counties. Contrary to public perception, these authors concluded that keeping a gun in the home not only failed to provide a protective benefit, but in fact nearly tripled the risk of homicide victimization in the home, generally by a family member or intimate partner. In an 11-city case control study examining risk factors for femicide in abusive relationships, abusive men with access to firearms were eight times more likely to kill their partner than abusive men without access (Campbell et al., 2003).

Recent findings suggest that the association between firearm access and severe partner violence is nuanced, and that although those with access to firearms do tend to perpetrate more severe domestic violence, they typically do so with nonfirearm weapons (Folkes, Hilton, & Harris, 2013). Although this seems to suggest that preventing access to firearms might not directly reduce an individuals’ risk of perpetrating severe violence, from a practical risk management perspective, it is relevant that the potential damage done had the individual retained access to a firearm would likely be minimized.

**Victim availability.** The level of risk posed and the risk management options available depend in part on victim availability. Threats against readily accessible individuals generally present more risk than threats against targets that are not readily accessible. However, there are two caveats that warrant consideration. First, despite the general recognition of victim availability as a risk factor (Otto, 2000), there is minimal direct evidence supporting this. Second, indirect evidence raises the possibility that low victim availability might not necessarily lower an individual’s overall risk so much as cause their violence to be displaced. For example, research on individuals who threaten a specific target finds that in a substantial proportion of cases, a different individual becomes the eventual victim (Warren et al., 2008). Such findings raise the possibility that certain individuals otherwise at high risk for violence might remain a high risk even when their intended victim is not readily accessible.
The Relation of Threats to Violence

Although an explicit threat is not required to trigger a clinician’s duty to protect (Jablonski v. U.S., 1983), the presence of a threat requires at a minimum a careful evaluation of violence risk. Notably though, given the emphasis on threats in duty to protect jurisprudence across most states, relatively minimal empirical attention has been given to the association between threats and subsequent violence in risk assessment research. In an early follow-up study of psychiatric patients who had made explicit homicidal threats, 3 out of 100 patients had committed homicide and four had killed themselves within 5 years of their threat (MacDonald, 1967). These findings simultaneously suggested that a vast majority of those who make homicidal threats will not follow through on it, but also that as a group, those who threaten homicidal violence are far more likely to commit homicide than those who do not.

In a more recent large-scale (N = 600) sample of individuals who had uttered threats to kill, nearly half (44.4%) were convicted of a violent offense in the next 10 years (Warren et al., 2008). This proportion increased to 58.3% when examining the subset of 252 threateners with a history of psychiatric treatment—who likely provide the best comparison group for clinicians working with patients who make threats. Identical to the base rate of homicide in MacDonald’s (1967) sample four decades earlier, 3% (n = 19) of threateners in Warren et al.’s (2008) total sample committed homicide within 10 years, 1.3% (n = 8) were convicted of attempted murder, and 2.6% (n = 16) completed suicide. Five of the homicide victims were the same target as the index threat and three more index targets were the victims of attempted murder. Targets of the initial threat were also the victims of assaults (n = 50), rapes (n = 3), stalking (n = 11), and additional death threats (n = 10). Notably, though, the target of the initial threat was only the target of subsequent violence in 13.9% of the cases.

Several static and dynamic risk factors emerged in Warren et al.’s (2008) sample, with substance misuse emerging as the strongest predictor and increasing the risk fivefold. Affective disorders were associated with a 3.5 times greater odds of future violence, and contact with psychiatric services and the presence of major mental disorders were associated with a 2.4 and 1.8 times greater odds of subsequent violence, respectively. Regarding static risk factors, male gender emerged as a strong predictor and was associated with an increased odds of 2.1 times for violent offending, whereas age at first conviction and number of prior criminal convictions were only modestly associated with risk of violence.

In a follow-up study that examined rates of violence approximately 12 months after uttering a threat to kill, nearly half (41.7%) committed some type of offence and 22.9% committed a violent offense (Warren et al., 2011). One participant (0.7%) committed a homicide, six (4.2%) committed a severe assault, and 25 (17.4%) committed a nonsevere assault in which the victim was not injured in the 12 months after their assessment. Although the identified target was the most frequent victim of subsequent violence, a substantial minority (40%) of subsequent victims were people other than the identified target, highlighting the nonspecific outcomes even when an identifiable victim is threatened. Those who threatened mass homicides against a specific group (opposed to an individual) had similar rates and severity of subsequent violence and prevalence of major mental disorder, although those who threatened mass homicide were much more likely to have an affective disorder (62.5% versus 18.4%).

