

The Prediction of Violence in Outpatient Psychotherapy

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This article presents a standard of care for the prediction of violence in outpatient psychotherapy. Major individual and situational correlates of violence are reviewed to provide an actuarial matrix for the further assessment of the patient's intrapsychic experience and interpersonal behavior during the psychotherapy hour.

The public expects the outpatient psychotherapist to predict and control his patients' violent behavior. This task is both exceedingly difficult and, in a sense, unfair, since the base rate for any violent act is extremely low.¹ There are no psychological tests that "predict let alone postdict" violent behavior,² and positive correlations between mental disorder and violence have yet to be empirically demonstrated.³ In fact, the wealth of research supports the hypothesis that mentally disordered individuals are neither more nor less violent than the general population.⁴ Nevertheless, evolving case law, beginning with the duty to warn in Tarasoff⁵ and the duty to protect in Tarasoff II,⁶ legally obligates the psychotherapist to both predict violence and protect the known or unknown victims from the foreseeable violent act.

The intent of this article is to establish a standard of care for the prediction of violent behavior in outpatient psychotherapy.⁷ At present no such standard exists, although the "second generation" of violence-prediction research will contribute by focusing upon prospective studies of violence following acute psychiatric hospitalization and concurrent studies of civil commitment decision-making by mental health professionals.⁸ There is, however, an immediate need to establish guidance for clinicians to predict outpatients' violence in a reliable and valid manner.

The need to make a prediction of violent behavior is usually precipitated by certain verbal material during the psychotherapy hour and invariably triggers intense anxiety in the psychotherapist. The management of the psychotherapist's anxiety is crucial to the predictive process, and any prediction should be made, if at all possible, with a supervisor or professional colleague. The predictive process begins at the moment when the material

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produced by the patient alarms the therapist and ends when he has made a decision that the patient is or is not an immediate danger to others.

The psychotherapist should be familiar with the actuarial data concerning violent behavior prior to the emergence of threatening material in the psychotherapy hour. Thorough knowledge of the correlates of violence will provide a more objective "anchoring"⁹ of the particular patient because he or she is being judged in the context of a similar demographic group. The initial scrutinizing of the patient as one of many subjects who may or may not fit a certain demographic profile will also dilute the psychotherapist's own emotional reactions.

Monahan¹ and Wilson and Herrnstein¹⁰ have carefully delineated the correlates of violent behavior. Both individual and situational factors must always be considered whenever a violence prediction is undertaken. I shall briefly review and comment on these anchoring points.

INDIVIDUAL CORRELATES OF VIOLENCE

1. *Past crime, particularly violent crime:* Notwithstanding recent challenges,¹¹ it is an axiom of psychology that the best predictor of future behavior is past behavior; hence, the single most important correlate of future violence is past violence.

2. *Age:* The frequency of violent behavior increases in adolescence and substantially decreases in the third decade of life. In 1980 the per capita arrest rate of 15 to 24-year-olds for violent crimes was three times the population average for these crimes.¹² Violent behavior seems to correlate with the interaction effect of testosterone level and social dominance ranking during adolescence.¹³

3. *Gender:* In the United States nine out of ten individuals arrested for violent crimes are male.¹⁰ Aggression appears to be one of the few biological differences between the sexes.¹⁴ In San Diego County, California, there are approximately 3000 males and 300 females in the custody of the Sheriff, a validating local statistic supporting this enduring 10:1 ratio.

4. *Race:* Black males are six times more likely to be the victims or perpetrators of homicide than white males.¹⁰ Blacks accounted for 12 percent of the population in 1977 and 46 percent of the arrests for violent crime.¹ This higher proportionality seems to hold true when cross-validated with other minority groups in similar geographic locations.¹⁵

5. *Intelligence:* There appears to be a clear and consistent relationship between criminality and lower-than-average intelligence. Performance IQ tends to reliably exceed verbal IQ in adolescent and adult offender populations.¹⁰ Affective violence appears to negatively correlate with intelligence.¹⁶

6. *Alcohol and psychostimulant use:* The disinhibiting effect of decreased serotonergic activity seems to be implicated in the strong positive correlation

between alcohol use and violence.¹⁷ Wolfgang and Strohm's¹⁸ classic study of 588 homicides during a five-year period found alcohol absent in only 36 percent of the cases. Anecdotal clinical experience also suggests that certain psychostimulants, such as methamphetamine and cocaine, may precipitate violence that is characterized by both intense rage and paranoia.