Four risk factors for violence in the next 12 months were identified in this sample of individuals who had uttered homicidal threats: (a) those with a history of substance misuse were 3.9 times more likely to be violent; (b) those with history of violence were 3.3 times more likely to be violent; (c) those with 10 years or less of education were 3.2 times more likely to be violent; and (d) those who did not receive mental health treatment during follow-up were 2.4 times more likely. The presence of all four risk factors combined showed good specificity (87.4%) but weak sensitivity (48.5%) in the prediction of future violence, with an area under the curve (AUC) value of .76 (Warren et al., 2011).

Typologies of Threats

Patients who make threats do not necessarily pose a threat. In State v. Schaler (2010), the Washington Supreme Court specified a “true threat” as one in which “a reasonable person
would foresee that the statement would be interpreted as a serious expression of intention to inflict bodily harm upon or take the life of another person” (State v. Schaler, 2010, p. 863). Schaler is noteworthy for mental health professionals in that the defendant’s argument that he was asking for help in discussing his violent dreams to a clinician was determined to lack the necessary mens rea to make it a “true threat.”

In distinguishing threats that do and do not present a genuine risk for subsequent violence, two overlapping typologies of threats have been offered. Meloy (1999) distinguished instrumental threats, which are intended to control or coerce others, from expressive threats, which function to regulate the threatener’s own affect. Expanding on this distinction, Warren et al. (2011) proposed a typology of three types of threats based on the threatener’s motivation. The first type, labeled screaming, is similar to expressive threats and function to regulate affect. The second, scheming, is similar to instrumental threats and function to control or influence others. Third, and unique to Warren et al.’s (2011) typology, shocking threats are primarily intended to elicit an emotional response in others.

The FBI’s threat assessment approach, which has its origins in evaluating threats made to the President, distinguishes direct threats—those made directly to the intended target or law enforcement—from leakage, which entails a communication to a third party of an intent to do harm (Borum, Fein, Vossekuil, & Bergland, 1999). Meloy and O’Toole (2011) note that leakage is sometimes but not always intentional and link threats made in psychotherapy to the concept of leakage. The evaluation of leaked threats should be evaluated in the context of general risk factors for violence and risk factors specific to those who have made homicidal threats, including substance abuse, prior violence, lower educational attainment, and untreated mental illness (Warren et al., 2008, 2011).

The Relation of Fantasied to Enacted Violence

In addition to the task of distinguishing threats that truly pose a risk for imminent violence, clinicians might also need to evaluate risk with patients who describe fantasies of physical or sexual violence. Fantasies can be defined as conscious thoughts fueled by emotion, and the ability for patients to express these thoughts without repercussion is a cornerstone of the therapeutic relationship. At the same time, working with patients who express recurrent fantasies of extreme violence or sexually sadistic behavior understandably raises the question: To what extent is fantasied violence predictive of actually carrying out such acts?

The MacArthur violence study examined the prevalence of violent fantasies in a large psychiatric sample and provided a longitudinal window into this association. Overall, violent fantasies were normative, with more than half of the patients experiencing them in the year after discharge. Although most who had these violent fantasies did not engage in subsequent violence, there was a small but significant association between violent fantasies and actual violence. There also exist compelling data showing that physically and sexually violent fantasies are not uncommon in the general population. Based on their review, Gellerman and Suddath (2005) concluded:

Considering the high prevalence of homicidal and sexually aggressive fantasies among non-incarcerated and presumably “non-criminal” individuals, one may wonder to what degree such fantasies could be considered deviant. Fantasies of murder were fairly common in “normal” Western European and American populations, while a range of fantasies of aggression and sexual violence were less common, but were by no means rare. Sadomasochistic behavior and fantasies were commonly reported, as well as fantasies of rape and sexual activity with very young, if not minor, partners. (p. 491)

These authors conclude that (a) violent fantasies are common, (b) do not specifically signal the potential for violent behavior, and (c) should not be considered to be particularly predictive of future dangerousness.
Protective Factors Mitigating Violence Risk

The historically narrow focus on risk factors at the expense of protective factors has been criticized as implicitly biased, “inherently inaccurate” (Rogers, 2000, p. 598), and a “gloomy vision” (de Vries Robbé, de Vogel, & Stam, 2012). Despite this, only recently has significant progress begun toward integrating protective factors into the assessment and management of violence risk. Although many gaps remain in current understandings of the associations between individual protective factors and violence risk, research nonetheless has emerged that supports a focus on protective factors in clinical practice.

Monahan and Steadman's (1994) distinction between different types of research studies that comprise the risk assessment literature is useful for understanding this seeming contradiction between the relatively minimal empirical attention to the association between individual protective factors and violence on the one hand, and the suggestion that despite this there exists empirical support for their clinical use on the other. According to Monahan and Steadman's (1994) delineation, the field of risk assessment requires, among other types of research, studies that identify and evaluate the relationship between individual risk factors and violence, as well as classification accuracy studies that evaluate instruments derived from combinations of identified risk factors.

Whereas the risk assessment literature has generally begun with the identification of relationships between specific risk factors and future violence, then progressed to classification accuracy studies of the measures derived from combinations of empirically supported risk factors, such has not been the case thus far in the literature on protective factors. Most notably, very little research has examined the relationship between individual protective factors and future violence. According to de Vogel, de Vries Robbé, de Ruiter, and Bouman (2011), who are among the leaders driving the recent focus on protective factors, “there is little scientific evidence for [individual] protective factors for violence risk . . . because of [the] lack of empirical studies into the role of protective factors” (p. 176). However, despite the lack of a robust empirical foundation for the links between individual protective factors and violence of the sort available in the literature on risk factors reviewed above, two structured professional judgment (SPJ) instruments primarily comprising dynamic protective factors have nonetheless been developed and have received preliminary support across multiple classification accuracy studies.

The Short-Term Assessment of Risk and Treatability (START; Webster, Martin, Brink, Nicholls, & Desmarais, 2009) includes 20 dynamic items (e.g., social skills, occupational, impulse control, social support, insight, medication adherence, and coping) that are each scored for their status as vulnerabilities and then strengths in a given individual. This conceptualization of risk and protective features as potentially residing with the same variable, opposed to requiring distinct concepts, is relatively unique to the START and highlights the inherent overlap between risk and protection depending on the presence or absence of certain characteristics. Recent meta-analytic findings suggest that START scores are strongly predictive of violence toward others in clinical populations and also serve as a good predictor of self-harm among psychiatric patients (O'Shea & Dickens, 2014). Of particular importance for clinicians, survey data from practitioners trained in the use of the START suggest that users find it relatively easy to use and view it as a valuable tool for organizing and revealing any gaps in information relevant to assessing and managing violence risk (Doyle, Lewis, & Brisbane, 2008).

The Structured Assessment of Protective Factors for Violence Risk (SAPROF; de Vogel, de Ruiter, Bouman, & de Vries Robbé, 2012) provides 17 items identified as protective factors, 15 of which are dynamic factors. Dynamic items are organized under three categories—internal factors, external factors, and motivational factors—all of which can be identified as representing key protective factors or treatment goals (see Table 1). Research with the SAPROF is rapidly accumulating and currently supports (a) an association between total SAPROF scores and future violence; (b) the sensitivity of the SAPROF to capturing change over the course of treatment; (c) an association between improvement on SAPROF scores over the course of treatment and reduced risk of future violence; and (d) the incremental validity of the SAPROF above and
Table 1

Structured Assessment of Protective Factors for Violence Risk Items

<table>
<thead>
<tr>
<th>Internal factors</th>
<th>Motivational factors</th>
<th>External factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Intelligence</td>
<td>6. Work</td>
<td>13. Social network</td>
</tr>
<tr>
<td>5. Self-control</td>
<td>10. Attitudes towards authority</td>
<td>17. External control</td>
</tr>
</tbody>
</table>


Beyond risk-only SPJ instruments such as the HCR-20 V3 (Douglas, Hart, Webster, & Belfrage, 2013).