SITUATIONAL CORRELATES OF VIOLENCE

1. *Family system:* The biological family provides both a genetic loading and a learning paradigm for the inhibition or disinhibition of violent behavior. Valzelli¹⁹ described the violent family as providing a type of "functional decortication" of the individual. It teaches a reliance on feeling alone to deal with the world.²⁰

2. *Peer system:* The inhibition or disinhibition of individual violence as a result of peer group pressure, perhaps subcultural norms, is well researched, particularly during adolescence.²¹

3. *Job environment:* Employment availability and satisfaction appear to negatively correlate with criminal recidivism and violent behavior.²²

4. *Availability of victims:* Factors include the mobility of both the aggressor and victim, population size, and population density. The size of the potential victim pool ranges from the person committing matricide to the randomly violent, impulsive individual who selects his victims only on the basis of physical proximity.

5. *Availability of weapons:* Implicit in this factor is the individual's ability to use a particular weapon. Availability influences the frequency, severity, and lethality of the violent act.²³

6. *Availability of alcohol:* There is a curvilinear relationship between consumption of alcohol and violence. High enough blood alcohol levels will result in a loss of voluntary muscular control and diminish the potential for actual physical harm to the victim.

The anchoring of the individual patient within this actuarial matrix provides a point of reference for the further analysis of his immediate interpersonal and intrapsychic reality. The predictive process is enhanced by the mutual consideration of both normative group data and individual differences.

INTRAPSYCHIC FACTORS

The evaluation of threatening verbalized material during the psychotherapy hour begins and ends with the question, is this the expression of violent intent? Implicit within this question, although pragmatically irrelevant, is the distinction between conscious intent and unconscious motivation to act. Intrapsychic assessment can be structured in the following manner:

a. *Primary Process and Secondary Process*

The emergent verbalized material will have elements of both primary and secondary processes in its form and content. Primary process will be manifest in the patient's desire for immediate gratification of the aggressive thought, the presence of unmodulated and noticeably raw affect, indications of mild to severe formal thought disorder, transient loss of reality testing, or the presence of primitive defenses such as projection (manifest as paranoid ideation), denial, splitting, and projective identification. Secondary process will be indicated by a desire and capacity to delay or displace gratification of the aggressive thought, modulated and controlled affect, no formal thought disorder, the maintenance of adequate reality testing, or the presence of higher developmental level defenses, such as rationalization, intellectualization, repression, and sublimation.

The predominance of primary-process mechanisms in verbalized aggressive material during psychotherapy raises the probability of violent acting out.

b. *The Relationship of Thought and Affect to Impulse*

The verbalized material of the patient may or may not correlate with violent acting out. If there is a relationship, the central question is whether aggressive thoughts inhibit or disinhibit violent behavior. This is better assessed at an earlier point in psychotherapy when the patient's prior history of violence is being explored; that is, an analysis of the patient's thoughts and feelings before, during, and after previous violent acts. The unwillingness or inability to evoke memories of intrapsychic experience concurrent with violent behavior is a poor prognostic indicator, and suggests a borderline personality organization with either psychopathic or histrionic traits, respectively.²⁴ If the patient is able to evoke his thought-affect experience, its evaluation as a catalytic or noncatalytic event in relation to violence should be determined and clinically documented. The assessment of aggressive thought-affect complexes when actual violence did not occur is also critical to prevent systematic bias in the direction of overpredicting violence (false positives).

c. *The Observing Ego*

With the development or presence of an observing ego in psychotherapy the syntonetic or dystonic nature of the violent thoughts in relation to the patient's ego can be assessed. Syntonetic aggressive material will be experienced by the patient as enjoyable, pleasurable, or comforting; sado-masochistic themes may be apparent; the material, if spontaneous, may be consciously welcomed; further intent to conjure up such fantasies may appear; and there may be a striking absence of superego elements such as projection of the

causation of the fantasies onto others or higher-level defensive attempts to rationalize the thoughts. Syntonic violent fantasies raise the probability of violent acting out, particularly when they have disinhibited violence in the past.