Regarding the overall predictive accuracy of the SAPROF total score for future violent offenses, for example, de Vogel et al. (2012) found an AUC value of .85 in a sample of discharged forensic psychiatric patients. This finding can be interpreted to mean that a randomly selected patient that did not become violent has an 85% probability of scoring higher on the SAPROF (i.e., has more protective factors present) than a randomly selected patient that was violent.

Essential to the SAPROF serving as a guidepost for treatment planning, research has shown that it is sensitive to capturing changes over the course of treatment and that these changes predict future violence. In a sample of 108 discharged forensic psychiatric patients, for example, SAPROF scores increased significantly over the course of treatment, suggesting that interventions had the intended effect of enhancing patients’ protection from future risk. Consistent with previous research on the predictive accuracy of total SAPROF scores, change scores on the SAPROF also predicted future violence at both 1-year (AUC = .78) and 11-years (AUC = .75) postdischarge (de Vries Robbé, de Vogel, Douglas, & Nijman, 2015). However, the extant research cannot pinpoint whether specific protective factors on the SAPROF are more or less responsible for decreasing violence risk.

Finally, recent research has begun to show that supplementing risk measures with structured measures of protective factors adds incremental validity in the prediction of violence. For example, in a sample of 188 forensic patients with a history of violence, both the HCR-20 V3 and the SAPROF were independently associated with violence (de Vries Robbé et al., 2013). Considered together, the SAPROF added incremental predictive validity to the HCR-20 V3, and the dynamic protective factors were particularly strongly associated with decreased risk. Similar results have been found with the START, suggesting that dynamic strengths in particular appear to enhance the predictive validity of risk judgments (Desmarais, Nicholls, & Read, 2010) while providing clearly defined and attainable treatment goals. In doing so, according to de Vries Robbé et al. (2012), the integration of protective factors “narrow[s] the gap between risk assessment and risk management” (p. 1260).
Historical Versus Clinical Factors

Specific risk factors are not equally important to different individuals. Empirically informed risk assessment, therefore, requires clinicians to integrate idiographic clinical information with the nomothetic research database to determine which risk factors are most relevant to a given individual. In doing so, clinicians should be familiar with differences that emerge in the risk assessment literature across samples and risk windows. One particularly relevant finding suggests that historical and clinical factors differ in their relative predictive power depending on the sample and the time frame used, and awareness of these differences can enhance the accuracy of violence risk assessments. These differences also highlight the importance of the distinction between imminent and time-unlimited risk models described above.

Static/historical factors have tended to provide the greatest predictive power in time-unlimited risk models, generally based on findings from forensic samples. Summarizing this tendency, Bonta et al. (1998) wrote:

Criminal history variables were the best predictors [of future violence], and clinical variables showed the smallest effect sizes. The findings suggest that the risk assessment of mentally disordered offenders can be enhanced with more attention to the social psychological criminological literature and less reliance on models of psychopathology. (p. 123)

This conclusion might, at first glance, appear to contradict the recommendation to primarily focus on dynamic risk factors (Douglas & Skeem, 2005; Dvoskin & Heilbrun, 2001).

In stark contrast to Bonta et al.’s (1998) conclusions deemphasizing clinical variables in the context of time-unlimited risk, however, research examining risk for imminent violence in psychiatric samples finds the opposite (McDermott et al., 2008; McNiel, Gregory, Lam, Binder, & Sullivan, 2003). Based on findings from 100 psychiatric inpatients evaluated for violence risk, McNiel et al. (2003) concluded:

The strongest predictive relationships were obtained for indices of clinical risk factors rather than historical risk factors. The results suggest that decision support tools, especially those that emphasize clinical risk factors, have the potential to improve decision making about violence in the context of behavioral emergencies. (p. 945)

Similarly, examining risk for violence during inpatient hospitalization in a sample of 108 forensic patients, McDermott et al. (2008) found clinical variables—such as impulsivity, anger, and psychiatric symptoms—to be most useful for identifying patients at highest risk for inpatient violence.

Risk Assessment in Clinical Practice

Evidence-based violence risk assessment and management does not necessarily require standardized risk assessment instruments. According to Hart (2009), evidence based violence risk practice is defined as “the process of gathering information about people in a way that is consistent with and guided by the best available scientific and professional knowledge to (a) understand their potential for engaging in violence against others in the future and (b) determine what should be done to prevent this violence from occurring” (p. 148). The emphasis on the general process underlying the decision opposed to the specific techniques used is consistent with what Hart (2003) has labeled the latitudinarian (opposed to the orthodox) approach to evidence-based risk assessment.