Dystonic aggressive material will be affectively experienced as displeasurable, irritating, or frightening; the violent thoughts may be obsessional and therefore felt as intrusive; superego elements will be apparent, and on a primitive level may be acted out through self-mutilation or suicide attempts; higher level superego responses to violent fantasies will be manifest as guilt or shame; allusions to moral injunctions against such behavior may be genuinely and contritely stated to the therapist.

d. *Transference Implications*

Both the reality and transference meanings of the patient's aggressive thoughts should be assessed. Transference possibilities are innumerable, but two are most common. First, the patient may be making an implied threat toward the psychotherapist for a specific reason. Second, the patient may be asking the psychotherapist to take control of his behavior or person.

e. *Psychopathic Implications*

Psychodynamics that infer psychopathic character traits must be carefully considered in the predictive process, particularly if primary-process indications are minimal or absent and aggressive verbalizations are quite ego-syntonic. Kernberg²⁴ has recently called this condensation of grandiose and sadistic strivings "malignant narcissism" (p. 290). The absence of a diagnosis of antisocial personality disorder,²⁵ of course, does not rule out the presence of enduring psychopathic traits or transient psychopathic states. The following clinical questions are germane: Is the patient deceiving the psychotherapist? Is the patient attempting to frighten or intimidate the psychotherapist for instrumental gain or sadistic gratification? Is the patient attempting to exercise omnipotent control over the psychotherapy to ward off any transference feelings of persecution by the therapist? What is not being expressed by the patient, such as more accessible and realistic targets for his violent propensities? What is the mode of aggression that is foreseen by the psychotherapist?

The latter question is particularly relevant to the diagnosis of psychopathy and the prediction of dangerousness. A model of aggression²⁶ that is inherently useful and empirically supported in the literature postulates two forms of aggression—*affective* and *predatory*—with distinct neuroanatomical pathways. *Affective* aggression is the result of external and internal threatening stimuli that evoke an intense and patterned activation of the autonomic nervous system, accompanied by threatening vocalizations and attacking or defending postures. Many of the pathways are tied closely to the spinothal-

amic tract and the periaqueductal gray, and are linked to pain responses. Predatory aggression leads to the destruction of prey if successful. It involves minimal autonomic arousal, vocalization, and no elaborate behavioral rituals. There may be a selective suppression of other sensory input and species-specific killing patterns. Neuroanatomical pathways appear to project from the hypothalamus into the ventral midbrain tegmentum.²⁷ Predatory violence is the hallmark of the psychopathic character, and one predatory act in the history of an affectively violent patient still implicates the presence of psychopathic or deviantly narcissistic²⁴ character pathology.

The clinical identification of such psychodynamics during outpatient psychotherapy, ranging from conscious deception at best to a history of predatory violence at worst, should be heavily weighed in the predictive process. Psychopathy will usually correlate with several of the actuarial variables cited earlier, particularly past violent behavior²⁸ and alcohol or psychostimulant abuse.²⁹

f. *Neurological and Neuropsychological Factors*

There is a growing body of research linking neurological abnormalities to violent behavior.^{30,31} Although it is premature, and too reductionistic, to posit neurological dysfunction as a major correlate of violence in general, it is propitious to consider it as an important individual difference in the assessment of the intrapsychic experience of a specific patient.

The standard of care in predicting violent behavior in outpatient psychotherapy is a judicious consideration of the patient's intrapsychic experience and interpersonal behavior when anchored by knowledge of the actuarial correlates of violence. If the psychotherapist is reasonably certain that the patient will be violent, he or she will begin to discharge the duty to protect.

SUMMARY

I have presented a model for the prediction of violence in outpatient psychotherapy. Twelve individual and situational correlates provide anchoring points for the location of a particular patient within his or her demographic group. This allows comparison of the patient to other groups of individuals that have certain characteristics that correlate with violence. The psychotherapist can then clinically evaluate the patient according to his or her unique intrapsychic experience and interpersonal behavior along six dimensions: primary and secondary processes, the relationship of thought and affect to impulse, the observing ego, transference implications, psychopathic traits or states, and neuropsychological factors. A standard of care that blends normative data and individual differences will help the psychotherapist make violence predictions with both empirical confidence and clinical sensitivity.

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