The practice of violence risk assessment in general clinical practice optimally involves an integrative, multi-step process that includes: (a) a comprehensive evaluation of empirically derived violence risk factors with particular attention to dynamic clinical factors, (b) an individualized anamnestic analysis, and (c) an identification of dynamic protective factors to guide risk management. This approach provides a framework for the integration of nomothetic data derived
Table 2
Historical Clinical Risk-20 Version 3 Items

<table>
<thead>
<tr>
<th>Historical</th>
<th>Clinical</th>
<th>Risk management</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1. Previous violence</td>
<td>C1. Lack of insight</td>
<td>R1. Plans lack feasibility</td>
</tr>
<tr>
<td>H2. Young age at first violent incident</td>
<td>C2. Negative attitudes</td>
<td>R2. Exposure to destabilizers</td>
</tr>
<tr>
<td>H3. Relationship instability</td>
<td>C3. Active symptoms of major mental illness</td>
<td>R3. Lack of personal support</td>
</tr>
<tr>
<td>H5. Substance use problems</td>
<td>C5. Unresponsive to treatment</td>
<td>R5. Stress</td>
</tr>
<tr>
<td>H6. Major mental illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H7. Psychopathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H8. Early maladjustment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H9. Personality disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H10. Prior supervision failure</td>
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</tbody>
</table>


from the best available research with idiographic information, allowing for highly individualized risk formulations that provide clear avenues for intervention.

Whether or not clinicians use formal risk assessment instruments to organize their evaluation of risk factors, they should at a minimum be familiar with the HCR-20 V3 (Douglas et al., 2013), the most widely used SPJ instrument. SPJ instruments, in contrast to actuarial instruments, are particularly relevant for clinicians whose primary task is risk management. According to Guy, Packer, and Warnken (2012), both actuarial and SPJ approaches “are capable of predicting violence with similar (and moderate) degrees of accuracy . . . [but] only the SPJ approach provides guidance for managing the identified risk” (p. 271). The HCR-20 V3, which emphasizes the formulation of violence risk with particular attention to risk management strategies, comprises 20 risk factors across Historical (10 items), Clinical (five items), and Risk (five items) management domains (see Table 2).

A particular focus on the evaluation of the clinical and risk management items is warranted both because of the predictive accuracy of these variables for imminent violence (McDermott et al., 2008; McNeil et al., 2003) and because of the increased opportunities they present for intervention. The use of instruments such as the HCR-20 V3 can serve at a minimum as a memory aid and touchstone for gathering relevant information.

Otto (2000) recommended that clinicians supplement structured and empirically derived approaches to violence risk assessment with an anamnestic analysis, which involves an individualized analysis of the specific conditions under which an individual has become violent in the past, to identify highly personalized risk and protective factors. Rooted in applied behavior analysis, anamnestic approaches seek to identify past triggers, stressors, or patterns that have resulted in violence in the past and that might provide relevant targets for risk management efforts. This is consistent with Monahan’s (1981) recommendation to consider the extent to which the current context approximates that in which the patient has become violent under stress in the past.

Otto (2000) also provided a sample of screening questions and detailed anamnestic follow-up questions for clinicians evaluating patients’ risk of violence. Some screening questions are
as follows: “What kind of things make you mad?”; “What do you do when you get mad?”; “What is the most violent thing you have ever done and how did it happen?”; and “Do you own weapons like guns or knives? Where are they now?” Anamnestic queries included the following items: “In what setting or environment did the altercation(s) take place?”; “What do you think caused the violence?”; “What were you thinking and how were you feeling before, during, and after the altercation(s)?”; “Were you using alcohol or other drugs at or around the time of the altercation(s)?” and “Can patterns or commonalities across this and other episodes be identified?” (Otto, 2000, p. 1252).

The identification of protective factors shown to mitigate risk for violence represents the third prong of optimal risk assessment and management practice. Beyond enhancing the predictive accuracy of risk-focused instruments, the integration of protective factors into a comprehensive assessment of violence risk provides clear targets for intervention. Clinicians can use any of several structured SPJ instruments that focus explicitly on protective factors, including the START and SAPROF. The SAPROF (see Table 1) has been translated into 10 languages (de Vries Robbé et al., 2013).

Risk Management in Clinical Practice

Much of the research addressing interventions for reducing patients’ risk for violence tends to focus on treatments for individual risk factors, and certain risk factors have received considerably more attention than others. For example, anger is unique among the risk factors for the amount of research devoted to its treatment, and, overall, both qualitative (Olatunji & Lohr, 2005) and meta-analytic (Saini, 2009) reviews support the efficacy of a variety of psychosocial treatments for reducing anger. Similarly, there exist bodies of research supporting psychosocial interventions to reduce the positive symptoms of schizophrenia (Turner, van der Gaag, Karyotaki, & Cuijpers, 2014), treat substance abuse (Carroll & Onken, 2005), and enhance social support (Masi, Chen, Hawkley, & Cacioppo, 2011), among others.

This single-factor approach, although providing information relevant to risk management, has generally overlooked strengths-based approaches aimed at increasing protective factors. Very recently, though, researchers have begun to address this gap in the literature by examining changes over the course of treatment across multiple risk and protective factors and how this is related to subsequent violence. For example, de Vries Robbé et al. (2015) examined pre-to posttreatment changes on the HCR-20 V3 and the SAPROF in a sample of male forensic psychiatric patients and found that reductions in risk factors and increases in protective factors were associated with decreased rates of community violence at both 1-year and 11-years post-release. Consistent with conceptual understandings of the interplay between risk and protective factors, these authors also found that a difference score of risk minus protective factors aided the prediction of violence. Such findings highlight both the multidetermined nature of violence and the multiple pathways for intervention, although more research addressing the integration of risk and protective factors is needed.

Recommendations for Practice

Table 3 outlines the Integrative Outpatient Violence Risk Assessment and Management (IVRAM) model, a five-step strategy based on the extant literature for the clinical assessment and management of violence risk in outpatient settings. Because patients’ presenting complaints are rarely specific to concerns with violent tendencies, the first step toward effective risk management requires clinicians to monitor all cases for potential violence risk management needs. More often than not, the recognition of the need for a comprehensive risk assessment must come from the clinician’s recognition of the importance of altering, at least temporarily, the direction of the ongoing clinical work. As one component of monitoring patients’ risk of violence, it is recommended that questions regarding patients’ histories of violence victimization and perpetration are included as part of clinicians’ standard intake procedures.

Not only can information derived from these questions inform clinical decision making about the need to target violence risk, but they can also provide a touchstone for further violence risk assessment and management if the need arises. As an example of using historical violence
Table 3

**Integrative Outpatient Violence Risk Assessment and Management Model**

1. Monitor all cases for potential violence risk management needs
2. Comprehensive assessment of risk and protective factors using SPJ guidelines
3. Risk-based anamnestic analysis whereby past violent incidents are assessed for the presence of patterned dynamic risk factors
4. Strengths-based anamnestic analysis whereby previous episodes of nonviolence under stressful circumstances are assessed for the presence of patterned dynamic protective factors
5. Identify appropriate risk and protective factors for targeted intervention
   - More acute and serious risks generally warrant more external intervention
   - Anamnestic data provide key treatment targets
   - Select targets most closely aligned to patients’ presenting complaints

*Note.* SPJ = structured professional judgment.

reported at intake as a touchstone, a clinician might subsequently ask: “Do you remember when we talked about that time when you were feeling disrespected by your neighbor and ended up hitting him with a bottle, going to jail, and paying that fine? Recently I’ve been getting the sense that you’re feeling pretty disrespected by your coworker, and I’m wondering if you’re feeling the urge to hit him as well?” By contextualizing current situations through the lens of previous incidents, clients are often more likely to reflect on not only the possible risk of their current situation but also the possible consequences.

In situations in which clinicians determine that a patient’s risk of violence requires further assessment, whether at intake or at any point over the course of treatment, clinicians should proceed to step 2 and conduct a comprehensive assessment of risk and protective factors. The use of established SPJ instruments—such as the HCR-20 V3 and SAPROF for risk and protective factors, respectively—are particularly valuable to ensure adequate consideration of a range of clinically relevant factors. At a minimum, it is recommended that clinicians develop comprehensive checklists to serve as a structured memory aid for the assessment of violence risk and protection. Based on the findings of this structured assessment of violence risks and protections against violence, clinicians should be able to arrive at an informed estimate of the patient’s overall level of risk (i.e., low, medium, high). However, based on this information alone, clinicians will generally not be able to determine which risk and protective factors are likely to be most relevant to their particular patient and, in turn, which risks and protections warrant initial clinical attention.

After evaluating the patient’s overall level of risk, clinicians should conduct an anamnestic analysis to determine the idiographic factors of particular clinical relevance (steps 3 and 4). In conducting an anamnestic evaluation of patients’ risk factors, tactful discussions about patients’ past acts of violence perpetration are essential. The interviewing approach used in the MacArthur Violence Study, which was based on the Conflict Tactics Scale (Strauss & Gelles, 1990), provides one useful model for obtaining a comprehensive violence history. Within this framework, patients are asked questions about a wide range of violent behaviors of varying levels of severity, with each behavior beginning with a question regarding victimization (“Has anyone ever slapped you with an open hand?”), followed by perpetration (“Have you ever slapped anyone with an open hand?”). In reviewing these incidents, the clinician’s primary aim is to evaluate which risk factors were present (and protective factors absent) when the patient was violent in the past.

Through a detailed anamnestic analysis, the previously decontextualized risk factors can be anchored in a patient’s history and prioritized in terms of relative importance for an individual. For instance, a clinician might discover that one patient has historically become violent during periods of medication noncompliance and paranoid symptomatology, whereas another patient
might have a similar violence history that more frequently took place in the context of periods of unemployment and substance abuse. Clearly, the targets for risk management interventions will differ depending on the idiographic violence history obtained. Relatedly, clinicians should conduct a strengths-based anamnestic analysis to identify key protective factors (step 4). This complimentary analysis entails a focus on times in the past in which the patient was able to remain nonviolent under stressful circumstances, with particular attention to the protective factors that were present.

Finally, based upon a detailed nomothetic and anamnestic analysis of risk and protective factors, clinicians use this information to guide empirically informed risk management efforts (step 5). Three primary considerations should guide clinicians in determining which risk and protective factor(s) to target. First, the determination that a patient presents an imminent risk to an identifiable target, which triggers legal responsibilities to protect third parties in most states, can influence clinicians’ risk management responses such that external interventions require serious consideration. In other words, as the likelihood and severity of violence risk increases, so too should clinicians’ consideration to involve external supports. External supports, such as contacting family members to assist with mitigating risk, detainment by law enforcement, and/or psychiatric hospitalization, can be conceptualized as external protective factors within the SAPROF scheme.

Second, except when there is an imminent risk to an identifiable third party, the primary focus of intervention should be directly informed from the risk and protective factors that emerged as central to the individual’s violence risk in the anamnestic analysis. Reasons for violence are often highly personalized, and as such interventions aimed at reducing violence risk will have to accommodate the psychosocial needs of the individual.

Finally, in the event that there emerge several valid treatment targets and the clinician must choose where to begin, consideration should be given to which of the potential treatment options are most closely aligned with the patient’s presenting concerns and goals. To the extent that risk management efforts align with the patient’s goals, the likelihood of maintaining treatment adherence and positive expectations is increased as interventions targeting specific risk and protective factors are employed to mitigate risk.

Conclusion

Violence risk assessment and management has become a routine aspect of outpatient clinical practice. There now exists a substantial body of research on risk factors, a range of well-established instruments to evaluate dangerousness, and an emerging body of evidence on strengths-based protective factors that together can enhance the accuracy of risk assessments and directly inform treatment planning. A five-part strategy for evaluating and managing violence risk is recommended, which emphasizes the integration of empirically derived dynamic risk and protective factors with a detailed anamnestic analysis. This approach underscores the integration of nomothetic information with highly personalized idiographic data, with the primary aim of informing empirically based and individually tailored risk management practice. As the gap between risk assessment and risk management continues to narrow, clinicians working in forensic and therapeutic settings will increasingly benefit from the contributions of the other.

References


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